MCES Quest

January 2010

Montgomery County Emergency Service, Inc.

Comprehensive Behavioral Health Services

Suicide Prevention and Criminal Justice

MCES started in 1974. Law enforcement played a role in our founding, and we have always had a close working relationship with all criminal justice agencies in Montgomery County. As part of our 35th anniversary observation we are dedicating this issue to a problem that we and our partners in law enforcement confront every day.

There are, on average, about 70 reported suicides per year in the county. There may be as many as 1500 suicide attempts each year, plus many more cases of suicidal ideation, expressions of suicidal intent, and open threats of suicide.

Our Crisis Intervention Specialist (CIS) training shows how to relate to a suicidal individual. This issue explains how they came to be that way, using a behavioral health perspective because police are often involved with suicide related to mental illness and substance abuse. Jail suicide, police officer suicide, and "suicide by cop" are also addressed.

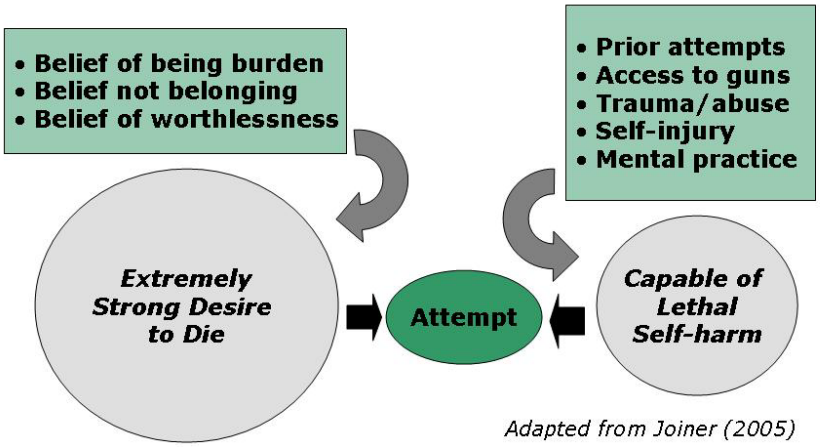
Why do people die by suicide?

In *Why People Die by Suicide* (2005), Thomas Joiner notes that two conditions must be present to overcome the instinct for self-preservation: (i) an intense desire to die caused by a lost sense of social belonging and the belief that one is a burden; and (ii) the capacity for lethal self-harm acquired through abuse, pain, past suicidality, and other factors. Both must be present for a suicide attempt. The ability to complete suicide is far less common than suicidal intent. It is only when the two coincide that a suicide attempt may occur.

Interpersonal relationship losses can lead to a person feeling that he or she doesn't belong. Depression may cause someone to feel that they are a burden. Both may, in some cases, lead to an intense desire to die, one of the prerequisites for suicidal behavior.

Risk rises with a past attempt, alcohol use, a history of trauma, violence, abuse, self-injury, severe physical or emotional pain, or access to firearms. These factors, plus mentally practicing suicide, lower inhibition to self-harm and increases "suicide competence."

Most suicides are not impulsive. Suicidal individuals become progressively more capable of taking their life over time. Suicide is the outcome of a process and a plan.



Adapted from Joiner (2005)

What Is the Terminology?

Lethal Means – The act or instrument by which suicide is completed (e.g., guns, pills, etc.)

Suicidal Behavior – Suicidal ideation, suicide attempt, or a suicide completion.

Suicidal Ideation – Occasional or persistent thoughts of self-harm or completing suicide.

Suicidality – Any level of suicidal behavior from ideation to making a plan to an attempt

Suicide Attempt –Deliberate self-harm intended to be fatal that does not result in death.

Suicide Completion – A suicide attempt that results in death.

Suicide Plan – An individual determination of when and how suicide will be completed.

Suicide Postvention –Aid following a suicide attempt or a suicide loss.

Suicide Trigger – A stressful event that precipitates suicidal ideation in an individual.

How is suicide connected to mental illness?

Most people who complete suicide do not have a known mental illness. The National Violent Death Reporting System found that just over 40% of the victims had a psychiatric diagnosis at the time of death in 2005.

Most of the suicidal people that police deal with have serious mental illness and/or substance abuse problems. They have frequent suicidal ideation, and often experience suicidal intent. Some use suicide threats or low lethality attempts to deal with problems. They have few supports. Police are their safety net.

Mental illness has a strong link to suicide. About 5% of all people with mental illness do complete suicide (compared to less than 1% in the general population).

A desire to die may come with major depression, bipolar disorder, and schizophrenia. There is a high incidence of suicide with these disorders, but the capability for lethal self-harm does not come from mental illness alone.

Mental illness contributes to suicidality, but it is not a cause. It is a strong risk factor. It plays a big part in an individual acquiring other risk factors for suicide. Individuals with mental illness will usually have many problems that bear on their risk for suicide.

What about alcohol, drugs, and suicide?

Suicide is a leading cause of death among people who abuse substances. Alcohol and drug use disorders elevate risk for suicide ideation and attempts, which in turn drives up the odds of suicide.

- Those treated for alcohol dependence have 10 times higher risk of completing suicide.
- IV drug users are at 14 times higher risk of eventually completing suicide.
- Misuse of alcohol and street or prescription drugs yields 40 times greater risk of suicide.

Here are some aspects of alcohol and drug use that increase suicide risk.

- Mood instability, chronic hopelessness, impulsiveness.
- Poor self image, low self-esteem, loss of support system.
- Less likelihood of seeking help and intervention.
- Low sensitivity to negative consequences of actions.
- Little future orientation, “all or nothing thinking.”
- Exposure to violence, suicide loss, and other trauma.
- Criminal justice system contact and incarcerations.

Alcohol is involved in 20%-25% of all US suicides. An estimated 7% of alcohol dependent persons complete suicide.

What about suicide attempts?

An attempted suicide is the closest thing to a completed suicide.

- Intent to die, a doable plan, lethal means are present.
- Ability to lethally harm one's self was present.
- Warning signs were missed or ignored.

An attempt is highly traumatizing and many who have made an attempt experience post-traumatic stress disorder. Attempters may be re-traumatized if they again become suicidal.

Attempts create a life-long risk of suicide. About half of all suicide victims made at least one previous attempt. Greatest risk is within three months of the first attempt.

Alcohol users are at high risk of attempting suicide. The majority of attempters have used alcohol and half used alcohol just prior to attempt

There are more attempts among young people than adults and elders. Teen girls make more attempts than boys. Greater access to guns by adults and elders turns attempts to completions.

What about people who are always talking about suicide?

One of the most frustrating suicidal behaviors is when someone frequently threatens suicide or voices suicide intent. This is called "chronic suicidality" because of its repetitive nature and because it tends to go on for a long time.

The threats are usually contingent, e.g., "I'll kill myself if I don't get into rehab tonight," and may be manipulative. The threats can be dramatic or involve "setting terms." Such threats may be used to evade pending legal issues or to get shelter. Most involve a low intent to die and are vague.

Chronically suicidal persons are troubled by hopelessness and a need for control. This behavior is a coping strategy. They learn that suicide threats get attention, open doors, and compel others to care.

Overtime "chronic suiciders" may raise their threat level while getting more used to the idea of suicide. Repeated threats can increase suicide capability by lowering resistance to self-harm. Family and friends may not see that a change in risk level that has taken place. They may be less vigilant because of many "false alarms." "Chronic suiciders" can become suicide victims.

What is it like to experience a suicide?

Every suicide leaves six to eight people severely affected. Losing someone you love to suicide is utterly devastating. It is the worst loss of all.

Suicide loss upsets well-being, overrides coping mechanisms, and causes extreme distress. It brings on anxiety, depression, and panic, and has significant affective and behavioral consequences. It generates severe emotional pain and shatters feelings of control and safety.

Guilt may arise because the bereaved individual didn't see the danger or do anything to prevent the death. There may be anger towards the deceased. Suicide leaves a numbing and disabling shock because of the suddenness, unexpectedness, and violence involved. Fear, stigma, shame, and a lack of understanding may spur denial and helplessness.

Other factors can worsen the effects of a suicide. These include witnessing the suicide or finding the body, losing a child (at any age), being estranged from the victim, being away from where the death occurred, or being unable to attend the services.

Police involvement after a suicide can be distressing. Investigating every unnatural death as a homicide does not mean there can be no sensitivity to those at the scene. Similarly, acts like cutting down a body, throwing away pills, or starting to clean up must be seen in the context of the family's loss.

Frequent dealings with individuals who repeatedly threaten suicide or who make low lethality attempts may induce callousness towards all suicidal persons. This can have tragic consequences.

What are the risk factors for suicide?

Risk factors are variables strongly associated with suicide. Some risk factors (e.g., a past attempt or abuse) are permanent; others may be eliminated or reduced (e.g., removing firearms); and some may be managed (e.g., maintaining treatment).

Several conditions act as short-term risk factors: a sense of being a burden, helplessness, not belonging, instability, agitation, panic, anxiety, relational conflict, aggression, and violence. Impulsivity is linked to suicide risk because it makes it more likely that individuals will take on behaviors that increase the capability for lethal self-harm.

A past suicide attempt and alcohol use are strong risk factors. Some risk factors are life-long (e.g., trauma). Others facilitate attempts (e.g., alcohol use). Risk factors may cluster and interact. Generally speaking, more risk factors means more risk, but serious risk may be present in individuals with only a few known risk factors.

Other risk factors are:

• White male, Native American, veteran, Latina teen	• Family history of suicide, mental illness
• Poor coping, problem-solving, help-seeking	• Firearms in the home or otherwise accessible
• Intimate partner conflict, social isolation	• Legal charges, financial problems, incarceration
• Family violence, including physical or sexual abuse	• Physical illness and disability

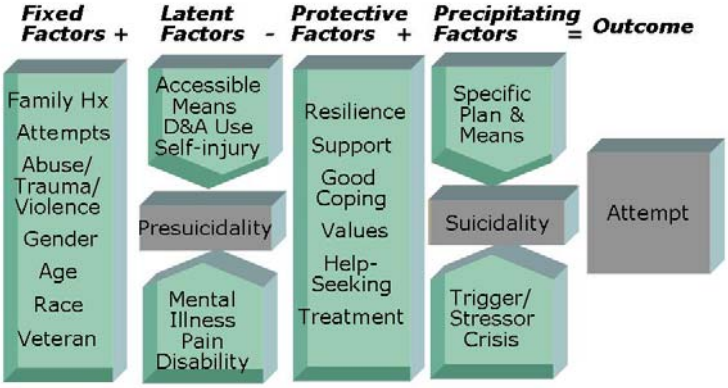
Gay men, lesbians, and bisexual persons have higher rates of suicidal ideation, attempts, and completions than do heterosexual individuals.

What are the protective factors?

Protective factors offset risk factors of suicide. They contribute to feeling that life is worth living. The main protective factors for suicide are:

- Strong family, social ties, support sources.
- Optimism, resilience, emotional stability.
- Strong self-esteem, sense of self-worth.
- Good problem-solving and coping skills.
- Religiosity, spirituality.
- No firearms, alcohol or drug use.

Female gender and being non-white (Afro-American, Asian, Latino) are protective factors. Social support is a strong protective factor. The role of protective factors is shown in this diagram.



What are the danger signs and warning signs?

Danger signs are early indications of risk that should result in immediate contact with a health care provider.

Danger Signs

- Hopelessness
  "There's no way that I can make things better"
- Feeling trapped
  "I feel like there's no way out"
- Withdrawal from family or friends
- Anxiety, agitation, sleep problems (too much or too little)
- Dramatic mood changes
- No reason for living
  "Life isn't worth living"
- Reckless, risk-taking behavior

Warning signs are indicators of heightened suicide risk in the near-term (i.e., minutes, hours, days), and should trigger an immediate crisis intervention response.

Warning Signs

- Threatening to hurt or kill self
- Looking for ways to kill self
- Talking or writing about death, dying, or suicide

These are the most specific warning signs but there are others. Among them are:

- Citing a doable plan specifying how and when
- Giving away valued possessions (e.g., pets, CDs, books, tools, money, etc.)
- Making unexpected visits or calls to family members or friends
- Settling up affairs, making a will, dictating funeral arrangements

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How is suicide risk identified?

Screening is the basic technique for finding suicide risk. It involves simple, direct questioning. It does not evaluate or estimate an individual's level of suicide risk.

Some screening questions are:

- Have you ever thought about killing yourself?
  When?
- Are you thinking about it right now?
  If so, for how long?
- Do you have a plan on how to kill yourself?
  What is it?
- Do you have the means to carry out this plan?
- Have you tried out or rehearsed your plan?
  When? How often?
- Have you ever attempted suicide?
  When? How?

Based on the responses, an individual may be referred for a suicide risk assessment to identify treatable risk factors and to assure safety. An assessment is a clinical judgment to determine the degree of suicide risk. It is performed by a psychiatrist. It is based on an interview, observation, and other sources. It weighs both risk and protective factors.

Assessments cannot predict when a suicide may occur. Assessments must be ongoing because of the transience and volatility of suicide risk.

What are some of the myths of suicide?

Egregious beliefs about suicide abound. Here are some of the most common.

Misconception	Reality
Those who talk about suicide are "all talk" and won't complete suicide.	Talking about suicide is a warning sign and many who talk about it do complete suicide.
Those who have attempted suicide are single-mindedly dedicated to dying.	Suicidal people only want to be free of hurt and would go on if their pain would end.
Asking someone if they are thinking about suicide will only give them "ideas."	Asking is often the only way to determine risk and to show that you care.
Those who have attempted suicide are at very low risk of actually completing suicide.	Many suicide victims have made one or more previous suicide attempt.
If someone says that he is suicidal, telling him to "do it" will snap him out of it.	This may be the single worst thing that anyone can do. Never say "go ahead and do it."
Surviving a suicide attempt shows that the individual wasn't really serious about dying.	An attempt always involves the intent to die.
Most suicides occur with little or no warning.	Most people do show signs of suicide.
Improvement following a suicidal crisis means that the suicidal risk is over.	Many suicides occur following 'improvement." Suicidal feelings can return.
Non-fatal acts are only attention-getting behaviors or only attempts to be manipulative.	For some, suicidal behaviors are pleas for help. It is always better to err on the side of safety.
Once a person is suicidal, he or she will be suicidal forever.	Most suicidal crises are temporary and will pass if help is provided.

What role does trauma play in suicidality and suicide loss?

Trauma is a reaction to a harmful or life-threatening occurrence that is outside the range of normal experience and beyond control. Trauma's impact is pervasive, life changing, and enduring.

Trauma can result from victimization, injury, exposure to homicide, suicide, and other fatalities, serious accidents, and interpersonal losses, as well as disasters. ***Suicide attempts and losing a family member or close friend to suicide are extremely traumatic incidents.***

Effects of trauma that may increase risk include anxiety, depression, hopelessness, hostility, impulsiveness, substance abuse, self-destructive behavior, humiliation, shame, guilt, lessened self-esteem, and feeling ineffective, distrustful, or threatened. Those affected by trauma feel less connected or that they are burdens to families and friends.

Trauma sufferers at risk of suicide include self-injurers, those making frequent threats or non-fatal attempts, veterans and members of the military, physicians, emergency responders, sexual assault victims, individuals with brain injury, and disabled persons.

What about police suicides?

Suicide among police officers claims more lives than deaths in the line of duty.

These factors are involved: access to firearms; marital problems; alcohol use; and job stresses such as exposure to trauma and death, including suicide; difficult administrative policies, changing assignments, and long and irregular work hours.

Police are members of a high risk group, adult males, with access to firearms, another very serious risk factor.

The nature of police work coupled with firearms familiarity creates the capability for lethal self-harm. Depression tied to personal or work problems is fertile ground for development of the desire to die. Risk is enhanced by veteran status, alcohol use, traumatic experiences and a don't-admit-weakness occupational culture.

Female officers complete suicide less frequently than males but more often than women in general. Female officers can acquire the same capability for lethal self-harm as male officers. They also have the same problematic lifestyle and job-related stress issues.

Correctional officers have an equal, if not higher, risk of suicide as police. One study found that correctional officers have a risk of suicide 39% higher than the general community. Their ranks are made up predominantly of adult males who carry guns and work in an extremely stress inducing setting.

The US military, especially the US Air Force have developed effective suicide prevention strategies that may be directly applicable to police and other cohesive, chain-of-command oriented communities in the criminal justice system. Key elements of these strategies are:

- Promote help-seeking and use of mental health services.
- Broad acceptance that suicide is preventable.
- "No acceptable losses" philosophy of prevention.
- Suicide prevention education to all personnel.
- Destigmatizing behavioral health
- Encouraging/protecting those using mental health care.

How can police suicide be prevented?

Officers must know that asking for help will not result in any punitive action; that all information will be confidential, and resources are available to help them deal with their problems.

All personnel, including civilian and management, must know the signs of depression and suicide and what to do if they see them in themselves or in co-workers. Some further options are:

- ***Professional Counseling*** - Sources independent of the department or municipality may be most practical. Referrals to local behavioral health agencies should be available.
- ***Police Chaplains and Outside Clergy*** - This assures confidentiality, and avoids stigma. Clergy of various religions should be available.
- ***Peer Counselors*** - These are officers trained to provide support and make referrals. This can involve access to personnel in other departments. Peer counselors are usually volunteers.
- ***"No Fault" Firearms Securing Policy*** - Officers should be able to discretely surrender duty and personal firearms for temporary safekeeping without penalty or the implication of discipline.
- ***Stress Education*** – Stress recognition, techniques of physical exercise, proper nutrition, interpersonal communication methods, and coping styles.
- ***Family Education*** – Orientation to police functions, problems in police marriages, methods for effective communication, and the family as a source of support.
- ***Pre-retirement Counseling*** – Officers should be prepared for the transition to life away from "the job" well before departure from active duty.

Provisions should also be made for the aftermath of a departmental suicide. It is preferable to have an officer who has experienced a colleague's suicide speak to those who wish such help.

What are some crisis intervention basics with a suicidal individual?

A suicidal person may not ask for help, but that doesn't mean that help isn't wanted. Most suicidal people just want to stop hurting.

Here are some "Don'ts" and "Do's" that apply to anyone who might be suicidal.

Don'ts

- Do not leave him/her alone or let him/her go off alone.
- Do not be judgmental.
- Do not argue, debate, analyze, or moralize.
- Do not try to cheer him/her up.
- Do not try to shock or challenge (e.g., saying "Oh, go ahead and do it if you want to!").
- Do not accept. "I'm okay now." (Nobody recovers immediately from suicidality.)

Do's

- Ask if he/she is thinking about suicide.
- If yes, go on to screen for risk.
- Take the intent or threat very seriously.
- L-I-S-T-E-N !!!
- Show that you care and say it.

If there is no apparent immediate danger (and no lethal means in view):

- Tell her/him that help is available and you can see that he/she gets it.
- Let her/him have some space.
- Try to get her/him to another area in case there are hidden means.
- Remove car keys, if possible.

If there is apparent immediate danger - ACT:

- Say that you are taking them to get help.
- See that the person receives a psychiatric evaluation.

What about hospitalization and suicide?

Imminent risk of suicide is a reason for an involuntary psychiatric evaluation under the PA "Mental Health Procedures Act":

> ***Clear and present danger to self shall be shown by establishing that within the past 30 days... the person has attempted suicide and that there is the reasonable probability of suicide unless adequate treatment is afforded under this act. …A clear and present danger may be demonstrated by the proof that the person has made threats to commit suicide and has committed acts which are in furtherance of the threat to commit suicide.***

An involuntary evaluation is indicated when strong threats or other expressions of intent are present, a doable plan and/or lethal means are available, and an attempt or other serious suicidal behavior was carried out. In PA, officers may arrange an involuntary evaluation by submitting a written statement of personally witnessed behavior ("302") to a County Mental Health Delegate.

Based upon the psychiatric examination, inpatient care may be ordered for those with suicidal ideation with a specific plan with high lethality (e.g. plans to shoot self and has a gun), high suicidal intent (e.g. "I can't take this any longer, I just want to die."), a past history of attempts or severe anxiety, agitation or perturbation, and the absence of community supports.

Hospitalization provides safety, crisis stabilization, comprehensive assessment, and development of an aftercare plan.

"Suicide by Cop" is a new phrase for an old phenomenon that may go back centuries. Its occurrence was noted in a seminal study of homicides in Philadelphia by Marvin Wolfgang in the 1950s. He used the term "victim-precipitated homicide" and identified many cases in which police were compelled to respond lethally to persons seemingly seeking to die.

What about "Suicide-By-Cop"?

"Suicide By Cop" (SBC) occurs when an individual using lethal means, or what seems to be such means, threatens an officer or others to provoke the officer to employ deadly force in self-defense or to protect others. SBC may account for 10% to 50% of all police shootings.

A recent study of several hundred SBC cases of in the US and Canada found:

- 80% of the victims possessed a weapon; 60% of these were firearms
- 50% of the victims discharged the firearm at police
- 19% employed a simulated weapon possession in making their threats

A disturbing finding was that SBC seems to be increasing, a trend noted by other studies.

In an SBC there is a desire to die and a doable plan likely to result in death. The plan may be a 9-1-1 call threatening harm to self or others, or another ploy for drawing police as a prelude to some activity that will compel a deadly response by the police.

SBC attempters and completers may show danger and warning signs. They have risk factors. Some triggers are marital problems, job loss, legal issues and so forth. It is preventable and crisis intervention can be effective. Police must manage and contain the situation as best they can but remember that it is their job to protect themselves and others when necessary.

What about suicide in jails?

The US jail suicide rate is more than four times higher than that of the general population. Jails are high risk environments for suicide. Smaller facilities pose the greatest risk.

Most jail suicides are by hanging, which may be fatal in five to six minutes. Prisoners may hang themselves from beds, clothing hooks, plumbing fixtures, cell doors, ventilation grates, windows, smoke detectors, or anything else available.

Jails may hold individuals with serious mental illness, individuals in withdrawal from alcohol or drugs, and others traumatized by incarceration. These situational risk factors are in addition to those already present in many of those in custody.

A US Department of Justice report gave this overview of jail suicides:

- Suicides account for almost one-third of jail deaths.
- Male prisoners were 56% more likely to complete suicide than females.
- White inmates accounted for nearly three-quarters of all jail suicides.
- Violent offenders completed suicide at nearly triple the rate of nonviolent offenders.
- Nearly half of jail suicides occurred in the first week. Almost a quarter took place on the date of admission or the following day.

According to Linsay Hayes, an expert on jail and prison suicide, officers must be aware that:

> *…suicide prevention begins at arrest. What an individual says and how they behave during arrest, transportation to the jail, and at booking are crucial in detecting suicidal behavior. Arresting officers should pay close attention to the arrestee during this time…*

Transporting officers must share their observations with those taking custody of the prisoner.

What about suicide in state prisons?

State prisons have a greater concentration of violent offenders, a high risk group, the inmate population turns over less frequently and the terms are longer. Most prison suicides in the US occur after the first year of imprisonment rather than close to arrival (parole violators are the exception).

The US Department of Justice reported that suicides made up 6% of inmate deaths in state correctional facilities in 2000-2001. From 2002-2005 the Pennsylvania Department of Corrections reported 26 suicides, just over 6 per year, less than 3% of all state inmate deaths. According to the PA DOC:

- 17% of inmates have mental illness but account for 60% of suicides.
- Males make up 98% of suicides; whites 50%.
- 40% of suicides are “Lifers” or long-term prisoners.
- 70% of attempters/completers had substance abuse histories.

High risk periods are when waiting for trial, sentencing, or release, after sentencing, "special days" (e.g., holidays, birthdays, anniversaries of weddings, the offense, imprisonment, etc.), and the receipt of "bad news" (e.g., a death, divorce proceedings, further legal difficulties, etc.). Risk also rises if there has been a recent suicide attempt in the facility.

What about probationers and parolees?

Probationers may experience marital problems, loss of employment and social associations, and community reproach. They may feel isolated and shamed, and that they are burdens.

Parolees take risk factors acquired in prison with them, which may become evident during the community reintegration process. Pre-prison risk factors such as substance abuse may resurface.

Risk screening should be part of community supervision, particularly those with mental health and/or substance use disorders who should be screened on an ongoing basis. Risk should be monitored at adverse life events or a move to more restrictive status.

Offenders returned to prison are at high risk. They may panic if they feel that future prospects for parole are diminished. Some have used substances prior to their readmission. Among nonviolent offenders, probation/parole violators have the highest suicide rates

Released inmates may face serious problems re-integrating into families, employment, and housing. Suicide has been found to be the fourth leading cause of death among re-entrants.

What about veterans and suicide?

In 2007, the VA Office of Inspector General reported that 5000 veterans complete suicide yearly and that physically and/or emotionally disabled vets are at highest risk. A national study also published in 2007 found that white veterans are twice as likely to complete suicide than non-veterans, 84% of completed with firearms, and 77% were age 45 or over.

A study of Iraq and Afghanistan veterans entering VA health care in 2002-2008 found many had received mental health diagnoses, including PTSD and depression. These disorders may involve a desire to die, social isolation, and feelings of being a burden. Returning veterans often feel out of place in the community. Military training, even in the absence of combat, provides a facility with firearms and the capacity for lethal self-harm.

Veteran status and high suicide risk have serious implications for the criminal justice system. Many police and correctional officers served in the military. Veteran suicide falls in the same age range as police suicide. The prevalence of alcohol abuse, traumatic brain injury, and other conditions put veterans at risk of criminal justice system contact. Those entering the criminal justice system should be screened for military service experience.

Guidelines for suicide death notification

Informing an individual or family of a suicide loss may be the most trying of police duties. Hearing of the loss is a critical point for most survivors. It can start their recovery or negatively affect them for years. Here are some guidelines:

- Keep the victim's name off the radio to keep media or curiosity seekers away from the home.
- Provide notification as soon as all facts are verified.
- Always go in person to demonstrate compassion and respect.
- Two people should go for more support and to manage any unexpected situation. It also allows separate discussions with those in the household, if necessary.
- Include a uniformed officer. The other member may be a non-uniformed officer, a Chaplain, a crisis or victim's service worker, or an EMT. Male/female teams are helpful.
- Start with something like "I have some very bad news for you." Speak slowly and give the available details. Always refer to the victim by name.
- Use wording like "he took his life" or "completed suicide." Make it clear from the outset.
- If the family denies that it was a suicide, don't argue. Refer them to the ME or Coroner.
- Try to not leave the family alone after notification (wait for clergy, friend, etc. to arrive).
- Answer questions about what happens next or give sources of assistance. Ask if there is anyone that you can call for them.
- Offer (but don't push) information about Survivors of Suicide or other grief resources.
- Stay long enough to show support. Close by saying: "We're very sorry that this happened."

This issue was written by Tony Salvatore, MA, who chairs MCES' s Suicide Prevention Committee and facilitated the Southeastern Pennsylvania Mental Health Suicide Prevention Work Group. Tony serves on the Pennsylvania Adult/ Older Adult Suicide Prevention Task Force and contributes to many county-level suicide prevention activities. This issue benefited from suggestions from several members of the criminal justice system in Montgomery County, PA and elsewhere. Comments or questions on this material may be directed to tsalvatore@mces.org or to 610-279-6100.

More information about suicide prevention is available at www.mces.org/suicideprevent.html

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