Research Trends

Preventing Suicide in Prisons, Part I

Recommendations from the International Association for Suicide Prevention Task Force on Suicide in Prisons

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Abstract. In 2000 the Department of Mental Health of the World Health Organization (WHO) published a guide named *Preventing Suicide. A Resource for Prison Officers* as part of the WHO worldwide initiative for the prevention of suicide. In 2007 there are new epidemiological data on prison suicide, a more detailed discussion of risk factors accounting for the generally higher rate of suicide in correctional settings in comparison to the general population, and several strategies for developing screening instruments. As a first step, this paper presents an update of the WHO guide by the Task Force on Suicide in Prisons, created by the International Association for Suicide Prevention. A second paper, by the same Task Force, will present some international comparisons of suicide prevention services in correctional facilities.

Keywords: prison, suicide, prevention, inmate, suicide attempt

In 2000 the Department of Mental Health of the World Health Organization (WHO) published a guide named *Preventing Suicide. A Resource for Prison Officers* as part of the WHO worldwide initiative for the prevention of suicide. This paper presents an update of the WHO guide by the new Task Force on Suicide in Prisons, created by the International Association for Suicide Prevention.

Suicide is often the single most common cause of death in correctional settings. Jails, prisons, and penitentiaries are responsible for protecting the health and safety of their inmate populations, and the failure to do so can be open to legal challenge. Further fueled by media interest, a suicide in a correctional facility can easily escalate into a political scandal. Moreover, suicidal behavior by custodial inmates means a stressful event for officers and for other prisoners. Therefore, the provision of adequate suicide prevention and intervention services is both beneficial to the prisoners in custody, as well as to the institution in which the services are offered.

Correctional settings differ with respect to inmate populations and local conditions: short-term detainees, pretrial offenders, sentenced prisoners, harsh sentencing practices, overcrowding (Huey & McNulty, 2005), possibility of purposeful activity (Leese, Thomas, & Snow, 2006), time spent locked up, sanitation, broad sociocultural conditions, prevalence of HIV/AIDS, levels of stress (Liebling, 2006), and access to basic health or mental health services. Each of these factors may influence suicide rates in different ways.

Inmates Are a High-Risk Group

As a group, inmates have higher suicide rates than their community counterparts (Snow, Paton, Oram, & Teers, 2002), and there is some evidence that rates are increasing despite sometimes decreasing numbers of prisoners (Fruehwald & Frottier, 2005). There is not just more suicidality within the institutions but more people who are

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imprisoned show suicidal thoughts and behavior throughout the course of their lives. Accordingly, pretrial detainees have a suicide attempt rate of about 7.5, and sentenced prisoners have a rate of almost 6 times the rate of males at home (Jenkins et al., 2005). These facts also indicate a basic problem with regard to the causes of suicide in custody: people who break the law inherently have many risk factors for suicidal behavior (they "import" risk), and the suicide rate is higher within the offender group even after their release from prison (Pratt, Piper, Appleby, Webb, & Shaw, 2006). That does not mean the correctional services have no responsibility for the suicide of offenders; on the contrary, these vulnerable offenders should be treated while they can be reached inside the prison. In addition, being imprisoned is in itself another stressful event even for healthy inmates (as it deprives the person of important resources).

Suicide Prevention in Correctional Settings

A number of jails and prisons have undertaken comprehensive suicide prevention programs and in some countries national standards and guidelines for suicide prevention in correctional settings have been established. Significant reductions in suicides and suicide attempts can be accomplished once comprehensive prevention programs have been implemented (Cox & Morschauser, 1997; Felthous, 1994; Gallagher & Dobrin, 2005; White & Schimmel, 1995). While the specifics of these programs differ in response to local resources and inmate needs, a number of activities and elements are common among them, which could form the basis for an understanding of best practices in this area.

Development of Suicide Profiles

A first important step toward reducing inmate suicide is to develop suicide profiles that can be used to target high-risk groups and situations. For example, studies show that pretrial inmates differ from sentenced prisoners with respect to certain key risk-factors for suicide. However, in some locations, the populations represented by these profiles will be mixed in a single facility (Paton & Jenkins, 2005).

Profile 1: Pretrial Inmates

Pretrial inmates who commit suicide in custody are generally male, young (20–25 years), unmarried, and first-time offenders who have been arrested for minor, usually substance-related, offenses. They are typically intoxicated at the time of their arrest and commit suicide at an early stage of their confinement (Shaw, Baker, Hunt, Moloney, & Appleby, 2004), often within the first few hours (because of sudden isolation, shock of imprisonment, lack of information, insecurity about the future). A second period of risk for pretrial inmates is near the time of a court appearance, especially when a guilty verdict and harsh sentencing may be anticipated. A large number of all jail suicides occurred within 3 days of a court appearance (Marcus & Alcabes, 1993). Moreover, after 60 days of confinement a certain kind of emotional exhaustion was observed, which could be called a "burn-out" (Frottier et al., 2002).

Profile 2: Sentenced Prisoners

Compared to pretrial inmates, those who commit suicide in prison are generally older (30–35 years), violent offenders who commit suicide after spending considerable time in custody (often 4 or 5 years). Their suicide may be precipitated by a conflict within the institution with other inmates or with the administration, a family conflict or breakup, or a negative legal disposition such as loss of an appeal or the denial of parole. Incarceration may represent a loss of freedom, loss of family and social support, fear of the unknown, fear of physical or sexual violence, uncertainty and fear about the future, embarrassment and guilt over the offense, and fear or stress related to poor environmental conditions. Over time, incarceration brings added stress such as conflicts within the institution, victimization, legal frustration, and physical and emotional breakdown. Accordingly, the suicide rate of long-term inmates seems to increase with length of stay (Frottier et al., 2002). So called "lifers" seem to be at a particularly high risk (Borrill, 2002; Liebling, 2006).

Risk Factors Common to Jails and Prisons

In addition to the specific profiles identified above, remanded and sentenced suicidal inmates share a number of common characteristics that can be used to help guide suicide prevention programs.

Situational Factors

Suicides tend to occur by hanging, when the victims are being held in isolation or segregation cells, and during times when staffing is the lowest, such as nights or weekends. There are many suicides when prisoners are alone even if they are technically sharing a cell (Hayes, 2006; Liebling, 2006). There is also a strong association between inmate suicide and housing assignments. An inmate placed in and unable to cope with administrative segregation or

other similar specialized housing assignments (especially if single celled) may also be at increased risk of suicide. Such housing units usually involve an inmate being locked in a cell for 23 h per day for significant periods of time (Metzner & Hayes, 2006).

Psychosocial Factors

Poor social and family support, prior suicidal behavior (especially within the previous 1 or 2 years), and a history of psychiatric illness and emotional problems are common among inmate suicides. Moreover, suicidal inmates often experience bullying (Blaauw, Winkel, & Kerkhof, 2001), recent inmate-to-inmate conflicts, disciplinary infractions, or adverse information (Way, Miraglia, Sawyer, Beer, & Eddy, 2005). Whatever individual stressors and vulnerabilities may be operating, a final common pathway leading an inmate to suicide seems to be feelings of hopelessness, a narrowing of future prospects, and a loss of options for coping. Therefore, individuals who voice feelings of hopelessness or admit to suicidal intent or suicidal plans should be considered at high risk of suicide.

Women

Although the vast majority of suicides that occur in correctional settings are committed by men (because the vast majority of inmates are men), women in custody are also at high risk of suicide (Paton & Jenkins, 2005). Female pretrial inmates attempt suicide much more often than their female counterparts in the community (Paton & Jenkins, 2005; Holley, Arboleda-Florez, & Love, 1995) and than their incarcerated male counterparts. Women seem to have higher rates of completed suicide than men (Mackenzie, Oram, & Borrill, 2003); they also have high rates of serious mental illness (Fazel & Danesh, 2002). While more specific risk profiles of pretrial and sentenced women are still lacking, women with poor social and family supports, prior suicidal behavior, a history of psychiatric illness, and emotional problems should be targeted for suicide prevention programs.

Juveniles

The experience of incarceration may be particularly difficult for juvenile offenders who are separated from their families and friends. Distressed young prisoners are especially dependent on supportive relationships with the staff (Liebling, 2006). Therefore, separating and isolating young prisoners may lead to additional risk for suicidal actions, which can happen at any time of their confinement (Hayes, 2005). Juveniles who are placed in adult correctional facilities should be considered to be at particularly high risk of suicide (Winkler, 1992).

Profiles Can Change over Time

Profiles may be useful for identifying potentially high-risk groups that may need further screening and intervention. As successful suicide prevention programs are implemented, high-risk profiles may change over time (Frottier et al., 2002). Similarly, unique local conditions may alter the traditional profile of high-risk inmates in any particular correctional setting. Therefore, profiles should be used only as an aid to identify potentially high-risk groups and situations. Whenever possible, they should be developed to reflect local conditions, and regularly updated to capture any changes that may occur. Risk factors are not fool-proof predictors and should not be used without careful clinical assessment. When trying to screen at-risk prisoners, it is particularly confounding that the profile of those who will eventually suicide looks more "normal" than the profile of those who will attempt suicide (Daigle, 2004).

Key Components of a Suicide Prevention Program

All correctional facilities, regardless of size, should have a reasonable and comprehensive suicide prevention policy that addresses the key components noted in the following sections.

Training

Very few suicides are actually prevented by mental health, health care, or other professional staff because suicides are usually attempted in inmate housing units, and often during late evening hours or on weekends when they are generally outside the purview of program staff. These incidents, therefore, must be thwarted by correctional staff who have been trained in suicide prevention and have developed an intuitive sense about the inmates under their care. All correctional staff, as well as health care and mental health personnel, should receive initial suicide prevention training, followed by refresher training each year. In addition, all staff who have routine contact with inmates should receive standard first aid and cardiopulmonary resuscitation training, training in the use of various emergency equipment located in each housing unit and "mock drills" should be incorporated into both initial and refresher training for all staff (Hayes, 2006).

Intake Screening

Since suicides in jails may occur within the first hours of arrest and detention, suicide screening must occur almost immediately upon entrance into the institution to be effec-

tive. Every new inmate should be screened at intake and again if circumstances or conditions change. Often, there are insufficient numbers of mental health staff in correctional facilities. Therefore, there is a need for uncomplicated indicators, so that prison officers are able to complete the screening process (Dahle, Lohner, & Konrad, 2005). Generally, screening questionnaires should ask for static (historical demographic) as well as dynamic (situational and personal) variables (Mills & Kroner, 2005).

When resources permit, suicide screening may be undertaken within the context of an intake medical and psychological assessment conducted by relevant facility-based professionals. Should suicide screening be a responsibility of correctional staff they should be adequately trained (Kerkhof & Blaauw, in press) and aided by a suicide checklist (Arboleda-Florez & Holley, 1998; Blaauw, Kerkhof, & Hayes, 2005; Dahle et al., 2005; Daigle, Labelle, & Côté, 2006). For example, within the context of a correctional-setting assessment, affirmative answers to one or more of the following items could be used to indicate an increased risk of suicide and a need for further intervention:

- The inmate is intoxicated and/or has a history of substance abuse.
- The inmate expresses unusually high levels of shame, guilt, and worry over the arrest and incarceration.
- The inmate expresses hopelessness or fear about the future, or shows signs of depression, such as crying, lack of emotions, or lack of verbal expression.
- The inmate admits to current thoughts about suicide (Lekka, Argyriou, & Beratis, 2006) (it is not wrong to ask a person if he/she is currently thinking about suicide so as not to introduce a "foolish idea").
- The inmate has previously received treatment for a mental health problem.
- The inmate is currently suffering from a psychiatric condition or acting in an unusual or bizarre manner, such as having difficulty in focusing attention, talking to oneself, or hearing voices.
- The inmate has made one or more previous suicide attempts and/or admits that suicide is currently an acceptable option.
- The inmate admits to current suicide planning; contacts to family and neighboring inmates should also be taken into consideration (Holley et al., 1995).
- The inmate admits or appears to have few internal and/or external supportive resources.
- The arresting/transporting officer's believes that the inmate is at risk for suicide.
- Facility records indicate that the inmate was assessed as a suicide risk during a prior confinement.

Suicide checklists are an important part of a comprehensive suicide prevention program for a number of reasons:

- They provide the intake staff with structured questions on areas of concern that need to be covered.
- When there is little time available to conduct an in-depth evaluation, they act as a memory aid for busy intake staff.
- They facilitate communication between officers and health care and mental health staff.
- They provide legal documentation that an inmate was screened for suicidal risk upon entrance into the facility and again, as conditions changed.

Once an increased risk of suicide has been identified, it should be noted in the individual's file so that the information is passed on to staff on a new shift or staff at another agency or facility. Finally, suicide checklists may be used at any time during an inmate's confinement to identify suicide risk and need for further intervention by a wide variety of adequately trained correctional and mental health staff. In case of a positive screening, a mental health professional must see the inmate within a very short term (Dahle et al., 2005; Daigle et al., 2006). Unfortunately, there is only limited information about potential protective factors (Bonner, 2000) – this knowledge could facilitate risk assessment and make it more precise.

Post-Intake Observation

Because many jail and prison suicides occur after the initial period of incarceration (some after many years), it is not sufficient to screen inmates only at the time of intake, but subsequently, at regular intervals. To be effective, suicide prevention must involve on-going observation. All staff must be trained to be vigilant during the inmate's entire period of incarceration. Toward this end, staff may look for indications of a an inmate's possible suicidality during the following periods:

- Routine security checks to watch for indications of: suicidal intent or mental illness such as crying, insomnia, sluggishness, extreme restlessness, or pacing up and down; sudden change in mood, eating habits, or sleep; divestment such as giving away personal possessions; loss of interest in activities or relationships; repeated refusal to take medication or a request for an increased dose of medication.
- Conversations with an inmate around the time of court hearings or other critical periods (such as the death of a family member or divorce) to identify feelings of hopelessness or suicidal intent.
- Supervision of visits with family or friends to identify disputes or problems that emerge during the visit. Families should be encouraged to notify staff if they fear that their loved one may harbor suicidal wishes.
- Because of the disproportionate number of suicides that occur in segregation, inmates should receive brief mental-status exams upon entry into these special housing units to ensure that concerns for mental illness and/or suicide risk do not contraindicate such placement.
- Officers need to cultivate the type of relationship with

the prisoner that will facilitate that prisoner disclosing his or her distress and despair if and when it arises.

Management Following Screening

Following screening, adequate and appropriate monitoring and follow-up is necessary. Therefore, a management process must be established with clearly articulated policies and procedures outlining responsibilities for placement, continued supervision, and mental health intervention for inmates who are considered to be at high risk of suicide.

Monitoring

Adequate monitoring of suicidal inmates is crucial, particularly during the night shift (when staffing is low) and in facilities where staff may not be permanently assigned to an area (such as police lockups). The level of monitoring should match the level of risk. Inmates judged to be actively suicidal require constant supervision. Inmates who have raised staff suspicions about suicide but who do not admit to being actively suicidal, may not require constant supervision but will need to be observed more frequently (e.g., close observation at between 5 and 15 minute staggered intervals). However, considering a suicide attempt by hanging can take just 3 minutes to result in permanent brain damage, and 5–7 minutes to be lethal, rounds even at a distance of every 10 to 15 minutes might be insufficient for an acutely suicidal inmate. Uninterrupted supervision and human contact should be provided while keeping an inmate in segregation. Individual counseling may be a chance for self-expression for the inmate and a possibility for clinical monitoring (Daniel & Fleming, 2006). Prisoners at risk should not be left alone, but observation and companionship should be provided (Kerkhof & Blaauw, in press; Snow et al., 2002).

Communication

Certain behavioral signs exhibited by the inmate may be indicative of suicidal behavior and, if detected and communicated to others, may prevent a suicide. The scene of arrest is often the most volatile and emotional time for the arrestee. Arresting officers should pay close attention to the arrestee during this time because suicidal behavior, anxiety, and/or hopelessness of the situation might be manifested. Prior behavior can also be confirmed by onlookers such as family and friends. Any pertinent information regarding the arrestee's well-being must be communicated by the arresting or transporting officer to facility staff (Hayes, 2006).

Because an inmate can become suicidal at any point during incarceration, correctional officers must maintain awareness, share information, and make appropriate referrals to mental health and medical staff. At a minimum, facility officials should ensure that appropriate staff are properly informed of the status of each inmate placed on suicide precautions. Multidisciplinary team meetings (to include correctional, health care, and mental health personnel) should occur on a regular basis to discuss the status of an inmate on suicide precautions. In addition, the authorization of suicide precautions for an inmate, any changes to those precautions, and observation of an inmate placed on suicide precautions should be documented on designated forms and distributed to appropriate staff. Such documentation should be both thorough and immediate, as well as disseminated to all staff who have contact with the inmate. Such documentation, if comprehensive and accurate, also protects the practitioner against professional negligence litigation (see Allan et al., 2006 for guidance on this matter).

Social Intervention

Social and physical isolation and lack of accessible supportive resources intensify the risk of suicide. Therefore, an important element in suicide prevention in correctional settings is meaningful social interaction (Kerkhof & Blaauw, in press). If segregation is the only available option for housing the suicidal inmate, constant observation should be provided (Way et al., 2005). Ideally the suicidal inmate should be housed in a dormitory or shared-cell setting. In some facilities, social support is provided through the use of specially trained inmate "buddies" or "listeners," which seem to have a good impact on the well-being of potentially suicidal inmates, as they may not trust correctional officers as much as other inmates (Hall & Gabor, 2004; Junker, Beeler, & Bates, 2005). As well as being used as a source of information about an inmate's suicidality, family visits may also be used as a means to foster social support.

It is important to note, however, that carelessly contrived or monitored social interventions may also carry risks. For example, highly suicidal inmates who are placed in shared cells have better access to lethal instruments. Unsympathetic cellmates may not alert correctional personnel if a suicide attempt is made. Therefore, placement of a suicidal inmate into a shared cell must never be considered as a substitute for careful monitoring and social support by trained facility staff (Liebling, 2006).

Physical Environment and Architecture

Most inmates commit suicide by hanging using bedding, shoelaces, or clothing. A suicide-safe environment would be a cell or dormitory that has eliminated or minimized hanging points and unsupervised access to lethal materials. Actively suicidal inmates may require protective clothing or restraints. Because of the controversial nature of restraints, clear policies and procedures must be in place if they are to be used. These must outline the situations in

which restraints are appropriate and inappropriate, methods for ensuring that the least restrictive alternatives are used first, safety issues, time limits for use of restraints, the need for monitoring and supervision while in restraints, and access to mental health staff (Hayes, 2006).

With increasing use of technology, camera observation has become a popular alternative to the direct observation by correctional staff in some locales. However, camera blind spots coupled with busy camera operators can lead to problems. Tragically, there are numerous examples of suicides that occur in full view of camera equipment. Moreover, most inmates dislike constant observation if it occurs without emotional support and respect (Paton & Jenkins, 2005). Therefore, camera surveillance should never be utilized as a substitute for the officer's observation of the suicidal inmate and, if used, should only supplement the direct observation of staff.

Mental Health Treatment

Mentally ill inmates who present a serious suicide risk should be provided adequate treatment with psychopharmacological agents that have become the standard in the general population (Daniel, 2006). Once an inmate is identified to be at high risk of suicide, further evaluation and treatment by mental health staff is indicated. In order to fully address inmate health and mental health needs, correctional facilities will need to forge strong links to community-based programs if they do not have sufficient staffing and resources within the institution (Pratt et al., 2006). Depending on the location, this may require multiagency cooperative service arrangements with general hospitals, emergency services, psychiatric facilities, community mental health programs, and substance-use programs.

If a Suicide Attempt Occurs

If a suicide attempt occurs, correctional staff must be sufficiently trained to secure the area and provide first aid to the inmate while they are waiting for facility-based or external emergency health staff to arrive. To avoid delays, efficient channels of communication to health staff and emergency response procedures should be planned in advance of an incident (Wool & Pont, 2006). Comprehensive psychological assessment of the inmate should also be undertaken as soon as possible (and medically feasible) after the incident. Such assessment should be conducted in a private area where an unhurried interview will not be interrupted and where the prisoner and the interviewer can be physically comfortable (Dear, 2006). The assessment should clarify the factors that precipitated the self-harming, the degree of suicidal intent, the underlying problems (both chronic and acute) with which the prisoner is grappling, whether or not the prisoner has a psychological disorder, the likelihood of further self-harming in the short-term (e.g., intense suicidal ideation that the prisoner is finding difficult to resist), and the type of help that is needed and that the prisoner is likely to accept (Dear, 2006).

So-Called Manipulative Attempts

In some situations, inmates who make suicidal gestures or attempts will be viewed as manipulative. These inmates are thought to use their suicidal behaviors to gain some control over the environment, such as being transferred to a hospital or moved to a less restrictive setting (Fulwiler, Forbes, Santagelo, & Folstein, 1997; Holley & Arboleda-Florez, 1998). The possibility of a staged suicide attempt to instigate an escape, or for some other nefarious motive, must also be an ever-present worry for security-minded officers, particularly those working in maximum and super-maximum security areas. Incarcerated men with antisocial or sociopathic personalities may be more prone to manipulative attempts as they are likely to have difficulty adapting to the over-controlled, collective regimentation of prison life (Lohner & Konrad, 2006). Self-mutilation and suicide attempts are not easily differentiated, even if the inmate is questioned about his(her) intent (Daigle & Côté, in press). There are indications that many incidents involve both a high degree of suicidal intent and so-called manipulative motives such as wanting to draw attention to one's emotional distress or wanting to influence one's situation, such as avoiding a transfer to another facility where family visits will be less frequent (Dear, Thomson, & Hills, 2000).

When correctional staff believe that certain inmates will attempt to control or manipulate their environment through self-destructive behaviors, they tend to not take the suicidal gesture seriously – not to give in to the manipulation. This is particularly true if an inmate has a history of rule violations or infractions (Holley & Arboleda-Florez, 1998). However, suicide attempts, whatever their motivation, can result in death, even if this was not the original intent. Because of the limited number of methods available, inmates may choose very lethal methods (e.g., hanging) even in the absence of a true wish to die, or because they do not know how dangerous the method is (Brown, Henriques, Sosdjan, & Beck, 2004). Attempts with less suicidal intent should be seen as expressive rather than purposive, i.e., as a dysfunctional way of communicating a problem. The correct response would be to ask about the inmates problems and not to punish him/her. Inattention to the self-destructive behaviors or punishment of self-destructive inmates through segregation may worsen the problem by requiring the inmate to take increasingly more dramatic risks. Thus, for acting-out, potentially self-injurious inmates, programs that foster close supervision, social support, and access to psychosocial resources are just as crucial.

If a Suicide Occurs

If a suicide occurs, procedures must be in place to officially document and report the incident, as well as provide the constructive feedback necessary to improve future suicide prevention activities. In addition, correctional and other facility-based staff who have experienced the suicide of an inmate, especially on under their supervision, may experience a range of feelings from anger and resentment to guilt and sadness. These individuals may benefit from more detailed debriefing or from formally organized peer or counseling support.

Although rare, correctional facilities provide one of the environments in which suicide clusters may occur (Paton & Jenkins, 2005). The examination of inmate suicide clusters has suggested that the increased risk of subsequent suicide appears to be limited to the 4-week period following the initial suicide, and appears to reduce over time (Cox & Skegg, 1993). Young inmates may be especially vulnerable for so-called copycat suicide attempts (Hales, Davison, Misch, & Taylor, 2003). Strategies to reduce the risk of contagious suicidal behavior include the provision of secure psychiatric care for prisoners with psychiatric illness, the removal or treatment of those particularly susceptible, and careful management by authorities of the transmission of knowledge that a suicide has occurred.

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