WHO/MNH/MBD/00.5
Original: English
Distr.: General

PREVENTING SUICIDE

A RESOURCE FOR PRISON OFFICERS

This document in one of a series of resources addressed to specific social and professional groups particularly relevant to the prevention of suicide.

It has been prepared as part of SUPRE, the WHO worldwide initiative for the prevention of suicide.

Keywords: suicide / prevention / resources / corrections / prisons / jails.

Mental and Behavioural Disorders
Department of Mental Health
World Health Organization
Geneva
2000

CONTENTS

FOREWORD

Suicide is a complex phenomenon that has attracted the attention of philosophers, theologians, physicians, sociologists and artists over the centuries; according to the French philosopher Albert Camus, in *The Myth of Sisyphus*, it is the only serious philosophical problem.

As a serious public health problem it demands our attention, but its prevention and control, unfortunately, are no easy task. State-of-the-art research indicates that the prevention of suicide, while feasible, involves a whole series of activities, ranging from the provision of the best possible conditions for bringing up our children and youth, through the effective treatment of mental disorders, to the environmental control of risk factors. Appropriate dissemination of information and awareness-raising are essential elements in the success of suicide prevention programmes.

In 1999 WHO launched SUPRE, its worldwide initiative for the prevention of suicide. This booklet is one of a series of resources prepared as part of SUPRE and addressed to specific social and professional groups that are particularly relevant to the prevention of suicide. It represents a link in a long and diversified chain involving a wide range of people and groups, including health professionals, educators, social agencies, governments, legislators, social communicators, law enforcers, families and communities.

We are particularly indebted to Dr Heather L. Stuart, Community Health and Epidemiology, Queen's University, Kingston, Ontario, Canada, who produced an earlier version of this booklet. The text was subsequently reviewed by the following members of the WHO International Network for Suicide Prevention, to whom we are grateful:

Dr Annette Beautrais, Christchurch School of Medicine, Christchurch, New Zealand

Dr Øivind Ekeberg, Ullevål Hospital, University of Oslo, Oslo, Norway

Professor Robert D. Goldney, University of Adelaide, Gilberton, Australia

Professor Richard Ramsay, University of Calgary, Calgary, Canada

Professor Lourens Schlebusch, University of Natal, Durban, South Africa

Dr Airi Värnik, Tartu University, Tallinn, Estonia.

Our gratitude also goes to Professor Julio Arboleda-Flórez, Queen's University, Kingston, Ontario, Canada, who contributed useful comments to this resource.

The resources are now being widely disseminated, in the hope that they will be translated and adapted to local conditions - a prerequisite for their effectiveness. Comments and requests for permission to translate and adapt them will be welcome.

Dr J. M. Bertolote

Coordinator, Mental and Behavioural Disorders

Department of Mental Health

World Health Organization

PREVENTING SUICIDE

A RESOURCE FOR PRISON OFFICERS

Suicide is often the single most common cause of death in correctional settings. Jails and prisons 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 fuelled by media interest, a suicide in correctional facility can easily escalate into a political scandal. 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. It is within this context that correctional settings worldwide struggle with the problem of preventing inmate suicide.

Correctional settings differ with respect to inmate populations and local conditions: short-term detainees, pretrial offenders, sentenced prisoners, harsh sentencing practices, overcrowding, sanitation, broad sociocultural conditions, the prevalence of HIV/AIDS, and access to basic health or mental health services. Each of these factors may influence suicide rates in different ways. Nevertheless, it is still possible to reduce suicides in jail and prison settings by adhering to certain basic principles and procedures.[1]

This document is aimed at correctional administrators who are responsible for developing or implementing mental health programmes in correctional settings, and to correctional officers who are responsible for the safety and custody of suicidal inmates. It provides some general background on suicide and identifies a number of key activities that can be used as part of a comprehensive suicide prevention programme to reduce suicide in correctional settings.

GENERAL SUICIDE FACTS

Suicide is a serious health problem. The World Health Organization estimates that one suicide attempt occurs approximately every three seconds, and one completed suicide occurs approximately every minute. This means that more people die by suicide than by armed conflict. Consequently, reducing suicide has become an important international health goal.[2]

The causes of suicide are complex.[3] Some individuals seem especially vulnerable to suicide when faced with a difficult life event or combination of stressors. The challenge for suicide prevention is to identify people who are most vulnerable, under which circumstances, and then effectively intervene. Towards this end, researchers have identified a number of broad factors that interact to place an individual at higher risk of suicide including socio-cultural factors, psychiatric conditions, biology, genetics, and social stress. The ways in which these factors interact to produce suicide and suicidal behaviours is complex and not well understood. Nevertheless, in various combinations they have been used to identify specific high-risk groups - populations of special concern because they often commit suicide at higher-than-average rates:

- Young males (ages 15-49);
- Elderly people, especially elderly males;
- Indigenous people;
- Persons with mental illness;
- Persons with alcohol and/or substance abuse;
- Persons having made a previous suicide attempt;
- Persons in custody.

INMATES ARE A HIGH-RISK GROUP

As a group, inmates have higher suicide rates than their community counterparts. For example, in pretrial facilities housing short-term inmates, the suicide rate is ten times that of the outside community. In facilities housing sentenced prisoners, the suicide rate is three times higher than in the outside community. Also, for every completed suicide that occurs, there are many more suicide attempts.[4]

Any combination of the following factors may account for the higher rates of suicide in correctional settings:

- Jails and prisons are repositories for vulnerable groups that are traditionally among the highest risk for suicide, such as young males, the mentally ill, socially disenfranchised, socially isolated, substance abusers, or previous suicide attempters.
- The psychological impact of arrest and incarceration or the day-to-day stresses associated with prison life may exceed the coping skills of vulnerable individuals.
- There may be no formal policies and procedures to identify and manage suicidal inmates.
- Even if appropriate policies and procedures exist, overworked or untrained correctional personnel may miss the early warning signs of suicidality.
- Correctional settings may be isolated from community mental health programmes so they have poor or no access to mental health professionals or treatments.

SUICIDE PREVENTION IN CORRECTIONAL SETTINGS

A number of jails and prisons have undertaken comprehensive suicide prevention programmes and in some countries national standards and guidelines for suicide prevention in correctional settings have been established. Reports from these areas show that significant reductions in suicides and suicide attempts can be accomplished once comprehensive prevention programmes have been implemented.[1] While the specifics of these programmes 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 towards 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.[5]

Profile 1: Pretrial Inmates

Pretrial inmates who commit suicide in police lockups or jails are generally male, young (20-25 years), unmarried, and first time offenders who have been arrested for minor, usually substance related, offences. They are typically intoxicated at the time of their arrest and commit suicide within the first 24 hours after being detained, often within the first few hours. A second period of risk for pretrial inmates is around the time of a court appearance, especially when a guilty verdict and harsh sentencing may be anticipated.

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 four or five 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 offence, 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.

Risk Factors Common to Jails and Prisons

In addition to the specific profiles identified above, suicidal inmates in both jails and prisons share a number of common characteristics that can be used to help guide suicide prevention activities.

Situational Factors

Both in jails and prisons, 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.

Psychosocial Factors

Poor social and family support, prior suicidal behaviour (especially within the last one or two years), and a history of psychiatric illness and emotional problems are common among inmate suicides. 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. Suicide comes to be viewed as the only way out of a desperate and hopeless situation. 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. Female inmates attempt suicide five times more often than their female counterparts in the community[6] and twice as often as their incarcerated male counterparts. They also have high rates of serious mental illness.[7] While more specific risk profiles of pretrial and sentenced women are still lacking, women having poor social and family supports, prior suicidal behaviour, a history of psychiatric illness and emotional problems should be targeted for suicide prevention activities.

Juveniles

The experience of incarceration may be particularly difficult for juvenile offenders who are separated from their families and friends. Juveniles who are placed in adult correctional facilities should be considered to be at particularly high risk of suicide.[8]

Profiles can change over time

Profiles are useful for identifying potentially high-risk groups that may need further screening and intervention. As successful suicide prevention programmes are implemented, high-risk profiles may change over time.[9] 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.

INTAKE SCREENING

Once correctional staff are trained and familiar with risk factors of suicide, the next step is to implement formal suicide screening of newly admitted inmates.[10] Since suicides in jails may occur within the first hours of arrest and detention, suicide screening must occur almost immediately upon entrance to the institution to be effective. To be most effective, every new inmate should be screened at intake and again if circumstances or conditions change. In correctional facilities with high turnover and limited resources, suicide screening of all incoming inmates may be impossible. A pragmatic solution would be to target screening to those inmates who match high-risk profiles and those who show signs of suicidal intent.

When resources permit, suicide screening may be undertaken within the context of an intake cursory medical examination conducted by facility-based health care staff. Should suicide screening be a responsibility of correctional staff they should be adequately trained[11] and aided by a suicide checklist.[10,12] 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.
- 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, lack of verbal expression.
- The inmate admits to current thoughts about suicide.
- 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 difficulty to focus attention, talking to self, 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.
- The inmate admits or appears to have few internal and/or external supportive resources.

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

- They provide the intake officer with structured questions on areas of concern that need to be covered.
- When there is little time available to conduct screening, they act as a memory aid for busy intake staff.

- They facilitate communication between officers and locations within the institution.
- They provide legal documentation that an inmate was screened for suicidal risk upon entrance into the facility and again, as conditions changed.

Even when cursory medical examinations are conducted by institutionally based health care staff, it remains important to use a structured suicide checklist for the same reasons. 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 of another agency or facility. Finally, the usefulness of suicide checklists is not restricted to intake; they are not intended as stand-alone risk estimation tools. They may be used at any time in an inmate's sentence to identify suicide risk and need for further intervention by a wide variety of adequately trained correctional staff.

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 eventually at regular intervals. To be effective, suicide prevention must involve ongoing observation. Correctional staff must be trained to be vigilant during the inmate's entire period of incarceration.[13] Toward this end, correctional staff may gather clues to a possible inmate's suicidality during the following activities:

- 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; refusal to take medication or a request for an increased dose of medication.
- Conversations with an inmate around the time of sentencing 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 officers if they fear that their relative may harbour suicidal wishes.

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 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 of suicide but who do not admit to being actively suicidal may require regular monitoring every 10-15 minutes.

Social Intervention

Inmates come to correctional settings with certain vulnerabilities to suicide. These, coupled with the crisis of incarceration and the ongoing stressors of prison life may culminate

in emotional and social breakdown leading to eventual suicide. 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.

The majority of suicides in correctional settings occur when an inmate is isolated from staff and fellow inmates. Therefore, placement in segregation or isolation cells for necessary reasons can increase the risk of suicide. Placing an inmate suspected to be at risk of suicide in a dormitory or shared cell may significantly reduce the risk of suicide, particularly when placed with sympathetic cellmates. In some facilities, social support is provided through the use of specially trained inmate "buddies". 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 into 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 social support by trained facility staff.[14]

Physical Environment and Architecture

Most inmates commit suicide by hanging using objects of clothing (socks, underwear, belts, shoelaces, shirts) or with sheets or towels. 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 professionals.

With increasing technology, camera observation has substituted visual checks by officers as a means of supervising actively suicidal inmates in some locales. However, camera blind spots coupled with busy camera operators may still lead to problems. Therefore, camera surveillance should be augmented with regular visual inspections (e.g. every 10-15 minutes).

Mental Health Treatment

Once an inmate is identified to be at high risk of suicide, further evaluation and treatment by mental health staff may be indicated. However, in many correctional settings access to mental health professionals is complicated by the fact that there are limited internal mental health resources and few, if any, links to community-based health and mental health facilities, which may be needed for inmates to be transferred.

It is unlikely that correctional facilities will ever have sufficient resources to meet all of the health and mental health needs of their inmate populations. Nor is it practical for them to develop such expertise when their primary responsibilities are custody and control. Thus, in order to fully address inmate health and mental health needs, correctional facilities will need to forge strong links to community based programmes. This means that criminal justice, mental health and health systems must be integrally linked in the service of suicide prevention in correctional settings. Depending on the location, this may require multiagency cooperative service arrangements with general hospitals, emergency services, psychiatric facilities, community mental health programmes, and addictions programmes.

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. Training of correctional staff in first aid procedures is a key component of suicide prevention. Indeed, provision of first aid by correctional staff on the scene should be part of a formally articulated standard operating procedure. To avoid delays, efficient channels of communication to health staff and emergency response procedures should be planned in advance of an incident. Emergency rescue equipment needs to be kept in working order, routinely tested, and available on the scene. Practice drills may ensure that facility correctional and emergency health staff provide an optimal response.[15]

Manipulative Attempts

In some situations, inmates who make suicidal gestures or attempts will be viewed as manipulative. They may use their suicide attempt to gain some control over the environment, such as being transferred to a hospital or moved to a less restrictive setting.[16,17] 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. For incarcerated women, repeated self-mutilation (such as slashing or burning) may be a response to the stress brought on by confinement and the prison culture.

When correctional staff believe that certain inmates will attempt to control or manipulate their environment through self-destructive behaviours, the tendency is not to take the suicidal gesture seriously - not to give in to the manipulation. This is particularly true if an inmate has a history of past rule violations or infractions. However, suicide attempts, whatever their motivation, can result in death, even if this was not the original intent. Inattention to the self-destructive behaviours 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, programmes 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. Thus, correctional and health staff should debrief each incident in an attempt to:

- reconstruct the events leading to the suicide;
- identify factors that may have led to the inmate's death that may have been missed or inadequately addressed;
- assess the adequacy of the emergency response;
- draw out any policy implications to improve future prevention efforts.

In addition, correctional and other facility-based staff who have experienced the suicide of an inmate 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 counselling support.

Prisons provide one of the environments in which suicide clusters may occur.[18] The examination of suicide clusters in prisoners has suggested that the increased risk of subsequent suicide appeared to be limited to the four week period following the initial suicide, and appeared to reduce over time.[19] Prison staff need to be aware of this period of increased risk. Strategies to reduce the risk of contagious suicidal behaviour include the provision of secure psychiatric care for prisoners with psychiatric illness, the removal or treatment of those particularly susceptible, and careful management of the transmission of knowledge that a suicide has occurred by authorities.

SUMMARY OF BEST PRACTICES

Best practices for preventing suicides in jail and prison settings are based on the development and documentation of a comprehensive suicide prevention plan with the following elements:

- A training programme (including refreshers) for correctional staff to help them recognize suicidal inmates and appropriately respond to inmates in suicidal crises.
- Procedures to systematically screen inmates upon their arrival at the facility and throughout their stay in order to identify those who may be at high risk.
- A mechanism to maintain communication between staff members regarding high-risk inmates.
- Written procedures which outline minimum requirements for housing high-risk inmates; provision of social support; routine visual checks and constant observation for more seriously suicidal inmates; and appropriate use of restraints.
- Development of sufficient internal resources or links to external community-based mental health services to ensure access to mental health professionals when required for further evaluation and treatment.
- A strategy for debriefing when a suicide occurs towards identifying ways of improving suicide detection, monitoring, and management in correctional settings.

REFERENCES

1. Felthous AR. Preventing jailhouse suicides. *Bulleting of the American Academy of Psychiatry and the Law*, 1994, 22(4): 477-488.

2. World Health Organization. Figures and facts about suicide. Geneva, 1999.

3. Task Force on Suicide in Canada. Suicide in Canada. Minister of National Health and Welfare, Ottawa, 1994.

4. Danto B. The role of the forensic psychiatrist in jail and prison suicide litigation. In: Rosner R, Harmon RB. *Correctional psychiatry*. New York, Plenum Press, 1989, 61-88.

5. Bonner RL. Isolation, seclusion, and psychosocial vulnerability as risk factors for suicide behind bars. In: Maris RW, Berman AL, Maltsberger JT, Yufit RI. *Assessment and Prediction of Suicide*. New York, The Guilford Press, 1992, 398-419.

6. Holley HL, Arboleda-Flórez J, Love E. Lifetime prevalence of prior suicide attempts in a remanded population and relationship to current mental illness. *International journal of offender therapy and comparative criminology*, 1995, 39(3): 190-209.

7. Fryers T, Brugha T, Grounds A, Melzer D. Severe mental illness in prisoners. *British medical journal*, 1998, 317: 1025-1026.

8. Winkler GE. Assessing and responding to suicidal jail inmates. *Community mental health journal*, 1992, 28(4): 317-326.

9. Farmer KA, Felthous AR, Holzer CE. Medically serious suicide attempts in a jail with a suicide-prevention program. *Journal of forensic sciences*, 1996, 41(2): 240-246.

10. Landsberg G, Cox JF, McCarthy DW, Paravati MP. The New York State Model of Suicide Prevention and Crisis Intervention with local jails and police lockups. In: Rosner R, Harmon RB. *Correctional psychiatry*. New York, Plenum Press, 1989, 89-108.

11. Farrell G, Mainprize B. Update on suicide prevention training: Correctional Service of Canada. Communications and Corporate Development, Program and Information Analysis, Ottawa, Canada, 1990.

12. Arboleda-Flórez J, Holley HL. Development of a suicide screening instrument for use in a Remand Centre setting. *Canadian journal of psychiatry*, 1998, 33: 595-598.

13. Landsberg G. Issues in the prevention and detection of suicide potential in correctional facilities. In: Rosner R. *Principles and practice of forensic psychiatry*. New York: Chapman and Hall, 1994, 393-397.

14. Danto BL. Suicide litigation as an agent of change in jail and prison: an initial report. *Behavioral sciences and the law*, 1997, 15, 415-425.

15. Hayes LM. From chaos to calm: one jail system's struggle with suicide prevention. *Behavioral sciences and the law*, 1997, 15: 399-413.

16. Fulwiler C, Forbes C, Santagelo SL, Folstein M. Self-mutilation and suicide attempt: distinguishing features in prisoners. *Journal of the American Academy of Psychiatry and the Law*, 1997, 25(1): 69-77.

17. Holley HL, Arboleda-Flórez J. Hypernomia and self-destructiveness in penal settings. *International journal of law and psychiatry*, 1998, 22: 167-178.

18. O'Carroll PW, Mercy JA, Steward JA. Suicide contagion and the reporting of suicide: Recommendations from a national workshop. *Morbidity and mortality weekly report*, 1988, 43 (No. RR-6), 1-9.

19. Cox B, Skegg K. Contagious suicide in prisons and police cells. *Journal of epidemiology and community health*, 1993, 47: 69-72.