

PREVENTING SUICIDE
IN JAILS AND PRISONS



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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 the revised version of 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.

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The collaboration of IASP with WHO on its activities related to suicide prevention is greatly appreciated.

The resources are 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.

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PREVENTING SUICIDE IN JAILS AND PRISONS

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 fuelled by media interest, a suicide in correctional facility can easily escalate into a political scandal. Moreover, suicidal behaviour by custodial inmates means a stressful event for officers and other prisoners faced with it. 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, pre-trial offenders, sentenced prisoners, harsh sentencing practices, overcrowding,¹ possibility of purposeful activity,² times spent locked up, sanitation, broad sociocultural conditions, the prevalence of HIV/AIDS, levels of stress,³ 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 correctional settings by adhering to certain basic principles and procedures.⁴

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

GENERAL SUICIDE FACTS

Suicide in the community 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.⁵

The causes of suicide are complex.⁶ 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.

Many characteristics of suicidal inmates may be shared by all other inmates and few studies have identified characteristics that distinguish prisoners who commit suicide from other prisoners. One Austrian case-control study⁷ identified four specific individual factors (a history of attempted suicide or suicidal communications; psychiatric diagnosis; psychotropic medication prescribed during imprisonment; a highly violent index offence) and one environmental factor (single-cell accommodation). It is unclear if these same factors are important in other parts of the world.

INMATES ARE A HIGH-RISK GROUP

As a group, inmates have higher suicide rates than their community counterparts,⁸ and there is some evidence that rates are increasing even in places where the numbers of prisoners are decreasing.⁹ There are not just more suicidal behaviours within the institutions but a lot of people who get imprisoned show a lot of suicidal thoughts and behaviour through the course of their lives. Accordingly pre-trial detainees have a suicide attempt rate of about 7.5 times, and sentenced prisoners have a rate of almost six times the rate of males out of prison in the general population.¹⁰ These facts also indicate a basic problem with regard to the causes of suicide in custody: On the one hand people who break the law inherently have a lot of risk factors for suicidal behaviour (they „import“ risk), and the suicide rate is higher within the offender group even after their release from prison.¹¹ 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. On the other hand, being imprisoned is also another stressful event even for healthy inmates (as it deprives the person of important resources).

Any combination of the following individual and environmental 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, persons with mental disorders, socially disenfranchised, socially isolated, people with substance use problems, and those who have previously enacted suicidal behaviours.
- The psychological impact of arrest and incarceration, drug addicts' symptoms of withdrawal, an expected long prison sentence or the day-to-day stresses associated with prison life may exceed the coping skills of the average prisoner, let alone the more vulnerable individuals.
- In some settings, there may be no formal policies and procedures to identify and manage suicidal inmates. In particular, even where screening for high-risk indicators is undertaken, there is often inadequate monitoring of prisoners' distress levels and hence there is little chance of detecting acute risk.
- Even if appropriate policies and procedures exist, overworked or untrained correctional, health care, and mental health personnel may miss the early warning signs of a suicide risk.
- 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. Significant reductions in suicides and suicide attempts can be accomplished once comprehensive prevention programmes have been implemented.^{12,13,14,15} 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 pre-trial 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.⁴

Profile 1: Pre-trial Inmates

Pre-trial 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, offences. They are typically intoxicated at the time of their arrest and commit suicide at an early stage of their confinement,¹⁶ often within the first few hours (because of sudden isolation, shock of imprisonment, lack of information, insecurity about the future). Individual establishments can reduce their suicide risk by paying attention to reception and first night procedures, induction processes, and levels of care for prisoners. A second period of risk for pre-trial inmates is near the time of a court appearance, especially when a guilty verdict and harsh sentencing may be anticipated. A great deal of all jail suicides occurred within three days of a court appearance.¹⁷ Moreover, after 60 days of confinement a certain kind of emotional exhaustion was observed, which could be called “burn-out”.¹⁸

Profile 2: Sentenced Prisoners

Compared to pre-trial 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. Accordingly, the suicide rate of long-term inmates seems to increase with length of stay.¹⁸ So called “lifers” particularly seem to be at a high risk.^{3,19}

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 programmes.

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 also a lot of suicides when prisoners are alone even if they are technically sharing a cell.^{3,20}

There is also a strong association between inmate suicide and housing assignments. Specifically, 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 hours per day for significant periods of time. There are a disproportionate number of inmate suicides that occur in these special housing units.²¹

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. Moreover, suicidal inmates often experience bullying,²² recent inmate-to-inmate conflicts, disciplinary infractions or adverse information.²³ 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.⁴ Female pre-trial inmates attempt suicide much more often than their female counterparts in the community^{4,24} and as their incarcerated male counterparts. Also the rates for completed suicides of women seem to be higher than those of men.²⁵ They also have high rates of serious mental illness.²⁶ While more specific risk profiles of pre-trial 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 programmes.

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.³ Therefore, separating and isolating young prisoners may lead to additional risk for suicidal actions, which can happen at any time of their confinement.²⁷ Juveniles who are placed in adult correctional facilities should be considered to be at particularly high risk of suicide.²⁸

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 programmes are implemented, high-risk profiles may change over time.¹⁸ 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 no fool-proof predictors and should not be used without careful clinical assessment. What is particularly confusing, when trying to screen at risk prisoners, is that the profile of those who will eventually die from suicide looks more “normal” than the profile of those who will attempt suicide.²⁹

KEY COMPONENTS OF A SUICIDE PREVENTION

PROGRAMME

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. Of course, it is not the officers' but prison authorities' responsibility to approve and install such programmes.

Training

The essential component to any suicide prevention programme is properly trained correctional staff, who form the backbone of any jail, prison, or juvenile facility. 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 programme staff. These incidents, therefore, must be thwarted by correctional staff who have been trained in suicide prevention and have become more attentive to the inmates under their care. Correctional officers are often the only staff available 24 hours a day; thus, they form the front line of defense in preventing suicides. Correctional staff, as well as health care and mental health personnel, cannot detect risks of, make an assessment, nor prevent a suicide for which they have no training.

All correctional staff, as well as health care and mental health personnel, should receive initial suicide prevention training, followed by refresher training every year. At a minimum, initial suicide prevention training should include, but not be limited to, the following: why correctional environments are conducive to suicidal behaviour, staff attitudes about suicide, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, recent suicides and/or

serious suicide attempts within the facility/agency, and components of the facility/agency's suicide prevention policy. In addition, all staff who have routine contact with inmates should receive standard first aid and cardiopulmonary resuscitation training. All staff should also be trained in the use of various emergency equipment located in each housing unit. In an effort to ensure an efficient emergency response to suicide attempts, "mock drills" should be incorporated into both initial and refresher training for all staff.²⁰

Intake Screening

Once correctional staff are trained and familiar with risk factors of suicide, the next step is to implement formal screening for suicide of newly admitted inmates.³⁰ Since suicides in jails may occur within the first hours of arrest and detention, screening for suicide must occur almost immediately upon entrance into the institution to be effective. To be most effective, 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.³¹ Generally, screening questionnaires should ask for static (historical demographic) as well as dynamic (situational and personal) variables.³²

When resources permit, screening for suicide may be undertaken within the context of an intake medical and psychological assessment conducted by relevant facility-based professionals. Should screening for suicide be a responsibility of correctional staff they should be adequately trained³³ and aided by a checklist for assessing suicidal risk.^{30,31,34,35} 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, lack of verbal expression.
- The inmate admits to current thoughts about suicide³⁶ (it is wrong to believe that it is bad to ask a person if he/she is currently thinking about suicide, not to bring on 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 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 (also contacts to family and neighbouring inmates should be taken into consideration²⁴).
- 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 had a risk for suicide during a prior confinement.

These checklists are an important part of a comprehensive suicide prevention programme 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 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.

Even when medical examinations are conducted by health care staff, it remains important to use a structured 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 these checklists is not restricted to intake; they are not intended as standalone risk estimation tools. They 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 has to see the inmate within a very short time.^{31,34}

Unfortunately, there is only limited information about potential protective factors³⁷ - this knowledge could facilitate risk assessment and make it more precise.

Post-intake Observation

Notwithstanding the importance of screening procedures, they play a very small part in the prevention of suicides in prisons. All a screening instrument can achieve is to inform staff that a particular prisoner has an elevated risk of attempting suicide at some stage in his or her period of incarceration: they do not predict when an attempt will occur or what the specific precipitants will be in a given case. Because many jail and prison suicides occur after the initial period of incarceration (some after many years), it is not sufficient to only screen inmates only at the time of intake, but eventually 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 gather clues to a possible inmate's 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 harbour 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 the risk for suicide 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 of 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 5-15 minute staggered intervals). However, considering a suicide attempt by hanging can take just three minutes to result in permanent brain damage, and 5-7 minutes to be lethal, rounds even at a distance of every 10-15 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.³⁸ Prisoners at risk should not be left alone, but observation and companionship should be provided.^{8,33}

Communication

Certain behavioural signs exhibited by the inmate may be indicative of suicidal behaviour and, if detected and communicated to others, may prevent suicide. There are essentially three stages of communication in preventing suicides of inmates:

- Communication between the arresting/transporting officer and correctional staff;
- Communication among facility staff (including correctional, health care, and mental health personnel); and
- Communication between facility staff and the suicidal inmate.²⁰

In many ways, suicide prevention begins at the point of arrest. During initial contact, what an individual says and how they behave during arrest, transportation to the jail, and booking are crucial in detecting suicidal behaviour. 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 behaviour, anxiety, and/or hopelessness of the situation might be manifested. Prior behaviour can also be confirmed by family or friends. Any pertinent information regarding the arrestee's well-being must be communicated by the arresting or transporting officer to facility staff.

As 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 who has been placed on precautions concerning suicidal behaviour. 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 placed on precautions. In addition, the authorization of precautions for an inmate, any changes to those precautions, and observation of an inmate placed on 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.

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.³³

As previously stated, 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 nevertheless increase the risk of suicide. If segregation is the only available option for housing the suicidal inmate, constant observation should be provided.²³ 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 seems to have a good impact on the wellbeing of potential suicidal inmates, as they may not trust correctional officers but other inmates.^{39,40} Family visits may also be used as a means to foster social support, as well as a source of information about the risk for suicide of an inmate.

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 and social support by trained facility staff.³

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.

With increasing 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 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.⁴ 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

Inmates with mental disorders who present a serious suicide risk should be provided with adequate psychopharmacological treatment which has become the general standard.⁴¹ Once an inmate is identified to be at high risk of suicide, further evaluation and treatment by mental health staff is indicated. However, in many correctional settings access to mental health staff 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 would be necessary.¹¹

In order to fully address inmate health and mental health needs, correctional facilities will need to forge strong links to community-based programmes if they do not have sufficient staffing and resources within the

institution. This means that criminal justice, mental health and health systems must be integrally linked for 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 substance-use 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 in the field. 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. All staff should be trained in the use of resuscitation equipment, which must be readily accessible to all staff. Each staff member should be aware of what to do if a suicide attempt occurs.⁴²

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 adequate interview will not be interrupted and where the prisoner and the interviewer can be physically comfortable. The assessment should clarify the factors that precipitated the self-harm, 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 mental disorder, the likelihood of further self-harm in the short-term (e.g., intense suicidal

ideation the prisoner finds difficult to resist), and the type of help that is needed and that the prisoner is likely to accept.

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 behaviours to gain some control over the environment, such as being transferred to a hospital or moved to a less restrictive setting.^{43,44} 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 all 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 conditions of prison life.⁴⁵ Moreover, for some prisoners, self-harming behaviour may be a possibility of reducing tension.⁴⁶ 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. As a matter of fact, self-mutilation and suicide attempts are not easily differentiated, even if the inmate is asked what his or her intent was.⁴⁷ There is indication 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 management, such as avoiding a transfer to another facility where family visits will be less frequent.⁴⁸

When correctional staff believe that certain inmates will attempt to control or manipulate their environment through self-destructive behaviours, 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 past rule violations or infractions.⁴⁴ However, suicide attempts, whatever their motivation, can result in death, even if this was not the original intent. Because of limited number of methods available, inmates

may choose very lethal methods (e.g. hanging) even in absence of a true wish to die, or because they do not know how dangerous the method is.⁴⁹ Attempts with less suicidal intent should rather be seen expressive than purposive, i.e. as a dysfunctional way of communicating a problem. The correct response would be to ask for the inmate's problems and not to punish him or her. Inattention to the selfdestructive 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 or the other inmates 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.

Although rare, correctional facilities provide one of the environments in which suicide clusters may occur.⁴ The examination of inmate suicide clusters 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.⁵⁰ Young inmates may be especially vulnerable for so called copycat suicide attempts.⁵¹ 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

First of all, staff culture and cooperation seem to be critical to the successful implementation of prison suicide prevention programmes. 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 and care givers to help them recognize suicidal inmates and appropriately respond to inmates in suicidal crises.
- Attention needs to be paid to the general prison environment (levels of activity, safety, culture and staff-prisoner relationships). In particular, the quality of the social climate of prisons is critical in minimizing suicidal behaviours. While prisons can never be stress-free environments, prison administrators must enact effective strategies for minimizing bullying and other violence in their institutions, and for maximizing supportive relationships among prisoners and staff. The quality of staff-prisoner relationships is

critical in reducing prisoners' stress levels and maximizing the likelihood that prisoners will trust staff sufficiently to disclose to them when their coping resources are becoming overwhelmed, feelings of hopelessness, and suicidal ideation.

- 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 acutely suicidal inmates; and appropriate use of restraints as a last resort for controlling self-injurious inmates.
- Inmates with mental disorders in need of treatment should receive it (pharmacological or psychosocial interventions) and be kept under strict observation.
- Development of sufficient internal resources or links to external community-based mental health services to ensure access to mental health personnel 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.

CONCLUSION

In conclusion, although we sometimes lack the ability to accurately predict if and when an inmate will attempt or commit suicide, prison officials and correctional, health care, and mental health personnel are in

the best position to identify, assess, and treat potentially suicidal behaviour. Even though not all inmate suicides are preventable, many are, and a systematic reduction of these deaths can occur if comprehensive suicide prevention programmes are implemented in correctional facilities throughout the world.

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