Preventing Suicide in Prison: A Collaborative Responsibility of Administrative, Custodial, and Clinical Staff

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Suicide is a sentinel event in prison, and preventive efforts reflect the adequacy and comprehensiveness of mental health, psychiatric, custodial, and administrative services in a correctional system. This article reviews the literature on suicide in prison during the past three decades and identifies the pattern and occurrence of risk factors. These risk factors are classified as demographic, institutional, and clinical. Based on this review, the author outlines specific administrative, custodial, and clinical steps and procedures that form the basis of a comprehensive suicide-prevention program that can be implemented in small and large systems. The author recognizes the limitations of staff availability, the budget constraints, and the ineffectiveness of efforts to prevent suicides that occur without any warning. Ultimately, a prevention program is the collective responsibility of administrative, custodial, and clinical staff.

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The study of suicide in prisons has increased dramatically since the 1980s. Factors contributing to this increase include the rising frequency of suicide in prisons; class action lawsuits related to suicide; deinstitutionalization of the mentally ill; and lack of community-based programs for mentally ill criminals.[1–6] Legal reforms, prison diversionary programs, and regional differences in suicide rates[7] have also influenced the research.

Suicide Rate: Problems and Controversies

Suicide is the third leading cause of death in U.S. prisons and the second in jails.[1] The suicide rate in prisons ranged from 18 to 40 per 100,000 during the past three decades.[8–11] Populous urban jails such as those in New York,[12] Atlanta,[13] and Miami[14] have higher suicide rates than do non-urban jails. A study of six Midwestern jails from 1966 to 1971 showed a rate of 58 per 100,000 inmates per year.[15] The jail suicide rate is nine times that of the general population, with a range of 107 to 187.5 per 100,000.[16] The rate of 10 to 17 per 100,000 in federal prisons is slightly lower than the rates in state prisons.[3] The highest rate in a prison is noted among death row inmates with 146.5 per 100,000.[17]

The suicide rate in prison is usually compared with the commonly accepted national general population rate of 12 per 100,000; however, the comparison is inaccurate because of the disparity in the distribution of men and women in prison. When this general population rate of 12 per 100,000 is broken down by gender, the rate for men is 18 and 6 for women. Therefore, a prison rate of 18 to 20 is comparable with the rate in males in the general population.[3]

Underreporting of suicide seems to be a problem. If a suicide victim is found and rushed to the hospital, only to die there, records may not show that the victim committed suicide in prison. Also, if the facility chooses to report some deaths as suicides—but

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not others, for fear of litigation—suicide rates could be inaccurate.[5] Prison staff are more likely to report white inmate suicide, accounting for possible underrepresentation of suicides of black inmates.[18] Risk factors such as drug abuse, unemployment, interpersonal conflicts, and mental illness are common to both the general public and prison. How different would the prison rate be if these factors were controlled?[17]

The suicide rate is calculated on the basis of average daily population (ADP) in jails and prisons, which does not factor in the admissions, leading to miscalculation of the actual rate.[1] Furthermore, the immediate post-release suicides noted among inmates who serve long sentences for violent crimes (such as homicide) and those who are heavy drug users before incarceration are generally left uncounted.[19,20]

Suicide Attempters Versus Suicide Completers

Although a suicide attempt in prison is generally categorized as a type of non-lethal self-injury similar to self-mutilation, it is fundamentally different.[21] All self-harming acts may be seen on a continuum of severity, not as distinct problems, since the motivation for self-injurious behavior is the same for both attempters and completers, and many attempt suicide before they are successful.[22] Some inmates attempt suicide with no intention of ever completing the act, while others persist, using more lethal methods until they are successful. According to Schaller *et al.*[23] and Green *et al.*,[24] both suicide attempters and completers are generally younger than 25, have previously attempted suicide, have a history of psychiatric treatment, and are likely to be addicted to opiates or other substances.[23,24] Most suicide attempters slash their wrists, as opposed to hanging or overdosing on medication, which are common methods used by completers.[25]

In general, prior suicide attempts increase the risk of suicide. From 45 to 63 percent of inmates who commit suicide have attempted it before.[26–30] Of those with a history of prior attempts who complete suicide, two-thirds used lethal methods (i.e., hanging, burning, swallowing a razor blade, strangulation, throat cutting, and drug overdose) during their prior attempts. Although Durand *et al.*[31] found a much lower rate of previous attempts (33 percent) among those who commit suicide, based on the literature, at least half of the individuals attempt suicide before completing the act.

Risk Factors

Because suicide research is retrospective, a definitive cause-and-effect relationship between risk factors and suicidal death cannot be established. Usually, what appears to be causative is reported as associated factors.

Demographic Factors

Generally, more than half of all inmates who commit suicide in prison are between 25 and 34 years of age.[27–29,32] They are often single with no job or family support. Very young prisoners (below age 21) are especially at risk.[22] In fact, the suicide rate among juvenile offenders placed in adult detention facilities is almost eight times greater than the rate in juveniles housed in juvenile detention facilities.[33] Although blacks are overrepresented in prisons, they are underrepresented among suicide completers as well as attempters.[11,27,29] Toch[34] found that blacks were also underrepresented in the self-mutilation group, whereas whites and Hispanics were overrepresented. Some researchers suggest that the differences among black, white, and Hispanic suicide rates can be explained by sociocultural factors such as better preparation for prison life by blacks as opposed to that of whites and Hispanics.[35] Haycock[5] disputes this theory, indicating that the factors that lead to inmate suicide are complex and personal and do not simply depend on sociocultural background.

Upper socioeconomic status and high degree of social and family integration before incarceration increase the risk of suicide in prison.[36] Suicides in prison fall into two groups: egoistic and fatalistic (Durkheim typology). Egoistic suicide occurs when an individual has a low level of integration into society, while fatalistic suicide occurs in a highly regulated, social environment where the individual sees no possible way to improve his or her life. Accordingly, most suicides in prison are egoistic, whereas those by death row inmates may be both egoistic and fatalistic, because they are socially isolated and heavily regulated, and at the same time, weakly integrated.[17]

Clinical Factors

Psychiatric Disorders: Eight to 15 percent of prisoners have a serious and persistent mental illness,[12,18] and the proportion is even higher in max-

imum-security prisons.[1] Many prisoners have multiple psychiatric disorders with co-morbid substance abuse.[37,38] Using the NIMH Diagnostic Interview Schedule (DIS) III–R, Teplin *et al.*[39] studied a randomly selected stratified sample of 1272 female arrestees in Cook County and found that 80 percent had one or more lifetime psychiatric disorders. Using similar methodology, Daniel *et al.*[40] found that 90 percent of consecutively admitted female prisoners had an Axis I disorder and 67 percent had more than one disorder. As far as the prevalence of psychiatric disorders among suicidal inmates is concerned, studies show a wide range from 33 to 95 percent.[3,22,28–30,41,42]

Although mood,[3,43] psychotic,[29] and personality disorders dominate diagnoses[30] among mentally ill prisoners, depressive disorders are more often linked to suicide than is any other psychiatric illness.[3,43] The onset of the mental disorder may be either before or during incarceration with most having a preincarceration diagnosis with onset before age 18. Other commonly found characteristics of suicidal inmates include a family history of mental illness, substance abuse, incarceration, suicide, psychiatric care, and medication treatment, though such factors are not uncommon among other inmates or the mentally ill in the community.

Depression, Hopelessness, and Anxiety: Depression and hopelessness seem to be the two most common psychological states at the time of a suicidal act.[44] Although depression and suicide are co-occurring phenomena, hopelessness and suicide have a stronger correlation than do depression and suicide. Ivanoff and Jang[45] developed a multivariate model to predict suicide by inmates studying the relationship between depression, hopelessness, suicidality, social desirability and other factors. Although age and visitors have no significant effect on suicidality, juvenile delinquency and violent crime directly increase it, as does higher education and income levels. Negative life events and sentence length indirectly impact suicidality by affecting depression. Both violent crime and previous income level affect hopelessness. Inmates with higher social desirability had lower levels of depression; thus, they had lower levels of suicidality.

Anxiety experienced by inmates at various times of incarceration, particularly on entry into the prison or just before release, may act as a risk factor. Anxiety symptoms mixed with agitation, depression, and hopelessness increase the risk further.

Personality Traits and Disorders: Although antisocial personality disorder is "endemic to correctional settings,"[46] the relationship between antisocial personality disorder and suicide risk seems to be somewhat complex. Verona *et al.*[47] used the Psychopathy Checklist-Revised (PCL-R) to study 313 male inmates in a federal institution in Florida and found a positive correlation between antisocial deviance (Factor 2) and suicidal tendencies in male inmates. Borderline Personality Disorder (BPD) increases the risk for suicide attempts and completions due to poor interpersonal skills, impulsivity, and affective instability. Impulsive suicide attempts under intoxication are more common among arrestees[48] and therefore intoxication is a significant factor in jails. In prison, impulsivity can be a factor in young prisoners with personality and depressive disorders and those who are victims of cluster suicides. Although a direct link between impulsivity and suicide cannot be established, only a few prepare to attempt suicide during the days preceding the act.[25]

Psychosocial Stressors: Institutional stressors such as undesired unit placement, work assignment, disciplinary confinement, interpersonal conflicts, legal processes, parole setbacks, and chronic medical conditions may act as precipitators of suicidal behavior. Nearly 50 percent of those who commit suicide experience acute stressors at the time of the suicide, whereas most suffer from chronic stressors.[3,27] Institutional conflict is seen as the most common acute stressor, whereas interpersonal conflict and chronic medical conditions are the most common chronic stressors.

The severity and type of crime seem to act as risk factors in certain prisoners, though not universally. Perhaps the guilt, shame, and stigma associated with the offenses may be the determining factor. Marital separation,[30] divorce,[49] or death of a loved one may precipitate serious suicide attempts. A prisoner is not usually able to participate in rituals associated with the funeral of a loved one. Mourning is difficult to accomplish[50] and expression of grief is likely to be viewed by others as a sign of weakness and vulnerability.

Loss or absence of one or both parents for more than 12 months before the age of 15 is correlated with attempted suicide.[51] Other risk factors include losing contact with one's children,[27] inability to

communicate due to language barriers,[25,28] or learning disability.[22] Mental retardation *per se* is not correlated with increased risk.

Substance Abuse as a Risk Factor: Being under the influence of an illegal drug heightens the risk of self-harm.[52] Inmates who suffer from Antisocial Personality Disorder, Schizophrenia, or Bipolar Disorder[53] are more likely to abuse substances. The risk of suicide is highest among opiate dependents who also have psychiatric disorders.[54] Opiate users are 10 times more likely to die from suicide than are non-users of the same age and gender.[55] Weitzel and Blount[56] did not find any significant difference between the type of drug and risk of suicide, and non-users were not significantly different from heavy users in the number of suicidal thoughts or attempts. However, when drug abusers are incarcerated, the ensuing forced abstinence and not having developed coping skills due to years of dependency may precipitate suicidal thinking.[25]

Medical Condition and Its Relation to Suicide: Salive *et al.*[11] found an increased risk of suicide among inmates with AIDS due to potential hopelessness, victimization, and threats by other inmates. No studies have been found that link hepatitis C and suicide, although interferon treatment is associated with depression and possible suicidal behavior. If a medical condition is chronic and causes intractable pain, it can be a risk factor. Prisoners with epilepsy are more likely than their non-epileptic peers to have depression and suicidal ideation.[57]

Institutional Factors

Stages and Setting of Confinement: In jails, the high-risk period is the first 24 to 48 hours. While there is no such period in prison, the first 30 days at reception centers are generally deemed to be critical for those with a history of suicide attempts.[29,48] Interfacility transfer of mentally disordered offenders seems to raise suicide risk, which may be related to the inmate's adjustment difficulties at the new site. Findings regarding length of incarceration and suicide risk are contradictory—some indicating a positive correlation,[36,58] whereas others indicate none[11] after 180 days of incarceration.

With regard to setting, most inmate suicides occur in maximum-security facilities, in single cells[11,28] or in isolation. Special treatment centers for addiction and sexually dangerous persons have a lower rate than in the general community, whereas it is much greater at inpatient hospitals for the "criminally insane"[18] and in supermaximum-security facilities.[17]

Time of the Day, Month, and Season: Contrary to general belief, suicides are not more likely to occur on weekends, religious holidays, or during holiday seasons.[42] However, the time of day seems to have some significance, in that most suicides occur between 7:00 p.m. and 7:00 a.m.,[27,31] possibly due to lower staff supervision during the night.[25] For unknown reasons, the most common time of year to commit suicide is between July and September.[22,30,59]

Prison Condition and Experience: Almost all departments of corrections in the United States have recorded an increase of prisoners in recent years, possibly due to the dramatic influx of drug offenders.[52] An overcrowded and short-staffed prison is likely to increase suicide risk due to lack of access to medical care, increase in assaults, lower staff-offender ratio, lack of opportunity for activity, lack of food and clothing, unwanted interactions, and rapidly changing social structures within the prison. As prisons become more crowded, the number of inmates who reside in single cells may decrease, a fact often cited as preventive, since the chance of committing suicide in multiple-occupant cells is limited.

Understandably, the transition from the outside world leads to loss of individual autonomy. As a result, inmates often engage in conflict with the prison staff as well as fellow inmates. Inmates of all ages with mental disorders and youthful inmates are at greater risk of abuse and victimization by other inmates. Threats and attacks may make a younger inmate act impulsively to take his or her life. A study of sexual coercion in prison noted that approximately 20 percent of inmates are reportedly pressured or forced into sexual contact with another person. One third of the male targets (36 percent of those subjected to sexual coercion) experience thoughts of suicide.[60]

Method of Suicide

Over 80 percent of suicides are completed by hanging. The feet of the hanging victim need not be off the floor for the attempt to end in fatality. Only 2 kg of pressure has to be applied to the neck to cut off blood flow to the brain. Hanging can be accomplished while kneeling, sitting, standing, or lying down. The fastening anchor can be close to the floor, such as a window bar, window crank, air duct vent, handrail on the wall, bedrail, cell bar, or lock box, or higher points such as light fixtures or shower heads.

Death occurs in five to seven minutes, but permanent brain damage takes as little as three minutes. Bed sheets, shoelaces, jump ropes, belts, socks, elastic waist bands, and wound bandages can all be used as a ligature. Asphyxia is the most common cause of death in hanging.[30] Although hanging does not always communicate a serious intent to die, the effectiveness of the method yields a high mortality rate.

Overdose of psychotropic drugs, especially tricyclic antidepressants, is the next most common method, followed by antihypertensives and over-the-counter pain medications.[28,29] Self-immolation is uncommon, yet it has a mortality rate of 33 percent in the groups studied. Victims tend to be female and to have severe psychopathology.[61] Other uncommon methods include hunger strike, swallowing sharp objects, and jumping from a height. Occasionally, homicidal hanging may masquerade as suicide.[62]

In summary, studies confirm that the most significant risk factors of suicide among prisoners consist of mental illness—particularly depressive disorder, psychological states of depression and hopelessness, prior suicide attempts, a preincarceration history of psychiatric disorder and substance abuse, and a recent psychosocial stressor acting as a precipitant. These findings are consistent with those reported recently by Kovasznay *et al.*[63] Other risk factors include being a young white male, placement in a maximum security prison, single-cell living or isolation, and interfacility transfer. These factors and the methods used should be taken into account in planning suicide-prevention strategies.

Suicide-Prevention Strategies

Suicide prevention must be the collaborative responsibility of administrative, custodial, and clinical staff and should be a top administrative and clinical priority in every prison. A comprehensive mental health and psychiatric service delivery system[64,65] supported by the administration forms the foundation of preventive efforts. A well-designed suicide-prevention program incorporates all aspects of identification, assessment, evaluation, treatment, preventive intervention, and training of all medical, mental health, and correctional staff.[64,65] Comprehensive mental health services in prisons are slowly being established in departments of corrections, largely due to successful class-action suits, legislative actions, and progressive-thinking administrators and clinicians. Fully trained mental health and correctional staff in prisons are rare because of lack of qualified professional pools, budgetary constraints, National Guard deployment, and the nature of correctional work. Creation of a specific division of administration dedicated to offender rehabilitation that oversees and coordinates medical, mental health, vocational, and educational services is important to ensure an adequate staff-patient ratio, a multidisciplinary treatment team approach, timely treatment planning, staff training, and overall rehabilitative services.

Administrative Steps

Policy Development and Implementation

Legally sound and defensible policies and procedures that are rigorously and systematically implemented form the basis of appropriate administrative and clinical practice. Key policies ensuring good clinical care and suicide prevention include those covering (1) suicide assessment, observation, and intervention; (2) psychotropic medication use; (3) involuntary/forced medication and involuntary medical treatment; and (4) inpatient hospitalization of the mentally ill. The policies must be reviewed with all medical, mental health, and correctional staff.

Implementation of Suicide Risk Rating Program

If properly implemented, a suicide risk rating program can capture high-risk individuals. A commonly used risk rating instrument is the Multi-Dimensional Risk Assessment.[66] The goal of this program is to identify suicidal inmates (on their arrival) and to monitor them as they move through the system. Inmates are given a Suicide Risk Rating score of 1, 2, or 3, indicating the severity of suicide potential. Visible placement of the SR score in the medical record and registering the high-risk inmates in chronic care clinics enable systematic tracking of them. An inmate is registered in a clinic at a specific facility, and the generated database follows him/her, even when the inmate is transferred to another facility, making data available for future mental health and psychiatric contacts. Many prisons have established a clinical/administrative-level committee consisting of medical director, psychiatrist, health services administrator, and assistant superintendent of administration, to discuss high-risk inmates.

Procedures for Administration of Psychotropic Medication

Policies and procedures covering the length and quantity of prescriptions, medication renewal, and nursing practices must address the type and mode of administration to avoid opportunities for hoarding of medications with lethal potential. Medications with non-lethal potential should be preferentially prescribed, reducing the frequency of overdose with such medications. The watch-take policy for administration of psychotropic medication instituted in many correctional systems is an effort to cut back on the instances of "cheeking" or hoarding. However, the watch-take practice does not eliminate fatal overdoses of somatic medications—an occurrence that is not uncommon in prisons. As an alternative, crushing of medications or administration in liquid form has been implemented. Although crushing medications seems to be a good addition to any psychotropic medication practice, in reality, this method is full of pitfalls. For example, some medications are in capsule or time-release form and cannot be crushed before ingestion. Furthermore, there is no guarantee that every granule of a crushed pill makes it into the inmate's mouth, which may alter the dosages.

A structured protocol for dealing with medication of noncompliant offenders and those who consistently refuse medications is a significant step in preventing suicide. Furthermore, if a suicidal inmate is incompetent to make a rational decision regarding medication and if he or she is gravely disabled, involuntary administration of medication may be implemented.

Administrative Management of Institutions

Four concerns relevant to suicide prevention deal directly with management of individual institutions and the correctional system as a whole. These include (1) segregation monitoring; (2) offender assignment; (3) out count and interfacility movement; and (4) cell design.

As a suicide-prevention measure, suicidal inmates should not be placed in segregation units, because such placement does not promote improved mental health. The National Commission of Correctional Health Care Prison Standards stipulate that suicidal inmates should not be housed or left alone unless constant supervision can be maintained.[64] If it is necessary to house an inmate alone, provision should be made for uninterrupted supervision and human contact. In addition, regular rounds in the segregation area to screen inmates for suicidal intent and mental illness should be a standard procedure.

Offenders must also be given housing assignments that are appropriate for the level of threat they present to themselves and/or others. Careful placement of younger inmates in appropriate facilities where their security and mental health needs can be met has the potential to lower the suicide rate in this group.

Inmates on "out count" for a court hearing may be temporarily placed in a county jail. The potentially suicidal inmate may find in the transfer a golden opportunity for self-harm, because of the laxity of supervision in jails. Vulnerability to suicide increases if the court hearing results in an unexpected outcome such as an additional long sentence. As a preventive measure, a copy of relevant records must always accompany the inmate with a history of suicidal ideation or attempt when placed on out count. Suicidal inmates should be treated in county jails just as they would be treated in prison (i.e., increased monitoring, evaluation by mental health staff, no access to harmful objects, and a watch-take medication policy).

A formal procedure to seek input or clearance from mental health staff before a mentally ill prisoner is transferred to another facility must be established. If the system does not have an electronic medical record system, the inmate's mental health records should be transferred promptly to the receiving facility. The transferred prisoner must be seen by a mental health professional within 24 hours and by a psychiatrist within 72 hours and, thereafter, on a regular basis. Finally, as a precautionary step, no prisoner on suicide watch should be transferred.

Designing a protrusion-free cell or a cell window-frame in a way that does not permit fastening a ligature band would help decrease suicides, although in practice such a design would be difficult to achieve. However, with a little planning the number of obvious anchors can be drastically reduced. Air vents can be designed with holes too small to permit threading of a sheet. Use of break-away shower heads and raised concrete slabs that hold mattresses off the floor are helpful. Many efforts to create suicide-proof cells have proven inadequate for the clever inmate seeking a way to kill himself. While a perfectly designed suicide-proof cell is unlikely, it is important that the entire interior of each cell be visible from the walkway. Frequent monitoring of inmates in their cells is

more important than any cell design. Nothing can replace human supervision as a deterrent to suicide.

Training and Education

Training correctional officers and mental health and medical staff to deal with suicidal inmates is crucial. If prison staff are given adequate training in recognizing, dealing with, and understanding the motivations behind suicidal behavior, they are less likely to feel that suicidal inmates are being manipulative. Training topics must include (1) identification of high-risk offenders; (2) how to identify signs and symptoms of mental illness; and (3) how to handle communication of intent. Training must occur regularly. Any staff can be trained to spot certain "warning signs" of suicide. Correctional officers and clinicians may observe slightly different warning signs, simply because these two groups deal with the inmate in different situations. With regard to clinicians, the training must also include steps to complete the Multidimensional Risk Assessment Form, modalities of intervention, and referral to appropriate professionals including the psychiatrist. It is helpful for correctional officers and mental health professionals to be familiar with the general profile of a suicidal inmate, although there are exceptions to every situation and this "profile" should be used with discretion. New York State has developed a model training program for identifying suicidal inmates[67] that uses a video, handbook, and tests to teach and evaluate the correctional officers. Any successful training program must emphasize good communication between correctional officers and mental health staff. Individuals from mental health staff and ranking administrative personnel should participate in the training. Also, having a corrections officer serve as a trainer makes other correctional officers feel that the training is worthwhile and applicable to their jobs.

Peer Groups and Inmate Training

Correctional facilities have attempted to create peer groups for populations who are often targeted for victimization, such as child sex offenders. When inmates are surrounded by those who have had similar experiences, they may be less likely to feel suicidal. Having a trained inmate to work with high-risk inmates may drastically reduce the likelihood of suicide.[29] The effectiveness of peer support groups and inmate training programs have not been properly studied, and anecdotal information questions the usefulness of these programs.

Handling Inmate Communication of Intent

Approximately 60 percent of inmates may communicate their intent to kill themselves either verbally or nonverbally. Verbal communication is either spoken or written but nonverbal communication can be much more ambiguous, such as giving away important possessions, refusing medication or asking for more medication, and cutting off contact with family members. An inmate may communicate his or her intent to a corrections officer, mental health staff, a friend, family member, judge, or cell-mate. It is often difficult to learn of communications to outsiders, because the recipient may not report it. If an inmate commits suicide after such a communication, the friend or family member usually denies knowing that the inmate was serious about committing suicide. It is not easy to convince other inmates to report communications; however, a confidential system for reporting, preferably in written form, must be established so that inmates do not feel they are putting themselves in danger when making a report. In view of the fact that correctional officers and clinicians have a higher degree of responsibility than do other recipients, they should make a report of the communication and forward it to a mental health professional, who in turn should confer with prison administration. The report should be added to the inmate's file and appropriate steps taken to ensure that the inmate is not at risk of self-harm.

Clinical Procedures

The primary focus up to this point has been administrative and custody staff responsibility. Suicide prevention must be a clinical priority as well.

Mandatory screening of all inmates for suicidal intentions has been instituted in almost all reception centers. Metzner *et al.*[2] proposed three different types of mental health screenings and evaluations that include initial screening at reception, mental health and medical evaluation within 7 days, and psychiatric evaluation on referral by a mental health professional. The screening ensures triaging of inmates for proper treatment and placement. Screening, a crucial step in the identification of suicidal inmates, involves face-to-face contact by intake staff. The screening tool must be a comprehensive and standardized measure that is valid and reliable. The

screening process must capture a complete history of any suicidal behavior, including all prior suicide attempts and/or periods of suicidal ideation, even if the inmate is not suicidal at the time of intake. After screening, if an inmate evidences suicidal ideation or behavior, a Multidimensional Suicide Risk Assessment form, modified for application in corrections, is completed to obtain a Suicide Rating (SR) score. Suicide risk assessment is a continual process performed by all mental health and psychiatric staff and should be performed at every clinical encounter. Such an assessment will allow the psychiatrist and other clinicians to take specific intervention steps, which may include placing the patient on suicide watch, modifying medications, and arranging to have one-to-one sessions, and will also alert correctional officers to keep an eye on the prisoner.

Those who are identified to be at some risk of suicide, as noted by an SR score, require intensive clinical monitoring. Since many inmates who commit suicide have contact with mental health staff before the suicide, warning signs and behavioral changes suggestive of self-harm must translate into increased watchfulness, careful monitoring, and intervention. Regular contacts by the clinician and systematic counseling can help the inmate with problems that may contribute to suicidal thoughts and/or attempts. Furthermore, the clinician is able to recognize normal patterns of behavior for that inmate and will be more closely attuned to any future changes than other staff members who interact with the inmate only sporadically.

Based on suicide risk assessment, a prisoner may be placed on suicide watch—a heightened state of observation where he/she is subjected to frequent checks by correctional staff. Documentation must include the reason for the suicide watch, details of what the prisoner is allowed to have in his or her cell during suicide watch, frequency of cell checks (for instance, every 15 minutes), and a procedure for termination of the watch. Records become critical from a forensic point of view in the event of suicide and possible litigation. Though video monitoring is an excellent tool for ensuring uninterrupted observation, it may not be as effective as the direct personal observation by staff (author's observation).

Treatment of Psychiatric Disorders and Substance Abuse

Prisoners with psychiatric problems must be placed in a proper treatment program.[12] Diagnostic specificity and accuracy and clarity of Axis I and II disorders are critical in determining appropriate psychotropic medications. Psychiatric manpower resources are very limited in corrections, and therefore reliance on psychotropic drugs as the sole suicide-prevention strategy is common.[66] Psychiatrists occasionally use suicide-prevention contracts as opposed to taking time to develop a therapeutic alliance. These contracts should be used as only a part of a greater treatment plan and not in lieu of suicide risk assessment and intervention. Specific procedures must be in place to facilitate the admission to a psychiatric hospital administered by the State Department of Mental Health of acutely mentally ill offenders, civil commitment of those who are likely to pose a danger to themselves or others to the Department of Mental Health on release,[68] and transition of mentally ill prisoners to community-based treatment programs.

Although detoxification programs are crucial in jails, a comprehensive substance abuse treatment program is important in the care of suicidal prisoners with a history of substance abuse. Most substance abusers undergo forced abstinence while incarcerated but on release may relapse due to "rekindling" resulting from exposure to personal triggers. Therefore, systematic treatment while incarcerated may reduce immediate post-release suicides.

Information Management System

The administrative and clinical aspects of a sound suicide-prevention program should be linked by an effective information-management system. Screening instruments, risk assessment forms, suicide watch reports, classification files, medical records, mental health records, psychiatric evaluations and progress notes, medication entries, the medication administration record, Suicide Risk Rating level 3 (SR 3) debriefing reports, and suicide debriefing and mortality reports all form essential components of the program for effective communication. A uniform system of documentation will assure seamless communication between staff and facilities. Forms provide a simple way to insure that certain pieces of information are documented every time. Some correctional departments use computerized systems that provide easy but confidential access to information from any location. Last but not least is the willingness of all staff to document observations, decisions, and actions adequately and thoroughly.

Psychological Autopsy and Mortality Review

Suicide prevention is an area that is constantly evolving. Following a suicide, a complete mental health debriefing (psychological autopsy) must be completed. This process involves drawing together pieces of information from the inmate's medical and mental health records, classification files, toxicology reports, and autopsy. The psychological autopsy should include basic demographic information, life history before incarceration (including family, mental health, and medical histories), criminal history, mental health contacts within the correctional facility, psychotropic drugs used, and pattern of prescriptions and other health concerns while in the facility. The psychological autopsy should be reviewed to highlight any patterns or areas of concern for prison staff. Policy and procedure changes may result from this process. Unlike the psychological autopsy, which is written primarily by mental health and correctional representatives, a mortality review is undertaken by a committee consisting of physicians, psychiatrists, and administrators. The committee discusses the incidents leading up to and including the suicide. The report includes a brief history of the inmate's psychological history, but most of it is focused on the suicidal act itself. The mortality review reports the last time the inmate was seen alive, the time that the inmate was found, who found the inmate, efforts that were made to resuscitate the inmate, when additional help arrived, whether the inmate was taken to a hospital, heroic measures taken at the hospital, and time of death. Every person who was involved in the suicide—from the discovery of the inmate until the inmate was pronounced dead—is interviewed so that a complete scene can be described. The mortality review is often used to evaluate the system's response to the suicide. Any difficulties that arise with prison staff response can be addressed so that similar situations are handled more effectively in the future. A detailed description of cause of death is completed as well.

Continuous Program Evaluation

It is difficult to determine whether specific suicide-prevention strategies actually decrease the number of suicides.[48] Empirical research cannot be conducted on suicide in prison, simply because it would be unethical to withhold certain preventive strategies from suicidal individuals for the sake of research. However, after implementation, the suicide-prevention program must be evaluated continually by standardized auditing, which allows necessary adjustments to be made in a timely manner. Both administration and service providers must evaluate individual components as well as the system as a whole. Therefore, a systematic program evaluation and quality-assurance plan should be developed and implemented. Indirectly, lower mental health scores, fewer incidents of suicidal behavior, or use of less psychiatric medication may denote improvement in the program. Of course, it would be necessary to perform a well-designed study to make sure that the improvements were not connected with other similarly timed events. Although studies of suicide in prisons are retrospective, prospective studies using comparison groups of non-suicidal inmates are needed. Women who commit suicide in prison should be studied extensively,[69] because data on that topic are minimal. Another area of research is to determine the effectiveness of timely medical intervention with serious suicide attempters.

Conclusion

When fully operational, the comprehensive suicide-prevention program outlined herein may not only save lives but also may reflect adequacy and thoroughness of overall mental health and psychiatric services delivery systems as well as correctional practices. Nearly 30 percent of inmates who commit suicide have no psychiatric illness and provide no warning signs. Mental health and correctional service providers may fail to identify this population. The program described is also a roadmap to avoid any malpractice or deliberate-indifference claims by a third party.

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