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Maurizio Pompili,[1,2] *M.D., Ph.D.; David Lester,*[3] *Ph.D.; Marco Innamorati,*[4] *Psy.D.; Antonio Del Casale,*[2] *M.D.; Paolo Girardi,*[2] *M.D.; Stefano Ferracuti,*[2] *M.D.; and Roberto Tatarelli,*[2] *M.D.*

Preventing Suicide in Jails and Prisons: Suggestions from Experience with Psychiatric Inpatients

ABSTRACT: Both among psychiatric inpatients and inmates of prisons and jails, suicide is highly prevalent with alarming rates. In many countries, there has been a call for action to prevent such deaths and to educate staff in the early recognition of suicide risk. A careful MedLine search was used to identify relevant papers dealing with suicide prevention in psychiatric inpatients. This paper reviews this research and the policy recommendations that have been developed for psychiatric hospitals in order to reduce the incidence of suicide in their patients. Results derived from this search indicated that these policy recommendations can be applied to suicide prevention in correctional settings, and it is argued that suicide prevention programs in correctional settings can benefit from the research conducted and the policy recommendations for suicide prevention in psychiatric facilities. In conclusion, the best practices for preventing suicides in jail and prison settings should include the following elements: training programs, screening procedures, communication between staff, documentation, internal resources, and debriefing after a suicide.

KEYWORDS: forensic science, forensic psychiatry, suicide, prison staff, prevention, inpatients, prisoners

Suicide is a huge, but largely preventable, public health problem, causing almost half of all violent death in the world, resulting in almost one million fatalities every year and economic costs in the billions of dollars, according to the World Health Organization (1). More people die from suicide than in all of the armed conflicts around the world and, in many places, about the same or more die from suicide as the number dying from traffic accidents. Until recently, suicide was more common among the elderly, but now suicide predominates in younger people in both absolute and relative terms in a third of all countries. Suicide profoundly affects individuals, families, workplaces, neighborhoods, and societies. Surviving family members not only suffer the trauma of losing a loved one to suicide, but they may also be at higher risk themselves for suicide and emotional problems.

Despite the prevalence of suicide in hospitals and prisons (2–4), suicide among inmates and inpatients has always been of less concern. The people in correctional facilities are labeled as "criminals" and those in psychiatric hospitals as "crazy," and they have been viewed as less valuable members of the society. Only in recent years, as lawsuits have held institutions liable for the deaths of those in their care, causing financial burdens to settle the lawsuits, have staff become concerned with preventing suicide in those who are institutionalized.

The two sets of administrators and researchers, those in psychiatric hospitals and those in correctional facilities, have typically carried out their research and program evaluations independently of each other. However, the problems that both types of facilities face have a lot in common, and they may be able to learn from each other's experience. The present paper discusses the problem of managing suicidal behavior in an institutional setting, comparing the problems faced by staff in psychiatric hospitals and in correctional facilities, and applying the knowledge gained in psychiatric facilities to suicide prevention in custodial institutions.

[1]McLean Hospital, Harvard Medical School, Boston, MA.
[2]Department of Psychiatry, Sant'Andrea Hospital, Sapienza University of Rome, Rome, Italy.
[3]The Richard Stockton College of New Jersey, Pomona, NJ.
[4]Università Europea di Roma, Rome, Italy.

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Methods

We performed careful MedLine and PsycINFO searches from 1980 to 2008. The following search terms were used: "prison" (which comprises prison, prisoner), "suicide" (which comprises suicide, suicidal, suicidality, and other suicide-related terms), "jail," "prevention," "staff," "psychiatric patients," and "psychiatric unit." In addition, each category was cross-referenced (when applicable) with the others using the MeSH method (Medical Subjects Headings). Selection of papers suitable for this study allowed the inclusion only of those articles published in English peer-reviewed journals. Included were those studies that added an original contribution to the literature. A total of 567 articles were located through our search; the most relevant articles were selected for this overview.

Results

Suicide in Mental Health and Correctional Facilities

Prisons typically have a concentration of high-risk individuals placed in high stress circumstances. Imprisonment and the events leading to it are highly stressful. Inmates are removed and then isolated from their families and friends, and they are placed in a highly controlled, dehumanizing environment. The problem has received much recent attention. The International Association for Suicide Prevention has set up a task force to compare suicide prevention services in correctional facilities in different nations and to

make recommendations (5,6), and several recent books have appeared on the topic (7,8).

Fazel and Danesh (9) surveyed 23,000 male prisoners in eight Western nations and found that 4% had psychoses, 10% had depressive disorders, and 65% had a personality disorder (primarily antisocial personality disorder). In addition, many prisoners have been abusing alcohol and drugs prior to incarceration and, therefore, undergo withdrawal in prison. The proportion of psychiatrically disturbed prisoners has increased in those nations where, in recent years, there has been a move to de-institutionalize psychiatric inpatients and move them into community care. This has resulted in large numbers of psychiatrically disturbed individuals becoming homeless and engaging in criminal activity. Many of them end up in prison. The need for psychiatric facilities and care in custodial institutions is great (10), and yet few, if any, jails and prisons have the monetary and staff resources to provide adequate psychiatric care. The resolution of this state of affairs is either to find alternative placements for the psychiatrically disturbed or to provide adequate funding for the provision of psychiatric services in correctional institutions.

As psychiatric institutions have the staff and resources to provide adequate treatment for suicidal patients and to implement sound suicide prevention programs, the following sections describe best practices based on the accumulated knowledge of psychiatric researchers and policy makers.

General Considerations

The leading indicators of inmate risk are severe depression, diminished self-esteem, complaints of emotional or psychological pain, talking about or threatening suicide, and nonlethal self-injury. A preoccupation with death is never "normal." In all settings, extreme sadness or crying, expressions of inability to cope or continue, extreme physical and psychological agitation, and excessive self-blaming should raise concern. A history of mental illness or suspected mental illness, and previous attempts or other suicidal behaviors are potential indicators.

However, most inmates with mental illness do not commit or even attempt suicide (11), and false positives (inmates identified as potentially suicidal but who really are not at risk for suicide) could not be eliminated from the assessment procedure. The situation was made worse because both inpatients and inmates gave few or no immediate warnings and seldom communicated their suicidal intent directly (12,13). Furthermore, the presence of fluctuating suicidal ideation suggests that suicide may be difficult to predict because almost all individuals who performed the act of suicide either had fluctuating suicidal ideation or were not continuously suicidal. Both these observations were consistent with the reports of inpatients in mental health settings committing suicide when they appeared to be improving (14–16). Inpatients had a high risk of suicide after they were removed from "suicide status." This underlines the fact that apparent improvement should never mean decreased vigilance (16). The link between suicide and apparent improvement mentioned above has several possible explanations. First, the patient's ambivalence about suicide may result in apparent improvement (14,17). Second, patients may try to trick staff by falsifying improvement (17). Third, apparent improvement may occur owing to resolution of conflict after making a decision to commit suicide (14,16). Finally, a lessening in the level of depression may result in more energy to undertake the actions necessary to commit suicide (18).

Substance misuse and intoxication constitute extremely high risk (19–21). Behaviors such as writing a will, giving away or packing up possessions, dropping individuals from visitor lists, and unrealistic remarks about "getting out" may indicate that an inmate is at higher risk of suicide. Inmates with serious physical illnesses such as cancer or HIV/AIDS (who have a 20 times greater risk of suicide) (22), and those who have been raped, intimidated to grant sexual favors, or bullied are at risk of becoming suicidal (23).

In all facilities, inmates and inpatients in isolation, seclusion, or administrative segregation account for a disproportionate number of suicides (22,24–27). Enforced physical isolation can be a frightening experience for a person who already feels estranged, and suicide may be committed even by individuals who do not make previous suicidal attempts or threats. Assaultive individuals when physically secluded may turn their aggression upon themselves and commit suicide. This points to the importance of understanding the individual needs of the mentally ill inmates and the danger of separating them from human contacts.

Copycat behavior may be a significant risk factor for suicide both among psychiatric patients (28) and inmates (29,30); thus, staff have to consider that risk rises when an inmate is bereaved by the suicide of another inmate with whom he/she had a close relationship, or if there has been a recent suicide attempt in the facility.

Periods of decreased staffing (such as on weekends, nights, and holidays) and darkness are times when many inmate suicides take place. Salmons (31) showed that many of the deaths in one unit were associated with periods at which there were lower levels of staffing than usual. In mental health settings, Hesso (32) also drew attention to the fact that a high rate of personnel turnover resulted in staff who were less experienced in suicide prevention. Interfacility transfers may also amplify the risk of suicide as may the loss of a valued job in the prison.

Jones (33) highlighted the fact that several environmental and operational factors might contribute to suicide such as:

1 inadequate or unavailable psychological services at initial intake and during incarceration;
2 poor communication among staff;
3 perception of self-injurious behavior as a means of manipulation;
4 basic elements of the institutional environment that constrain personal efficacy and control;
5 limited staff training and direction in suicide prevention;
6 limited staff direction to respond to suicide incidents; and
7 investigations after a suicide have been directed primarily toward establishing an appropriate response by staff without the accompanying thorough investigation of the causes of the suicide.

Risk factors common to psychiatric inpatients and custodial inmates are shown in Table 1, while Tables 2 and 3 present prisoner risk factors proposed by the World Health Organization (34,35).

Screening and the Use of Profiles

Screening and profiling suicidal inmates is not a popular tactic for correctional staff. Screening is often thought to identify too many false positives, and false positives encourage staff to disregard warning signs of potential inmate suicide. Profiles are also thought to be so general that they lack usefulness. Even when the detention center staff assess suicide risk there is weak interjudgmental agreement between the detention center evaluation and a clinical assessment (36). This may require development of standardized procedures in detention facilities.

TABLE 1—*Risk factors common to jails and prisons.*

Environmental Factors
Being in isolation or segregation cells
Shifts with reduced staffing (e.g., nights or weekends)
Psychosocial Factors
Distal Factors
Poor social and family support
Prior suicidal behavior (especially within the last 1 or 2 years)
History of psychiatric illness and emotional problems
Proximal Factors
Hopelessness
Narrowing of future prospects
Loss of options for coping
Feeling of being bullied
Suicidal intent or suicidal plans

TABLE 2—*Factors which may be suggestive of higher suicide risk among inmates according to the World Health Organization (40).*

Psychosocial Factors
One or more individual vulnerabilities (e.g., young age, mental illness, social disenfranchisement, social isolation, substance abusing or dependence, and previous suicide attempts)
Environmental Factors
No formal policies and procedures to identify and manage vulnerable individuals
Burn-out and overworking
Overcrowding (41)
No continuing training for personnel
No coordination with community mental health programs

In mental health settings, there are many standardized rating scales and interviews which have been explored for their usefulness in evaluating suicidal risk (37), and one or more of these scales are always used to evaluate the suicide risk of psychiatric patients. Problems of usefulness and efficiency (false positive) of these scales, although not without foundation even in the clinical settings, have never prevented the use of these scales in psychiatric facilities because any relevant staff member who fails to make a sound investigation and estimation of the suicidal risk of a patient would be judged to have been guilty of malpractice.

Although false positives can never be eliminated completely from the assessment procedure, more research comparing inmates who committed suicide with those who do not could help to identify more meaningful risk and predictive factors, thus making assessment more efficient and reliable. In particular, these risk factors may be different for different types of institutions and even differ for individual institutions. Therefore, each institution, especially large institutions, should explore developing their own modification of available screening instruments, validating them in their specific populations of inmates.

Once correctional staff is trained and familiar with risk factors of suicide, the next step is to implement formal suicide screening of newly admitted inmates. As suicides in jails may occur within the first hours of arrest and detention, suicide screening must occur almost immediately upon entrance to the institution in order for it 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 matched high-risk profiles and those who showed signs of suicidal intent. When resources permit, suicide screening on intake may be undertaken within the context of a cursory, medical examination conducted by facility-based health care staff. Should suicide screening be a responsibility of correctional staff, they should be adequately trained and aided by the use of a suicide checklist.

TABLE 3—*Answers suggested by the World Health Organization (40) which, if affirmative, may indicate an increased risk of suicide and a need for further intervention.*

Is the inmate intoxicated?	The inmate shows dysfunctional changes in physiological functioning and/or behavioral functioning (e.g., sudden mood changes and instability not due to environmental stimuli, deficits in cognitive processes) just after the consumption of a psychoactive substance.
Does the inmate express unusually high levels of shame, guilt, and worry over the arrest and incarceration?	
Does the inmate express hopelessness or fear about the future, or show signs of depression?	He could show some of the following conditions: He says he feels sad, empty, or depressed, or appears to others tearful and irritable. He acts as if he has lost interest or pleasure in his everyday activities. His sleep habits change, showing insomnia or hypersomnia during his daily routine. He shows psychomotor agitation or retardation, diminished ability to concentrate or indecisiveness. He expresses feelings of worthlessness or desperation.
Does the inmate admit current thoughts about suicide or lack of reasons for living?	He could say he feels life was not worth living, thinks that for him, and for his own family, it would be better if he were dead, or thinks of ending his life.
Has the inmate previously received treatment for a mental health problem?	
Is the inmate currently suffering from a psychiatric condition or acting in an unusual or bizarre manner?	He has a great difficulty focusing attention, talks to self, hears voices; has disorganized speech or behavior, flat or inappropriate affect or stereotyped movements.
Has the inmate made one or more previous suicide attempts and/or admits that suicide is currently an acceptable option?	He says he has nothing to prevent him from killing himself.
Does the inmate admit current suicide planning?	He says he thought about his death and, now, he knows exactly what to do.
Does the inmate admit or appear to have few internal and/or external supportive resources?	He says he feels lonely or he has few or no visitors. He says he cannot continue.

Suicide checklists are an important part of a comprehensive suicide prevention program for a number of reasons. First, they provide the intake officer with structured questions on areas of concern that need to be covered. Second, when there is little time available to conduct screening, they act as a memory aid for busy intake staff. Third, they facilitate communication between officers and locations within the institution and, finally, they provide legal documentation that an inmate was screened for suicidal risk upon entrance into the facility and, again, as conditions changed.

Once an increased risk of suicide has been identified, it should be noted in the individual's file so that the information is passed on to staff on a new shift or staff of another agency or facility. Finally, the usefulness of suicide checklists is not restricted to intake, and they are not intended as stand-alone risk estimation tools. They may be used at any time in an inmate's incarceration to identify suicide risk and to indicate the need for further assessment and intervention by adequately trained correctional staff.

In recent years, the trend in psychiatry has been away from "predicting" suicide in psychiatric patients to "assessing" the suicidal tendencies of psychiatric patients. A variety of scales to assess suicidal intent and both states and traits associated with suicidality have been identified for this purpose (37). In particular, standard assessment tools exist for measuring levels of depression and hopelessness (10). Using these scales and building a record in each inmate's file can prove useful in looking for changes in the inmate's state of mind which may presage a suicidal act. The measures of hopelessness, reasons for living, and psychache are associated with higher suicide risk both in mental health inpatients and inmates (38,39)

The fact that profiles may have failed to provide useful information in the past does not mean that this will remain true in the future. Profiles are useful for identifying potentially high-risk groups who may need further screening and intervention. As successful suicide prevention programs are implemented, high-risk profiles may change over time. 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.

Screening in Jails

Jail suicides usually involve young, highly traumatized (19,40), alcohol-compromised individuals, often first-offenders, detained in settings with little screening for suicide risk, insufficient training of staff, and limited supervision of the detainees. A national study of 1986 jail suicides (41) found that 89% were not screened for suicidal behavior at booking, 51% of the deaths occurred in the first 24 h of incarceration, and 48% of those who were intoxicated died within the first 3 h of their stays. The first 24 h of detention in jails are the most dangerous with regard to suicide. As Crammer (42) highlighted, transitions may have potentially disruptive effects on severe mentally ill individuals, and initial acclimation to jail life and discharge may be considered as situations at higher risk for suicide (43,44). Yarden (45) drew attention to the importance of suitable discharge plans from mental health facilities. Adverse circumstances such as return to a family in which the individual's presence represents a severe emotional or financial strain most likely will add to the suicide risk for a mentally ill inmate (46).

Post-Intake Observation

Because many jail and prison suicides occur after the initial period of incarceration (some after many years), it is insufficient to screen inmates at the time of intake; they also have to be assessed 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 (47). Toward this end, correctional staff may gather clues to a possible inmate's suicidality during the following activities:

1 Routine checks to watch for indications of suicidal intent or mental illness, such as crying, insomnia, sluggishness, extreme restlessness or pacing up and down; sudden changes 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.
2 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.
3 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 harbor suicidal wishes.

Staff Variables Which Impair Assessment

The general problem of screening procedures for risk of suicide at the time of intake and at regular intervals does not solve completely problems related to suicide prevention in prisons because various psychological state and trait characteristics may compromise the staff's ability to identify suicidal risk. Literature from mental health settings informs us that staff difficulties in dealing with the subject of suicide and the staff's own personal problems are a major contributor to misleading evaluations of suicidal risk (48). In addition, acceptance by the staff of the inmate's right to kill himself, fear and anger, and difficulties in dealing with suicidal individuals may be some of the most important contributions to misleading evaluations in psychiatric and correctional facilities.

Achté et al. (49) noted that an understanding and tolerant therapeutic attitude on the part of the entire staff, free from hostility, reduced the danger of suicide. Staff members must be trained to develop empathic skills, but it is hard work dealing with seriously disturbed patients, especially when they have several stigmatized characteristics such as substance misuse, aggressiveness, impulsivity, or self-injurious and violent behaviors. For example, Warren et al. (50) indicated that the mentally disordered were overrepresented among offenders who threaten violence and that both homicidal violence and suicide behavior were frequent among threateners with a schizophrenic illness.

The concept of "terminal malignant alienation" (14,17) explains in part the difficulties in managing such individuals. Some patients, particularly those with recurrent relapses and resistance to conventional psychiatric treatment, may be perceived by staff as manipulative, provocative, unreasonable, overdependent, and feigning disability (14,17,51,52). Inpatients with fluctuating suicidal ideation are particularly likely to fall into these categories and may lead staff to ignore suicidal ideation (A.K. Shah, P. Bell, personal communication, 1996). This may also result in a hostile attitude toward the individual and a lower level of support, leading to feelings of alienation in the inmates. The combination of such alienation and fluctuating suicidal ideation can lead to failure in the recognition of seriousness of suicidal risk (14,17).

Another possible contributing factor that may impair staff skills in recognizing suicide risk among inmates with severe mental illness is work stress and burnout (16). Stressed and burnt-out staff are less able to function appropriately in preventing suicide. In addition, staff may lack proper training about suicide and, therefore, may appear unsympathetic toward suicidal patients and deny or suppress warning signs for suicidality (53).

Management Following Screening

Following screening, adequate and appropriate monitoring and follow-up are 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 shifts (when staffing is low) and in facilities where staff may not be permanently assigned to an area (such as in police lockups). The level of monitoring should be on a case-by-case basis and 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 min.

With increasing technology, camera observation has been substituted for 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.

A "suicide prevention" facility is one with a calm routine, carried out daily by staff who are themselves unworried and confident of the immediate future. Inmate suicides may occur when the calmness is broken, the routine disrupted, and the staff themselves disturbed. The inmates' personal relationships with others in the facility are important, and suicide may occur where there is a failure to develop any relationships with staff members or other convicts. In this connection, Farberow et al. (54) described a "dependent-dissatisfied" person who made continual repetitive demands on others, regardless of effect, thus alienating them. In mental health settings, Morgan (55) reported cases of individuals who were so provocative, difficult, and unreasonable that the staff ultimately felt hostile towards them before their suicides.

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 whatever reason 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 and social support by trained facility staff.

Other suicide prevention strategies that are currently employed include good staff-prisoner relationships, comprehensive risk assessments, and provision of support through the Samaritans. The Samaritans is an organization first established in England, but which has now spread to many nations in the world, that provides crisis intervention for anyone in crisis, including suicidal individuals, staffed by volunteers who are trained to provide the services (http://www.befrienders.org). It has provided suicide prevention services in several prisons in England and Canada using inmates as "listeners" for other inmates in crisis (56).

Physical Environment and Architecture—The main issues faced by psychiatric and correctional facilities after screening individuals for suicidal risk is to ensure that suicidal inmates do not have the opportunity for committing suicide.

Most inmates and inpatients commit suicide by hanging using objects of clothing (e.g., socks, underwear, belts, shoelaces, and shirts) or with sheets or towels (53,57), with jumping the next most common method, and efforts to reduce the number of suicides in hospitals focus on these methods. 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.

In a safer cell, all the corners are rounded, the pipes are covered, the light fittings are modified, and a safe ventilator is placed instead of windows that open and that could, therefore, be used to attach a ligature. When a cell is built to the full specifications, it is called a safer cell. Limited budgets sometimes limit the full implementation of the safer cell design in which case the cells are designated as reduced-risk cells.

Although most means of self-harm can be removed from cells and the opportunities for committing suicide minimized, there are a number of other unintended effects that the cells can have on prisoners. These include increased isolation, frustration, and depression as a result of being held in a particularly abnormal environment and over which the occupant has little control.

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. 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 with community-based programs. This means that criminal justice, mental health, and health systems must be linked for the task of suicide prevention in correctional settings. Depending on the location, this may require multi-agency cooperative service arrangements with general hospitals, emergency

services, psychiatric facilities, community mental health programs, and addiction programs.

After a Suicide Attempt

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 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.

Postvention

Following an inmate suicide, it is important to have debriefing sessions not only to help the staff and fellow inmates who may be traumatized by the individual's suicide, but also to explore the sequence of events and to ascertain whether opportunities for preventive actions were missed and what other tactics might have been employed to prevent the suicide.

Manipulative Prisoners

Few issues challenge prison officials and staff more than the management of manipulative inmates. It is not unusual for inmates to call attention to themselves by threatening suicide or by feigning an attempt in order to avoid a court appearance, bolster an insanity defense, get relocated to a different cell, be transferred to the prison infirmary or a local hospital, receive preferential staff treatment, or seek compassion from a previously unsympathetic spouse or other family member.

Although the prevailing theory is that any inmate who would go to the extreme of threatening suicide or engage in self-injurious behavior is suffering from at least an emotional imbalance that requires special attention, too often prison staff conclude that the inmate is not dangerous and is simply attempting to manipulate his or her environment. They often suggest such behavior should be ignored and not reinforced through intervention. In fact, it is not unusual for even mental health professionals to resort to labeling, with inmates engaging in "deliberate self-harm" termed "manipulative" or "attention seeking," and only "truly suicidal" inmates seen as "serious" and "crying for help."

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 supermaximum 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 believes that certain inmates will attempt to control or manipulate their environment through self-destructive behaviors, 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 behaviors or punishment of self-destructive inmates through segregation may worsen the problem by requiring the inmate to take increasingly more dramatic risks. Thus, for acting-out, potentially self-injurious inmates, programs that foster close supervision, social support, and access to psychosocial resources are just as crucial.

Research has shown that inmates engaging in manipulative suicidal behavior have a high risk for subsequent suicide. Furthermore, in suicide prevention units in the community, occasionally being manipulated by a client who is not really suicidal is tolerated. To label an individual as manipulative and "not really a serious suicidal risk" runs the risk of mislabeling and failure to recognize a seriously suicidal client. Only after repeated manipulations using suicidal actions by a client should the staff member consider other tactics for dealing with the client.

Conclusions

Summary of Best Practices

Based on experiences in psychiatric inpatient units, the best practices for preventing suicides in jail and prison settings should include the development and documentation of a comprehensive suicide prevention plan with the following elements:

1 A training program (including refreshers) for correctional staff to help them recognize suicidal inmates and respond appropriately to inmates in suicidal crises.
2 Procedures to screen inmates systematically upon their arrival at the facility and throughout their stay in order to identify those who may be at high risk.
3 A mechanism to maintain communication between staff members regarding high-risk inmates.
4 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.
5 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.
6 A strategy for debriefing when a suicide occurs towards identifying ways of improving suicide detection, monitoring, and management in correctional settings (Table 4).

TABLE 4—*Suggestions for organizing a clinical conference after a suicide.*

Adopt the psychological autopsy method which examines the patient's records and collects information from people involved.
Involve everyone who dealt with the individual.
Point out the utility of the meeting in order to assess preventive measures.
Avoid self blaming, accusations, and judgments of clinical practice; instead emphasize how awareness of the problem can stimulate new therapeutic skills.
Allow people more closely involved in the individual's suicide to have the opportunity to speak without interruptions and in a quiet atmosphere.
Point out what kind of coping strategies can be used.
Analyze the role of legal enquiries.
Discuss possible reactions from patient's family.
Consider the possibility of meeting with the individual's family members.

Staff of both psychiatric inpatient units and correctional facilities need to be trained and aware of the warning signs for suicide and have a plan of action for helping those at risk. They need to be better equipped to identify and communicate with inmates about suicidal behaviors as well as to communicate among themselves about these issues. Prison staff are not expected to make clinical diagnoses, but rather to be able to recognize developing signs and symptoms associated with mental disorders, substance abuse, or suicidal risk. Providing them with the vocabulary, techniques, and skills to be comfortable with these issues will enhance their ability to intervene effectively and make appropriate referrals (58). It is therefore important to develop guidelines for hospitals and health delivery systems as well as prisons that ensure adequate resources to implement confirmation of mental health follow-up appointments.

Sound staff training has been associated with greater completion of treatment on the part of persons who have sought care in emergency departments (59). From a health care perspective, both the patient and the health care delivery system benefit from better linkages between emergency and appropriate follow-up care.

Mental and substance use disorders as well as suicide risk are often not assessed in institutions because of the time constraints involved and because the staff is not appropriately trained to recognize the presence of these conditions. Incorporating targeted screening tools and techniques into facilities is expected to increase the number of individuals identified with symptoms of depression, substance abuse, and suicide risk. Appropriate treatment and follow-up care for these problems over time would be expected to prevent suicides.

The provision of feedback to staff and other relevant stakeholders on the ongoing progress of an evaluation is often overlooked, resulting in missed opportunities to improve the evaluation and ensure that its findings are ultimately used by the field. Examples of ways to provide feedback include weekly meetings with program staff; monthly discussions or roundtables with a larger group; newsletters; and/or biweekly memos from the evaluator(s) on insights and reflections for response and comment. Ongoing dialog and frequent communication are essential elements in ensuring that providers remain engaged in the project. This communication may also assist the evaluation team to refine the prevention program.

However, it may well be that the kinds of individuals who are attracted to the profession of correction are not the best individuals to provide the kinds of services described above. In that case, it is critical that jails and prisons obtain additional funds either (1) to hire sufficient numbers of mental health professionals to provide these services or (2) to pay mental health facilities in the community to provide these services for the custodial institutions. Funding is always an issue but custodial facilities must weigh the relative cost of providing these mental health services versus paying the significant others of inmate suicides after the civil litigation.

References

1. World Health Organization. Suicide huge but preventable public health problem, says WHO. World suicide prevention day: 10 September. Cent Eur J Public Health 2004;200:6.
2. Daniel AE, Fleming J. Suicides in a state correctional system, 1992–2002: a review. J Correct Health Care 2006;12(1):24–35.
3. Metzner JL. Class action litigation in correctional psychiatry. J Am Acad Psychiatry Law 2002;30(1):19–29; discussion 30-2.
4. Tatarelli R, Mancinelli I, Taggi F, Polidori G. Suicide in Italian prison in 1996 and 1997: a descriptive epidemiological study. Int J Offender Ther Comp Criminol 1999;43:438–47.
5. Daigle MS, Daniel AE, Dear GE, Frottier P, Hayes LM, Kerkhof A, et al. Preventing suicide in prisons, part II. International comparisons of suicide prevention services in correctional facilities. Crisis 2007;28(3):122–30.
6. Konrad N, Daigle MS, Daniel AE, Dear GE, Frottier P, Hayes LM, et al. Preventing suicide in prisons, part I. Recommendations from the International Association for Suicide Prevention Task Force on Suicide in Prisons. Crisis 2007;28(3):113–21.
7. Tartaro C, Lester D. Suicide and self-harm in prisons and jails. Lanham: Lexington, 2008.
8. Towl G, Snow L, McHugh M, editors. Suicide in prisons. Oxford: BPS Blackwell, 2002.
9. Fazel S, Danesh J. Serious mental disorder in 23000 prisoners: a systematic review of 62 surveys. Lancet 2002;359(9306):545–50.
10. Daniel AE. Care of the mentally ill in prisons: challenges and solutions. J Am Acad Psychiatry Law 2007;35(4):406–10.
11. Hendin H. Suicide: a review of new directions in research. Hosp Community Psychiatry 1986;37(2):148–54.
12. Nyman AK, Jonsson H. Patterns of self-destructive behaviour in schizophrenia. Acta Psychiatr Scand 1986;73(3):252–62.
13. Abram KM, Choe JY, Washburn JJ, Teplin LA, King DC, Dulcan MK. Suicidal ideation and behaviors among youths in juvenile detention. J Am Acad Child Adolesc Psychiatry 2008;47(3):291–300.
14. Morgan HG, Priest P. Suicide and other unexpected deaths among psychiatric in-patients. The Bristol confidential inquiry. Br J Psychiatry 1991;158:368–74.
15. Allebeck P, Varla A, Wistedt B. Suicide and violent death among patients with schizophrenia. Acta Psychiatr Scand 1986;74(1):43–9.
16. Goh SE, Salmons PH, Whittington RM. Hospital suicides: are there preventable factors? Profile of the psychiatric hospital suicide. Br J Psychiatry 1989;154:247–9.
17. Morgan HG, Priest P. Assessment of suicide risk in psychiatric in-patients. Br J Psychiatry 1984;145:467–9.
18. Shah AK, Ganesvaran T. Suicide among psychiatric in-patients with schizophrenia in an Australian mental hospital. Med Sci Law 1999;39(3):251–9.
19. Chapman JF, Ford JD. Relationships between suicide risk, traumatic experiences, and substance use among juvenile detainees. Arch Suicide Res 2008;12(1):50–61.
20. Cuomo C, Sarchiapone M, Di Giannantonio M, Mancini M, Roy A. Aggression, impulsivity, personality traits, and childhood trauma of prisoners with substance abuse and addiction. Am J Drug Alcohol Abuse 2008;34(3):339–45.
21. Howard MO, Balster RL, Cottler LB, Wu LT, Vaughn MG. Inhalant use among incarcerated adolescents in the United States: prevalence, characteristics, and correlates of use. Drug Alcohol Depend 2008;93(3):197–209.
22. Way BB, Miraglia R, Sawyer DA, Beer R, Eddy J. Factors related to suicide in New York state prisons. Int J Law Psychiatry 2005;28(3):207–21.
23. Blaauw E, Winkel FW, Kerkhof AJFM. Bullying and suicidal behaviors in jails. Crim Justice Behav 2001;28:279–99.
24. Bonner RL. Stressful segregation housing and psychosocial vulnerability in prison suicide ideators. Suicide Life Threat Behav 2006;36(2):250–4.
25. Way BB, Sawyer DA, Barboza S, Nash R. Inmate suicide and time spent in special disciplinary housing in New York State prison. Psychiatr Serv 2007;58(4):558–60.
26. Kovasznay B, Miraglia R, Beer R, Way B. Reducing suicides in New York State correctional facilities. Psychiatr Q 2004 Spring;75(1):61–70.
27. Beisser AR, Blanchette JE. A study of suicides in a mental hospital. Dis Nerv Syst 1961;22:365–9.
28. McKenzie N, Landau S, Kapur N, Meehan J, Robinson J, Bickley H, et al. Clustering of suicides among people with mental illness. Br J Psychiatry 2005;187:476–80.
29. McKenzie N, Keane M. Contribution of imitative suicide to the suicide rate in prisons. Suicide Life Threat Behav 2007;37(5):538–42.
30. Cox B, Skegg K. Contagious suicide in prisons and police cells. J Epidemiol Community Health 1993;47(1):69–72.
31. Salmons PH. Suicide in high buildings. Br J Psychiatry 1984;145:469–72.
32. Hesso R. Suicide in Norwegian, Finnish, and Swedish psychiatric hospitals. Arch Psychiatr Nervenkr 1977;224(2):119–27.
33. Jones D. Study of inmate suicides. Frankfort: Kentucky Corrections, 1986.
34. World Health Organization. Preventing suicide: a resource for prison officers. Geneva: WHO, 2000.

35. Huey MP, McNulty TL. Institutional conditions and prison suicide: conditional effects of deprivation and overcrowding. Prison J 2005; 85(4):490–514.
36. Stathis S, Litchfield B, Letters P, Doolan I, Martin G. A comparative assessment of suicide risk for young people in youth detention. Arch Suicide Res 2008;12(1):62–6.
37. Yufit RI, Lester D. Assessment, treatment, and prevention of suicidal behavior. Hoboken: Wiley, 2005.
38. Chapman AL, Specht MW, Cellucci T. Factors associated with suicide attempts in female inmates: the hegemony of hopelessness. Suicide Life Threat Behav 2005;35(5):558–69.
39. Mills JF, Green K, Reddon JR. An evaluation of the Psychache Scale on an offender population. Suicide Life Threat Behav 2005;35(5):570–80.
40. Roe-Sepowitz D. Characteristics and predictors of self-mutilation: a study of incarcerated women. Crim Behav Ment Health 2007;17(5):312–21.
41. Hayes LM. National study of jail suicides: seven years later. Psychiatr Q 1989 Spring;60(1):7–29.
42. Crammer JL. The special characteristics of suicide in hospital inpatients. Br J Psychiatry 1984;145:460–3.
43. Bird SM. Suicide in recently released prisoners. Lancet 2006; 368(9546):1492–3; author reply 3.
44. Kariminia A, Law MG, Butler TG, Levy MH, Corben SP, Kaldor JM, et al. Suicide risk among recently released prisoners in New South Wales, Australia. Med J Aust 2007;187(7):387–90.
45. Yarden PE. Observations on suicide in chronic schizophrenics. Compr Psychiatry 1974;15(4):325–33.
46. Vaughn CE, Leff JP. The influence of family and social factors on the course of psychiatric illness. A comparison of schizophrenic and depressed neurotic patients. Br J Psychiatry 1976;129:125–37.
47. Landsberg G. Issues in the prevention and detection of suicide potential in correctional facilities. In: Rosner R, editor. Principles and practice of forensic psychiatry. New York: Chapman and Hall, 1994;393–7.
48. Saarinen PI, Lehtonen J, Lonnqvist J. Suicide risk in schizophrenia: an analysis of 17 consecutive suicides. Schizophr Bull 1999;25(3):533–42.
49. Achte KA, Stenback A, Teravainen H. On suicides committed during treatment in psychiatric hospitals. Acta Psychiatr Scand 1966;42(3):272–84.
50. Warren LJ, Mullen PE, Thomas SD, Ogloff JR, Burgess PM. Threats to kill: a follow-up study. Psychol Med 2008;38(4):599–605.
51. Schwartz DA, Flinn DE, Slawson PF. Suicide in the psychiatric hospital. Am J Psychiatry 1975;132(2):150–3.
52. Kullgren G. Factors associated with completed suicide in borderline personality disorder. J Nerv Ment Dis 1988;176(1):40–4.
53. Pompili M, Mancinelli I, Ruberto A, Kotzalidis GD, Girardi P, Tatarelli R. Where schizophrenic patients commit suicide: a review of suicide among inpatients and former inpatients. Int J Psychiatry Med 2005; 35(2):171–90.
54. Farberow NL, Shneidman ES, Neuringer C. Case history and hospitalization factors in suicides of neuropsychiatric hospital patients. J Nerv Ment Dis 1966;142(1):32–44.
55. Morgan HG. Death wishes? The understanding and management of deliberate self-harm. Chichester: John Wiley, 1979.
56. Schlosar H. Befriending in prisons. Crisis 1997;18(4):148–9.
57. Shaw J, Baker D, Hunt IM, Moloney A, Appleby L. Suicide by prisoners. National clinical survey. Br J Psychiatry 2004;184:263–7.
58. Grossman J, Hirsch J, Goldenberg D, Libby S, Fendrich M, Mackesy-Amiti ME, et al. Strategies for school-based response to loss: proactive training and postvention consultation. Crisis 1995;16(1):18–26.
59. Rotheram-Borus MJ, Piacentini J, Cantwell C, Belin TR, Song J. The 18-month impact of an emergency room intervention for adolescent female suicide attempters. J Consult Clin Psychol 2000;68(6):1081–93.

Additional information and reprint requests:
Maurizio Pompili, M.D., Ph.D.
Department of Psychiatry
Sant'Andrea Hospital
0189 Roma
Italy
E-mail: maurizio.pompili@uniroma1.it