Perrie Lecture - Newbold Revel 15 June 2001

Suicides in Prison: Ten Years On

Alison Liebling, *Institute of Criminology, Cambridge.*

Alison Liebling undertook several important pieces of research into suicides in prisons in the late 1980s and early 1990s. In this lecture she reflected on that research and its relevance today, and linked some of those findings to her current subject of research and the broader themes of staff prisoner relationships and regimes.

Social death begins when the institution ... loses its interest or concern for the individual as a human being and treats him as a body - that is, as if he were already dead.

(Shneidmon 1973:159)

When I read this, 1 could hear the words of so many officers, telling me 'we lock up 300 bodies on this wing', or I was reminded of the 'body book' signed at reception when the police handed over a prisoner. A first ever Thematic Inspection had been carried out on 'Suicide in Prison' in 1984. This had been inspired by three hangings within 12 months at HMP Swansea, and a 'lack of care' verdict brought by an inquest jury following the suicide of a young prisoner at Ashford Remand Centre. In Scotland, a series of suicides at Glenochil young offenders complex resulted in a detailed report on the then current suicide prevention procedures (SHHD 1985). Dr Derek Chiswick, a forensic psychiatrist and main author of the report concluded: 'this is not a psychiatric problem, it's a management problem'.

It was in this context - of growing concern, increasing numbers, an especially rapid increase in the numbers of young prisoners taking their own lives, and some revisiting of suicide prevention procedures - that I began the research I conducted for my PhD degree. I had been working in young offenders' institutions - a Detention Centre and two Youth Custody Centres, interviewing staff and prisoners as part of a Home Office funded study of throughcare. I had been struck by the prevalence of self-injury, the helpless and sometimes angry reaction of staff, and the use of strip cells for those considered at risk. Some prisoners thought attempting suicide was a prison disciplinary offence. It had been a criminal offence until 1967. Those considered at risk carried a large red 'F' on their files - this stood for 'felo-de-se': the murder of oneself.

The late 1980s and early 1990s, witnessed dramatically increasing suicide rates in prison, particularly amongst the young. What was often overlooked was the dramatic increase in suicide amongst young males in the community: those in lower socio-economic groups were particularly at risk. Large groups amongst the prisoner population share those characteristics associated with increased suicide risk in the community: adverse life events, negative interpersonal relationships, social and economic disadvantage, alcohol and drug addiction, contact with criminal justice agencies, poor educational and employment history, low self-esteem, poor problem-solving ability, impulsivity, and low motivational drive. Whilst the media blamed overcrowding and prison conditions, the prison population was also carefully selected to be at risk. Prisons like Risley, Brixton, and Leeds suffered from apparent epidemics. Was this a problem of conditions, demographics, imitation, psychiatric disorder, manipulation, lack of care, prison culture, inactivity, or management?

I reviewed the literature. The first UK study I could find appeared in the third report of the Commissioners of Prisons in 1880. It was commissioned by Dr Gover, the first Medical Inspector to be appointed by the newly established Board of Prison Commissioners, in response to a growing concern over the high numbers of suicides in English prisons at the time. 81 suicides were considered. They occurred mostly in the first week of custody; 42 per cent were first time prisoners; a third were on remand; prison staffs lack of knowledge of individual prisoners was relevant: those establishments least able to assign a motive to the suicides were those with the highest numbers. This study was followed by another, and the question was always raised whether suicides were related to the special environment of the prison, or the special characteristics of prisoners (see Smalley 1911; Goring 1913; Topp 1979).

These largely medical and psychiatric studies, based on small samples, continued sporadically until Dooley's more systematic 1990 study of suicides in English and Welsh prisons between 1972 and 1987 (Dooley 1990a; 1990b). All of these studies followed the same pattern: despite the fact that a rather low proportion of completed prison suicides were found to have a history of psychiatric treatment (around 30 per cent, compared to 90 per cent in community studies),

Table 1: Prison Suicide: a Typology

	1 . Life and-very long sentence prisoners	2. Those psychiatrically ill	3. Poor copers
Motivation	guilt/no future	alienation, loss of self-control fear/helplessness	fear/helplessness, distress/isolation
Age	30+	30+	16-30
Proportion of Total	5-20%	10-22%	30-45%
Relevance of Situation	chronic	varied	acute
History of Previous Self-injury	low	medium	high
Features	often (76%) on remand, after midnight; some well into sentence'	psych, history present; single, homeless	often more typical of prison pop i.e. acquisitive offences

Source: Liebling 1999

the problem was studied by, and largely managed by, psychiatrists. One of the concerns expressed to me by prison staff at the time, was that they would refer an at risk prisoner to the hospital. He would be seen by the visiting psychiatrist. No psychiatric disorder would be found, and the prisoner would be returned to the wing, where his problems would continue. Staff felt frustrated, and were angry when suicides took place a few days after this kind of referral. Staff thought (perhaps hoped) that suicide was a medical issue, and felt out of their depth; healthcare staff thought, once the possibility of clinical illness was ruled out, that threats and self-injury were discipline issues, and belonged on the wing. This was a very unsatisfactory state of affairs.

The available research told us that suicides occurred more frequently in prison than in the community — but that when equivalent populations were compared, this difference was reduced in magnitude. Prison suicides could not be explained by depressive illness, but they were often associated with youth, unmarried status, the nature of their relationships outside and the stresses they were experiencing related to their imprisonment.

Prison suicides represented 'a profile which is distinct from the population of suicides generally, but little different from that of the general prison population' (Hankoff 1980: 166). Studies have concluded that the suicide rate in prison is disproportionately high, that most completed prison suicides are male (although a significant number are female), that a disproportionate number are on remand at the time of death, that a third have a history of in-patient psychiatric treatment, that lifers are over-represented, most have previous convictions and that 40 per cent have been seen by a doctor in the week preceding death (see Topp 1979; Backett 1987; Dooley 1990a).

Most completed suicides are accomplished by

hanging, over half have injured themselves before (often in custody), many have serious drug and alcohol problems and many are accomplished by the young (up to 30). About a third of all prison suicides occur very early in custody (within the first week). It is significant, in particular, that a history of psychiatric treatment is less likely among prison suicides than among those in the community (Backett 1987; 1988). Only one third of prison suicides are found to have a psychiatric history, as opposed to 80-90 per cent of suicides in the general community (Backett 1987; Dooley 1990a). A high proportion of those at risk are found to have psychological difficulties falling short of a formal psychiatric diagnosis, such as alcohol or drug problems, personality disorders or borderline personality disorders, self-reported anxiety and depression. This has important implications for prevention strategies, which have historically treated suicide risk as an exclusively medical or psychiatric problem.

Over time, and in line with studies of absconding, studies shifted their attention from the identification of the at risk individual which they largely failed to achieve to the identification of the at risk situation. Early in custody, areas of seclusion, following bad news or a relationship breakdown: these situational factors helped to account for many prison suicides. Some combination of individual and situational factors was likely.

My own research differed from the many classic studies which had tended to rely on official records of completed suicides and their characteristics in the search for a profile of the suicidal prisoner. Such research seemed flawed - partly because not all self-inflicted deaths received suicide verdicts at inquests (so that many deaths were left out of the studies) but also because official records cannot reflect very much about a person's inner world. They are often, as prisoners know, selective constructions which serve specific functions unrelated to the problem of suicide. It seemed to me that there were two key problems with this profile-prediction approach. First, prison suicide was not a single problem with a single profile, but could be regarded as at least three types of problem, with quite different causal pathways and different relationships with the prison environment.

In Table 1, we see three distinguishable groups, for whom the relevance of the prison environment may differ. The three groups: lifers/long sentence prisoners, the psychiatrically ill, and 'poor copers' each have a different profile; with regard to age, history, possible motivation and the types of situational factors which appear to contribute to their deaths. Treating them as a homogenous group masks important features of each type. Long sentence prisoner suicides (which include a high proportion of domestic homicide cases), tend to be older than average. Some take their lives significantly later during their sentences. Including this group of prison suicides in a general profile may distort

the profile towards violent offences and longer sentences. Removing them and treating them as a group enables us to regard their particular circumstances more appropriately. Secondly, the psychiatrically ill. It is well established that there is a strong association between psychiatric illness and suicide, but this is only true of one sub-group of prison suicides. There is an established link between the closure of psychiatric institutions and increases in suicides in prison amongst this population (see Liebling 1999). Finally, the group which I have characterised as 'poor copers'. This group are the most significant in relation to the prison experience, as they resemble other prisoners most closely.' They are arguably the most preventable group, despite being perhaps the most difficult to identify. It is important to note that the 'poor copers' or vulnerable constitute the most numerous group of prison suicides and that the significance of the immediate prison situation may be most acute in these cases. It is also important to note that more of this group have attempted suicide or injured themselves before.

The second reason for treating recorded information cautiously is that the records do not tell us enough. I wanted to talk to prisoners who had attempted suicide, to compare their accounts of their lives and their prison experience with prisoners who were not at risk. In the special environment of the prison, many prisoners do survive serious suicide attempts, as intervention is possible. This raised the question of intent: what counts as a suicide attempt? How is a suicide attempt distinguished from self-injury? How are the two related, if at all?

I wanted someone to stop me. But no-one stopped me. So I carried on.

(Prisoner)

In the community, attempted suicide and self-injury have typically been treated as separate behaviours having a limited association with completed suicide. This is despite the evidence that such a separation is 'artificial' and follow up studies of suicide attempts showing up to 30 times greater risk of suicide than the general population. Studies of suicides and suicide attempts in prison often seek differences between populations who engage in these supposedly distinct behaviours. The causes of the two behaviours are in fact found to be similar. Acts of self-injury, like suicide attempts and suicides, are associated with feelings of 'melancholy tinged with self-contempt' (Cooper 1971), depression, self-doubt and the search for relief (Toch 1975; Liebling 1992). They are acts of 'dead-end desperation', expressing, 'an intolerable emptiness, helplessness, tension ... a demand for release and escape at all costs' (Toch 1975: 40). The populations involved overlap considerably, completed suicides often having a history of attempted suicide or self-injury. Half of all those who die by

suicide in prison have injured themselves before a third in prison (Dooley 1990a). In addition, in the controlled environment of the prison, many potentially lethal suicide attempts are prevented by chance intervention. The relationship between the two is complex and has been largely neglected or over-simplified in research, both in prison and in the community. It may be useful to see suicide - both in action and intent as a continuum. Self-injury may be the first overt symptom of a level of distress only steps away from a final act of despair. Prisoners who self-injure are trying - against the odds - to make themselves a legitimate object of concern.

Many recent studies see attempted suicide as an indication of low coping resources, and destructive behaviour patterns which render the individuals concerned especially vulnerable to suicide (see Liebling 1992; also Toch 1975; Zamble and Porporino 1988). If there is no response to what can be seen as a 'last ditch' effort to change an unbearable environment, suicide may be likely. Self-injury can incorporate a vast spectrum of 'harm' to the self, and there is no straight-forward relationship between level of harm or seriousness of injury and the level of intent reported. I like Mark Williams term 'cry of pain' much better than the dismissive 'cry for help'.

Self-injury and suicide can be, then, 'expressions of a common suicidal process' (Goldney and Burvil 1980: 2). The continuities between them (particularly in terms of motivation, causes and prevention) may be more important than their differences. Both may be reactive rather than purposive (or 'manipulative', for example), and impulsive rather than planned. When asked, 'Did you think about it before you did it?'... prisoners say, 'I didn't plan it. 1 didn't think about it, but I knew it was coming; do you know what I mean?' (Liebling 1992). It is important to inquire why the behaviour occurred rather than what it was intended to achieve (Wicks 1974). Both activities may contain the cognitive ambivalence expressed by suicide attempters who live. Responding at the first step, and providing alternatives, support, and solutions, may divert prisoners from the destructive route along which they are setting. There are convincing arguments, then, for studying suicide attempts in prison as a way of understanding completed suicide in prison, but the relationship between the two should always remain open to enquiry.

Main Findings: Understanding Vulnerability and Suicide Risk

Depression and anger. What it was, I was thinking all about the family and what was going on all around me, and with me not having any letters for a week or two, I just thought, well there's no point in me being here, no-one cares about me.

(Suicide attempter)

There was no hope, no light at the end of the tunnel. Once you 're in the system you 'II never get out of it; the only way out of it is to become dead or anonymous, because that's the only way they will ever leave you alone. That's the only way you can start to rebuild a life, because once you've been in this system and they know all about you they will arrest you for things you don't do. They will put you inside a prison for things you don't do and they will generally fuck up your life all the time.

(Suicide attempter)

The first study I want to briefly relate took place in four closed Young Offenders Institutions between 1988 and 1990 (Liebling 1992) and the second took place in three local/remand centres and one closed training prison between 1990 and 1992 (Liebling and Krarup 1993). In the first study, interviews were carried out with 50 prisoners who had attempted suicide and 50 prisoners drawn randomly from the general population within the same establishments. In the second study, interviews were carried out with 62 prisoners who had attempted suicide and with 80 prisoners drawn randomly from the populations in the same establishments. Interviews were long and semi-structured and included detailed questions about prisoners' backgrounds, their criminal justice histories, their experiences of imprisonment and their plans for release. Questions were also asked about suicide attempts, suicidal thoughts and prisoners' explanations for such events both in their own case and on behalf of other prisoners in general.

A number of important and consistent differences emerged in both studies between the two groups and these differences were most marked in the accounts prisoners gave of their experiences of imprisonment. Most of these results could not have been obtained by using recorded information. In the descriptions we obtained of prisoners lives, backgrounds and criminal justice histories, the significant differences to emerge between the suicide attempters and a comparison group were differences of degree. The presence or absence of family breakdown, violence, local authority care and previous offending, and the pattern of their education and employment histories were similar. However, the degree (frequency and consequences) of family violence, the reasons for placement in local authority care, the reasons for prolonged absences from school, and the period spent in the community between custody were significantly different. Suicide attempters were more likely to report multiple family breakdown, frequent violence leading to hospitalisation, local authority placement as a result of family problems (as opposed to offending), truancy as a result of bullying (as opposed to boredom or peer pressure) and very short periods spent in the community between custody.

In terms of their criminal justice histories, suicide attempters had a slightly earlier start and slightly higher numbers of previous convictions. Many of those in the suicide attempt group spent less than three months in the community between sentences (see Appendix 1). Successful coping in prison reflected in part, prisoners' lives in the community.

Suicide attempters were found to have fewer qualifications from school than comparison groups. This is particularly significant as many were unable to read and write without difficulty. They were frequent truants and they were significantly more likely to have been involved in violence at school, including having been the victims of bullying. They were more likely to have been in local authority care, and this was slightly more likely to have been for family or behavioural problems than for offending behaviour alone. They were more likely to have received psychiatric treatment, both in and out of hospital, and they were more likely to report major alcohol and drug problems. More of the suicide attempters had injured themselves before coming into custody: only a quarter had not injured themselves in any way before their sentence. Suicide attempters were more likely to report experiences of sexual abuse (this was especially common amongst both groups of female prisoners (see Liebling, 1992) and amongst young male suicide attempters). On a range of background characteristics, then, suicide attempters could be differentiated from comparison groups, using a dimensional approach.

Once in prison, the scale and quality of the differences between the two groups were clearer. On most questions relating to the prison experience, the suicide attempters both were and saw themselves as considerably worse off than their peers:

Hell. I live a hell every time I close my eyes and go to sleep. I live a hell every time I get up in the morning and have to face this lot. I live a hell every time I look at people in here shouting nonce and beast and every time I go for me meal ... Every time I see somebody sitting here crying because his wife's left him and he can't have contact with his kids, or he wrote a letter and the letter's got lost, or nobody writes to him, or somebody stands there and slits his face open because of what he's in for. Bleak, isn't it?

(Suicide attempter)

They were less likely to be engaged in activities, less likely to have a job in prison, and less likely to report being able to get anything constructive out of what they did. They were more likely to report difficulties with other prisoners and with staff:

Yes. I was shocked. I wasn't even thinking about any violence in prisons. I just got .beat in, on A wing, in the dinner queue. One of them came over and saw me crying against a locked door - they took me over the hospital.

(Suicide attempter)

Some (of the staff) are all right, they do communicate with you. But they can say hard things. They'll turn round and say to you: 'Go and sit with the other outcast', things like that, which isn't very nice. I know these people have to work here and the place must become very dull for them as well, I respect that ... but they say things like, 'I bet you he's never had a good woman in his life'. That hurts.

(Suicide attempter)

They were less likely to enjoy PE or use the gym, and were more likely to pose disciplinary problems. They were least likely to be receiving regular or helpful contact from outside, either from families and friends or from the Probation Service, although many of the comparison group of prisoners also found this aspect of prison life especially painful:

How can you think big of yourself when you're not getting no visits? There's some guys in here who think because they're getting visits and you're not, that you're some kind of joey for them.

(Prisoner: comparison group)

Yes. It would make it easier for me (to receive more visits) because I'd know then that there is somebody out there who cares, whereas when nobody comes to visit me, my head automatically thinks, there's no-one who cares about me, there's no point in being here.

(Suicide attempter)

Well, a woman from the Samaritans came after I slashed up, to talk to me. She asked me why I did it. I said I was bored and depressed, and lack of contact with the family. It helped a bit, but not that much. She asked me to write to her. It has crossed me mind a few times to write.

(Suicide attempter)

Visits were described in detail as major events - with anxious anticipation, frequent disappointment, and feelings of being 'gutted' when they were over, or when visitors failed to turn up. Handling the emotional roller-coaster of visits was a skill, and was linked to a capacity to immerse themselves in activities.

Most important in terms of understanding their immediate vulnerability to suicide, and linked to this general capacity to handle prison life, suicide attempters were unable to occupy themselves when left alone in their cells:

Alone. I felt so alone, you know? Four walls, nobody there.

(Suicide attempter)

I suppose there must be ways (of passing the time) but I just don't bother. I could read, but there again, I can't be bothered. I just can't get into it.

(Suicide attempter)

There's nothing. It's not just boredom; it's problems outside (too) ... And when you ask for someone to talk to, you can't get no-one ... Then you sit here. You think, what's the point?

(Suicide attempter)

It was this sense of there being nothing, this dependence on 'sustaining external resources', which left some groups of prisoners unable to cope in conditions of confinement and isolation. In addition to being the group least able to occupy themselves constructively when alone, the suicide attempt group were also most likely to end up in those locations within the prison most likely to involve longer than average periods of isolation (for example, health care centres, segregation units, and vulnerable prisoner units). Suicide attempters found many aspects of the prison situation more difficult to cope with than comparison groups of prisoners drawn randomly from the same populations. Their vulnerability, characterised by a history of adverse life circumstances followed by persistent problems in 'coping', was exposed by many different aspects of the prison world, from activities and relationships to planning for the future:

It's all sorts of things, like. I could say things that are still happening from years ago ... I know there are other people in here like me, you know, who've been through what I've been through, but like, I've been in care from age six to 16, and from 16 I've been in prison, with the exception of five months. So, like, when I tell them I need to be taught the basic things of life, they turn round and say to me, it should be up to me to go out and learn these things. But how can I when I don't know what the things are to learn? When I go to someone else, they just say the same things in different words. I've just got fed up with it.

(Suicide attempter)

Since I did it last time, I have thought about doing it again. I've even thought about overdosing. These people, right, they think, 'Oh, he's trying to commit suicide, he's daft, he don't know what he's doing'. But we think - I've done it - we know what it feels like to be hurt, they don't. All they're thinking is, 'He's daft'. They don't know what you're going through. They don't know what your mind's thinking. You can't talk to no-one in here, so you take it out on yourself, and that's why the majority of people commit suicide in prison, because they can't talk to no-one.

(Suicide attempter)

Their release plans were poor and unrealistic, and they avoided thinking about outside and the future.

Background factors were less significant than cognitive appraisals of the current situations. In other words, it was less 'who they are', and more 'what they think and feel', that counted. Many badly wanted help:

What I really need is psychological help ... Understanding would be a better word. Understanding, rather than paying £250 a week or whatever it is, just to keep somebody like me in prison. But they've never once tried to son my head out, or rehabilitation, which they could probably do for half that amount...

(Prisoner)

\ Those who are most vulnerable are exposed to a highly demanding environment in which survival skills are highly valued and indications of weakness or helplessness may bring about verbal and physical abuse, theft, taxing, sexual violence and psychological torment.

The Role of Prison Staff

Prison officers were crucial in the handling of prisoners at risk. They could be of immense practical [•2   help - facilitating phone calls, job changes, home leave, discussing possible work opportunities on release, parole procedures and psychiatric referrals. They could also be helpful in personal ways:

They cheer you up ... just in the way they speak to you and take time to speak to you

(comparison group)

Prisoners complained that staff were always busy and that there weren't enough of them - this was in 1988, before the onset of managerialism and market testing. Prison officers complained bitterly about paperwork, and were sceptical of the relationship between paperwork and the causes of and solutions to suicidal feeling. They complained about lack of communication, particularly between themselves and the health care centres. The main problems were lack of feedback from the hospital, their unwillingness to accept prisoners thought to be at risk on to the hospital, the lack of adequate instructions given to staff on the wings on the prisoner's return, and the generally low level of information sharing that went on. Hospital staff felt that staff expected the. hospital to provide a refuge for discipline and control problems, and that officers sometimes over-reacted to prisoners in distress and were too keen to 'send their problems to us'.

Both sides wished they had more 'half way houses' where discipline and medical expertise could be shared, despite the fact that neither side ever suggested that suicide risk might lie somewhere between discipline and medical concerns. Relationships were better where health care staff appeared regularly on wings, for example, to give out treatments. There was a clear barrier, reminiscent of 'shared working' between prison and probation staff in the old days, where officers thought the hospital could pick and choose their clients, kept themselves empty wherever possible, and received extra privileges for doing less work. Prison staff lacked confidence in dealing with suicide risk, and tended to underestimate the painfulness of prison. They felt procedures worked best when 'it's all avoided by letting him have a cry on your shoulder' (Senior officer).

Reflections on Current Developments

My feeling is that far too many of these points remain relevant today than I would like to believe.*- There have been some major developments - including what looks like a first downturn in the figures. There is much better quality information - suicide verdicts are no longer used as the basis for research or management information. Research has flourished, and is started to become more integrated instead of the separate studies we used to see. The ending of the use of strip cells (if indeed it has been ended) is symbolic of a generally less punitive response to vulnerability .The use of suicide investigations has been valuable - and a recent Masters' thesis conducted by Gordon Morrison, the Controller of Wolds, has helped to capitalise on the learning from these very useful procedures.

The recent expansion of SASU and its reincarnation as the 'Safer Custody Group' is a most welcome development. It is clear that alongside clearly stated commitment to reducing suicides. resources have followed. Regimes in prison have improved in most places, and prisoners no longer j routinely spend most of the day locked up (although I there are some important exceptions). Likewise, I would argue that relationships with staff and the role of the prison officer more generally, have improved, for various reasons. It is just possible that in the theoretical model that myself and colleagues are continuing to develop, the prison is making a less obvious contribution, but the vulnerability of the population continues to increase. We still do not know enough about individual psychological survival in prison. (Have markedly improved regimes resulted in a less gruelling and more constructive experience of imprisonment for prisoners?) We cannot assume this, without evidence. Is there a clear relationship between regime provision and suicide risk? What is the relationship between prison conditions and the prison experience? These are the questions we have to ask next.

Appendix I: Suicide in Prison: A Vulnerability Profile

<u>Criminal Justice History</u>

pessimistic pre-sentence report*
many previous convictions*
short periods in the community* (<3-6m)

<u>Background</u>

no qualifications/poor reading ability*
frequent truancy bullied at school* family
and behaviour problems (leading to care)*
major drink and drug use/dependence**
previous psychiatric treatment***
witnessed or experienced family violence*
previous suicide attempts/self-injury****

<u>Experience of Prison and Coping with Custody</u>

prefers to share cell *
inactive in cell*****
cannot relieve boredom*
avoidance of physical education/other
activities****
few friends in prison*
met only mates in prison*
difficulties with other inmates*
disciplinary problem*
feels disciplinary system is unfair*
experience of segregation/solitary
confinement**
frequent/recent referral to medical services***
reports current problems****
problems sleeping****
finds prison (and 'being banged up') difficult**
not hopeful about release*

<u>Family and Outside Contact</u>

few or unreliable visits*
writes few letters***
misses family*
little contact from probation* finds
thinking of outside difficult

<u>General</u>

wants to change self*
day-dreams*
feelings of hopelessness***
suicidal thoughts/attempts*****
thinks others' attempts are serious*

* p<.05. ** p<.005., *** p<.OOL, ****
p<.0005., ***** p<.OOOl.

I based on Uebling 1992; Liebling and Krarup
1993; Blud 1995.