

Inmate Suicide: Prevalence, Assessment, and Protocols

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This article describes the prevalence of suicide for incarcerated adults in detention centers, jails, and prisons; factors associated with suicide risk; methods for assessing suicide risk in this vulnerable population; and current protocols for suicide prevention programs in jails and prisons. [*Brief Treatment and Crisis Intervention* 7:40–54 (2007)]

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Although prison suicide is not a likely occurrence, it is the leading cause of preventable death in jails and correctional facilities (Way, Miraglia, Sawyer, Beer, & Eddy, 2005). Inmates are particularly at risk during the first 24 hr under custody as they face the reality of incarceration (Hayes, 1995). The risk further increases for detainees and offenders when they are held in detention centers or lockups with no way to post bail, particularly if this is the first incarceration for felony offenses. At this point, inmates are faced with compounded stressors. The jail environment embodies fear, distrust, lack of control, isolation, and shame and is often dehumanizing. Coping with entering this environment, inmates often feel overwhelmed and hopeless, leading some of them to choose suicide as a way to escape. Further-

more, offenders are likely to have several risk factors that predispose them to suicidal behavior, including preexisting thought disorders, alcohol or substance abuse problems, mood disorders, and previous suicide attempt histories (Way et al., 2005). Additionally, Tartaro and Lester (2005) found that prison suicide rates are correlated with suicide rates for adult males in the general U.S. population, pointing to the importance of societal risk factors along with individual factors. This article describes the prevalence of suicide for incarcerated adults, factors associated with suicide risk, methods for assessing suicide risk in this vulnerable population, and current protocols for suicide prevention programs in jails and prisons.

Defining the Problem

Although the definition of suicide may seem fairly straightforward, the concept deserves some clarification as it can describe a range of thoughts and behaviors from suicidal ideation (thoughts and planning), to suicidal gestures (self-harming behaviors), to suicide attempts

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(serious harm to self that could result in death with no intervention), and finally to completions (harm to self resulting in death). Furthermore, means of suicide are particular to the prisoner population as they live in very restricted and tightly controlled environments.

Inmates use several methods to kill themselves, including gas inhalation, drug overdose (Cox, 2003), and hanging (Cox, 2003; Tatarelli, Mancinelli, Taggi, & Polidori, 1999). In a comprehensive evaluation of suicide prevention programs in prisons, White and Schimmel (1995) found that hanging was the most common method of suicide; hangings constitute approximately 80% of all prison suicides. Cox (2003) conducted case reviews of suicides in one particular correctional facility and found that, along with hangings, prisoners overdosed on Tylenol, Deepen, and Elavil, similar to drugs reported in other correctional facilities.

Closely related to suicide are inmate reports of a multitude of self-injurious behaviors, including cutting, head banging, ingesting foreign objects, and foreign substance ingestion (Cox, 2003). However, researchers and criminologists debate whether these behaviors have different underlying motivations from suicidal acts and should thus be categorized as categorically different or whether they are indications of more serious suicidal risks in the future (Apter et al., 1995). Evans, Albers and Macari (1996) describe a continuum with self-harming behaviors at one end, suicidal gestures and attempts in the middle, and suicide completion at the other. Research indicates that these behaviors are all related; Cox (2003) found that 86% of prisoners who completed suicide in a 5-year period had histories of physical self-destruction.

Scope of the Problem

Research clearly indicates that suicide rates in prisons and jails far exceed suicide rates in

the general public (Cox, Landsberg, & Paravati, 1989; Hall & Gabor, 2004; Hayes, 1997; Tartaro & Lester, 2005). The differences in suicide rates between inmates and the general public are inconsistent, however, ranging from three to nine times higher in correctional facilities (Hall & Gabor, 2004; Hayes, 1997; Tartaro & Lester, 2005).

The U.S. prison population was 258,165 in 1978, increased to 969,216 in 1996, and was over 2 million in 2005 (Tartaro & Lester, 2005; Travis, 2005). Logically, the number of inmate suicides increased along with the prison population. There were 60 prison inmate suicides in 1978, and this number increased to 155 in 1995. However, this seeming increase in prison suicides appears to be due, in part, to the large increase in the prison population, as suicide rates have actually decreased from 23 suicides per 100,000 inmates in 1978 to 16 suicides per 100,000 inmates in 1995 (Tartaro & Lester, 2005). Suicide rates in state prisons seem to have stabilized since 1995. In 2002, there was a minor decrease to 14 suicides for every 100,000 prison inmates, which equals approximately 280 suicides (Tartaro & Lester, 2005).

Researchers have generally found that local jail suicide rates are consistently higher than state prison suicide rates (Mumola, 2005; Tartaro & Lester, 2005). Jail suicide rates, however, have also declined steadily over the past two decades (Figure 1). In 1983, there were 129 suicides per 100,000 inmates reported (Hayes, 1995). In fact, the majority (56%) of jail deaths in 1983 were due to suicide. In 2002, the suicide rate in jails decreased to 47 suicides per 100,000 inmates (Tartaro & Lester, 2005). In 1997, suicide was the leading cause in prisons (Hayes, 1997); however, natural causes (52%) recently surpassed suicide (32%) as the most frequently cited cause of death.

Certain types of facilities are at increased risk for suicide. Larger jails have fewer suicides than smaller jail facilities; with the nation's 50 largest jail systems (29 per 100,000 inmates) reporting

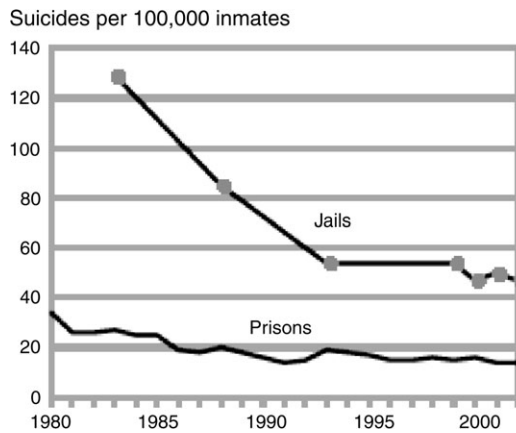


FIGURE 1
Graph adapted from Mumola (2005).

half as many suicides as other jails (57 per 100,000 inmates). Offenders with a history of violence were most at risk; prisoners incarcerated for violent offenses in both local jails (92 per 100,000) and state prisons (19 per 100,000 state prisons) had rates much higher than average. Consequently, facilities housing a high proportion of violent offenders may be especially at risk for prisoner suicide.

States differ considerably in reported rates of suicide. During a 2-year period, three states reported no prison suicides (New Hampshire, Nebraska, and North Dakota), whereas South Dakota reported as many as 71 suicides per 100,000 inmates and Utah reported 49 suicides per 100,000 inmates (Mumola, 2005). The variation across states, although seemingly due to many factors, may underscore differing protocols that exist between states for identifying suicidal prisoners and implementing prevention and intervention plans. The implementation of suicide prevention programs in prisons is discussed in more detail later in this chapter.

Risk Factors

Over the past two decades, several important risk factors for suicide have been identified.

The presence of several of these risk factors should alert mental health professionals to suicidal inmates and help professionals classify which inmates constitute a serious risk. The majority of risk factors are relevant for suicidal adults in the general population; however some risk factors are specific to incarcerated individuals. For example, as previously mentioned, type of offense is related to suicide rates, with inmates convicted of violent crimes demonstrating higher suicide risk than nonviolent offenders (Way et al., 2005). Furthermore, White and Schimmel (1995) found that in their sample of prisoners who completed suicide, 28% of suicides were precipitated by new legal problems and 23% by inmate-related conflicts. Correia (2000) asserts that the inmate's sentence length and feelings regarding this sentence are important in determining potential suicide risk. Newly sentenced inmates and those with longer imposed sentences are of greater risk for suicide (Lester, 1987). Each inmate, however, may respond differently to their sentences. Professionals should assess individual responses to determine how the sentence may be affecting the inmate's self-esteem, family and interpersonal relationships, and employment (Rowan & Hayes, 1995).

Certain demographic characteristics have been associated with higher rates of suicide. Way et al. (2005) analyzed data from the mental health treatment charts of all completed suicides between 1993 and 2001 ($N = 76$) in New York State that had contact with mental health services. Suicidal inmates were compared with the patients on the mental health caseload and with all the New York State inmates in custody. Way et al. (2005) found that inmates that committed suicide were significantly younger than the total mental health group and the total prison population ($p < .001$). The mean age for inmates that committed suicide was 32.8 years, the mean age for the mental health caseload was 37.1 years, and the mean age for all New York prisoners

was 34.6 years. Only 4% of the suicide victims were women, which is significantly different from the mental health caseload (14%) but not the total New York prison population. African American inmates were significantly less likely to commit suicide than inmates of other races. Approximately 24% of the inmates that committed suicide were African American, whereas 44.6% of the mental health caseload were African American and 51% of the total New York prison population were African American. Furthermore, in an evaluation of several suicide prevention programs, White and Schimmel (1995) found that the majority of the inmates that committed suicide were white (65%) and male.

A prior history of suicide attempts is another important indicator of suicide risk (Moscicki, 1997). Thus, professionals should review inmates with several suicide attempts or patterns of increasing suicidal threats for severity of current risk. To examine the relationship between past self-harm and current depression, hopelessness, and suicidal ideation, Palmer and Connelly (2005) conducted a study to compare depressive symptoms among prisoners who had made a prior attempt at self-harm with prisoners that never made prior attempts. The researchers matched the participants of the two groups, each consisting of 24 inmates, according to age, race, penal status, offense, whether they had previously been incarcerated, and the number of previous sentences. The following three scales were used to measure hopelessness, depression, and suicidal ideation: Beck's Hopelessness Scale (BHS), Beck's Depression Inventory-II (BDI), and Beck's Scale for Suicidal Ideation (BSSI).

Palmer and Connelly (2005) found significant differences between inmates who reported an experience of self-harm (the vulnerable prisoners) and the comparison group on all three measures. Inmates who had experienced self-harm in the past had significantly higher ratings of hopelessness, depression, and suicidal ideation. The vulnerable prisoners had a mean score of

10.13 on the BHS, 17.42 on the BDI, and 6.38 on the BSSI. In comparison, inmates who did not report an experience of self-harm in their past had a mean score of 6.29 on the BHS, 15.13 on the BDI, and 1.17 on the BSSI. These are differences of 3.84, 12.29, and 5.21, respectively, all statistically significant. The results of this study indicate the importance of previous self-harm as a risk factor for current suicidal ideation, with depressive symptoms acting as moderating variables.

In addition to the risk associated with personal experience with self-harm, inmates with a history of suicide in their families are also at increased risk, especially if the suicide involved an immediate relative, partner, or child (Brent et al., 1998). Similarly, inmates who have recently experienced loss of a significant person in their lives due to death or divorce are also particularly at risk (Hall, Platt & Hall, 1999).

The way the inmate articulates his/her suicidal thoughts is also a useful indicator of risk. Inmates who describe suicidal impulses with anxiety and/or determination should be noted, as well as inmates who demonstrate problems with impulse control (Polvi, 1997). Charts are useful for noting histories of impulsive behaviors that have warranted disciplinary action in the past (Correia, 2000). Although impulsivity is worrisome, so is careful planning. Inmates who articulate a plan for how they would commit suicide, especially with particularly lethal/realistic means, are considered an immediate risk compared with those who have not considered how they would commit suicide (Hall, Platt, & Hall, 1999).

Inmates that are currently under the influence of substances and/or have severe addiction problems have an increased risk of suicide (Rowan & Hayes, 1995). In fact, because inmates sometimes smuggle drugs into correctional facilities, substances can affect inmates long after entrance into a facility. Subsequently, suicide prevention programs are wise to respond with

immediate observation of those suspected to be under the influence (Correia, 2000).

Lack of social support has been shown to place inmates further at risk. Inmates with social networks in the facility may reduce their sense of hopelessness or fear, thereby reducing suicide risk, whereas inmates with familial social support outside the facility may be more open to prevention efforts (Correia, 2000).

Psychiatric Diagnosis

Suicidal prisoners have been found to have elevated rates of psychiatric diagnosis (Cox, 2003). Fulwiler, Forbes, Santangelo, and Folstein (1997) found that suicidal prisoners have more frequent diagnoses of depression and dysthymia but fewer diagnosis of childhood hyperactivity, antisocial, aggressive, and impulsive personality traits than their self-harming counterparts. Thus, self-harmers may be using self-injurious behaviors as means of escape or coping, whereas a high percentage of suicidal prisoners have consistently been shown to be clinically depressed (69%, Saarinен, Lehtonen, & Lonnqvist, 1999; 62%, Tatarelli et al., 1999).

Suicidal prisoners have also been found to have elevated rates of bipolar disorder (Fulwiler et al., 1997) and psychotic disorders (Tatarelli et al., 1999). In fact, Cox (2003) found 41% of prisoners who committed suicide to be diagnosed with a psychotic disorder. Delusions of persecution are particularly dangerous; depressed inmates with delusions are five times more likely than depressed inmates who do not have delusions to commit suicide (Roose, Glassman, Walsh, Woodring, & Vital-Herne, 1983). Schizophrenia, in particular, is highly correlated with suicide. Research has shown that approximately 35% of inmates committing suicide in federal prisons carry a diagnosis of schizophrenia in their pasts (U.S. Department of Justice, 1999). White and Schimmel (1995) found that, of the 43 suicidal

inmates studied, 11 inmates had severe psychotic disturbances, 6 had a mood or affective disorder, 4 had paranoid ideations, 1 had organic syndrome, and 1 had posttraumatic stress disorder.

Personality disorders have also been linked to suicide in incarcerated individuals; Kullgren, Tengstrom, and Grann (1998) report that offenders with personality disorders are 12 times more likely to commit suicide than offenders without personality disorders.

A study by Way et al. (2005) extended the understanding of the psychiatric disorders specific to suicidal inmates when they compared the mental health disorders of New York inmates who committed suicide with inmates on the mental health caseload who were not suicidal. The primary or secondary diagnoses of major mood disorders were significantly underrepresented among the suicide victims compared with the mental health caseload (Way et al., 2005). Conversely, schizophrenia ($p < .001$), adjustment disorder ($p < .001$), and personality disorder ($p < .001$) were significantly overrepresented among the suicide victims.

With the elevated rates of psychiatric disorders reported in suicidal inmates, it is not surprising that a history of prior psychiatric treatment is the most consistent predictor of suicide in prisoners. Prisoners with a psychiatric history are eight times more likely to make a suicidal gesture during incarceration (Ivanoff, Jang, & Smyth, 1996). Cox (2003) reports that 85% of prisoners who committed suicide had histories of psychiatric care, with approximately 40% having been hospitalized in psychiatric hospitals prior to incarceration.

In addition to mental health histories, suicidal inmates have higher rates of chronic health conditions. Most prevalent are reports that 36–66.7% of inmates who committed suicide were HIV positive (Tatarelli et al., 1999). Research indicates that HIV-positive inmates are most at risk shortly after diagnosis rather than during later debilitating stages, indicating that suicide

may be a way of coping with this chronic illness (Conwell, 1994). Researchers have found other chronic and neurological health problems at elevated rates in suicidal inmates, including, diabetes, prostate disorder, hyperthyroid, closed seizure disorder, and history of head injury. Suicidal inmates are often in poor health and are likely to suffer from an array of serious psychiatric and medical conditions.

Suicide Assessment Measures

Most clinicians ask three simple questions to determine if a client is realistically suicidal: (a) Are you currently thinking of committing suicide? (b) Do you have a plan to commit suicide? And if so, (c) What is your plan to commit suicide? If the client has a realistic plan to commit suicide, then the clinician generally considers the client to be acutely suicidal, and they follow suicide prevention protocol. Along with these three popular questions, there are several suicide assessment measures that clinicians can administer to gauge the intensity of their client's suicidal behavior.

According to the American Correctional Association (ACA, 2004), mental health workers or trained officers at local jails and prisons must assess suicidal ideations and risk for all new inmates during the initial screening process. Although there are several suicide assessment measures, this article will focus on two of the most popular: the Scale for Suicide Ideation (SSI) and the Suicide Behaviors Questionnaire (SBQ). For a more detailed discussion of other suicide assessment tools the reader is directed to a review by Range and Knott (1997).

The SSI (Beck, Kovacs, & Weissman, 1979) is a 21-item, interviewer-administered rating scale and is considered one of the most widely used measures of suicidal ideation. The SSI measures the intensity of clients' attitudes, behaviors, and plans to commit suicide. Each item on the scale

has three options, scored between zero and two, with a total summation rating of 28. There are five screening items: three items assessing the respondents wish to live or wish to die and two items measuring the respondents desire to commit suicide. Researchers have found the SSI to be associated with the suicide items from the BDI and the Hamilton Scale for Depression. Additionally, internal consistency, inter-rater reliability, test-retest reliability, and concurrent validity have all been established (Beck, Brown, & Steer, 1997; Beck et al., 1979).

The SBQ (Linehan, 1981) is a self-report measure of suicidal thoughts and behaviors. The questionnaire uses a Likert scale to measure the frequency of suicide ideation, communication of suicidal thoughts, and attitudes and expectation of actually attempting suicide. The SBQ has been administered in psychiatric outpatient settings and with college students. Researchers found acceptable internal consistency and high test-retest reliability over a 2-week period. Additionally, the SBQ has a relatively high correlation with the SSI. Finally, along with internal consistency and test-retest reliability, concurrent validity has been well established (Cotton, Peters, & Range, 1995).

The SBQ has been adapted into a four-question, rater-administered, semistructured clinical interview called the Prison Suicide Behaviors Interview (PSBI; Ivanoff & Jang, 1991). The developers have used the PSBI in several studies measuring suicidality in prisoners (i.e., Ivanoff & Jang, 1991), and it has been shown to have good test-retest reliability and to be a valid measure of prisoners' suicidal behavior (Smyth, Ivanoff, & Jang, 1994).

Suicide Prevention Standards, Protocols, and Programs

Although researchers have identified significant risk factors for suicide and developed

and tested standardized assessment tools, correctional facilities have been slow to respond to suicide risk among inmates.

Developing Standards for Suicide Prevention

As previously mentioned, inmate suicide was the leading cause of death in jails and prisons throughout the United States in the late 1970s and early 1980s. Subsequently, in the mid-1980s, the ACA and the National Commission on Correctional Healthcare (NCCHC) developed standards for prisons and jails to follow to reduce their suicide rates (Danto, 1997). Both organizations ultimately revised and modernized their standards in the early 1990s. The ACA developed the following five standards: (a) correctional staff should observe all inmates every 30 min and more frequently for inmates who are suicidal, (b) health-trained staff should conduct medical screening on all inmates upon arrival to the facility, (c) Professional staff should complete a health appraisal on all inmates within 14 days of arrival, (d) Staff are required to have training in first aid and cardiopulmonary resuscitation (CPR) and should be able to respond to a medical emergency within 4 min, and (e) a written suicide prevention program has to exist and be approved by a medical or mental health professional (Danto, 1997).

The NCCHC standards state that there must be an intervention to handle a suicide attempt that involves notifying jail administrators and outside authorities such as family members (Danto, 1997). The NCCHC standards are more comprehensive than the ACA standards and specifically address suicidal inmates by developing the following four levels of suicide prevention:

1. Inmates who recently tried to commit suicide should be housed in a safe room with visual checks every 5–10 min, including when the inmate is asleep.
2. Inmates considered at high risk to commit suicide should be in a safe room and observed every 5 min while awake and 10 min while asleep.
3. Inmates considered at moderate risk for suicide should be observed every 10 min while awake and every 30 min while sleeping.
4. Inmates who might be at risk for becoming severely depressed should be observed every 30 min while awake and sleeping.

Protocols for Suicide Prevention Programs

The ACA (2004) has continued to revise their suicide prevention standards over the years, with the intent of prison and local jail administrators using the standards as a guide for suicide prevention. The ACA standards state that all new employees who have regular contact with the inmates must receive 40 hr of training during their first year of employment, which staff members must complete before working independently at an assigned position. This training includes recognizing signs of suicidal thinking and behavior, along with suicide prevention techniques. Furthermore, the ACA standards state that health care providers or specially trained officers conduct a suicide assessment during initial screening for new inmates. Finally, the jail or prisons' mental health staff have the discretion to segregate the suicidal inmates, if the inmate is considered an imminent threat, by placing him in an isolation room. Staff must observe an inmate housed in an isolation unit no less than every 15 min (ACA, 2004).

Protocols for assessing and preventing prisoner suicide are developed in institutions that attempt to incorporate decisions made in federal courts as well as national professional groups (Hayes, 1995). The degree to which individual prison systems follow these guidelines and recommendations varies greatly across

states. The NCCHC created some of the first and most comprehensive national standards to move beyond insisting adequate suicide assessment, prevention and intervention, to identifying essential components of suicide prevention programs. The NCCHC's prevention program included 11 components:

1. Identification (screening forms using observations and interviews to assess suicide risk)
2. Training (all staff trained to recognize cues of suicide risk)
3. Assessment (mental health worker conducts thorough assessment and assigns risk level)
4. Monitoring (specify procedures for regular monitoring of prisoners at risk)
5. Housing (avoid isolation unless constant observation is possible; house with other inmates in safe environment with 10- to 15-min checks)
6. Referral (refer potentially suicidal prisoners to mental health providers)
7. Communication (procedures for constant communication between mental health provider and corrections staff)
8. Intervention (immediate intervention procedures for stopping a suicide in progress)
9. Notification (procedures for notifying authorities and family members of suicide attempts or completions)
10. Reporting (careful documentation of screening, monitoring efforts, and suicide attempts or completions)
11. Review (plan for review by prison administrators and medical professionals if suicide occurs)

The National Center on Institutions and Alternatives (NCIA) narrowed the above recommendations to include six critical components utilized to evaluate all 50 state Department of Corrections' (DOC) suicide prevention protocols

(Hayes, 1995). The six most critical components (staff training, intake screening/assessment, housing, levels of supervision, intervention, and administrative review) were found in only three DOCs across the country, and 14 DOCs (27%) had no or limited suicide prevention plans (Hayes, 1995). The degrees to which these six critical components are currently implemented in DOCs nationwide are described briefly below.

Staff Training. Correctional staff, who have the most contact with prisoners, are usually present in a suicide attempt and are responsible for most monitoring. It is therefore concerning that staff training was explicitly mentioned by only 27 DOCs (52%) in the suicide prevention plans.

Intake Screening/Assessment. Assessments should consider a number of empirically supported factors shown to predict suicide attempts, including family history of suicide, recent significant loss, first incarceration, lack of social support, and psychiatric history. Brief screenings by intake personnel should identify prisoners with any level of risk, whereas more thorough assessment should be conducted by mental health professionals to clarify risk level and recommend preventative measures. A clear procedure for screening and assessment at intake was similarly only present in 29 DOCs' (56%) suicide prevention policies (Hayes, 1995).

Housing. Housing potentially suicidal inmates in isolation, although convenient to correctional staff, increases risk of suicidality and is not recommended as it increases alienation and decreases monitoring. Suicidal prisoners should be housed with other inmates (or in mental health facilities), in cells where dangerous objects have been removed, and should be located close to staff. Furthermore, removal of prisoners' clothing (including belts and

shoelaces) as well as physical restraints should be avoided and used as a last resort. The majority of DOCs' suicide prevention protocols considered housing concerns (39 DOCs or 75%; Hayes, 1995).

Level of Supervision. The overwhelming majority of suicide attempts in custody are by hanging. Brain damage from strangulation can occur within 4 min, death often within 5–6 min from oxygen loss (Yeager & Roberts, 2006). The ability of prison staff to respond promptly in suicide attempts is dependent on the level of supervision imposed by the suicide prevention protocol. Procedures should differentiate risk levels and assign levels of supervision according to risk level, with higher risk prisoners under continuous 1:1 observation. Standard observation includes roving staff persons making continuous or intermittent/unpredictable rounds and observations of suicidal prisoners. In addition, correctional officers should be examining the cell for slight changes in content (presence of sheets, blankets, shoelaces) and alterations to the safety features (altered room fixtures). Finally, staff are in a position to identify shifting inmate acuity levels or increased levels of anxiety and/or agitation (Yeager & Roberts, in press). The use of cameras and television monitoring is recommended as a supplement but not a replacement to face-to-face observation. Among DOCs, 41 (or 79%) addressed supervision in their protocols; however, policies varied with the frequency of observation (Hayes, 1995).

Intervention. Correctional staff are likely to be the first to intervene in a suicide attempt or completion. Intervention procedures should include first aid and CPR training, assessment of genuine emergency, and alerting other staff to call for medical help. Staff should never assume that the prisoner has died but instead follow lifesaving procedures until medical per-

sonnel can make a determination. Only 12 of the 50 DOCs (23%) included intervention procedures in their protocol (Hayes, 1995).

Administrative Review. Should a suicide completion take place, administrators should conduct a thorough review to determine if the appropriate prevention and intervention procedures were taken and to identify any factors that could have indicated suicide risk. This review should result in recommendations for needed changes in policy/procedures. These assessments should include critical review of all personnel involved with the prisoner, including physicians, nurses, mental health professionals, correctional staff, and administrators. Only 14 DOCs (27%) addressed reviews in their suicide prevention protocols (Hayes, 1995).

Effective Suicide Prevention Programs in State Prisons

In 1995, Lindsay Hayes wrote an extensive and well-cited report on the prevention of prison suicide to the U.S. Department of Justice. Although Hayes found that few state prisons had comprehensive suicide prevention policies, he did state that there are some effective suicide prevention programs that have reduced the rates of inmate suicide. Hayes (1995) conducted an evaluation of state prisons in search for a model suicide prevention program. The following two conditions had to be met in order to be considered a model program: (a) the prison facility adhered to each of the six critical components of a written suicide prevention policy (staff training, intake screening/assessment, housing, levels of supervision, intervention, and administrative review) and (b) the facility had an extended suicide-free period. Although Hayes did not consider any program to have model suicide prevention programs, he did find two programs to be highly effective: Elayn Hunt Correction Center (EHCC) in St. Gabriel,

LA, and the State Correctional Institution—Retreat (SCI-Retreat) in Hunlock Creek, PA.

Elayn Hunt Correctional Center. The EHCC successfully implemented a suicide prevention program that contains a diagnostic center and all six critical components of a written suicide prevention policy. EHCC is fully staffed with four full-time physicians, two part-time psychiatrists, six psychological associates, nine clinical social workers, and one substance abuse counselor. All new inmates receive a complete medical examination, a thorough psychological assessment, and an in-depth classification review at the Adult Reception and Diagnostic Center. Along with providing medical and screening services, EHCC offers a variety of individual and group counseling sessions focusing on adjustment for newly incarcerated inmates, HIV/AIDS, substance abuse, problem solving, and crisis intervention (Hayes, 1995). Below is a brief description of EHCC's implementation of the six critical components of a suicide prevention program proscribed by the NCIA.

Staff Training. Every staff member that works directly with the inmates received 2 hr of training in recognizing suicidal inmates and intervening when necessary. EHCC provides instructions on how to identify suicidal behavior and has a documented suicide prevention policy. Additionally, all staff are trained in CPR and first aid (Hayes, 1995).

Intake Screening/Assessment. EHCC's mental health staff ask all new inmates questions about current and prior suicide risk and provide the inmate with information about the risk of suicide. Additionally, all staff that work with and observe inmates must fill out a form indicating if a new inmate displays any of the following behaviors often associated with being suicidal: self-destructive acts, suicidal/homicidal idea-

tions, depression, mood changes, agitation, hostility, insomnia, and overall bizarre behavior. Then, if the mental health professional considers an inmate to be suicidal, they are placed on suicide watch for 24 hr at a time (Hayes, 1995).

Housing. Suicidal inmates are housed away from the general prisoner population. If possible, each prison cell contains two suicidal inmates to avoid isolation. If an inmate is in a cell by himself, however, the security officers have frequent conversations with them, with the purpose of avoiding isolation. The cells that house suicidal inmates have high visibility to make it easy for the staff to observe the inmates (Hayes, 1995).

Levels of Supervision. EHCC contains two levels of suicide watch: standard and extreme. Although standard suicide watch is for inmates that have expressed a desire to commit suicide but are not considered actively suicidal, extreme suicide watch is for inmates that mental health workers consider actively suicidal (Hayes, 1995).

Intervention. Every housing unit at EHCC has two correctional officers that are the first responders if an inmate attempts suicide. Additionally, each housing unit has the following: paramedic shears, large and regular size gauze bandages, ace bandages, elastic rolls, disposable pocket masks, latex gloves, bite block, and a tool designed to cut a variety of materials that could be used in attempted hangings (Hayes, 1995).

Administrative Review. If an inmate successfully commits suicide at EHCC, an investigation must take place by a four-member team that includes a mental health worker, a correctional investigator, a security advisor, and a medical staff member.

Results of implementing the suicide and suicide prevention policies at EHCC have been

promising. In the 11 years after implementation, only one inmate committed suicide and that was during the first year (Hayes, 1995).

State Correctional Institution–Retreat. Although SCI-Retreat does not have the extensive reception and diagnostic services that EHCC has for newly admitted inmates, it does have a suicide prevention program that contains all six critical components of a suicide prevention policy. Staff at SCI-Retreat include a full-time psychologist, a social worker, a part-time psychologist, a part-time physician, and 15 nurses (Hayes, 1995). SCI-Retreat, like EHCC, is highlighted for addressing the six NCIA components.

Staff Training. All staff that have contact with inmates are trained in symptoms of suicidal behavior and the facilities procedures to prevent suicide.

Intake Screening/Assessment. All inmates are initially screened at the Department of Correctional and Classification Center before being transferred to SCI-Retreat. Upon arrival at SCI-Retreat, mental health professionals ask about current and past suicidal ideations. Additionally, security officers are instructed to inform the unit manager if they witness any of the following behaviors: threats, depression, or self-mutilation. Then, the psychologist uses the Suicide Potential Checklist to assess the inmates' suicide risk and will put the inmate on suicide watch if they deem necessary. Only mental health staff may remove an inmate from suicide watch (Hayes, 1995).

Housing. All inmates on suicide watch are housed in the medical infirmary. Mental and medical staff must decide whether to give the inmate clothing and bedding, based on their level of supervision (Hayes, 1995).

Level of Supervision. SCI-Retreat contains three different levels of supervision for suicidal

inmates: close watch, constant watch, and regular watch. Close watch, which is the second highest level, is for inmates that professionals do not consider actively suicidal but have the potential. Correctional staff members visually observe inmates on close watch every 15 min. Constant watch is reserved for inmates that mental health professionals consider actively suicidal. Correctional staff observe inmates on constant watch continually. Lastly, regular watch is used as a step-down from the other two levels, and inmates are to be observed every 30 min (Hayes, 1995).

Intervention. All the housing units at SCI-Retreat contain first aid kits, disposable pocket masks, and a tool for cutting materials in attempted hangings.

Administrative Review. In event of a suicide attempt, all staff that had contact with the inmate beforehand must submit a statement explaining the behaviors that may have led to the suicide attempt. A clinical review team interviews staff and inmates to determine factors that may have led to the suicide attempt (Hayes, 1995).

Comprehensive Models and Innovative Suicide Prevention Programs

New York Model for Local Jails. Based on the ACA and NCCHC standards, New York State developed a comprehensive crisis intervention program for local jails (Cox et al., 1989). Cox et al. (1989) explain that the New York Office of Mental Health and the New York Commission of Corrections collaborated with Ulster County Mental Health Services, the New York State Division of Criminal Justice, and a state-wide advisory group to develop a suicide prevention crisis model. The model contains the following four components: (a) policy and procedural guidelines, (b) suicide prevention intake screening guidelines, (c) an 8-hr training

TABLE 1. Client, Staff, and System Goals

Client goals	Staff goals	System goals
1. Identify suicidal inmates	1. Provide all staff with training	1. Improve collaboration between mental health and criminal justice
2. Reduce incidence of suicide	2. Provide staff with orientation to jail rules	2. Develop operational guidelines
3. Stabilize suicidal inmates agencies		3. Provide cost-effective model
4. Prevent decompensation		
5. Provide services in timely manner		
6. Provide care to all mentally ill inmates		

program on suicide and suicide prevention, and (d) the development of a mental health practitioner's manual. Additionally, according to Cox et al. (1989), there are six essential requirements of the New York model, including an interagency conceptual agreement, essential direct services, delineation of responsibilities among agencies, interagency communication, staff education, and formal suicide investigations when suicides occur.

Interagency Conceptual Agreement. The interagency conceptual agreement is between criminal justice and mental health agencies. The directors of these agencies have the responsibilities for implementing the crisis intervention program to reach agreements regarding the target population, the specific goals to be achieved, and the anticipated consequences for the target population (Cox et al., 1989). Table 1 delineates the goals developed in the New York model.

Essential Direct Services. According to Cox et al. (1989), the essential direct services include identifying inmates at risk for suicide and referring them to receive the necessary mental health and medical services. Mental health and medical interventions should include emergency mental health services, psychiatric inpatient treatment, nonemergency mental health

services, and emergency medical services. Additionally, for the suicidal inmates' protection, the New York model states that suicidal inmates should be housed in special units away from the general prison population.

Delineation of Responsibilities Among Agencies/ Interagency Communication. Criminal justice and mental health agencies must know what aspects of suicide prevention they are responsible for. Through interagency communication, which is necessary to assure continuity of care, directors should document their agencies responsibilities.

Staff Education. In the New York model, there are three components to staff education. First, the model includes activities to assure that officer, medical, and mental health staff have the knowledge and skills necessary to conduct the suicide prevention services. Second, medical staff must be trained in psychotropic medications, program referral, and suicide risk factor identification. Finally, mental health staff must be oriented to the criminal justice system (Cox et al., 1989).

Formal Suicide Prevention. Formal suicide investigations are conducted for four reasons: (a) to determine the causes and circumstances of the suicide; (b) to make officers and staff

accountable for providing security, treatment, making decisions, and being cognizant of structural failings; (c) to establish clear and curative actions; and (d) to provide services that deal with the emotional reaction by other inmates (Cox et al., 1989).

According to Cox et al. (1989), the preliminary results of the New York suicide prevention were promising. The total number of suicides in local New York State jails decreased from 21 the year before implementing the model, to 12 the following year, and just 5 the year after that.

Innovative Prison Suicide Prevention Program

Hall and Gabor (2004) published a paper discussing an innovative peer suicide prevention program in Alberta, Canada. Prison administrators in Alberta developed a peer suicide prevention program based on the idea that inmates are more likely to confide in one another than in the staff members (Hall & Gabor, 2004). The name of the program is SAMS in the Pen. Volunteers meet with distressed inmates upon self-referral or request from staff or another inmate. Ninety percent of the inmates that sought services self-referred themselves.

The top three reasons that inmates self-referred themselves, or were referred by staff or another inmate, were emotional problems, incarceration-related problems, or family and relationship problems. In a review of documentation, Hall and Gabor (2004) found that the percentage of inmates that sought services at risk for suicide ranged from 21% to 28%. Between 0.6% and 2.1% was assessed as being acutely suicidal.

Results of the peer suicide prevention program were encouraging, but unfortunately, administrators cancelled the program for unknown reasons. In the 5 years prior to implementation, there were four completed

suicides, equaling a suicide rate of 131 suicides for every 100,000 prisoners. During the 5-year period the program operated, there were two completed suicides, equaling a rate of 65.5 suicides for every 100,000 prisoners. In the 2 years following the cancellation of the program, there were two successful suicides, equaling a rate of 165 suicides per 100,000 prisoners.

Conclusion and Recommendations for the Future

Although national associations and federal courts began developing suicide prevention protocols for local jails and state prisons 20 years ago, there are still many DOCs that do not implement these standards. This is concerning, considering that prison and jail inmates are at elevated risk for suicide compared with adults in the general population. Empirical studies have greatly advanced our understanding of the particular factors that put inmates at risk for suicide. Demographic variables, attitudinal and emotional variables, psychological symptoms, and histories of suicide and loss have led to the development of standardized suicide risk assessment tools. These empirically tested tools help practitioners accurately identify prisoners at risk of suicide. Accurately assessing risk, however, is only helpful to the extent that employees at correctional facilities consistently use assessment tools and follow prevention protocol for inmates considered at risk. Correctional treatment specialists and mental health practitioners working within the criminal justice system are challenged to advocate for more stringent adherence to suicide prevention program protocols. Such efforts are likely to prevent unnecessary deaths among vulnerable inmate populations and to protect facilities from the malpractice lawsuits that often follow completed suicides of adults confined in correctional facilities.

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