Evaluating Suicide Prevention Activities

Evaluating suicide prevention activities is a complex task, and in a prison environment, the complexity increases when an effort is made to determine who is ***responsible*** *for the suicide - the individual or the prison system. This is assuming that the prison system, in itself generates suicide and is primarily responsible.*[1] *Although the system is not blameless, it is not necessarily a causal factor in inmate suicide. Rather, the incarceration of an individual may merely be a symptom of other problems which would predispose the individual to suicide.*

The argument that the prison system is responsible for those placed under its care also has its limits. Of course, the prison system must establish conditions that minimize the risk of suicide among inmates. In this regard, the prison system assumes the same "responsibility" as society at large does for its members.

The debate on the responsibility of those who intervene may rob the suicidal individual of responsibility for an act that may be one of rare individuality and privacy. Szasz[2] *points out the ambiguity of appointing people to monitor other supposedly "irresponsible" people.*

Apart from cases of obvious mental disorder, this article maintains that individuals must remain ultimately responsible for their actions. This, however, does not stop us from offering the necessary assistance. Taking responsibility away from individuals also means taking control over them. One is the corollary of the other. The prison system (particularly psychiatrists, according to Szasz) must face its responsibilities, but within its own limits. It is in this spirit that the Correctional Service of Canada must approach suicide prevention. Evaluating Our Intervention Once suicide prevention services have been provided to inmates, how is their effectiveness to be determined? Should evaluations be limited to measuring suicide rates? The debate, at present, seems to revolve principally on this question. Certainly, statistics show that the suicide rate is higher for the offender population. However, this, as mentioned earlier, does not mean that imprisonment causes suicide. Nor should we conclude that a possible decrease, or increase, in suicide rates is necessarily the result of our prevention activities. This would be limiting the question to one very specific factor, even though it seems, at first glance, to be the most significant. Suicide Rates To evaluate our suicide prevention efforts as they relate to inmates, we should see how the issue is addressed with non-offenders. Historically, suicide prevention efforts were first systematized in prevention centres in England (the Samaritans) and in the United States (the Los Angeles Suicide Prevention Center). These centres concentrated their activities on telephone counselling, done mainly by volunteers.

Soon after the establishment of these centres, attempts were made to measure their effectiveness in terms of fluctuations in the suicide rate of the populations concerned. For example, Bagley[3] asserted that the suicide rate had dropped only in English cities and towns served by the Samaritans but not in any others. However, a more detailed study of the problem revealed that these cities and towns were not necessarily comparable,[4] and that the area in which prevention centres had an impact was not well defined.

Some will say that, in a prison environment, this methodological problem does not arise, since populations and areas are well defined. Nothing could be further from the truth. Our offender populations

move from one penitentiary to another, from one security level to another, from one jurisdiction to another and from one form of release to another. Moreover, these people are exposed to all sorts of prevention methods - ours, but also those conveyed through newspapers, community organizations, radio programs, books and so on.

Bagley's study (cited above) was also criticized with regard to the availability of methods used by suicidal people.(5) When the prevention centres were established, England was undergoing a transformation of its gas supply system. Gas was now less toxic than it had been, and could no longer be used by potential suicide victims: hence, there was a general decrease in the rate of suicide by **gas** but not by any other means. This called into question the Samaritans' effectiveness in reducing **all** types of suicide.

We can therefore conclude that the effect of our own prevention efforts in penitentiaries may also be confused with the effects of other factors: the availability of means of suicide (which we already control in part), environmental changes, changes in clientele and so on.

The debate fuelled by Bagley' 5 original study did not shed much light on the question but only gave rise to doubt, if anything. The literature(6) is now in agreement that, in the non-offender population, it is difficult to cite the fluctuation of suicide rates as justification for suicide prevention programs. Only one other study,(7) in the United States this time, has shown that suicide prevention centres are somewhat beneficial, but only to one segment of the client population. On the whole, this evaluative approach was ineffective.

Therefore, in a prison environment, why do we look at suicide rates to prove our suicide prevention programs' effectiveness? From a strategic viewpoint, it is understandable that our organization's objective is to lower the suicide rate among inmates. Achieving this objective must, however, involve systemic measures that not only include a specific suicide prevention program, but also encompass other related measures - modification of the environment, structures, the clientele, health programs and so on. If the objective is achieved, success must then be attributed to all these factors, not only to the specific prevention program. The Intervention Process So, by which means should specific suicide prevention programs be evaluated? With the non-offender population, certain authors have measured the rate of use and the rate of client satisfaction with regard to the services offered. We know that in a prison environment the dynamics underlying relations between staff and inmates might distort such measures.

However, the quality of service - the intervention process itself - could be evaluated from a point of view that may be either technical or clinical.

Evaluating the intervention process using the technical model is similar to evaluating a program. In this case, effectiveness is determined in terms of the achievement of structural objectives or the performance of prescribed tasks. Ross and Motto(8) suggest establishing standards for operating a prevention service, then checking subsequent implementation of the service. This approach is particularly attractive in relation to our suicide prevention services, assuming that an effort is first made to standardize our approach across institutions. We can then measure specific objectives, such as the number of resource persons, the number of inmates referred, the waiting period for evaluating a person referred, the number

of trained front-line workers and the scope of supervisory measures.

An approach based on clinical evaluation is necessarily more qualitative. Therefore, the evaluation criteria must be carefully selected since they may suggest value judgments about the best intervention method for suicidal people. With the non-offender population, for example, frequent efforts have been made to measure the empathy level of the counsellors, suggesting the correct approach must be Rogerian, that is humanistic.(9) Likewise, other researchers wanted to check the level of respect, human warmth and patience of the counsellors.(10) We can see that these evaluation criteria, which are often subjective, do not necessarily reflect the type of intervention that should be used with suicidal people. Intervention aimed at suicidal people is often more directive (asking questions, giving advice) than empathic (showing acceptance, reflecting feelings) because of the urgency of the situation and also because the client is particularly in need of assistance.

Therefore, the entire clinical intervention process must be evaluated, rather than just the aspect of empathy. Taking the approach used for a crisis intervention model, we can, for example, evaluate the establishment of contact with the client, definition of the problem, exploration of solutions, commitment to an action plan and planning of follow-up.(11) Such evaluations cannot, however, be systematized in an organization such as the Correctional Service of Canada since they require an investment of energy that cannot be sustained beyond a special research project.

However, the clinical approach, even if it is restricted to a limited observation period, can generate more information about intervention methods generally used with suicidal people. In addition, if such exploratory methods regarding the **process** are coupled with measurements of the possible **effects** of the intervention techniques, we can then consider which methods are best used in a given case. For example, in a recent study conducted in Quebec, we identified what verbal behaviour characterized volunteers working with suicidal people.(12) This verbal behaviour, assessed in terms of the number of techniques used, becomes an operational measurement of the intervention process. This measurement can then be evaluated in relation to fluctuations in clients' depressed moods, the urgency of their suicidal impulses and their subsequent behaviour. Conclusion Even with a non-offender population, suicide prevention is difficult to measure in terms of suicide-rate fluctuations. Our organization must therefore maintain realistic objectives, while assuming specific responsibilities in dealing with inmates who may be suicidal. The individuality and privacy of the suicidal act should prompt us to show some humility concerning our intervention, humility that does not prevent us from making every effort to save human lives.

However, if we are concerned about evaluating our specific prevention programs, we should then focus on measurements of the intervention **process** rather than its **effects**.

The above argument considers only the phenomenon of suicide, ignoring such parallel phenomena as suicide-like behaviour and self-mutilations. The precise identification of these actions, particularly in a prison environment, is not unanimous and must, we know, be carried out while taking the dynamics of the environment into account. However, when these various actions do correspond with a suicide attempt, we suggest that the evaluation models proposed above would still work here. The process initiated to prevent suicide is the same as that initiated to prevent suicide attempts. Our evaluation methods based on the intervention process should therefore cover both.

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(4)*B.M. Barraclough, C. Jennings and J.R. Moss, "Suicide Prevention by the Samaritans: A Controlled Study of Effectiveness,"* The Lancet *(30 July 1977): 237-239.*

(5)*N. Kreitman, "The Coal Gas Story: United Kingdom Suicide Rates, 1960-71,"* British Journal of Preventive and Social Medicine, *30 (1976): 86-93.*

(6)*S.M. Auerbach and P.R. Kilmann, "Crisis Intervention: A Review of Outcome Research,"* Psychological Bulletin, *84, 6(1977): 1189-1217.*

(7)*H.L Miller, D. W Coombs, J.D. Leeper and S.N. Barton, "An Analysis of the Effects of Suicide Prevention Facilities on Suicide Rates in the United States,"* American Journal of Public Health, *74, 4(1984): 340-343.*

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(9)*D.A. Knickerbocker and R.K McGee, "Clinical Effectiveness of Nonprofessional and Professional Telephone Workers in a Crisis Intervention Center," in D. Lester and G. W Brockopp (eds.),* Crisis Intervention and Counselling by Telephone *(Springfield, Ill.: C.C. Thomas, 1973, p.298-309.*

(10)*S. Hirsch, "A Critique of Volunteer-Staffed Suicide Prevention Centres,"* Canadian Journal of Psychiatry, *26(1981): 406-410.*

(11)*K.A. Slaikeu,* Crisis Intervention: A Handbook for Practice and Research *(Boston, Mass.: Allyn & Bacon, 1984).*

(12)*M.S. Daigle and B.L. Mishara, "La prévention du suicide au téléphone: les interventions des bénévoles québécois." Paper presented at the Fifth Provincial Meeting of the Association québécoise de suicidologie, Sherbrooke, Quebec, 1991.*