The Issue of Suicide in Canadian Federal Penitentiaries(1)

It is the nature of prisons that they contain individuals who have flot conformed to the codes of normal social behaviour. For many, breaking the law is only part of a larger picture of failing to establish stable social relationships. If these individuals were able to form the kind of support networks that we take for granted, many would flot be in prison at all. They are a high-risk population for suicide and a difficult population to work with in preventing suicide.

Research on the Prediction of Prison Suicide

> ...the suicidal prisoner presents ...few characteristics which would assist the process of identification.(2)

Research on suicide prediction outside prisons generally presents its findings in terms of risk factors for suicide. It is assumed that the more risk factors a person possesses, the more likely the person is to commit suicide. A number of points should be stressed. First, the assumption that risk factors "add up" in this way has been questioned.(3) The presence of a risk factor is not itself a cause of suicide. Real difficulties are encountered in trying to explain why anyone committed suicide, and even greater difficulties are encountered in trying to predict who is likely to commit suicide tomorrow.

In prisons, this problem of prediction is much worse. Many inmates possess enough risk factors to be automatically defined as high risks by community standards, even before the particular stresses of prison life are included.

Studies on prison suicide tend to follow a stereotyped format. The relatively high risk of suicide in prison systems is stressed (incidence may be said to be rising,(4) but these figures are subject to challenge(5)). Findings include:

- The initial phase of imprisonment is the most vulnerable time (but "some suicides occurred many years after reception into prison"(6)).
- Prisoners on remand are the highest risk group.(7)
- A high proportion of violent and sex offenders and lifers are among those who commit suicide.(8)
- A history of psychiatric problems is common.(9)
- The most common method by far is invariably hanging,(10) followed by slashing and overdose.

The main findings of much recent research are practically identical to those in an 1880 medical inspector's report to the Board of Prison Commissioners in England and Wales (see Table 1).(11)

Table 1

More likely in early weeks of custody.

Prisoners three times more likely than population at large.
First-time prisoners and those on remand most vulnerable. Violent prisoners especially prone.
"... just as every death from natural causes represents much sickness in the population at large, so does every suicide in prison represent much bodily and mental suffering."
Dr. R.M. Gover, Report to the Board of Prison Commissioners of England and Wales, 1880.

In an article under submission for publication, Green et al. 12 examining 133 suicides in Canadian federal prisons during the period 1977-1988, found that suicide was not more common among prisoners in certain age ranges, and it was not significantly related to offence type or sentence length. Only one individual who committed suicide was a first-time offender. Most were single, and most had attempted suicide previously. Alcohol and drug abuse, and previous psychiatric problems, were common. Time of suicide was spread evenly throughout the 24-hour period. The researchers found a marked variation in suicide numbers between Correctional Service of Canada regions, but they had not adjusted their figures to the regional inmate populations. A crude ratio between these suicide numbers and the percentage of inmates contained in each region suggests a linear variation in numbers across the country, with an almost threefold difference in rates between the Atlantic and Pacific regions. These ratios are shown in Table 2.

Table 2

Suicides in Federal Institutions by Region			
	% of suicides*	**% of inmates****	**Ratio**
Atlantic	13	8.5	1.53
Quebec	37	30.6	1.20
Ontario	30	27.8	0.83
Prairies	11	18.7	0.75
Pacific	8	14.4	0.55
* Based on figures in C.M. Green et al. "A Study of 133 Suicides Among Canadian Federal Prisioners" Unpublished article.			
** Based on figures from Basic Facts 1990, produced by the Correctional Services of Canada.			

> A number of authors have suggested methods to prevent jail suicide, although few have been evaluated rigorously, and their appropriateness in longterm prison populations has not been determined.(13)

The frankness of Salive et al. in acknowledging the lack of useful research on prevention programs does not prevent them, like most authors, from making suggestions on how correctional services should prevent suicides.

It is customary to distinguish between **secondary** prevention efforts aimed at individuals who have already been identified as at risk and **primary** prevention efforts addressing factors in the environment that might reduce overall suicide rates.

Comprehensive secondary prevention programs might include special facilities to house suicidal inmates and allow special observation, including 24-hour, one-on-one surveillance if necessary; measures to recruit family and friends to help authorities identify those who may be suicidal; and the use of "inmate observation aides."(14) However, little consideration is given to the very real problem of ensuring that such programs are available to the truly suicidal and are not overwhelmed with inmates seeking "relief from the obligations of the imprisoned."(15) Also, there is little evidence that such potentially expensive programs can be effective. Indeed, "Convincing arguments can be made against the effectiveness of prevention strategies aimed at identifying the at-risk individual and attempting to prevent his suicide."(16)

Primary prevention efforts generally require advance planning and implementation. They require the judiciary to change policy on remand and sentencing, and consideration of prison design before prisons are built. They almost always require higher staffing levels, and their implementation can have very little to do with front-line staff who are, nevertheless, generally asked to communicate better with the inmates.

> When considering the prevention of suicide in prison it may be more appropriate to emphasise general measures designed to reduce stress and promote coping mechanisms, rather than concentrate on the recognition of the suicidal prisoner.(17)

> Opportunities for the primary prevention of suicide lie in the use of alternatives to imprisonment, in hospitalisation and treatment when appropriate and in policies that are designed to reduce the stress of imprisonment by improvements in prison conditions and the provision of adequate support services for prisoners.(18)

Such statements may read well, but they can appear naïve in the context of rising prison populations and economic constraints.

"Common sense might suggest that people who kill themselves in prison do 50 **because** they are in

prison,"(19) and most administrations are likely to agree with Her Majesty's Chief Inspector of Prisons that "general penal reforms were not justifiable on the basis of a single issue such as suicide."(20)

The Problem in Practice

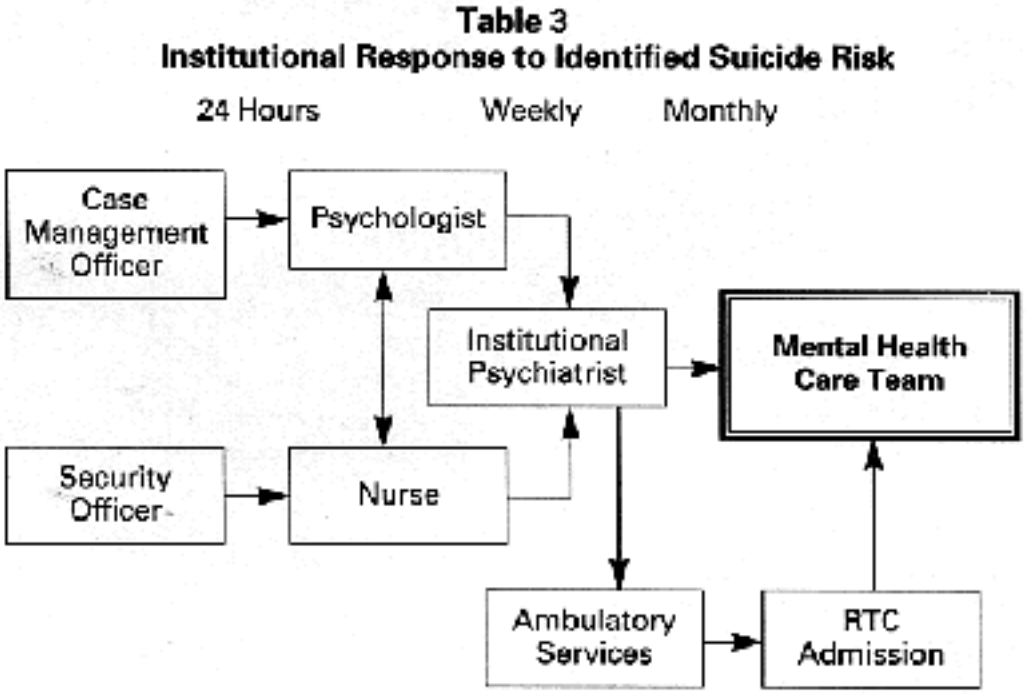
It is well known that those who attempt suicide are different in significant ways from those who succeed, though obviously the two groups overlap and a history of suicide attempts is recognized as an important risk factor for suicide.(21) In practice, attempted suicide is probably the most common way in which potentially suicidal individuals are identified. The other way is if somebody expresses an intent to commit suicide. It is rare for potentially suicidal individuals to be identified by other behaviour, unless it is part of a mental illness.

Mentally ill inmates consistently represent a considerable proportion of prisoners who commit suicide, and their suicides are probably the easiest to prevent. Treatment of the illness can reduce risk, and it is this group that psychiatric services can most help. Assisting other potentially suicidal inmates is a major problem for professionals.

Every penitentiary in the Ontario region maintains an active system for monitoring those at risk for suicide. This system is illustrated in Table 3. A mental health care team meets on a regular basis to discuss intervention and management of those identified. Possible interventions are limited in prison, and, in crisis, often the only option is to isolate suicidal inmates and deny them access to the usual tools for suicide - a razor blade or a noose. Razor blades are easily concealed in a body cavity, nooses are readily improvised. Therefore, initial intervention usually consists of canvas or paper gowns in a bare ceil, perhaps with 24-hour camera observation. This saves lives, but it can result in a loss of trust, and it cannot be pursued indefinitely.

Table 3

Table 3
Institutional Response to Identified Suicide Risk



In isolation, the crisis can be resolved unless the isolation areas contain a number of disturbed inmates. Only in isolation can any realistic attempt be made to assess the "actual" suicide risk. In assessing suicide risk at this stage, after searching for evidence of mental illness, I try to identify the social situation that might have precipitated the crisis (but inmates are frequently reticent about this), and I rely on the patients' own statements about their intentions. If they are prepared to give their word that they no longer intend to harm themselves, I usually accept the risk of reducing surveillance, especially if the person is clearly willing to accept help in the form of ongoing counselling of some kind.

However, the benefits of different kinds of counselling are questionable. There is no good evidence that counselling works, and it can be expensive and time-consuming. It is accepted in the field of drug abuse that forming relationships with concerned peers, people from the same background themselves struggling with similar problems, can be as effective as professional interventions. The same possibly applies to those who are mentally well who intend to commit suicide. But, encouraging the formation of peer groups in prisons carries with it its own dangers. Peer groups supported by the prison administration can be taken over by powerful inmates and become an instrument to exploit the weak and disadvantaged.

For staff involved with a suicide case, some emotional reaction is probably inevitable. A study of 43 train drivers who had experienced someone jumping in front of their train found that, one month after, 21 had recurrent and intrusive distressing recollections of the event, 13 had difficulty staying or falling asleep and 17 showed irritability or outbursts of anger. Sixteen percent of the drivers could be diagnosed as suffering posttraumatic stress disorder, and a further 39.5% qualified for other psychiatric diagnoses such as depression or phobic states.(22) In another study, almost half the psychiatrists who had a patient commit suicide reported stress levels comparable to those found in people seeking help after the death of a parent.(23)

For some staff, a reaction may take the form of an apparent hardening of attitude against inmates. This can be seen as a protection against an underlying sense of guilt. In others, and this may seem the more

healthy response, there will be a bereavement reaction that might include depression, tears and a questioning of themselves and their purpose in life.

Suicide in Clusters

If little is known about the general problem of suicide, much less is known about clusters of suicide within prisons, except that they occur.(24) Outbreaks of suicide have been observed in communities following media depictions of suicide in fictional characters. One prison suicide cluster has been blamed on a restriction of access to psychiatric services.(25)

In trying to understand epidemic suicide, sociological perspectives are likely to be more useful than medical or psychological concepts. Individuals may have their own reasons for deciding to die, but in an epidemic, these are clearly influenced by wider social factors. The growing public concern with each new suicide can itself feed into, and encourage, the next suicide. Until the fundamental faults are addressed, or until such suicides receive no further publicity, the epidemic may continue. One of the more than 50 recommendations of a Correctional Service of Canada investigation into a cluster of seven suicides in the Atlantic region in 1983 was to "undertake a program which would lead to the media in the area downplaying suicide by an inmate...,"(26) but the attempt to restrict media attention may increase a sense of despair and suspicion, making an epidemic worse.

Conclusion

Suicides in prison come in clusters, some of which may be explained, some may not. Such a cluster may be emerging across the country. The explanation for this probably has to do with wider social factors, perhaps an economic recession or prison overcrowding.

Prediction and prevention of suicides are difficult in this high-risk environment, and front-line staff are easily discouraged when management shows little understanding of their problems. Those involved deserve consideration and respect for their struggle in an area with few clear guidelines. Well-intentioned calls to be more alert to suicide prevention are likely only to erode morale.

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*(1)*A complete version of this article may be obtained from the author, G. Neil Conacher, Director, Psychiatric Services, Regional Treatment Centre, Kingston Penitentiary, Kingston, Ontario K7L 4V7.
(2)S.A. Backett, "Suicide in Scottish Prisons," British Journal of Psychiatry*, 151 (1987): 218-221, p. 221.*
*(3)*S. Levey, "Suicide," in R. Bluglass and P. Bowden (Eds.), Principles and Practice of Forensic Psychiatry *(Edinburgh: Churchill Livingstone, 1990).*
*(4)*E. Dooley, "Prison Suicide in England and Wales, 1972-87," British Journal of Psychiatry*, 156(1990): 40-45.*
*(5)*A. House, "Prison Suicides," British Journal of Psychiatry*, 156(1990): 586-587.*
*(6)*Dooley, "Prison Suicide in England and Wales, 1972-87, "p. 40.
(7)Backett, "Suicide in Scottish Prisons." See also Dooley, "Prison Suicide in England and Wales, 1972-

87." And see W. Hurley, "Suicides by Prisoners," Medical Journal of Australia, *151 (1989): 188-189.*
*(8)*Dooley, "Prison Suicide in England and Wales, 1972-87." See also Hurley, "Suicides by Prisoners. " And see M.E. Salive, G.S. Smith and T.F. Brewer, "Suicide Mortality in the Maryland State Prison System, 1979 Through 1987," Journal of the American Medical Association, *262 (1989): 365-369.*
*(9)*Backett, "Suicide in Scottish Prisons." See also Dooley, "Prison Suicide in England and Wales, 1972-87." See also Hurley, "Suicides by Prisoners. " And see Salive, Smith and Brewer, "Suicide Mortality in the Maryland State Prison System, 1979 Through 1987."
(10)Dooley, "Prison Suicide in England and Wales, 1972-87." See also Hurley, "Suicides by Prisoners. "And see Salive, Smith and Brewer, "Suicide Mortality in the Maryland State Prison System, 1979 Through 1987."
(11)D.O. Topp, "Suicide in Prison," British Journal of Psychiatry, *134 (1979): 24-27*
*(12)*C.M. Green, G. Andre, K. Kendall, T. Looman and N. Polvi, "A Study of 133 Suicides Among canadian Federal Prisoners." Under submission, Regional Psychiatric Centre (Prairies), 1992.
(13)Salive, Smith and Brewer, "Suicide Mortality in the Marvland State Prison System, 1979 Through 1987."
(14)J. Rakis and R. Monroe, "Monitoring and Managing the Suicidal Prisoner," Psychiatric Quarterly, *60(1989): 151-160, p. 154.*
*(15)*J. Haycock, "Manipulation and Suicide Attempts in Jails and Prisons," Psychiatric Quarterly, *60(1989): 85-98, p. 85.*
*(16)*Levey, "Suicide, "p. 609.
(17)Backett, "Suicide in Scottish Prisons, "p. 221.
(18)Hurley, "Suicides by Prisoners, "p. 190.
(19)House, "Prison Suicides, "p. 587.
(20)Levey, "Suicide, " p. 608.
(21)K. Hawton and J. Fagg, "Suicide, and Other causes of Death, Following Attempted Suicide," British Journal of Psychiatry, *152 (1988): 359-366.*
*(22)*R. Farmer, T. Tranah, L O'Donnell and J. Catalan, "Railway Suicide: The Psychological Effects on Drivers," Psychological Medicine, *22 (1992): 407-414.*
*(23)*C.M. Chemtob, R.S. Hamada, G. Bauer, B. Kinney and R. Y Torigoe, "Patients' Suicides: Frequency and Impact on Psychiatrists," American Journal of Psychiatry, *145 (1988): 224-228.*
*(24)*Hurley, "Suicides by Prisoners."
(25)K. Skegg and B. cox, "Impact of Psychiatric Services on Prison Suicide," The Lancet, *336(1991): 1436-1438.*
*(26)*E.H. Botterell, S.N. Akhtar, J. Fagan, R.C. Kaill and W.F. McCabe, "Report of the Study Team: Seven Suicides in the Atlantic Region; February 17 - August 25, 1983," p. xvii.