

Chapter 25

Preventing Suicide in Detention and Correctional Facilities¹

Robert D. Canning, Ph.D. and Joel A. Dvoskin, Ph.D.

Suicide is a significant and tragic public health problem. The World Health Organization estimates that 800,000 individuals die by suicide annually (see <http://www.who.int/mediacentre/factsheets/fs398/en/>) making it the 15th leading cause of death worldwide. In the United States, in 2013, over 41,000 individuals (mostly men) died by suicide (CDC WISQARS, accessed July 9, 2015) making it the tenth leading cause of death in the country.

Until almost forty years ago, suicide in jails and prisons was not the subject of significant and systematic study by government agencies or academia. Hayes (1981) published the first national study of jail suicide in 1981, and later the first national study of prison suicide (Hayes 1995). Since then, due in part to the sheer increase in prison populations in the United States and the intense scrutiny this has brought, academic and governmental interest in suicide and suicide prevention in correctional settings has grown. Responding to the apparent need, professional medical and mental health groups have promulgated guidelines for suicide prevention strategies in their position statements about the treatment of correctional populations. (See, e.g., American Psychiatric Association 2016).

¹ In general, this chapter is intended to apply to all forms of correctional incarceration and detention. Except where we intend to refer to a specific type of institution, we use the word “prisoner” to refer to prisoners, detainees, and residents of jails, prisons, and juvenile correctional and detention facilities.

This interest has been heightened since 2000, when the U.S. congress passed the Death in Custody Reporting Act, which requires jurisdictions to report information on all deaths in custody (see <http://www.bjs.gov/index.cfm?ty=dcdetail&iid=243>). In 2001, the release of the Surgeon General's National Strategy for Suicide Prevention acknowledged the need for improved suicide prevention in the correctional environment (U.S. Surgeon General 2001).

I. Epidemiology of Suicide and Suicide Attempts in Jails and Prisons

Suicide has been a leading cause of death in U.S. correctional populations for many years. Between 2000 and 2012, suicide was the number one cause of death among American jail prisoners (Bureau of Justice Statistics, 2014). But the frequency of suicide in jails has dropped from 479 in 1979 to 300 in 2012, despite an increase in the U.S. jail population from less than 200,000 prisoners in 1979 to over 700,000 at mid-year 2013 (Hayes and Rowan 1988; Bureau of Justice Statistics 2014). Overall, the rate of suicide in American jails has dropped from 129 per 100,000 prisoners in 1983 to 54 per 100,000 in 1999, and 41 per 100,000 in 2012 (Hanson 2010).

Between 2001 and 2012, the overall rate of suicide in U.S. state prisons was 16 per 100,000 prisoners.² In terms of raw numbers, the 3,807 prison prisoners who died by suicide during this period were only exceeded by deaths due to cancer (10,122), heart disease (9,874), and liver disease (3,709). By comparison, during the same time period, only 672 homicides occurred in U.S. prisons.

² For comparison, the rate of suicide deaths in the U.S. between 2000 and 2012 was 11.4 deaths per 100,000. (Web-based Injury Statistics Query and Reporting System, U.S. Centers for Disease Control and Prevention, accessed November 17, 2014)

Demographic Factors. Both in the community and in correctional settings, suicide rates vary as a function of demographic characteristics. The overwhelming majority of suicide deaths in both jails and state prisons are among male prisoners. The Bureau of Justice Statistics (BJS) reports that between 2000 and 2012, male jail prisoners committed 92% of suicides, while in state prison systems over 95% of suicides were committed by males (Bureau of Justice Statistics 2013a; 2014). This large disparity is due, but only in part, to the high percentage of males held in U.S. jails and prisons and also to the higher suicide rates for males generally.

Suicide rates in jails and prisons vary by racial group, and mirror the different rates found in the community. In U.S. jails between 2000 and 2012, for instance, 71% of suicides were by white prisoners and in state prisons, 58%, despite only 46% of jail prisoners and 30% of state and federal prisoners being white (Bureau of Justice Statistics 2013c; Bureau of Justice Statistics 2014). Hispanic and African American prisoners have comparatively lower rates of suicide in both jails and prisons. In the first decade of the 21st century, Hispanic prisoners accounted for 12% and 16% of suicide deaths in jails and prisons, respectively, while African-American prisoners accounted for 14% and 21% respectively.

Individual Risk and Protective Factors. Risk factors for completed suicide in prison and jails are similar to those found in the community. But in addition, correctional settings present a unique set of “correctional” factors that have been found to contribute to the risk for suicide. As in the community, previous suicide attempts and psychiatric disorder are the most important risk factors for suicide among prisoners. Given the number of seriously mentally ill individuals

incarcerated in the last thirty years, it is not surprising that the prevalence rate for serious mental illnesses such as schizophrenia, bipolar disorders, depressive disorders, and psychotic disorders is higher than in the community (Teplin 1994; Prins 2014). This, combined with the stressful correctional environment increases the risk for suicide among mentally ill prisoners (Fazel et al. 2008).

A systematic study of studies of jail and prison suicides found that suicidal ideation, previous suicide attempts, a current psychiatric diagnosis, and being prescribed psychotropic medication were significant risk factors for suicide (Fazel et al. 2008). These authors point out that the combination of a psychiatric diagnosis and a history of self-harm is a particularly important risk factor for prisoners.

Although there has been substantial research on completed suicides among prisoners in the last three decades, less well understood are the numbers and rates of suicide attempts and other forms of self-injurious behavior in American prisons and jails. The one national survey that attempted to quantify the level of self-injury in prison systems nationally found that self-injury causes significant disruption, yet most states do not even keep a tally of such events. (Note, however, that many incidents of self-injurious behavior are not believed to be suicide attempts.) The authors estimate that approximately two percent of state prisoners engage in some form of self-injurious behavior annually (Appelbaum et al. 2011). A study of South Carolina prisoners found that those who self-harm are likely to be younger, of Caucasian race, unmarried, with more disciplinary infractions, and were more likely to have a psychiatric diagnosis than prisoners who did not self-harm (Smith and Kaminski 2010).

Drug and alcohol use disorders are significant risk factors for suicide (Moscicki 2001; Nock et al. 2008). The high prevalence of substance use disorders in U.S. correctional populations (Teplin 1994; National Center on Addiction and Substance Abuse 2010), likely contributes to the prevalence of suicide in jails and prisons. In jails, the likelihood of intoxication or withdrawal from drugs or alcohol may also contribute to the prevalence of suicide during the first few days of detention.

Evidence that prisoners have higher overall mortality than community members (Patterson 2010) and that illness (Nock et al. 2008) and chronic pain (Tang and Crane 2006) are potent risk factors for suicide in the community suggest that medically ill prisoners are at increased risk of suicide (Way et al. 2005). Receiving a terminal diagnosis in prison or jail is a distressing and depressing event. Palliative care and hospice services may be limited and the demands of treatment may be onerous and only exacerbate the poor conditions of some prisoners. Further, separation from loved ones may be especially painful when one is facing death. Prisoners faced with this situation may choose to end their own life. In addition, studies of released prisoners have found that the higher suicide risk associated with medical illness follows prisoners back into the community, resulting in high rates of suicide (and other causes of death) in the period after leaving prison (Binswanger et al. 2007; Rosen, Schoenbach and Wohl 2008; Zlodre, Jakov, and Fazel 2012).

Most prisoners in jails and prisons have suffered some form of childhood victimization (Maxfield and Widom, 1996). In the 1980's, the intimate connection between childhood

adversity and later criminal activity and psychopathology (particularly Post-Traumatic Stress Disorder) became clear (Widom 1989). Childhood maltreatment has been found to be a significant risk factor for suicide attempts (Johnson, Cohen, Gould, Kasen, Brown, and Brook, 2002). Given these findings, all prisoners should be asked about a history of child maltreatment, which can be regarded as a chronic risk factor for suicide (Nock et al. 2008). Of course, because of the high prevalence of trauma in the lives of prisoners, trauma alone is a non-specific risk factor that would yield many false positives. However, inquiry about the nature of a prisoner's trauma history can provide important insight into the nature of suicide risk.

A number of studies have found that there are unique "correctional" risk factors, both related to the individual prisoner and the context in which they are living. For instance, Fazel and colleagues (2008) noted that lengthy prison terms were associated with increased risk of suicide. They also found that being housed alone, pre-adjudication status, having a conviction for murder or a life sentence, or a violent offense were significant correlates of death by suicide.

The threat or fact of physical or sexual assault significantly increases the risk of self-harm or suicide for the victim. The BJS reports that 4.0% of state prisoners, and 3.2% of jail prisoners reported some form of sexual assault in 2011-12 (U.S. Department of Justice, 2013). Physically small or frail, mentally disordered, intellectually disabled, homosexual, and transgendered prisoners may all be at risk of being assaulted by other prisoners.

The stress of life in correctional settings can take a toll on individual prisoners. Consistent with the diathesis-stress model of suicidal behavior, vulnerable prisoners, like vulnerable non-

prisoners, may attempt suicide after exposure to a variety of life stress. Medical illness, mentioned above, is one such stressor, but in jails and prison, prisoners are exposed to other stressors that can increase their risk for self-harm, including suicide. For example, overcrowding has been found to increase the probability of suicide in prison populations (Huey and McNulty 2005). And in a study of New York state prisoners, Way and colleagues (2005) found that receipt of “bad news” such as death of a family member increased the risk of suicide.

Contextual Factors. In correctional settings, the type of housing can increase the risk of suicide (Hughes and Metzner 2015). There has been much discussion in recent years (for instance, see Berger, Chaplin, and Trestman 2013) of the deleterious effects of “segregated” housing. This type of housing can be either short-term or long-term, and is designated in a variety of ways, such as disciplinary segregation, administrative segregation, security housing units, or super-max. In these settings, a prisoner is confined to a cell for many hours per day and their interaction with other prisoners or staff can be very limited. In the most common and severe forms of segregation, a prisoner may be alone in a cell for up to 23 hours per day. Some prisons have assigned segregation prisoners to two-man cells, which remains a far cry from normal social interaction.

Bonner (2006) and Way (2007) found that when prisoners are moved to higher-security segregated settings, suicide risk may increase (See also Hughes and Metzner 2015.) This is particularly true if the re-housing is sudden and unexpected. The ability of staff to identify those prisoners who will suffer the most (and need more help) in segregated settings is difficult. In order to identify prisoners who are responding poorly to segregation as early as possible, many prisons now conduct regular rounds by mental health clinicians, typically consisting of brief cell-

front conversations with every segregation prisoner. It is important to allow either the prisoner or the clinician to request a private clinical contact when requested or deemed appropriate.

One of the most pervasive and difficult problems is the predatory and violent nature of the correctional setting (see Toch, 1997 as quoted in Cohen, 2011, p. 13-4). Prisoners seek safe environments in which to live; and when they perceive the situation as hopeless and feel trapped, with few or no alternatives for relief, they can become suicidal. Large prison and jail systems that struggle with gang and drug problems often have gang “dropouts” who can quickly become suicidal – even when separated and segregated for safety reasons. The anxiety and agitation these prisoners experience can rise to psychotic proportions and quickly precipitate a suicidal crisis.

The physical design of prisons and jails should always take into account the possibility of suicide. Older, many-tiered prison buildings are particularly challenging from a suicide prevention perspective, largely due to the difficulty in observing prisoners frequently. Even modern, two-tiered prison buildings, however, are not immune to suicide risk, and require the measures described below.

Designing and equipping cells with furnishings that are suicide-resistant should be part of every new facility. Among other things, the cells should be free of protrusions from which a prisoner could easily suspend a ligature. Ventilation grates should have a small enough mesh that it will be extremely difficult to suspend a ligature. Cells should also be free of sharp, protruding edges that would facilitate self-harm. Finally, cell doors should have large enough vision panels to allow observation of the entire cell from a safe distance. Obviously, all of these considerations

are especially important in single-person cells, and mandatory in any cell that is to be used for prisoners on suicide precaution status.

Protective Factors. Protective factors or buffers are characteristics of the individual or their surroundings that decrease the likelihood of suicidal behavior. In prison, as in the community, the most important protective factor is an individual prisoner's social connectedness. In addition, studies have found that being housed with other prisoners (Fazel et al. 2008), contact with family members, and being married (although see Fazel et al. 2008 for a contrary finding) are negatively correlated with suicide.

II. Legal Basis for Suicide Prevention

There is little dispute about the constitutional and tort law necessity of a suicide prevention system in every correctional institution.

While the original jurisprudence regarding deliberate indifference emerged from 8th amendment claims against prisons, it is now clear that similar requirements emerges from the 4th, 5th, 6th, and 14th amendments (Bell v. Wolfish, 1979) and apply to all forms of detention and incarceration, for youth and adults alike. For a more complete explanation of the legal basis for suicide prevention, see Cohen (2011).

Because federal courts have recognized that it is impossible to prevent all suicides, the legal requirements are that every detention correctional facility or system makes reasonable efforts to prevent suicides.

Even in cases where there has been no deliberate indifference, civil courts may find negligence, malpractice, or other forms of tort resulting in death. Again, the results of these cases should not be based solely on the outcome, but whether or not the facility took the reasonable steps, such as those outlined below, to prevent suicides. See Cohen (2011) for details of these cases.

- a. *Ruiz v. Estelle* was the first of several landmark cases that found correctional systems in violation of the 8th Amendment of the Constitution. In *Ruiz*, Judge Justice found that Texas had inflicted cruel and unusual punishment upon prisoners by not providing adequate screening, appropriate treatment, sufficient mental health staff to support treatment, a medical records system, an up-to-date medication management system, and a program to identify and treat prisoners with elevated suicide risk.
- b. *Langley v. Coughlin* extended the requirements of *Ruiz* and delineated in more detail exactly what a constitutional mental health system should look like.
- c. *Farmer v. Brennan* described “deliberate indifference” as a failure to act when there is prior knowledge (either explicit or implicit) of risk. In suicide cases, this principle extends to knowledge of prior attempts and the potential for suicide.
- d. *Coleman v. Wilson* applied the standard of deliberate indifference and found California’s massive correctional system at fault in most of the same ways as Texas in *Ruiz*. Although the state’s suicide prevention program was not initially found deficient, overcrowding and issues of suicide among prisoners in segregated settings quickly came to the foreground. The court pushed the state to expand suicide prevention programs beyond the class of seriously mentally ill prisoners, targeting the general prisoner population, instituting suicide prevention training for all staff (not

just custodial and mental health staff), and extending screening procedures throughout the system. This case also points out the difficulty of reducing suicide rates in the context of overpopulation and poor conditions of confinement.

In addition to class actions regarding conditions of confinement, custodial suicides can also result in individual actions alleging civil tort liability for wrongful death. Depending upon the circumstances, and whether or not the state has a cap on tort liability for government agencies, these cases can result in extremely large payouts to the estates or surviving relatives of prisoners who have committed suicide. Six- and seven-figure awards are not unheard of both in state (e.g. *Estate of Price v. Black Hawk County*, No. 00-CV-2008 [N.D. Iowa March 21, 2003] which awarded the family of a jail prisoner \$300,000 after his suicide) and federal courts (e.g. *Belbachir v. County of McHenry*, No. 06-C-1392, U.S. Dist. Court [N.D. Ill.] in which the court awarded \$1 million to the estate of an immigration detainee who hanged herself in custody).

The impact of forty years of litigation on correctional health care practices cannot be overstated. There has been a steady improvement in the conditions of confinement and better guidance for prison administrators about the boundaries of adequate and constitutionally appropriate health care, including suicide prevention.

III. National Standards and Best Practice Guidelines for Suicide Prevention in Correctional Settings

In addition to improvements in prison suicide prevention driven by litigation, other changes have come from the increased involvement of professional organizations that have written standards for care based in part on community standards of care and best practices.

The National Commission on Correctional Health Care (NCCHC) (2008), the American Psychiatric Association (APA) (2016), and the American Correctional Association (ACA) (2003) have all promulgated standards for medical and mental health care that include specific recommendations for suicide prevention programs. These standards guide correctional administrators and medical and mental health administrators and are often looked to by the courts as the minimum standards for suicide prevention programs in correctional systems.

Until the Surgeon General's Report in 1999, implementation of systematic public health suicide prevention programs in the community were marginally successful, and thus had little influence on the organization and implementation of suicide prevention programs in correctional settings. Recently, a number of highly successful suicide prevention programs have been implemented in large integrated health care systems (Hampton 2010; Knox et al. 2010), and the lessons learned from these programs must be disseminated and implemented in correctional settings.

As part of the U.S. Surgeon General's National Action Alliance for Suicide Prevention (2012), the Clinical Care and Intervention Task Force (2014) examined several of these integrated healthcare systems. Based on their analysis, the task force recommended that suicide prevention programs in large-scale health systems be organized around three critical principles: Core Values, Systems Management, and Evidence-Based Clinical Care Practice. Many correctional systems have implemented one or even two of these principles, but few have adopted and fully

implemented all three. In the next sections of this chapter we will discuss important components of suicide prevention programs with these three basic principles in mind.

The evidence is clear; implementing a comprehensive public health approach to suicide prevention in jails has proven successful. According to Hayes (1988; 2012) the suicide rate in detention facilities throughout United States has been substantially reduced during the past 20 years, dropping from 107 jail suicides per 100,000 prisoners in 1986 to 38 jail suicide deaths per 100,000 prisoners in 2006 (Hayes 1988; 2012). Hayes (2012) writes, “Recent research has suggested that many jail suicides occur in facilities lacking comprehensive suicide prevention programs, with only 20% having written policies encompassing all the essential components. In other words, we know how to prevent jail suicides, even though not every jail does it.

IV. Essential Components of Correctional Suicide Prevention

A. Core Values

Based on a review of the health care systems noted above, the Clinical Care and Intervention Task Force recommended that all behavioral health organizations adopt a set of core values in order to implement suicide prevention effectively. All three organizations evaluated had strong leadership that set the tone for the organization and articulated that any suicide attempt was an unacceptable event. The attitudes and beliefs of the organization emanated from the entire leadership corps. This principle was best exemplified by the U.S. Air Force program, the epitome of a “top-down” organization,” in which the cultural changes necessary to make suicide

prevention a top priority were established by the Chief of Staff, the highest-ranking uniformed officer (Knox et al. 2010).

In correctional systems, too often suicide prevention is considered the domain of mental health programs alone. Correctional leaders must resist this bias and make suicide prevention a system-wide priority that is part of everyone's job. This is, in part, due to the nature of suicide in correctional settings, where many prisoners – not just those in mental health care – are at elevated risk for suicide over long periods of time and the need for prevention programs to reach all prisoners. To be fair, there are many examples where wardens, sheriffs, and jail directors have made a strong, personal investment in suicide prevention.

The Task Force recommended that suicidal behavior needs to be treated without regard to underlying pathology and requires multiple levels of service in a team environment. Linkages must be established between all levels of care, between providers of all disciplines, and over time. Especially important is the communication that allows all parts of the institution to be aware of information related to suicide risks for individual prisoners and detainees, as well as information gleaned from investigations of serious and fatal suicide attempts. For instance, implementing universal screening in primary care cannot be successful in the correctional setting without systems in place to support primary care providers and manage suicidal prisoners no matter the time of day or custodial status.

Around-the-clock management and care is required if acutely suicidal patients are to be adequately cared for. Creating trusting and productive therapeutic alliances is an important

aspect of any successful treatment for suicidal patients. Fostering a culture of shared responsibility and team care can allay clinicians' anxiety, which in turn will increase the effectiveness of their interventions.

Finally, for any program to succeed, systematic evaluation of the program is an absolute necessity. This last point is particularly important. The Task Force and others (see, the Strategic Planning Approach to Suicide Prevention, accessed July 6, 2015 from <http://www.sprc.org/basics/about-suicide-prevention/planning>) recommend that any suicide prevention program be accompanied at the outset by an evaluation program that will delineate the important elements of the program, track progress, and produce feedback for the plan sponsors and participants.

Without a systematic evaluation plan, programs cannot gain insights into what is working and is not. The nature of evaluation and quality improvement systems for suicide prevention must include self-critical and multidisciplinary investigation of suicide deaths and serious suicide attempts, as well as frequent audits of the suicide risk screening program and the quality of comprehensive suicide risk assessments by clinicians. Among custody staff, there must be audits of the frequency of observation of prisoners on various suicide prevention statuses.

It is especially important to resist the practice of separate investigations for custody, mental health, and health care after a completed suicide. The goal of these investigations is not to assign blame, but to identify steps that can and must be taken to reduce the chances of another death under similar circumstances. These "lessons learned" seldom fall neatly into the bailiwick of one part of the organization to the exclusion of others. Communication between custody and health care is a shared responsibility whose failures can result in tragedy; separate investigations are

unlikely to identify these cross-discipline areas of potential improvement, and are thus presumptively inadequate.

B. Systems Management

Policy and Procedures. Specific written policies and procedures guide an institution's actions to detect and treat suicidal prisoners. An adequate suicide prevention policy will guide the actions of all staff, including medical, mental health, and custody staff. The policy will account for all of the essential elements of suicide prevention included in this chapter. Ideally, all three parts of the institutional staff will operate under the same policy. However, in many institutions, the medical and mental health providers may work under contract or through an intergovernmental agreement. If all of the groups cannot utilize the same policy, the policies in place must be compatible and explicitly reference each other. Once the policies and procedures are in place, staff at all levels must be trained in them so that they are aware of their roles and the expectations of the system for their care of suicidal prisoners.

Generally, the policies and procedures of each institution should comport with the standards of the National Commission on Correctional Health Care (NCCHC), the American Correctional Association (ACA), or similar organizations, to assure that the national standards are met.

Suicide Prevention Committees. One of the most important innovations in suicide prevention is the creation of a suicide prevention committee. The committee, whether system-wide or for a single institution, should be truly multi-disciplinary, including representatives from various

levels of security, medical, and mental health staff. The chair of the committee can be from any discipline but should be someone with a vested interest and meaningful authority in preventing suicides and able to provide leadership for the system or institution. These committees are typically responsible for development and implementation of the program's policies and procedures, and for ensuring that the facility's quality improvement systems pay adequate attention to suicide prevention. If a local committee, the responsibility is to translate the larger system's policies into local procedures that fit with the mission of their institution.

For example, a high-security institution's suicide prevention committee may want to implement a program of suicide screening of prisoners housed in segregated settings for more than a certain period of time on the theory that extended stays in segregation raise the risk of self-harm or suicide. To accomplish this, they must work with multiple stakeholders – mental health providers, nursing staff, and of course custodial employees at all levels. The program must be able to identify who should be screened (e.g., mental health patients or all segregation prisoners), who will do the screening (e.g., nursing or mental health staff), what instrument to use, how the screenings must be documented, and to make sure the screening can be accomplished safely (e.g., whether the screening staff is accompanied by a correctional officer). The results of the screenings must be tracked and a process put into place to ensure prisoners who “screen positive” are evaluated in a timely manner and the information from the screening is available to those who need it. Finally, the system must be evaluated over time for its effectiveness. New programs like this may be the result of court initiatives, quality management data, evaluations of recent suicide deaths, or simply informal observations by staff.

When suicide prevention committees create procedures, it is imperative that they create lines of communication across all disciplines and professional boundaries in the facility. This is particularly important whether medical or mental health care is provided by a contract provider, a separate department within the facility's jurisdiction, or through an intergovernmental agreement.

Sufficient professional and analytic staff should be devoted to the suicide prevention program to allow it to function effectively. Leadership of suicide prevention programs must have the support of the top-level leaders of the correctional system, whether a local sheriff running a 50-prisoner jail, or a state-level secretary of corrections who must manage a system of thousands of prisoners in numerous institutions.

Other responsibilities of a suicide prevention committee include review of self-harm incidents and suicide deaths. Suicide deaths are extreme and uncommon events but every system should have a set of policies and procedures to review, evaluate, and learn from these tragic events.

Whatever review process a system establishes (e.g., root cause analysis, morbidity and mortality review, or psychological autopsy), the review must be integrated into the quality improvement program so the system can improve practices and move forward (Hayes 2010).

The committee's responsibilities can be quite broad, encompassing risk-reduction policies that target individual groups of prisoners (e.g., those returning from parole or court proceedings who may be at increased risk), custodial practices (e.g., how often custodial officers check on

prisoners in different kinds of housing units), or even architectural features of new construction to reduce the risk of hanging from furnishings and fixtures.

One of the most important tasks for any suicide prevention committee is oversight of training. The coordination and monitoring of training for custodial, medical, and mental health staff is an essential piece of suicide prevention. Emergency response training, drills, and tracking of training are necessary to maintain readiness. It is also important to ensure that new employees are trained adequately and continuing staff have ongoing training. Particularly important are those who screen prisoners on intake and in other settings (see below), and mental health staff whose duty is to make judgments of suicide risk and implement safety plans for prisoners who may have become suicidal.

Managing quality in suicide prevention: Suicide prevention committees should be embedded in the larger system's quality improvement program. Policies that delineate the nature and kind of data collected and the frequency of collection need to be in place. Ideally, a computerized tracking system should be in place to afford the committee the ability to analyze trends and outcomes of the programs. In large systems with a number of jails or prisons, a central office suicide prevention committee should be responsible for aggregation and analysis of system-wide data and devising procedures for making sure that the information from those analyses is cycled back into the care setting, and that lessons learned are shared between facilities.

Quality improvement programs should track a number of general indicators such as staffing and training; the frequency and numbers of suicide risk assessments; referrals for suicide risk

assessments and their source; and emergency responses. Exactly what is tracked depends on the type of correctional system, it's size, and the resources available.

When a suicide death occurs, a suicide prevention program should have an evaluation process ready to respond (Hayes 2010). Suicide evaluations should be a systematic inquiry into the events, both proximal and distal, that preceded the death, the circumstances of the event including emergency response, and if necessary recommend corrective actions and/or investigations of the conduct of staff or the identification of policies and procedures that may need changing. Investigations may be completed by a section of the correctional department or by an independent agency; but the goal of any evaluation of these sentinel events is always prevention. As noted below, some aspects of suicide investigations may be carried out exclusively by physicians and nurses. However investigations are completed, it is imperative that the final investigation include all significant parts of the organization, including (at least) custody, mental health, and health care.

Both directed and regular peer review should be part of correctional quality improvement programs. These may range from formal procedures as part of licensed medical or professional staff organizations (often called mortality and morbidity reviews) to less formal but regular processes among a small number of mental health workers in a county jail (Ruiz 2010).

Adequate quality improvement requires that all correctional systems have processes to change and improve. This may involve giving information to decision-makers in easily understandable ways, to show compliance with quality standards and targets, or policies which require review of

incidents and quality improvement plans when processes may have broken down. Once a final set of recommendations emerged from these reviews and investigations, it is important to document each recommendation and track its successful implementation.

Collaboration and Communication. The principals of collaborative care must be adhered to. This is particularly important in correctional settings where multiple health care-related processes plus custodial processes must be adhered to in order to assure not only adequate healthcare, but also safety and security.

Staff must both understand and believe that they are part of a larger team dedicated to reducing suicides. Just as connectedness acts as a protective buffer for those having thoughts of suicide, team cohesiveness fosters connectedness and good communication.

Trained and Skilled Work Force. No adequate healthcare system can function without a critical mass of providers who possess the appropriate skills and training to work with suicidal individuals. Staff training is an essential component of every suicide prevention program (see ACA, APA, and NCCHC standards) (Hayes 2010). Systems must have in place ways to recruit and retain well-trained staff at all levels; this includes adequate salaries and benefits.

As noted above, litigation following suicide deaths and class actions regarding suicide prevention programs can have devastating effects upon correctional and detention systems. These effects include not only money damages; they can also result in consent decrees, settlement agreements, and other forms of outside oversight than can negatively affect

institutional morale. Prison suicide litigation has focused on a number of factors, including the necessity to assure the availability of an adequate number of qualified – and trained – mental health professionals. Qualified mental health professionals (QMHP's) are typically defined as professionals with at least a master's degree who are licensed in a mental health profession, such as psychiatry, clinical or counseling psychology, social work, nursing, counseling, etc. QMHP's are needed to oversee the screening process, perform comprehensive suicide risk assessments, and to provide the treatment that is needed for a serious mental illness or to alleviate the despair that led to the prisoner's suicidality. Whether they are provided by employees, contractors, or interagency agreement, every correctional facility must have an adequate number of trained mental health clinicians.

Specific training in suicide risk assessment is necessary given the evidence that even highly educated providers have often not been adequately trained in the details of how to talk to a suicidal individual, elicit the information necessary to make an accurate judgment of risk, and develop a safety plan to reduce the short-term risk of self-harm (Schmitz et al. 2012).

But training mental health providers is not enough in today's correctional environment. Training medical, nursing, custodial, chaplaincy, and other non-healthcare employees about the identification and referral of a prisoner for evaluation is necessary. Ideally, every staff member with prisoner contact should receive training that includes the identification of prisoners in need of mental health assessment, especially those for whom suicide is a current or historical issue. This includes a working knowledge of the signs and symptoms of acute and chronic suicidality,

general and specific risk factors, and warning signs of short term risk that indicate the need for emergency treatment.

All detention and correctional officers, as well as anyone else likely to perform a suicide watch, must be trained in the policies, practices, and post orders regarding the proper conducting of a suicide watch. This includes timeliness, observing signs of life, and allowing prisoners an opportunity to communicate a worsening of their condition or an intensifying of their suicidal ideations or intentions. It also includes the required documentation of watches and emergency procedures.

For those staff assigned to intake screening (e.g. correctional or detention officers or nurses), special training is mandatory. This training includes when and how to inquire about ambiguous responses, how to document responses, and how and when to refer acute cases for immediate mental health assessment and treatment, as well as implementation of suicide-preventive watches until a clinician is available.

Training must also include emergency preparedness, supported by ongoing drills to ensure that emergency medical and mental health responses to suicide attempts are timely and competent. The schedule of drills must be part of the system's policies and a local facility's procedures.

All correctional, mental health, and medical staff must also be well trained in how to document observations about suicide risk, and especially their documentation of serious suicide attempts, completed or not. In our experience, mistakes (or even intentional falsification) in documentation

in the immediate aftermath of a suicide attempt can have pernicious effects. For example, without an accurate account, it is difficult or impossible to identify corrective actions that could prevent future tragedies. Further, staff should be clearly trained to understand that cover-ups are often far more deleterious to careers than the errors that were covered up; and in our opinion, falsification of documentation of suicide-related events should be treated as an extremely serious and potentially lethal violation of policy.

C. Evidenced-based clinical care

The Action Alliance Task Force made strong recommendations about the need for organizations to adopt methods of assessment and treatment that are evidence-based even while recognizing that the research base is thin (National Action Alliance: Clinical Care & Intervention Task Force 2014). This is particularly so in research in correctional mental health practice, where treatment research is difficult and complex. They also stressed that stigma can negatively affect treatment and that organizations will sometimes avoid suicidal patients because of what they call “fatalistic misperceptions” that there is nothing to do for individuals determined to take their lives.

Correctional systems of care must resist these biases and through training and education resist perpetuating them or becoming a culture of avoidance.

Detection, assessment, and treatment of suicidal individuals are difficult tasks for both individual clinicians and systems of care. As noted earlier, collaboration, and communication are essential elements of any systemic approach to care of suicidal individuals. Suicide prevention is a process over time that includes screening, assessment of risk, and management of suicidal prisoners. We

now discuss the important elements of suicide prevention and note evidence-based interventions that have shown efficacy in preventing suicide attempts and even suicide deaths, and should be considered for implementation in correctional settings.

Screening. Although universal screening for suicide risk in the general population has shown limited utility (O'Connor et al. 2013) screening among prisoners, a population with elevated risk for suicide, is an important suicide prevention tool in correctional settings (Hayes 1995; 2012).

Screening instruments should be short, valid, and target those psychological domains and risk factors that are most appropriate for the setting in which they are used. The screening process should ideally employ a screening instrument designed for correctional settings (Maloney 2015; Mills and Kroner 2005; Steadman et al. 2005; Ford et al. 2007). Every screening should include questions about suicide risk. While many of the questions seem obvious (e.g., current suicidal thoughts, recent history of attempted suicide, etc.), they provide newly admitted prisoners with an opportunity to reveal their thoughts of suicide and to get help. For a summary of suicide prevention screening instruments see Maloney et al. (2015).

In addition to the choice of screening instrument, those who administer screenings must be trained on their use and the procedures when a prisoner gives positive answers to questions. Personnel who administer screenings can range from law enforcement officers in jail booking sections to nursing staff and even mental health professionals in large correctional reception centers. When a non-mental health staff member administers a screening, the measure should

have built-in scoring rules to reduce the need for clinical judgment. In this situation, the measure itself makes the decision about referral rather than the person administering the measure.

It is in the nature of the screening process that it should maximize false positive results and minimize false negative. The cost of a false positive error is merely an additional assessment, while the cost of a false negative error could result in a preventable death. In other words, staff must be taught to err on the side of caution in deciding whether to refer a prisoner for further assessment. Once a screening is completed, the results must be documented and if necessary conveyed to other clinical staff for follow-up. Additionally, the data should be included in the system's quality improvement system for analysis and evaluation purposes.

Screening of prisoners should be routine at certain times and places. Transfers and entry into new facilities should occasion screening for mental health concerns and suicide risk. Because a transfer to segregation may increase the risk of suicide, screening either before re-housing or soon after may identify vulnerable prisoners in need of increased mental health attention. As noted above, many jurisdictions conduct mental health rounds for all segregation prisoners at least weekly. For prisoners who endure lengthy stays in segregated housing, face-to-face, confidential assessments are typically required at regular (e.g. monthly) intervals.

Screening is important when prisoners return from hospital stays, court proceedings, parole hearings, or even after visiting. As part of an integrated health care system, screening should (and can) be performed in medical clinics as part of routine practice. All prisoners attend medical clinics periodically and are interviewed by nurses or physicians but typically less than 20%

regularly receive mental health services. Research in the community has shown that it is much more likely that an individual who dies by suicide has seen a medical provider in the year before their death than a mental health provider (Luoma, Martin, and Pearson 2002). Thus, every medical visit should include some inquiry into suicidal ideation.

Assessment. Suicide risk assessment and the judgment of suicide risk is a complex and difficult clinical task. It may be the most difficult task a clinician can perform – no matter the setting. The standard of care in suicide risk assessment is not the prediction of suicide but rather conducting and documenting a systematic review of risk and protective factors (along with warning signs of very short-term risk), formulating and justifying a risk level, and construction of a plan of care based on the data gathered and the judgment of risk (Silverman 2014).

Clinicians are often asked, “If the person is really suicidal, why would they tell you?” It is important to understand that suicidal prisoners are presumptively ambivalent, as evidenced by the fact that they are (so far) still alive. Clinical experience suggests that prisoners are often frightened of their own suicidal wishes. They sincerely want to die, but something is keeping them alive, at least for the time being. The goal of suicide is often to escape the extreme psychological distress they are experiencing, and the provision of competent help can often help the individual get past their suicidal crisis. In other words, even if a suicidal threat or attempt is literally a “cry for help,” the individual’s suicidal intentions and fears are real, resulting in tragic outcomes if the help is not provided.

The use of risk factors to gauge someone's risk for suicide has a long history but is fraught with problems. It is not enough for a clinician to simply add up the risk factors, balance them with protective factors, and compute a risk "score." The process is not additive and is plagued by the lack of general consensus about how to weigh each risk and protective factor and how to designate the levels of risk. High risk for one prisoner may be only low to moderate risk for another. Additionally, suicidal states wax and wane over time suggesting that suicide risk assessment is a process over time rather than a one-time event (Berman and Silverman 2014; Silverman and Berman 2014).

Experts are quick to point out that most risk factors clinicians are taught to assess give little hint about the short-term risk of suicide (Silverman and Berman 2014). For instance, a history of suicide attempts gives little information about what the person will do in the next few hours or days and even the presence of suicidal ideation has a low correlation with eventual suicide. In addition to the assessment of risk and protective factors, it is important, particularly in crisis evaluations, to use what are called "warning signs" – signs and symptoms of near-term (hours, days, weeks) risk. The risk of suicide is analogous to the risk of heart attack. When evaluating for the short-term risk of heart attack, it is less important to evaluate the history of smoking or a family history of heart disease than to ask about shortness of breath or radiating pain in the upper left quadrant of the chest. In the same way, accurately assessing the short-term risk of suicide may depend more on warning signs than on stable risk and protective factors.

There are a number of warning sign "schemes" in the literature on suicide risk assessment, but recently the American Association of Suicidology has publicized a set of ten warning signs that

go by the acronym IS PATH WARM. These ten warning signs (ideation, substances, purposelessness, anxiety, feeling trapped, hopelessness, withdrawal, agitation/anger, recklessness, and mood instability) were created by a consensus panel of experts and are currently being tested in a variety of settings. They can be taught to both laypersons and professionals, and thus, in the correctional setting, can be taught, disseminated, and “advertised” to all staff (Rudd et al. 2006). Recent advances in the assessment of suicide risk have pointed out the importance of stratifying risk over time (Silverman 2014). It is important to differentiate between chronic and acute risk (also called “static” and “dynamic” risk) (Rudd 2006). Chronic risk factors such as historical and demographic factors are long-term risks that “prime the pump” and raise individuals’ susceptibility to the effects of acute or short-term risk factors. Acute risk factors, if powerful and having significant meaning for the individual, can precipitate suicidal crises even in the absence of chronic risk.

Acute risk factors (and warning signs) are important elements for treatment planning with suicidal prisoners. Safety plans should target acute risk factors and warning signs, i.e. modifiable risk. For instance, in a correctional setting, placement in segregation removes a prisoner from his/her personal belongings, his/her social group, possibly his/her school or job assignment – in short, losses in all areas of social functioning. The provision of daily exercise (psychomotor activation), daily structured contact with staff (rounding by health care), individual in-cell activities (entertainment devices and activity booklets), and possibly group activities (relatedness) can counter the effects of isolation and provide buffers against suicidal urges.

Perhaps surprisingly, one of the most useful and important questions to ask a suicidal prisoner is, “How is it that you are still alive (i.e., in the face of all of your psychological pain and despair)?” Asked respectfully, this question can elicit protective factors that are preventing the person from acting on their suicidal impulses and cognitions. Examples include family connections (e.g., “I couldn’t do that to my kids”) or religious values (e.g., “I don’t want to burn in hell”). Learning about protective factors can inform treatment interventions. Further, acknowledging the person’s ability to withstand suicidal ideation allows clinicians to reinforce attributes such as resilience and courage, thereby improving a dangerously impaired self-image.

Learning about a prisoner’s protective factors or “buffers” can help clinicians to reduce risk by reinforcing interpersonal relationships, maintaining contact with families, and emphasizing future-orientation. Safety plans for suicidal prisoners should always focus on enhancing protective factors, if possible. However, it is important for clinicians to remember that high levels of acute risk can overwhelm the positive benefits of protective factors.

Many systems create a specific form for evaluators to fill out when a suicide risk assessment is performed. No form can substitute for clinical judgment, but a well-constructed form can provide documentation that the clinician “covered all the bases” of a reasonable and adequate risk assessment (Simon 2009). A form should contain all elements of a risk assessment: sections for chronic and acute risk and protective factors, room for a mental status examination and suicide inquiry, a section to note the risk level (commonly low, moderate, high) and its justification, and finally, space for a detailed safety plan that addresses the modifiable risk factors and protective factors that should be enhanced.

Clinical interventions and treatments. Treatment planning and management of suicidal prisoners begins as the assessment phase ends. Each assessment (especially those conducted in response to a crisis evaluation) should include a short-term “safety plan” that emphasizes enhancement of protective factors, reduction of acute risk factors (possibly housing issues or issues involving recent transfers), and treatment of current distress and agitation. These safety plans could be modeled after brief interventions used in emergency departments in the community (Stanley and Brown 2012), but specifically tailored to correctional settings.

Once a suicidal prisoner has been stabilized and short-term risk has subsided, the prisoner should be thoroughly assessed to determine the necessity of an individualized and targeted treatment plan that includes measurable outcomes. (Even if the suicidal episode is determined to be reactive to a recent event and of very short duration, it is important to follow up with the prisoner several days after removal from suicide observation to make sure that the assessment was accurate.) These plans are typically a product of a treatment team including psychiatry, nursing, therapists (psychologist, social worker, or counselor), and custodial staff. It is important to include custodial staff in treatment planning since one of the goals of correctional mental health treatment is to allow prisoners to function successfully in the correctional environment. Custodial staff have specialized knowledge that may be important for the team to take into account such as case factors (long sentence, adjustment in other institutions, etc.) Further, correctional officers are often in contact with inmates 24 hours per day, allowing for important observations about the prisoner’s functioning when no clinical staff are present.

Treatment plans should describe in sufficient detail the problems associated with the prisoner's mental illness. Problems are best expressed in behavioral terms and should include ways to measure progress (or the lack thereof). Cognitive-behavior treatment protocols often focus on engaging the prisoner in a collaborative process that makes the prisoner an active participant in treatment. Given some prisoners' security levels and the safety of staff, special treatment arrangements sometimes must be made.

Suicide-specific treatment planning should target those specific problems that may have led to the crisis (e.g., hopelessness, social withdrawal, or psychiatric syndromes such as bipolar disorder or depression). Group treatment can be especially helpful for the interpersonal isolation and feelings of burdensomeness that can lead to suicidal thinking (Chaiken and Brizendine 2015).

As noted earlier, the evidence base for the efficacy of treatments for suicidal behavior is poor. The situation for prison and jail programs is even worse since few psychosocial treatments have shown success in the correctional environment. Nonetheless, treatments for suicidal prisoners should adhere to what evidence does exist. The Action Alliance's Task Force identified two carefully studied approaches to treatment for suicidal behavior: Dialectical Behavior Therapy (DBT) (Linehan 1993) and Cognitive Therapy for Suicidal Behavior (Wenzel, Brown, and Beck 2009). Of the two proposed models, DBT has actually been implemented in a number of youth correctional settings and its principles have informed forensic and correctional treatment protocols (McCann, Ball, and Ivanoff 2000; McCann et al. 2007; Schmidt and Ivanoff 2014).

Suicide Observation. Prisoners who attempt suicide while incarcerated are often subject to increased monitoring, either in housing units or inpatient psychiatric settings. Although not technically a “treatment” of suicidal behavior, close observation can be crucial in the early stages of treatment to assure the safety of suicidal prisoners.

If a prisoner is observed harming themselves or makes suicidal statements, any staff member (custodial, nursing, medical) should be able to place them on suicide observation status until the prisoner is evaluated by a QMHP. In general, suicide observation statuses (either constant 1:1 watch or periodic checks) occurs under conditions that make suicide extremely difficult to accomplish, such as suicide-resistant holding cells or inpatient hospital units. On the other hand, the conditions of suicide watch must never be unnecessarily punitive.

The standard of care for suicide watches is a matter of some debate. Some experts believe that a suicide watch must include constant observation by a staff member within arm’s length of the prisoner at all times. Of course, this is the safest method of suicide watch; however, depending upon the number of people deemed to be at high risk of suicide, it can be extremely expensive to have one staff person assigned to each prisoner on suicide precautions. In addition, security considerations can dictate that the prisoner be placed in celled housing, either in a housing unit or a dedicated psychiatric facility.

In our opinion, if a prisoner is not actively harming themselves, and is housed in a suicide-resistant environment, it is often reasonable to observe the prisoner at variable intervals. The maximum amount of time that can elapse between observations, however, is also a matter of

some debate. Some facilities continue to use 15 minutes as the presumptive interval between observations, which we believe to be unsafe. In our opinion, the emerging standard of care for observation of prisoners deemed to be at high risk of suicide is much shorter (e.g., variable observations that are never more than 5 or at most 10 minutes apart) for prisoners on suicide watch. However, a QMHP must have the latitude to order constant observation when appropriate..

After a prisoner is released from the highest level of suicide observation, it is best to have an intermediate status, often called “step-down” or safety watch status. Any change from a more stringent level of observation to a less frequent schedule of observation implies the prisoner no longer poses an immediate risk of self-harm. When such a change occurs, a QMHP must complete a risk assessment that documents the factors that have changed during the interval, and justifies the change in observation. The intermediate level of precaution is there to allow the staff to err on the side of caution.

Step-down or safety watch status is typically a variable observation interval not exceeding 15 minutes between observations; and again, the prisoner should be housed in an environment that is reasonably suicide resistant. Periodic welfare checks, no matter the interval, should be completed at uneven intervals (“staggering”) to avoid allowing prisoners the opportunity to “time” staff and harm themselves in the interval between checks. For example, if the maximum interval between welfare checks is 15 minutes, the prisoner will be checked five times per hour at unequal intervals not to exceed 15 minutes.

Prisoners are aware of most jail and prison procedures, including the often-austere conditions that prevail in correctional psychiatric units. These units may require “strip out” conditions in which the prisoner is deprived of clothes, a bed, even eyeglasses, and is required to eat from paper plates. Patients in these settings are commonly provided heavy tear-resistant blankets and smocks, must sleep on tear-proof mattresses, and are often housed alone. Housing prisoners under these conditions, although believed necessary for safety reasons, can discourage prisoners from being forthcoming about their suicidal intentions. These units can thus be the antithesis of therapeutic conditions and, despite a prisoner’s dire circumstances and extreme distress, they will often deny suicidal ideation to avoid being moved to one of these settings.

Wherever a prisoner is housed on suicide observation status, the conditions must never be unnecessarily harsh or unpleasant. Treatment conditions should include adequate and supervised out-of-cell activities, whether for routine exercise or mental health treatment, and a continuation of the usual privileges afforded in regular housing units: telephone calls, mail, some personal belongings, reading materials, and visitation. Any exceptions must be based on individualized assessment and documented.

Recognizing that isolation can increase suicide risk, and conversely, that the presence of others in the living space can be protective, some facilities use multi-person dormitories as a “safe zone” to house suicidal prisoners who are not deemed to pose an immediate risk toward others. These settings also allow for one staff member to closely watch several suicidal prisoners.

One of the most common complaints of correctional mental health clinicians (and custodial staff) is that prisoners frequently dishonestly claim to be suicidal in order to gain some advantage. It is common to read or hear accusations of feigning, malingering, and manipulating when an inmate reports suicidal thoughts, intentions, or plans. Some clinicians claim that the best way to reduce false claims of suicidality is to make the conditions of suicide watch especially harsh. Sadly, however, harsh conditions of suicide watch will also dissuade truly suicidal inmates from asking for help, when they perceive the “help” as punitive.

Because there is no way for clinicians to “read minds,” and given that suicidal prisoners are presumptively ambivalent about death, it is dangerous to jump to the conclusion that an inmate is feigning a wish to die without clear evidence that this is true. Further, even if a prisoner is malingering, it is important to try to understand their motive. For example, in many correctional facilities, there is a shortage of clinical staff, which means that a prisoner who is perceived to have a moderate depression will not receive much help. In such cases, a prisoner might “gild the lily” and exaggerate their symptoms of depression or anxiety, simply to get some help. It is very important to avoid creating the belief that only a serious attempt will be taken seriously.

A reasonable middle ground is to avoid rewarding or punishing prisoners for expressing suicidal feelings. If the only secondary gain is treatment, it will reduce the likelihood that prisoners will see suicidal claims as a way to dramatically improve their living circumstances. Finally, it is important to compare the relative risks of respecting or rejecting a prisoner’s report of suicidality. If clinicians respond to a dishonest claim of suicidality, the risk is some extra psychiatric treatment. On the other hand, cynical rejection of honest claims of suicidal intent are likely to result in preventable death. The choice is clear.

Treatment Concerns and Conditions of Confinement: Experts in correctional mental health practices have recently suggested that prisoners in treatment for serious psychiatric problems – including those who are suicidal – receive as much time out of their cells as is practically and safely possible (see *Coleman v. Wilson*), even when security concerns (e.g., danger to others, escape, etc.) require extremely secure housing. Depending on the circumstances, staff availability, and design features, they have recommended at least twenty hours of out-of-cell activities each week. Generally, at least ten hours per week should be devoted to some form of formal therapeutic program (e.g., individual or group psychotherapy, education, etc.) with the remainder of the 20 hours devoted to informal activities such as recreation. Again, any exceptions must be carefully documented, along with interventions designed (and documented) to overcome any reasonable barriers to out-of-cell activity.

Although a very few high security or behaviorally disordered prisoners may need restrictions on free access to reading materials, these are important tools for prisoners in treatment.

Bibliotherapy (an expressive therapy technique that uses a client's relationship to the content of books) is a valuable technique that should not be restricted. Some systems have produced their own activity books or brought in treatment manuals for patients.

Some prisoners with serious mental illnesses present such a serious danger to staff and other prisoners that there is no reasonable alternative to separating them. Historically, such prisoners have often been housed in administrative segregation units, where they have received little or no meaningful treatment. While the use of long-term segregation is hotly debated, several points of

consensus are clear. First, segregating prisoners with or without mental illness should only be used when absolutely necessary, and when no less restrictive alternative will safely address the risk. Second, prisoners with serious mental illness who are housed in highly secure placements cannot be denied clinically appropriate mental health services. While these services must be delivered safely, they cannot be denied for non-clinical reasons. Third, when prisoners refuse such treatment, their refusals must be addressed by clinicians and documented in the prisoner's treatment plan. Interventions may include Motivational Interviewing, more frequent cell-front visits to build trust, and in extreme circumstances, the use of involuntary medication.

A far better way to safely serve the needs of prisoners with serious mental illness who pose a serious and imminent risk to others is to create secure therapeutic units. In recent years a number of correctional systems (e.g. Massachusetts, New York, Pennsylvania, and Colorado) have instituted special therapeutic housing units with dedicated staff and self-contained programs for prisoners with serious mental illnesses who exhibit severe behavior problems, personality disorders, or chronically elevated suicide risk. Programs vary in length of stay but are typically at least six months in duration and can extend to 24 or 36 months. They may be targeted at a particular treatment population (Borderline Personality Disorder, sex offenders, or those with chronic severe psychosis) and often involve behavioral incentive programs with a step-wise progression of levels of privileges.

If secure treatment settings are created, the necessity to house a prisoner with serious mental illness in administrative segregation should be eliminated. Further, smaller correctional facilities and systems may have too few such prisoners to warrant creation of secure mental health

treatment units. In the extremely rare instance when it is deemed necessary to house a prisoners with serious mental illness in a segregated setting due to violence, serious infractions, or even for personal safety concerns, additional mental health services should be provided. In some settings it may be possible to hold treatment groups and include recreation therapy to prisoners held in high security housing. They should be afforded at least ten or more hours of out-of-cell activities each week. This may include exercise yard, law library visits, recreation therapy or, for some, group therapy sessions (Andrade and Metzner 2014). In California, for instance, prisoners with mental health problems housed in segregation units are seen at least weekly by a QMHP, have an assigned psychiatrist if prescribed psychotropic medications, and a QMHP attends each classification committee to advise custodial staff of the needs of the prisoner and the general terms of their treatment. Treatment plan is more frequent with prisoners in these settings.

Discharge Planning. Planning for discharge, whether from jail to prison, prison or jail to the community, or from a specialized treatment program to mainline prison or jail housing, can be a risky proposition for suicidal prisoners.

For those returning to the community from prison, the imminent return to the locale of a heinous crime or where social supports have disappeared after many years in prison can precipitate intense distress and possibly suicidal crises. Research has found that recently released prisoners are at high risk of mortality and morbidity from a number of causes (Pratt et al. 2006; Binswanger 2007). Care planning must occur with enough lead time to not only arrange continuity of care but also the basic social infrastructure of life outside prison – identification

cards, housing, and possibly employment opportunities. Prisoners, particularly “lifers” who have spent a decade or more in prison, must be prepared for “life outside.”

Ideally, a parole or discharge date is known with enough leeway that planning can start 12-18 months prior to release. Planning may include classes on navigating social services, parole requirements, and dealing with day-to-day interactions that may trigger anger, anxiety, or frustration for someone used to the relatively regimented life inside prisons and jails.

Discharge planning to the community from jail has a host of challenges. Jail stays are often extremely and unpredictably short, which limits the time that clinicians have to create comprehensive discharge plans. Commonly, pre-trial detainees may be unexpectedly released directly from court. In such cases, treatment plans must be simple, focusing on housing, continuity of psychiatric care, and basic entitlements such as food stamps. Because many defendants were homeless when they were arrested, finding safe housing for prisoners with serious mental illness upon their release from jail is often difficult or impossible. On the other hand, because jail stays are typically of shorter duration than prison terms, re-establishing social networks may be less a worry for those prisoners who had stable housing or employment prior to their arrest. Finally, many prisoners will leave jail and move directly to state prisons. In such cases, it is imperative that the jail system transmit a discharge summary, with special attention to prisoners who are deemed to pose a chronic or acute risk of suicide.

Many prisoners, especially those with serious mental illnesses, will enter jail or prison with entitlements such as Social Security Disability Insurance or Medicaid. In the past, the benefits

were terminated upon admission to a correctional institution and difficult to reinstate in a timely manner upon release. Increasingly, states are arranging for these benefits to be suspended instead of terminated, which allows for virtually immediate reinstatement upon release and continuity of mental health treatment.

Release from segregated housing or specialized treatment programs, particularly after lengthy stays, to the general population may pose increased risks for prisoners still recovering from a suicidal crisis. Some systems have created transitional housing for such prisoners who can be closely observed during the period after discharge. California's state prison system has taken an *in vivo* approach and houses prisoners from inpatient psychiatric programs in their original housing, providing daily mental health encounters for five days after release plus 24 hours of periodic custodial welfare checks (which can be extended). Release planning may also take into account the need for enhanced treatment services. Special care should be taken at these junctures to assure continuity of care between settings through person-to-person contacts and procedures that ensure important information is communicated.

Some prisoners will move from jail or prison to psychiatric inpatient status, typically because they are deemed to meet civil or forensic commitment standards upon their release from a correctional facility. Similarly, in some states, certain sex offenders are civilly committed as sexually dangerous persons immediately upon release from prison. In such cases, it is imperative that the sending institution provide a complete discharge summary, paying special attention to treatment received and risk factors related to suicide.

V. Special Considerations for Types of Confinement Settings

While all forms of detention and incarceration bear a responsibility to make reasonable efforts to reduce the risk of suicide, and some risks overlap across institutional type, many of the specific risks vary significantly according to the type of institution and housing type.

For example, a high percentage of newly admitted jail and juvenile detainees are under the influence of alcohol or stimulants, which can impair impulse control and judgment, exacerbating the extreme stressor of being arrested and locked up. These substances are especially dangerous in the context of individuals whose impulse control is already weak, due to youth, head injuries, or various forms of mental illness (e.g. hyperactivity, fetal alcohol syndrome, etc.). A related problem concerns prisoners who arrive in detention facilities actively addicted to narcotics, alcohol, or other drugs, as the distress of withdrawal can lead to desperate measures, up to and including attempted suicide (Hayes and Rowan 1988).

The presence of diverse ethnic groups is a special challenge in all forms of incarceration, but especially in immigration facilities where the number of languages spoken can be quite high, making it difficult or impossible to have staff that speak every relevant language. There are no easy answers to this dilemma, but some facilities allow the detainee to designate a trusted fellow detainee or officer who speaks their language to serve as a translator. While this may be a necessity in moments of crisis, it is important to understand that even well-intentioned friends are not trained interpreters, and may inadvertently communicate inaccurately. Thus, as soon as possible, the most reliable arrangements should be made.

Suicide rates in prison are significantly lower than those in jail (Bureau of Justice Statistics 2014). However, reducing the number of suicides in prisons has proven to be a more difficult challenge, for several reasons. First, because the incidence of suicide is lower in prisons than in jails, reductions are harder to achieve. Second, the window of risk is less clear. For example, prison suicides can occur at any time during an incarceration, often because of some form of bad news that the prisoner has received (e.g., death of a loved one, divorce, or parole rejection), unbeknownst to staff. In contrast, the majority of jail suicides have historically occurred during the first hours and days of detention, making them easier to prevent when proper suicide prevention systems are in place. However, it is worth noting that jail suicide prevention programs have succeeded in reducing the incidence of jail suicide, mainly those that were occurring early in the person's detention. The suicides that have proven more difficult to prevent are those that are similar to prison suicides, such as those that result from bad news from home or unexpected bad results in court.

Hayes (2012) considers the jail environment to be conducive to suicide because of the environment (e.g., prisoners' lack of control, the authoritarian environment, the isolation from social networks, and the dehumanizing aspects of confinement) and the vulnerability of jail prisoners, who are often in psychological crisis. Other writers (e.g. Haycock 1991) have hypothesized that the deprivations suffered in jails (rather than the prisoners' vulnerabilities) increase suicide rates.

The notion that jail conditions may play a primary role in their high rates of suicide may have some merit given that many jail prisoners make the transition to prison and appear to function quite well in the new environment. Prisons, by their very nature, are built for long-term confinement, and although chronically stressful places, have much more to offer prisoners in the way of educational, vocational, and rehabilitative programs that can relieve the day-to-day stress and monotony of confinement, and offer meaningful experiences for prisoners, thus lowering the risk of suicide.

Segregated housing. It is now a matter of broad consensus that prisoners with current psychotic symptoms and those deemed to present an imminent risk of suicide should not be housed in segregation settings. The degree to which segregation causes psychological harm, and the characteristics of prisoners at greatest risk, remain in need of further study (Berger, Chaplin, and Trestman 2013).

Every segregation unit should have “rounding” on a regular basis. Rounding by nursing or mental health staff supplement security checks by custodial staff and is a recognition that these settings can increase the risk of the development of mental health symptoms. Typically all prisoners in a unit, whether receiving mental health treatment or not, are contacted at least several times per week by staff for a brief encounter in which an assessment of their mental state and well-being is made and documented. The goal is to identify problems and treat them as early as possible.

Prisoners housed in short-term segregation often do not have many of their personal belongings (television, books, letters, etc.). In-cell activities may be provided to increase stimulation and decrease boredom. Overall, increasing the opportunities for social interaction, pro-social forms of distraction (e.g., music, television) and providing ways to “cut through” the boredom and isolation of segregated settings can prevent the onset or worsening of mental health symptoms among prisoners in segregated housing.

VI. Conclusion

Some suicides are, of course, easier to prevent than others. Because jail and juvenile suicides are often impulsive and situationally determined, the “prevention windows” of time, place, and people are narrower; thus it is easier to focus preventive attention on them. As a result, jails that have implemented relatively simple and cost-effective measures have been able to reduce the prevalence of suicide significantly during the last 3 decades.

Preventing suicide in prison is more challenging, though not impossible. Unlike jail, where stress is especially predictable at the front door, prison stressors (e.g., “Dear John letters,” negative parole decisions, death of a loved one, etc.) can occur at any time during a prisoner’s incarceration, and staff members often have no way of knowing about it. Non-impulsive, planned suicides seem most difficult, unless one considers that many of the prisoners who engage in such behaviors have been depressed for a long time before deciding that suicide is the only way to end their psychological or physical pain. Thus, the presence of user-friendly and competent mental health care, including therapeutic treatment of severe depression, is likely to prevent suicides,

even if the prisoners and treatment staff are unaware of what might have happened in the absence of effective treatment.

The most vexing aspect of suicide prevention, of course, is that one often has no way of knowing what one has prevented. Further, because suicides, as rare events, are inherently unpredictable, correctional programs must be diligent in their efforts to lower the risks of suicide for all of the prisoners in their care.

Correctional suicide prevention programs, as integrated health care systems, should adhere to the highest standards of care and adopt goals similar to those of systems that have committed to and succeeded in reducing suicide (Action Alliance: Clinical Care & Intervention Task Force 2014). Bringing these programs into alignment with the core values, standards, and methods of these programs will move them toward the goal of significantly lowering suicide rates.

Finally, it is important to remember that suicide is typically borne of despair. To the extent that correctional institutions forget their correctional mission and become instruments of punishment alone, the likelihood of despair will increase. In a very real sense, all of the very useful and important tools outlined in this chapter pale in comparison to instilling hope, which is the only remedy for despair that has ever worked. Helping people feel some sense of dignity and meaning in the worst of circumstances has always been the most impressive accomplishment of well-run institutions, and for those correctional leaders and advocates who have managed to create hope amid despair, we offer our profound respect. Sadly, you'll never know what you have prevented, but that does nothing to lessen the importance of your work.

References

- American Correctional Association. 2003. *Standards for adult correctional institutions, 4th ed.*
Washington, D.C.: American Correctional Association.
- American Psychiatric Association. 2016. *Psychiatric Services in Correctional Facilities, 3rd ed.*
Washington, D.C.: American Psychiatric Publishing Inc.
- Andrade, Joel T., and Metzner, Jeffrey L. 2014. "Serious Mental Illness and Segregation: Recommendations for Implementing a System that Works." Presentation at the Mental Health Conference of the National Commission on Correctional Health Care, Boulder, CO, July 13-14 .
- Appelbaum, Kenneth L., Savageau, Judith A., Trestman, Robert L., Metzner, Jeffrey L., and Baillargeon, Jacques. 2011. "A national survey of self-injurious behavior in American prisons." *Psychiatric Services* 62(2): 285-290.
- Berger, Robert H., Chaplin, M. Paul, and Trestman, Robert L. 2013. "Commentary: Toward an Improved Understanding of Administrative Segregation." *Journal of the American Academy of Psychiatry and the Law* 41: 61-64.
- Berman, Alan L. and Silverman, Morton M. 2014. "Suicide Risk Assessment and Risk Formulation, Part II: Suicide Risk Formulation and Determination of Levels of Risk." *Suicide and Life-Threatening Behavior* 44(4): 432-443.
- Binswanger, Ingrid A., Stern, Mark F., Deyo, Richard A., Heagerty, Patrick J., Cheadle, Allen, Elmore, Joann G., and Koepsell, Thomas D. 2007. "Release from Prison – A High Risk of Death for Former Inmates." *New England Journal of Medicine* 356(2): 157-165.
- Bonner, Ronald L. 2006. "Stressful Segregation Housing and Psychosocial Vulnerability in Prison Suicide Ideators." *Suicide and Life-Threatening Behavior* 36(2): 250-254.

- Brown, Gregory K., Ten Have, Thomas, Henriques, Gregg R., Xie, Sharon X., Hollander, Judd E., and Beck, Aaron T. 2005. "Cognitive Therapy for the Prevention of Suicide Attempts: A Randomized Controlled Trial." *Journal of the American Medical Association* 294: 563-570.
- Bureau of Justice Statistics. 2005. "Suicide and Homicide in State Prisons and Local Jails." Washington, D.C.: U.S. Government Printing Office.
- Bureau of Justice Statistics. 2013a. "Jail Inmates at Midyear 2012 – Statistical Tables." Washington, D.C.: U.S. Government Printing Office.
- Bureau of Justice Statistics. 2013b. "Sexual Victimization in Prisons and Jails Reported by Prisoners, 2011-12" Washington, D.C.: U.S. Government Printing Office.
- Bureau of Justice Statistics. 2013c. "Mortality in Local Jails and State Prisons, 2000-2011 – Statistical Tables." Washington, D.C.: U.S. Government Printing Office.
- Bureau of Justice Statistics. 2014. "Mortality in Local Jails and State Prisons, 2000-2012 – Statistical Tables." Washington, D.C.: U.S. Government Printing Office.
- Chaiken, Shama, and Brizendine, Brittany. 2015. "Group Psychotherapy" In *Oxford Textbook of Correctional Psychiatry*, edited by Robert L. Trestman, Kenneth L. Appelbaum, and Jeffrey L. Metzner. New York: Oxford University Press.
- Cohen, Fred, with Knoll IV, James L., Kupers, Terry A., and Metzner, Jeffrey L. 2011. *Practical Guide to Correctional Mental Health Care and the Law*. Kingston, N.J.: Civic Research Institute.
- Fazel, Seena, Cartwright, Julia, Norman-Nott, Arabella, and Hawton, Keith. 2008. "Suicide in prisoners: A systematic review of risk factors." *Journal of Clinical Psychiatry* 69(11): 1721-1731.

- Ford, Julian D., Trestman, Robert L., Wiesbrock, Valerie H., and Zhang, Wanli. 2009. "Validation of a Brief Screening Instrument for Identifying Psychiatric Disorders Among Newly Incarcerated Adults." *Psychiatric Services*, 60: 842–846.
- Hampton, Tracy. 2010. "Depression Care Effort Brings Dramatic Drop in Large HMO Population's Suicide Rate." *Journal of the American Medical Association* 303(19): 1903-1905.
- Hanson, Annette. 2010. "Correctional Suicide: Has Progress Ended?" *The Journal of the American Academy of Psychiatry and the Law*. 38: 6-10.
- Haycock, Joel. 1991. "Capital Crimes: Suicides in Jail." *Death Studies* 15: 417-433.
- Hayes, Lindsay M. 1983. "And Darkness Closes In: A National Study of Jail Suicides." *Criminal Justice and Behavior*. 10(4): 461-484.
- Hayes, Lindsay M. 1995. "Prison Suicide: An Overview and Guide to Prevention." *The Prison Journal*. 75(4): 431-456.
- Hayes, Lindsay M. 2010. "Toward a Better Understanding of Suicide Prevention in Correctional Facilities." In *Handbook of Correctional Mental Health*, edited by Charles L. Scott, 2nd ed. Arlington, VA: American Psychiatric Publishing Inc.
- Hayes, Lindsay M. 2011. "Checklist for the 'Suicide-Resistant' Design of Correctional Facilities." Windsor Mill, MD: National Center on Institutions and Alternatives.
- Hayes, Lindsay M. 2012. "National Study of Jail Suicide: 20 Years Later." *Journal of Correctional Health Care*. 18(3): 233-245.
- Hayes, Lindsay M., and Rowan, Joseph R. 1988. *National Study of Jail Suicide: Seven Years Later*. Alexandria, VA: National Center on Institutions and Alternatives.
- Huey, Meredith P., and McNulty, Thomas L. 2005. "Institutional Conditions and Prison Suicide: Conditional Effects of Deprivation and Overcrowding." *The Prison Journal*. 85(4): 490-514.

- Hughes, Kerry C. and Metzner, Jeffrey L. 2015. "Suicide Risk Management." In *Oxford Textbook of Correctional Psychiatry*, edited by Robert L. Trestman, Kenneth L. Appelbaum, and Jeffrey L. Metzner. New York: Oxford University Press.
- Johnson, Jeffrey G., Cohen, Patricia, Gould, Madelyn S., Kasen, Stephanie, Brown, Joselyn, and Brook, Judith S. 2002. "Childhood Adversities, Interpersonal Difficulties and Risk for Suicide Attempts During Late Adolescence and Early Adulthood." *Archives of General Psychiatry* 59(8): 741-749.
- Knox, Kerry L., Pflanz, Steven, Talcott, Gerald W., Campise, Rick L., Lavigne, Jill E., Bajorska, Alina, Tu, Xin, and Caine, Eric. 2010. "The US Air Force Suicide Prevention Program: Implications for Public Health Policy." *American Journal of Public Health* 100(12): 2457-2463.
- Linehan, Marsha M. 1993. *Cognitive Behavioral Treatment of Borderline Personality Disorder*. New York: The Guildford Press.
- Luoma, Jason B., Martin, Catherine E., and Pearson, Jane L. 2002. "Contact With Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence." *American Journal of Psychiatry* 159: 909-916.
- Maloney, Michael P., Dvoskin, Joel A., and Metzner, Jeffrey L. 2015. "Mental Health Screening and Brief Assessment." In *Oxford Textbook of Correctional Psychiatry*, edited by Robert L. Trestman, Kenneth L. Appelbaum, and Jeffrey L. Metzner. New York: Oxford University Press.
- Maxfield, Michael G. and Widom, Cathy Spatz. 1996. "The Cycle of Violence: Revisited 6 Years Later." *Archives of Pediatric and Adolescent Medicine* 150(4): 390-395.
- McCann, Robin A., Ball, Elissa M., and Ivanoff, Andre. 2000. "DBT With an Inpatient Forensic Population: The CMHIP Forensic Model." *Cognitive and Behavioral Practice* 7: 447-456.

- McCann, Robin A., Ivanoff, Andre, Schmidt, Henry, and Beach, Bradley. 2007 “Implementing Dialectical Behavior Therapy in a Residential Forensic Settings with Adults and Juveniles.” In *DBT in Clinical Practice: Applications Across Disorders and Settings*, edited by Linda A. Dimeff and Kelly Koerner. New York: The Guilford Press.
- Metzner, Jeffrey L. 2015. “Systems Monitoring and Quality Improvement.” In *Oxford Textbook of Correctional Psychiatry*, edited by Robert L. Trestman, Kenneth L. Appelbaum, and Jeffrey L. Metzner. New York: Oxford University Press.
- Mills, Jeremy F., and Kroner, Daryl G. 2005. “Screening for Suicide Risk Factors in Prison Inmates: Evaluating the Efficiency of the Depression, Hopelessness and Suicide Screening Form (DHS).” *Legal and Criminological Psychology* 10: 1-12.
- Moscicki, Eve K. 2001. “Epidemiology of Completed and Attempted Suicide: Toward a Framework for Prevention.” *Clinical Neuroscience Research*, 1, 310–323.
- National Center on Addiction and Substance Abuse at Columbia University. 2010. “Behind Bars II: Substance Abuse and America’s Prison Population.” New York: Author.
- National Commission on Correctional Health Care. 2008. *Standards for Mental Health Services in Correctional Facilities*. Chicago: Author.
- Nock, Matthew K., Borges, Guilherme, Bromet, Evelyn J., Cha, Christine B., Kessler, Ronald C., and Lee, Sing. 2008. “Suicide and Suicidal Behavior.” *Epidemiologic Reviews* 30: 133-154.
- O’Connor, Elizabeth, Gaynes, Bradley N., Burda, Brittany U., Soh, Clara, and Whitlock, Evelyn P. 2013. “Screening for and Treatment of Suicide Risk Relevant to Primary Care: A Systematic Review for the U.S. Preventive Services Task Force.” *Annals of Internal Medicine* 158: 741-754.
- Patterson, Evelyn J. 2010. “Incarcerating Death: Mortality in U.S. State Correctional Facilities, 1985–1998.” *Demography* 47(3): 587-607.

- Pratt, Daniel, Piper, Mary, Appleby, Louis, Webb, Roger, and Shaw, Jenny. 2006. "Suicide in Recently Released Prisoners: A Population-Based Cohort Study." *The Lancet* 368: 119-123.
- Prins, Seth J. 2014. "Prevalence of Mental Illnesses in U.S. State Prisons: A Systematic Review." *Psychiatric Services* 65: 862-872.
- Rosen, David L., Schoenbach, Victor J., and Wohl, David A. 2008. "All-Cause and Cause-Specific Mortality Among Men Released from State Prison, 1980-2005." *American Journal of Public Health*. 98(12): 2278-2284.
- Rudd, M. David. 2006. *The Assessment and Management of Suicidality*. Sarasota, FL: Professional Resources Press.
- Rudd, M. David, Berman, Alan L., Joiner Jr., Thomas E., Nock, Matthew K., Silverman, Morton M., Mandrusiak, Michael, Van Orden, Kimberly, and Witte, Tracy. 2006. "Warning Signs for Suicide: Theory, Research and Clinical Applications." *Suicide and Life-Threatening Behavior* 36(3): 255-262.
- Ruiz, Amanda. 2010. "Continuous Quality Improvement and Documentation." In *Handbook of Correctional Mental Health*, edited by Charles L. Scott, 2nd ed. Arlington, VA: American Psychiatric Publishing Inc.
- Schmidt III, Henry, and Ivanoff, Andre. 2014. "Treating Self-Injurious Behaviors in Residential Settings." *Best Practices in Mental Health* 10(1): 16-28.
- Silverman, Morton M. 2014. "Suicide Risk Assessment and Suicide Risk Formulation: Essential Components of the Therapeutic Risk Management Model." *Journal of Psychiatric Practice* 20: 373-378.

- Silverman, Morton M., and Berman, Alan L. 2014. "Suicide Risk Assessment and Risk Formulation, Part I: A Focus On Suicide Ideation in Assessing Suicide Risk." *Suicide and Life Threatening Behavior* 44(4): 420-431.
- Simon, Robert I. 2009. "Suicide Risk Assessment Forms: Form Over Substance?" *Journal of the American Academy of Psychiatry and the Law* 37: 290-293.
- Smith, Hayden P., and Kaminski, Robert J. 2010. "Inmate Self-Injurious Behaviors: Distinguishing Characteristics Within a Retrospective Study." *Criminal Justice and Behavior* 37(1): 81-96.
- Schmitz Jr., William M., Allen, Michael H., Feldman, Barry N., Gutin, Nina J., Jahn, Danielle R., Kleepsies, Phillip M., and Simpson, Skip. 2012. "Preventing Suicide Through Improved Training in Suicide Risk Assessment and Care: An American Association of Suicidology Task Force." *Suicide and Life-Threatening Behavior* 42(3): 292-304.
- Stanley, Barbara, and Brown, Gregory K. 2012. "Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk." *Cognitive and Behavioral Practice* 19: 256-264.
- Steadman, Henry J., Scott, Jack E., Osher, Fred C., Agnese, Tara K., and Robbins, Pamela Clark. 2005. "Validation of the Brief Jail Mental Health Screen." *Psychiatric Services* 56: 816-822.
- Tang, Nicole K.Y., and Crane, Catherine. 2006. "Suicidality in chronic pain: a review of prevalence, risk factors and psychological links." *Psychological Medicine* 36(5): 575-586.
- Teplin, Linda A. 1994. "Psychiatric and Substance Abuse Disorders among Male Urban Jail Detainees." *American Journal of Public Health* 84: 290-293.
- U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. 2012 "2012 National Strategy for Suicide Prevention: Goals and Objectives." Washington, D.C.: Department of Health and Human Services.

- U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention: Clinical Care and Intervention Task Force. 2014. "Suicide Care in Systems Framework." Washington, D.C.: Department of Health and Human Services.
- Way, Bruce B., Miraglia, Richard, Sawyer, Donald A., Beer, Richard, and Eddy, John. 2005. "Factors Related to Suicide in New York State Prisons." *International Journal of Law and Psychiatry* 28(3): 207-221.
- Way, Bruce B., Sawyer, D.A., Barboza, S. and Nash, R. 2007. Prisoner Suicide and Time Spent in Special Disciplinary Housing in New York state prison. *Psychiatric Services*, 58, 558-560.
- Wenzel, Amy, Brown Gregory K., and Beck, Aaron T. 2009 "Cognitive Therapy for Suicidal Patients: Scientific and Clinical Applications." Washington, D.C.: American Psychological Association.
- Widom, Cathy Spatz. 1989. "The Cycle of Violence." *Science* 244(4901): 160-166.
- Zlodre, Jakov, and Fazel, Seena. 2012. "All-Cause and External Mortality in Released Prisoners: Systematic Review and Meta-Analysis." *American Journal of Public Health* 102(12): e67-e75.