# Preventing Suicide in Prisons, Part II

## International Comparisons of Suicide Prevention Services in Correctional Facilities

Marc S. Daigle[1], Anasseril E. Daniel[2], Greg E. Dear[3], Patrick Frottier[4], Lindsay M. Hayes[5], Ad Kerkhof[6], Norbert Konrad[7], Alison Liebling[8], and Marco Sarchiapone[9]

[1]University of Québec at Trois-Rivières and Centre for Research and Intervention on Suicide and Euthanasia (CRISE), Canada, [2]University of Missouri School of Medicine, Columbia, MO, USA, [3]Edith Cowan University, Joondalup, Australia, [4]J.A. Mittersteig, Vienna, Austria, [5]National Center on Institutions and Alternatives, Mansfield, MA, USA, [6]Vrije Universiteit, Amsterdam, The Netherlands, [7]Institute of Forensic Psychiatry Charité, Berlin, Germany, [8]Cambridge Institute of Criminology, Cambridge, UK, [9]University of Molise, Campobasso, Italy

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**Abstract.** The International Association for Suicide Prevention created a Task Force on Suicide in Prisons to better disseminate the information in this domain. One of its objectives was to summarize suicide-prevention activities in the prison systems. This study of the Task Force uncovered many differences between countries, although mental health professionals remain central in all suicide prevention activities. Inmate peer-support and correctional officers also play critical roles in suicide prevention but there is great variation in the involvement of outside community workers. These differences could be explained by the availability of resources, by the structure of the correctional and community services, but mainly by the different paradigms about suicide prevention. While there is a common and traditional paradigm that suicide prevention services are mainly offered to individuals by mental health services, correctional systems differ in the way they include (or not) other partners of suicide prevention: correctional officers, other employees, peer inmates, chaplains/priests, and community workers. Circumstances, history, and national cultures may explain such diversity but they might also depend on the basic way we think about suicide prevention at both individual and environmental levels.

**Keywords:** prison, suicide, prevention, inmate, suicide attempt

This is the second paper published by the Task Force on Suicide in Prisons created in January 2006 by the International Association for Suicide Prevention (IASP). The mandate of the group is to bring together the available knowledge and expertise on suicidal behavior in prisons in order to facilitate the wider dissemination of the fundamentals of effective suicide prevention. The nine members of the Task Force (all co-authors of these papers) represent eight different countries. With the help of the Internet, they held seven virtual meetings within one year. A typical web meeting starts with a first e-mail sent by the chair of the Task Force (Marc Daigle) to all the members. Each member sends his or her reply (with copies to all other members) within 2 or 3 weeks. Then the chair has 1 or 2 weeks to write a general consensus on the opinions of the members. That consensus is then sent to all members with new questions or subjects to be discussed. Then a new virtual meeting starts, again lasting 2 or 3 weeks. So far, this disciplined process within the group has resulted in the organization of a symposium and two publications. There are also plans for future tasks to be completed: collecting the grey literature on a website, comparing suicide screening instruments, and developing an international research project.

The first paper published by the Task Force (Konrad et al., this issue) represented the consensus of the nine experts about the basic essential practices for suicide prevention in correctional facilities that all countries should adopt. Resources permitting, countries would build on those basic essentials in order to achieve effective prevention of suicide and other self-harm. The first paper was published in collaboration with the World Health Organization. In this second paper we summarize the types of facilities for suicidal inmates and categories of workers involved in suicide prevention within each country represented by the Task Force members.

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*Table 1.* Correctional adult facilities in eight countries

| | | | Status of the offender | | | | | |
|---|---|---|---|---|---|---|---|---|
| Country and population rate[a] | Not guilty by reason of insanity | Others with mental health problems | Remanded | Sentenced No time limit | Sentenced <1 year | Sentenced <2 years | Sentenced >1 year | Sentenced >2 years |
| Australia 117 | Forensic hospitals or managed in the community by Health Services | Forensic hospitals (mainly for short stay while severely unwell) or prisons (in mostly cases) | Prisons | Prisons | | | | |
| Austria 106 | High security hospitals (not guilty) or special forensic institutions (guilty) | No special treatment units – in exceptional cases forensic departments in general hospitals | Jails | Prisons | Jails | Prisons | Prisons | Prisons |
| Canada 116 | Forensic hospitals (provincial) | Forensic hospitals (provincial) | Prisons (provincial, sometimes separated from sentenced) | | | Prisons (provincial) | | Penitentiaries (federal) |
| Germany 96 | Forensic hospitals (provincial) | Prison hospital or Forensic hospital (provincial) or general psychiatric hospital | Prisons (provincial) (mostly separated from sentenced) | Prisons (closed and open) | | | | |
| Italy 98 | Ospedale psichiatrico giudiziario (forensic hospital) | No special treatment units. In exceptional cases forensic hospitals and psychiatric observation wards | Casa circondariale | Casa di reclusione | Casa mandamentale Casa circondariale | Casa mandamentale Casa circondariale | Casa circondariale Casa di reclusione | Casa circondariale Casa di reclusione |
| Netherlands 123 | Forensic hospitals in mental health care and maximum security hospitals (TBS) | Special treatment units within prisons | Jails | Prisons | Jails | Jails/prisons | Prisons | Prisons |
| UK Eng-Wales 142 North Ireland 72 Scotland 132 | Forensic hospitals | Forensic hospitals, some special treatment units | Local prisons | Local prisons | Local prisons | Local prisons (for allocation) | Training prisons | Training prisons |
| USA 714 | Forensic Hospitals | | Jails (city or county) | Prisons | Jails (city or county) | Prisons or Jails depending on jurisdiction | Prisons (state or federal[b]) | Prisons |

*Note*. [a]Prison population rate per 100,000 of the national population (as reported by Walmsley, 2005). [b]For felony offences.

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*Table 2.* Suicide prevention services for inmates in eight countries

| | Type of worker | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Type of service | Booking/in-take officer | General duty officer | Social or psy-chosocial worker/crimi-nologist | Nurse | General prac-titioner doc-tor or Medi-cal officer | Psychiatrist | Psychologist | Chap-lain/priest | Other em-ployee | Peer inmates | Outside com-munity work-er (Samari-tan or other) |
| Intake screening, referring, tagging | acgikntu | | i | agku | aik | | a | | | k | |
| Ongoing screening, refer-ring, tagging | | acgikntu | acgitu | acgintu | acgintu | agint | acgikntu | acgiknu | acgktu | acgiktu | |
| Evaluation of suicidal risk | t | ak | actu | u | acgikntu | acgikntu | acgkntu | | | | |
| Evaluation of mental health (as related to suicidal risk) | | | u | aku | acgikntu | acgikntu | acgknu | | | | |
| Daily suicide watch for high risk inmates | | acgikntu | acnt | akn | i | | ant | | act | acgiktu | |
| Medication | | | | gik | acgikntu | acgiknu | | | | | |
| Transfer to inside or outside hospital | | a | | | acgikntu | acgikntu | a | | | | |
| Isolation, contention, anti-suicide clothes | | acgiktu | | | | t | | | | | |
| Crisis intervention (inside facilities) | | an | | uk | cgik | cgiktu | acgintu | cgu | | acgt | |
| Crisis intervention (on line interventions) | | | u | | i | i | i | i | | | acu |
| Professional counseling/ psychotherapy | | | anu | | | cgitu | acgintu | | cu | | |
| Nonprofessional counsel-ing/assistance | | | | | | | | k | k | acgkt | k |
| Group meeting at entry (awareness group session) | | ak | ct | | | | | | | k | k |
| Support group for at risk in-mates | | k | t | k | | | kt | | | acu | ak |

*Note.* Countries: a = Australia; c = Canada; g = Germany; i = Italy; k = United Kingdom; n = Netherlands; t = Austria; u = USA.

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## Method and Results

Inspired by clinical experience and international literature on suicide prevention, a questionnaire was built by the chair of the Task Force. The information was then commented on by each member of the Task Force. Table 1 shows the types of correctional facilities (excluding police facilities/lockups or juvenile institutions) in the different countries. The table makes the usual separation between remanded inmates (those who are not yet sentenced) and those with different lengths of sentence. While some of the same terms are used in different countries they do not always cover the same realities. For example, the term "prison" is usually generic but in some countries it has a more specific meaning. For that reason, the Task Force of the IASP refers to "prisons," as does most of the literature. But, to be more specific to the countries covered in this study, there are more names for such facilities: prisons as such but also gaols, jails, penitentiaries, casa circondariale, and casa di reclusione. Beyond these technicalities, usually unknown in the general population, this table also shows where inmates with mental health problems are directed within or parallel to the correctional system. So-called forensic hospitals or units often house those very high-risk prisoners but those hospitals differ in terms of the degree of the independence that patients can be legally and/or procedurally permitted. Nevertheless, this diversion of some inmates is of special interest in the field of suicide prevention if we agree that mental health problems are often related to suicidal ideations and behavior. As for the prison population rate, often called the incarceration rate, the table also shows that the United States has by far the highest. The other seven countries have rates below 150 per 100,000, as do 58% of countries of the world (Walmsley, 2005). Table 2 shows that, at many steps of the process and in most countries, mental health professionals are present in all correctional systems: psychologists, psychiatrists, and general medical practitioners. Nurses and social workers are present in smaller numbers, but they might not have specific training in mental health or suicide prevention. Inmate peer-support and correctional officers (guards), who have day-to-day contact with vulnerable prisoners, also play critical roles in suicide prevention (Liebling & Tait, 2006). Across countries there is great variation in the involvement of outside community workers.

## Discussion

The data reported in this paper are specific to Western countries and, indeed, only to eight of them. In less developed countries, the situation might be much different, especially in countries at war or with many political prisoners. Consequently, the present picture might only represent the best practices in the Western world. Incidentally, it may not be by chance that the experts of the actual Task Force are from these eight countries. Nevertheless, "best practices" are not the same across these eight countries. Mental health professionals are present in all systems but each country has its own way of looking at suicide prevention. Most people would agree that suicide prevention is not only a matter of medical services but not all countries have developed parallel services. For example, peer inmates are not used the same way in all countries and we know of substantial resistance to this form of help, considering especially that the ultimate legal responsibility for suicide prevention has to be assumed by the authorities of the prisons. As for these peer groups, they may also be trained by outside workers like The Samaritans but, again, contacts with such community organizations seem rare in many countries. This seems to confirm that some prisons often behave as closed systems. As we have previously argued (Konrad et al., this issue), suicide prevention not only involves evaluating and treating *individuals*, as Table 2 suggests. Individuals come to correctional settings with certain vulnerabilities but it is when these vulnerabilities are coupled with the crisis of incarceration and the ongoing stressors of prison life that they tend to culminate in emotional and social breakdown and possibly also suicide or other self-harming behavior. Therefore, we must also act on improving meaningful social interaction and the quality of the general prison environment (Liebling, 2006).

Moreover, Table 2 by itself does not illuminate the extent or quality of the services available in prison. As a first step in international collaboration, it is mainly a listing of what may be available. Consequently, the general impression offered by the table may be biased high up. Nevertheless, the table shows, especially to those who do not know the field, the diversity of approaches used in prison. Some settings may even be innovative and original.The subsequent sections provide brief commentaries on the data pertaining to each of the eight countries, emphasizing the national specificities.

### Australia

In Australia the system varies markedly across the eight states and territories, although the information in Tables 1 and 2 is true in most jurisdictions. Several states have introduced "crisis care" units in prisons, enabling placement of high-risk prisoners into high-monitoring, high-support units that avoid the usual isolating and dehumanizing suicide-watch procedures that are applied in many prisons around the world. For example, in the Western Australian crisis care units, prisoners wear normal prison clothes instead of the usual ill-fitting and uncomfortable rip-proof safety clothing that prisoners are normally made to wear while on suicide watch. Another feature of prisons in most Australian states is the important role that prison officers play in determining the level of supervision needed (conjointly with psychologists and other mental health clini-

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cians), and in providing practical and emotional-welfare support to prisoners. In fact, the dominant paradigm in Australian prison systems is that preventing suicide and other self-harm is the duty of all who live and work in prisons. For example, psychological, medical (including nursing), and correctional staff contribute to both the formal (e.g., screening instruments) and informal (e.g., monitoring prisoners for signs of distress) identification of self-harm risk. Furthermore, multidisciplinary teams are responsible for designing and monitoring the management of high-risk prisoners and for documenting team decisions.

Peer-support programs (Snow & Biggar, 2006) operate in most states and outside community groups (The Samaritans or others) provide different levels of services to prisoners' families. Such family support is known to be critical to prisoners' adjustment (Adams, 1992; Bennett, 1988; Dear, Thomson, Hall, & Howells, 2001). Finally, all deaths in custody in Australia are investigated by the State Coroner, providing the impetus for many of the procedural improvements and increases in resources. On the other hand, coronial recommendations are piecemeal and sometimes frustrate administrators' genuine efforts to maintain consistent effective policies and procedural guidelines for staff.

## Austria

Epidemiological surveys conducted in custodial settings concluded that a negative consequence of the shift of psychiatric care from mental hospitals to community-based services was that some of the most disadvantaged discharged mental patients could not cope with their new situation and finally entered the correctional system (Frottier, Matschnig, Benda, König, & Fruehwald, 2002). Recently, further evidence for a "new era of institutionalization" was presented, showing the increase of forensic beds not only in Austria but in various European union member states during recent years (Priebe et al., 2005). Because of the increase of inmates with psychiatric needs in correctional settings, and the increase of suicide rates in custody, which seems to be a direct consequence (Fruehwald & Frottier, 2005), suicide prevention is a major task for staff of custodial institutions in Austria (Frottier, Fruehwald, Schwärzler, & Bauer, 2002).

The investigations show that suicide rates have been continuously rising in the past 2 decades. In Austria, as in other countries, the evaluation of incoming inmates is not done by a trained psychiatrist and the examination takes place only within the first week of incarceration. Therefore, a suicide screening instrument for prison officers (Fruehwald, Frottier, Matschnig, König, & Bauer, 2004) will be used in all 28 Austrian prisons by the end of 2007. The screening, which is completed immediately after entering prison, provides a first estimation of suicide risk and differentiates between low, medium, and high suicide risk. Further preventive decisions (e.g., increased frequency of control, no use of single-cells, offering a "listener," structuring the day by means of prison work, referral to medical/psychiatric care, etc.) can be more easily recommended according to this baseline estimation. If the suicide risk is estimated to be high the patient is put under observation until he/she has been assessed by a psychiatrist. If necessary, a transfer to psychiatric inpatient units is recommended. Mentally disordered offenders not guilty by reason of insanity (NGRI) are treated in a special forensic institution or in regional psychiatric hospitals. Only a few of the latter have special forensic-psychiatric departments. Compared with psychiatric hospitals, the situation in the special forensic institution is rather poor in regard to staffing. Despite this fact, NGRI exhibiting a higher degree of dangerousness are placed in these institution because of their higher security standards. Mentally disordered guilty offenders are mainly treated in a special institution in the capital and in special departments of the Austrian prisons for offenders with longer sentences. Until recently, the majority of responsible mentally disordered offenders were kept in prisons together with all other not mentally disordered inmates. The expansion was carried out to cope with the increasing numbers of responsible mentally disordered offenders. However this was not accompanied by an increase of psychiatrists, psychologists, or social workers. Moreover, modern instruments and standardized programs are only used in the two special institutions for the treatment of mentally disordered offenders.

## Canada

As shown in Table 1, the Canadian correctional system operates at two levels, the provincial one with its correctional centers (called prisons or jails) and the federal one with its penitentiaries. Although the federal system may have more resources and more time to treat inmates (especially those sentenced to longer terms), both systems offer the same array of services that are pictured in Table 2. Mental health professionals are more often present at the federal level but a comprehensive suicide prevention program exists at both levels. In the Canadian correctional systems, peer programs and structures for communication with the community may be considered two original national experiences.

At the federal level, peer programs were implemented in two regions. They are small group of inmates who operate as first-line people and whose role is mainly to identify those at risk, to give them some first-hand advice, and to refer them to professional services. The evaluation of these programs could not really demonstrate their efficacy, showing also that the recruitment of peer inmates to be included in these programs may be problematic. For example, correctional officers may not agree with the selection of some older inmates who may be perceived as gaining some control when participating in the group. There are also some concerns about security and responsibility when including peers in the process of helping suicidal inmates. Nevertheless, interviews with inmates involved with the programs

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have indicated that they have been helpful (Daigle & Bistodeau, 1998; Schlosar, 1997). Both levels of Canadian facilities have long term experience with using community resources in suicide prevention, especially offering easy access to community crisis lines. Some training on correction matters may be offered to the community telephone workers but some of them may also be involved in the training of correctional employees. At the provincial level, the Quebec prisons, where they have local suicide prevention committees in each large facility, a community representative is often part of the meetings. That helps to disseminate information to the community about positive work done inside the walls and it also brings new and original ideas inside the prison. For example, following a coroner's inquest on the suicide of an inmate, the local committee of the Sept-Îles prison was able to identify one weakness in its suicide prevention program: the lack of communication with the families of inmates. Consequently, the committee added a message on plastic-coated cards on each table in the prison visitors' lobby: "If the inmate you visit talks about suicide, call us at 99999." Innovative, simple, and at almost no cost.

## Germany

The obligatory physical examination upon entering a German prison includes an evaluation of a history of addiction in order to combat a possible dependency disorder or withdrawal symptoms. At the same time, the prison physician must diagnose the suicidal risk, even if standardized instruments are not used to do so. Inmates judged to be actively suicidal get constant supervision. Inmates who have raised staff suspicions regarding suicide but who do not admit to being actively suicidal will be observed frequently. Normally the suicidal inmate is housed in a dormitory or shared-cell setting.In cases of imminent suicide risk or suicidal behavior, transfer to a general psychiatric hospital or other nonprison facilities as well as obligatory transfer to medical prison are possible options. Inpatient psychiatric care of prisoners is subject to wide regional variations in Germany. Only four federal states (Baden-Württemberg, Bavaria, Berlin, Saxony) have psychiatric departments in penal institutions under the legal authority. In the other federal states, inpatient and outpatient psychiatric care of prisoners is provided by external institutions and consulting specialists. External institutions for inpatient psychiatric care include forensic-psychiatric security hospitals and general psychiatric facilities.

## Italy

The Italian Justice System prescribes subjects not liable for reason of mental insanity to be interned in forensic psychiatric hospitals, and a differential treatment system and sentence calculation, which also takes into account social dangerousness, is provided compared to other penitentiary institutions. Inmates who develop a psychiatric disorder during imprisonment commonly receive treatment inside the penitentiary institution; only severe cases are transferred to Penitentiary Psychiatric Observation Wards. Such structures, however, are only charged with evaluating and observing inmates, as treatment is not provided. As soon as a diagnosis of psychiatric disorder is made, the judge decides if clinical conditions are consistent with continuation of sentence in jail. In every Italian jail, medical services are provided night and day in institutions with more than 225 inmates; in minor institutions only a daily service is provided. A psychiatric consultant is on duty for a number of hours per month depending on the number of inmates inside the institution; such organization lacks a central coordination to provide guidelines for intervention and treatment, and every single professional is in charge of evaluating the best treatment for inmates.

## Netherlands

Suicide prevention is underdeveloped in the Dutch penal institutions. Although the Ministry of Justice commissioned scientific research into screening of suicidal detainees (Blaauw & Kerkhof, 1999), the instrument is not being used as a screening instrument at intake in prisons and jails. It is only used after an inmate expresses suicidality. Whenever there is a suspicion of suicidality, the inmate is seen by a psychologist, who uses the screening instrument as a tool. Many psychologists have received special training in suicide prevention by Blaauw and Kerkhof. Some psychologists offer postvention to officers after a suicide has taken place (Blaauw, Kerkhof, & Hayes, 2005; Blaauw, Kerkhof, Winkel, & Sheridan, 2001). It is well known that any prisoner worries excessively. Worrying is related to hopelessness, depression, anxiety, sleeping problems, health complaints, and suicidality. Worrying by depressed and hopeless inmates is one of the warning signs or proximal risk factors for suicide that were studied in The Netherlands (Kerkhof & Van 't Veer, 2004). In daily practice however, not much attention is being paid to suicidal worrying. Those admitting suicidal impulses are generally watched over more frequently and if necessary transferred to special departments for inmates with mental health problems. Treatment on these special wards is targeted at depression and other psychiatric conditions. Programs targeted at treatment of suicidal impulses among inmates are still nonexistent.

## UK

In the UK, most local prisons (where the large majority of suicides occur) have introduced first-night centers, where prisoners can be assessed and reassured, including by peer-support groups. Some of these centers have been specially

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built, ensuring appropriate facilities (such as private offices, good access to telephones, etc.). Suicide prevention coordinators ensure that services within the prison are linked and that mental health in-reach nursing staff expertise is used to support ground staff in looking after at-risk prisoners. A thorough assessment is carried out on reception, and referrals can also be made to assessment teams at any stage in the custodial process.

Many prisons have both “safe cells” and “care suites”, supported by prisoner Listener schemes (prisoners trained by The Samaritans) as well as by uniformed and specialist staff. It is also the dominant view in England and Wales that preventing suicide is the duty of all who work in prisons. Multidisciplinary teams carry out regular case reviews once an individual prisoner is referred to the ACCT (Assessment Care in Custody and Teamwork Implementation) system. Physical education staff are increasingly involved in “healthy living” and other supportive initiatives as the emphasis shifts from a narrow focus on suicide prevention to a broader concern with promoting well-being. Some innovative practices are emerging in men’s and women’s prisons, involving alternative therapies such as massage, yoga, and acupuncture. Deaths in custody are investigated by the Prisons and Probation Ombudsman (as well as by the Coroner) and specific thematic investigations have been conducted in establishments where more than one death occurs over a short period of time (Prisons and Probation Ombudsman for England and Wales, 2003).

### USA

At the sentencing stage in the USA, felony convictees receiving sentences of any length may be placed in prisons. Some prisons receive those who are sentenced to a 120 day “shock sentence,” especially drug offenders for treatment. All accused persons in the USA who are found not guilty by reason of insanity (NGRI) under state jurisdiction will be committed to a state forensic hospital for treatment (representing only 1% of the inmates). Those who are found guilty but mentally ill (GBMI) in some states such as Michigan will be sentenced to prison but may be tagged for treatment. During the pretrial stage, all those who are adjudicated as incompetent to stand trial will be committed to a state forensic hospital until competency is restored. In the Federal system, those who are adjudicated as incompetent to proceed to trial will be committed to the Bureau of Prisons for treatment until competency is restored and then if restored proceed to trial. Because of the massive deinstitutionalization of the mentally ill from the state hospitals and the lack of systematic diversionary programs for the mentally ill criminal offenders, the state prisons have become the de facto state hospitals. In the USA, prisoners have a constitutional right to receive medical and mental health care that meet minimal standards. In a key US Supreme Court case (*Ruiz v. Estelle,* 1980), the court outlined minimum requirements for mental health services in correctional settings: trained mental health professionals, systematic screening and evaluation, treatment, appropriate use of behavior-altering medications, accurate recording, and suicide-prevention programs. Guidelines for clinically sound and legally defensible mental health care and suicide-prevention programs have also been established by the American Correctional Association (ACA), American Psychiatric Association (APA), and National Commission of Correctional Health Care (NCCHC).

## Conclusion

International groups like the Task Force on Suicide in Prisons are a good opportunity to gain new insights in specific problems such as the prevention of suicide in high risk groups. In this case, the internet technology made the group very effective and produced findings that, for the first time, could be compared and analyzed. As expected, similar services are available in many countries but there are also many differences. These differences could be explained by (1) the availability of the resources, (2) the structure of the correctional and community services, but also (3) the different paradigms about suicide prevention.

The real availability of resources might be a key explanation if we had compared countries with very differing levels of wealth, but that was not the case. Of course, undeveloped countries would have less money to invest in their correctional systems, especially when, for example, they also have to think about services to offer in schools or hospitals for senior citizens. In more developed countries, the availability of resources might be more dependent on social and political considerations, like the relative openness of the tax-payers to pay attention to unpopular groups of citizens. That never-ending debate can have very real impacts on the general level of services in prisons. Remember also that the USA is considered a wealthy nation and that it has a very high incarceration rate as well as a pool of very good researchers in the field of suicide prevention in prison. Nevertheless, it does not seem that the US has better services in prison than do other countries.

The structure of correctional and community services may explain more of the observed differences. In particular, the organization of mental health services, as well as the share of responsibilities, may well explain why there are more or less medical practitioners in prison or why an inmate with mental health problems will or won’t be sent to a special unit. Prisons depend on the way the whole society organizes its health system, although specific partnerships may be negotiated between health and justice departments. In that sense, an effective organization of a specific service might not be easily exported to another country.

Differences between the eight countries that involve nonprofessional employees, the inmates themselves, or the outside community, may well be explained by the different paradigms that have been adopted in each country. Unfor-

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tunately, we were not in a position to obtain clear data on the theoretical, political, and philosophical paradigms that underpin suicide prevention processes, partly because there are enormous variations even within countries, but also because officially stated paradigms often differ from actual practice. There have been few studies on this matter and it is a matter in need of researchers' attention. Nevertheless, our data show that, in the field of suicide prevention, all correctional systems evolve around the availability of mental health services. That can be called the common and traditional paradigm. However, we also see that these systems differ in the way they include (or not) the other partners of suicide prevention: correctional officers, other employees, peer inmates, chaplains or priests, and community workers. Circumstances, history, and national cultures may explain such diversity but it also may depend on the basic way we think about suicide prevention. Such implicit paradigms need to be analyzed in order for all organizations to be more efficient but, as mentioned earlier, we already know of some resistance, such as sharing responsibilities with peer inmates. Some other experiences involving the outside community mean that we would include citizens who are more used to criticizing the "prison system." Beyond all this, it may only be that we need to think about suicide prevention at both the individual and environmental levels.

This paper is only a first step in comparing the different national correctional systems for suicide prevention. The data are mainly descriptive and basic, although they were analyzed by an international team of experts. For example, the categories and terms used in the descriptions may cover different national realities and, even in each country, large variations exist. Nevertheless, this paper opens a new field of interest, as well as was the constitution of an international group like the Task Force on Suicide in Prisons.

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About the authors:

All nine authors are members of the Task Force on Suicide in Prisons of the International Association for Suicide Prevention.

Marc Daigle, PhD, is Professor of Psychology at the University of Québec at Trois-Rivières (Canada). He is also researcher at the Centre for Research and Intervention on Suicide and Euthanasia (CRISE) and at Philippe-Pinel Institute. His research focuses on program evaluation and suicide prevention, mainly in suicide prevention centres and correctional settings. Dr Daigle chairs the Task Force on Suicide in Prisons of the International Association for Suicide Prevention (IASP).

Anasseril E. Daniel, MD, MRC Psych, is a Clinical Professor of psychiatry at the University of Missouri School of Medicine in

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Columbia and has extensive experience in both clinical and administrative aspects of prison psychiatry. His research interests include serious suicide attempts and suicide in prisons. He has also published more than 30 articles in peer-reviewed journals on topics such as delinquency and crime among adolescents, female offenders, and the insanity defense. He is an associate editor of the *Journal of the American Academy of Psychiatry and the Law*.

Greg Dear, PhD, is Senior Lecturer in Forensic and Clinical Psychology at Edith Cowan University, Australia. He has published in the areas of self-harm in prison, prisoners' coping behavior (including use of social supports), psychological assessment, and substance use and the family. His current research areas are the prevention of self-harm in prison settings, substance use and family functioning (particularly parenting and drug use), and forensic applications of psychological theory and assessment methods to family law contexts and child protection.

Patrick Frottier is a Forensic Psychiatrist and Trained Child Psychiatrist and Psychotherapist. He is Medical Director of the Central Psychiatric Prison of Austria for the treatment of responsible mentally disordered offenders (JA Mittersteig, Vienna). His current research focus on suicide prevention in custody, epidemiology of mental disorders in custody, risk- assessment and (group)therapy for forensic patients.

Lindsay M. Hayes is a Project Director of the National Center on Institutions and Alternatives and he is recognized as an expert in the field of suicide prevention within jails, prisons, and juvenile facilities within the United States. He conducts training seminars and assesses suicide prevention practices in various state and local correctional systems throughout the country, serves as an expert witness/consultant in suicide litigation cases, and has conducted the only national studies of jail, prison, and juvenile suicide for the federal government. Mr. Hayes has reviewed and/or examined over 2,000 cases of suicide in jail, prison, and juvenile facilities throughout the United States during the past 26 years.

Ad Kerkhof is Professor of Clinical Psychology, Psychopathology, and Suicide Prevention at the Vrije Universiteit Amsterdam in The Netherlands. His research focuses on suicide prevention in mental health care and in the community. He studied (with Eric Blaauw) suicide prevention in detention in The Netherlands, which resulted in a screening instrument for suicide risk. He was previously Editor-in-Chief of *Crisis: The Journal of Crisis Intervention and Suicide Prevention*.

Norbert Konrad is Professor of Forensic Psychiatry at the Free University (now Charité) Berlin and Medical Director of the Department of Psychiatry and Psychotherapy in the Berlin Prison Hospital. His research focuses on prison psychiatry (prevalence of mental disorders, prison suicide, prison psychosis, criminal responsibility, treatment of mentally disordered offenders). Dr Konrad is Secretary of the WPA (World Psychiatric Association) Section Forensic Psychiatry.

Alison Liebling is Professor of Criminology and Criminal Justice at the University of Cambridge and Director of the Institute of Criminology's Prisons Research Centre. She has published numerous books on suicides in prison, including three on deaths in custody. Her current research includes a detailed evaluation of the relationship between prison quality and prison suicide, a study of prolific self-harm among women prisoners, the development of a prison quality survey for staff, and a study of values, practices and outcomes in public and private sector corrections. She is on the editorial board of *Punishment and Society*: the *International Journal of Penology*; and is General Editor of the *Oxford University Press Clarendon Series in Criminology*.

Marco Sarchiapone, MD, is Professor of Psychiatry at the University of Molise. His primary research field is suicidology and specifically the analysis of biological and psychological risk factors for suicidal behavior. Prof. Sarchiapone is Co-chairman of the Suicidology Section of the Association of European Psychiatrists, Secretary General of the Suicidology Section of the World Psychiatric Association, and Referent for Psychiatry of the Italian Society of Penitentiary Medicine.

Marc Daigle

Center for Research and Intervention on Suicide and Euthanasia
Philippe Pinel Institute of Montreal
University of Québec at Trois-Rivières
P.O. Box 500, Trois-Rivières
Québec G9A 5H7
Canada
Tel. +1 819 376-5011, #3509
Fax +1 819 376-5195
E-mail marc.daigle@uqtr.ca

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