Suicide in Prisons: A Brief Review

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ABSTRACT

Suicide is a serious public health issue in correctional facilities around the globe (World Health Organization, 2007). Mental illness and related factors, such as substance use, negative childhood experiences, and past suicide attempts are strong risk factors among correctional populations (Mumola, 2005). Prison system suicide rates in the U.S. can be reduced with awareness and proactive interventions. The purpose of this article is to help mental health and criminal justice professional recognize common suicidal risk factors among justice-involved individuals, particularly those who are incarcerated. In addition, the article includes a brief discussion of suicide risk factors during prisoner reentry and suicide risks among correctional officers.

Keywords: Correctional Facility, Mental Illness, Prison, Reentry, Suicide

INTRODUCTION

Approximately 4,500 inmates die in state and federal correctional facilities across the United States annually (Noonan, Rohloff, & Grinder, 2015). Current estimates indicate suicide is the leading cause of death in jails and juvenile facilities (Noonan & Rohloff, 2015). Suicide also is the fifth most common cause of death in state and federal prisons (Noonan & Rohloff, 2015). Studies indicate that incarcerated individuals are more likely to attempt and die by suicide than individuals living in the general population (Noonan, 2016). This trend underscores the importance of training mental health and criminal justice professionals to recognize suicidal risk factors among those who are incarcerated. With proper training and ongoing education, mental health and criminal justice practitioners can reduce the likelihood of inmate suicide.

Inmates with mental illness do not account for all prison suicides but preventing prison suicides must include persons with serious mental illness being diverted out of the criminal justice system and into mental health treatment or mental health facilities, when possible and appropriate (Marzano, Hawton, Rivlin, Smith, Piper & Fazel, 2016). Facility-based prevention includes staff training, screening, assessment, monitoring at-risk inmates, in addition to having supports and treatment resources to mitigate suicide risk (Tripoldi & Bender, 2007). Mental health courts are designed to help address the mental health needs of offenders in the community rather than incarceration. Mental health courts utilize a team-based approach that includes judges, attorneys, and treatment providers who collaborate to address the individualized mental health needs of each court-involved offender. Left untreated, offenders with mental illness are at a high risk for reoffending. Therefore, one of the primary goals of mental health courts is to reduce the likelihood of recidivism for individuals with mental health-related issues.

Reentry is a time when individuals are more at risk to attempting suicide (Binswanger et al., 2007). Formerly incarcerated individuals must find housing, employment, and they frequently struggle to reestablish or repair personal relationships they had prior to incarceration. These pressures heighten feelings of depression and anxiety, which, in turn, may increase suicide risk among offenders. Post-release suicide risk can be decreased by pre-discharge screenings and arranging near-term care in the community as indicated (Binswanger et al., 2011). The purpose of this article is to help mental health and criminal justice professional recognize common suicidal risk factors among justice-involved individuals, particularly those who are incarcerated. The article also includes a brief discussion of suicide risk factors during prisoner reentry and suicide risks among correctional officers.

Interpersonal Psychological Theory of Suicide

The lens most often used to examine inmate suicide is Joiner's (2005) interpersonal psychological theory of suicidal behavior. The theory posits that individuals must have a desire to die by suicide and the capability to act on their desire. Those who have a desire to die typically exhibit two characteristics: perceived burdensomeness and a sense of low belongingness (Joiner, 2005). Additionally, those who possess the capability to attempt suicide must overcome their innate desire for self-preservation. Typically, this is achieved through placing themselves or being placed in repeated adverse or painful situations that reduces their fear of injury and death.

For example, individuals who attempt or die by suicide have histories of self-harm, repeated accidental injuries, and numerous physical fights. These repeated exposures or experiences with pain foster a "fearlessness" in individuals and help them to overcome the desire for self-preservation (Joiner, 2009, para. 3). Like others, we use Joiner's (2005) interpersonal psychological theory of suicide to frame our discussion of suicide among incarcerated populations and present potential suicide detection and prevention strategies.

What is the problem?

The World Health Organization (WHO, 2007) has identified inmate suicide as a significant problem globally and prevention of suicide in prisons a top priority. Estimates show that suicide is a serious prison health issue. For example, from 2001-2014 there were 2,260 suicides in U.S. prisons (Noonan, 2016). In 2014, there were 249 prison suicides compared to192 prison suicides in 2013, which represents a 30% increase (Noonan, 2015; 2016). On average, 205 prisoners die by suicide yearly or 7.1% of all prison deaths, a suicide rate of 20 per 100,000 (Noonan, 2016). By contrast, the overall U.S. suicide rate that year was 13 per 100,000 (Curtin, Warner, & Hedegaard, 2014). Additional research indicates suicide within correctional facilities is three to nine times higher than in the general population (Hall & Gabor, 2004; Hayes, 1995; Tartaro & Lester, 2005). As such, prisons are high suicide-risk settings.

Most inmates arrive with some level of existing risk and this baseline risk is exacerbated, or new risk factors are acquired, once incarcerated. Post-release data demonstrates that those who were formerly incarcerated may continue to suffer mild to moderate suicide risk (see Dumont, Brockman, Dickman, Alexander, & Rich, 2012). Correctional administrators and personnel have a duty to protect those in custody and to minimize the risk of suicide on re-entry (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). It is essential for forensic mental health and suicide prevention professionals to understand risk factors for suicides in prison, the range of suicidal behaviors among inmates, and basic measures to keep risk in check. While this article addresses suicide among prison inmates, higher suicide rates are found in local jails compared to state and federal prisons (Cox, 2003; Mumola, 2005; Tripoldi & Bender, 2007).

Why is there a problem?

Part of the source of the problem of prison suicides is an increasing number of inmates with serious mental illness in county and state prisons. In the 1960s, the institutionalization of people with mental illnesses was met with legal challenges under the Lanterman-Petris-Short Act in California (Lenell, 1977), The Lanterman-Petris-Short Act went into effect in 1972 and set in motion national debate about the treatment of individuals with mental illness. In 1981, President Reagan signed the Omnibus Budget Reconciliation Act that created block grants and shifted the responsibility of allocating funding for the treatment of mental illness to the states rather than the federal government. The Omnibus Budget Reconciliation Act (1981) triggered the deinstitutionalization of mental health facilities across the U.S. Although the Omnibus Reconciliation Act (1981) was aspirational in theory, this initiative it placed a significant burden on the U.S. correctional system to house people with serious mental health issues (Kliewer, McNally, & Trippany, 2009). In other words, correctional facilities across the country became de facto mental health facilities.

As of 2017, estimates indicate that 553,742 people are homeless on any given day (Henry, Wiatt, Rosenthal, & Shivji, 2017). Over 111,000 of these homeless people have a severe mental illness and over 89,000 have a chronic substance abuse problem (U.S. Department of Housing and Urban Development, n.d.). The National Institute of Mental Health (2017) classifies individuals with mental illness utilizing two broad categories: any mental illness (AMI) and serious mental illness (SMI). The Government Accountability Office (GAO) estimates that, in 2016, there were 7,831 or 4.2% of federal inmates with a SMI. However, it is important to note this statistic omits those diagnosed with mild to moderate mental health concerns (Maurer, 2018). A 2011-2012 survey found that 14.5% of prisoners in state and federal facilities had a SMI compared to 44.3% of jail inmates (Bronson & Berzofzsky, 2017). A total of 36.9% of the state and federal prisoner population had been diagnosed with AMI compared to 44.3% in jails (Bronson & Berzofzsky, 2017).

Prisons often house individuals who are violent and troubled, and many of these individuals live in a single facility or specialized housing unit (Oregon Department of Corrections, 2009). While there is variation among inmates, it is the violent inmates who tend to victimize or threaten vulnerable inmates, especially those with a mental health diagnosis or disorder. Research demonstrates that many inmates are subjected to acts of random physical violence, sexual assault, and exploitation (Kupers, 1999). Both male and female prisoners are victims of rape and other sexual abusive behavior, including being touched or grabbed in a sexually threatening manner or touched or groped in the genital area (Bell, Coven, Cronan, Garza, Guggemos, & Storto, 1999; Scranton & McCulloch, 2009). Struckman-Johnson, Struckman-Johnson, Rucker, Bumby & Donaldson (1996) report that among male inmates who are forced or coerced into sexual acts, 56% suffer depression and 36% consider suicide. Studies also show that female inmates are more likely to suffer from post-traumatic stress disorder (PTSD) and depression if they experience sexual victimization during incarceration (Coles, 2010). In addition, sexually victimization among women prisoners is a risk factor for suicide (Coles, 2010; Fazel, Ramesh & Hawton, 2017).

Inmates are socially isolated from their family and friends, which contributes to psychological distress (Eisenberger, Lieberman, & Williams, 2003). Research demonstrates that supportive social connections mitigate impulsive actions, (Kleinman, Risking, Schaeffer, & Weingarten, 2012), foster superior coping skills related to external stressors (Goldsmith, Pellmar, Kleinman, & Bunney, 2002), and protect against suicidal ideations and behaviors (Joiner, 2005). Conversely, research shows that, in prison, social connections weaken, and suicide risk rises with length of imprisonment. Moreover, specific offenses may generate shame, embarrassment, guilt, and the belief that their families would be better off were they dead, all of which may contribute to suicidal thoughts, plans, and intent. Furthermore, the loss of control and autonomy and feeling trapped inherent to incarceration often heightens a person's a desire to die (Mandracchia & Smith, 2015). In fact, feeling trapped in a situation, emotionally or physically has such a strong correlation with suicide that it is a metric applied in the psychological autopsy process (American Association of Suicidology, 2013).

Lastly, overcrowded facilitates have higher rates of inmate suicide, which are related to population size, staff turnover, security level of the institution, and prison function (van

Ginneken, Sutherland, & Molleman, 2017). Health care staff and mental health professionals working in overcrowded correctional facilities may be overwhelmed by the number of inmate-patients in need of care. As a result, prison medical and mental health care practitioners may experience "compassion fatigue," which results in diminished levels of care (King, 2006, p. 10).

What do we know about prison suicide?

Suicide patterns in correctional facilities are similar to those observed in the general population. For example, in both settings, males are more likely to attempt and die by suicide than females. Whites also are more likely to attempt or die by suicide than Blacks or Hispanics (Kochanek et al., 2016; Noonan & Rohloff, 2015). Although there are common demographic characteristics across research studies that identify individuals more prone to self-harm or suicide risk, mental health professionals and correctional administrators should exercise caution when attempting to apply such profiles. The most serious concern regarding the application of demographic profiles is the increased possibility of false-positives and false-negatives (Pompili et al., 2009). False positives are inmates identified as suicidal when, in fact, they are not. The allocation of additional supervision and resources provided to false-positives may be to the detriment of the false-negatives, or inmates who are actually suicidal but did not fit the profile (see Tartaro, 2018)

A more accurate set of suicide risk factors to examine are static and dynamic factors in an inmate's life and surroundings. Static factors are unchangeable and include information about the inmate-client's medical, psychological, and legal history. For instance, static factors include prior or current mental health diagnosis, history of substance abuse, history of violence, and prior history of suicide attempts. Research consistently shows that static factors affect suicide risk. For example, across correctional facilities, pretrial or remand inmates tend to be more likely to die by suicide than sentenced inmates (Frottier et al., 2002; Myslimaj & Eglantina, 2016; WHO, 2007). Among sentenced inmates, those serving life are at greater risk of suicide (Borrill, 2002; Reeves & Tamburello, 2014; WHO, 2007). Offenders with violent criminal histories are twice as likely to take their own lives than offenders with non-violent criminal histories. Among non-violent offenders, probation and parole violators had the highest suicide rates (Mumola, 2005). Research also indicates that prisoners are most likely to attempt or die by suicide during their first year of incarceration (Chammah & Meagher, 2015).

Dynamic factors are changeable. Suicidal ideation and attempts, institutional disciplinary violations, housing assignments, incarceration-related conflicts, and the receipt of bad news from court or home are examples of dynamic factors (Reeves & Tamburello, 2014; Tartaro, 2018). Mental health professionals working in correctional facilities can help inmate-clients develop appropriate coping strategies thus reducing the likelihood of suicidal thoughts and attempts. However, correctional officers typically have more frequent interaction with inmates on a day-to-day basis. As a result, officers are more likely to learn about negative or stressful situations inmates experience.

What are the risk factors for suicide in prisoners?

The following acronym, UNSAFE, is a mnemonic for remembering and identifying the major risk factors for suicide among prisoners:

Table 1.

Major Risk Factors for Suicide Among Prisoners

U	Unconnected, weak social support, and loss
N	Negative view of self or one's future
S	Shame because of nature of offense
A	Attempt history, especially while in custody
F	Family history of suicide and mental illness
E	Emptiness, depressed, sad, or hopeless

Source: Salvatore and Nell (2011).

Pre-existing mental illness, divorce, death of a friend or family member, a history of prior suicide attempts (Fowler, Jack, Lyons, Betz, & Petrosky, 2018), or having experienced adverse childhood events (Afifi, Enns, Cox, Asmundson, Stein, & Sareen, 2008) may predispose a prisoner to risk. Separation from outside social support, being placed in solitary confinement, assault, new charges, or a lengthening of a sentence may further increase suicide risk. However, the Oregon Department of Corrections (2009) recently studied inmate suicide across their facilities and found that inmates who attempted suicide are more likely to be incarcerated for a shorter period of time, reside in specialized housing units, recently had a new cell assignment, and had more visits from family and friends.

We found it surprising that more visits equated to more attempts in this study. Although, it is plausible to consider, the more frequent visits or interaction with others and reminders of life outside of the prison context, the increase in feelings of separation, loss, grief, sadness, and perhaps hopelessness and helplessness experienced which could contribute to suicidal ideations and attempts. Future studies should explore features of visits, such as quality of the prisoner's social interactions, the loss of decision making power within their families, and receipt of bad news.

What about veterans?

Inmates, who are veterans, are at high risk of suicide and account for approximately 8% of the incarcerated population in the U.S. (Bronson, Carson, Noonan & Berzofsky, 2015). A greater percentage of veterans (64%) than non-veterans (48%) are imprisoned for violent offenses; about half of all veterans in prison (48%) have a mental health condition; and incarcerated veterans with combat experience are especially likely to have a psychiatric disorder (Bronson, Carson, Noonan & Berzofsky, 2015). Incarcerated veterans may have additional risk

factors, such as being accustomed to pain and habituation to violence (Haney et al., 2012). Exposure to physically painful and/or fear-inducing experiences are routine aspects of military training and service. Both aspects contribute significantly to the capability for lethal self-harm, which is a necessary condition for a suicide attempt (Joiner, 2005; Mandracchia & Smith, 2015; Van Orden, Witte, Cukrowicz, Braithwaite, Selby &, Joiner, 2010).

What role does mental illness play in prison suicides?

The relationship between suicide and mental illness is one of the most studied areas of suicide research, which has identified it as key risk factor for suicidal behavior and linked psychiatric disorders to a wide range of strong risk factors for suicide (Mishara & Chagnon, 2016). As mentioned previously, prisons have become the destination of default for many people struggling with mental health issues (Allison, Bastiampillai, & Fuller, 2017). Prison inmates with mental illness also appear to have an associated cluster of risk factors for suicide. For example, researchers conducting a study of suicide victims in Texas prisons found that 60% had been diagnosed with a psychiatric disorder, most commonly mood disorders, and reported pre-sentencing histories of alcohol and drug abuse, and past suicide attempts (He, Felthous, Holzer, Nathan & Veasey, 2001). This same pattern is evident in the U.S. prison population. Specifically, in 2005, over one-half of prison inmates had a mental health problem, over 700,000 inmates, and almost three-quarters reported substance dependence or abuse and about one-quarter had experienced past physical or sexual abuse (James & Glaze, 2006). In addition, 13% stated they had attempted suicide in the past 12 months (James & Glaze, 2006).

A research team's review of several prison suicide studies found mental health problems, preceding or arising during incarceration, to be associated with near-fatal suicide attempts in prisoners, but cautioned the attempts appeared due to a variety and interaction of factors rather than any one factor (Marzano et al., 2016). For example, Marzano et al. (2016, p. 323) found "psychiatric morbidity and comorbidity, trauma, social isolation, and bullying" are predictive factors for near-fatal suicide attempts in prisoners. A history of non-fatal acts of self-harm, even if there was no suicidal intent, is also a risk factor (Matsumoto et al., 2005).

Almost 30% of inmate suicides involve no obvious or diagnosed mental illness and such cases may be missed in screenings targeting psychiatric signs and symptoms (Daniel, 2006). It is important that this lack of diagnosis be kept in mind and that prison suicide prevention efforts, while strongly considering an individual's mental health history and prior care as integral, must also look beyond psychiatric diagnoses. Correctional staff and mental health professionals who are in direct contact with prisoners should be aware of cultural phenomena that exacerbate psychological pain or cultivate a negative feedback loop that increase feelings of hopelessness, sever social connections, or exacerbate mental health conditions, including those that are sub-clinical (Caulkins, 2014; 2015).

What are some signs of suicidality in prisoners?

Suicidality refers to the entire spectrum of suicidal phenomenon from ideation, planning, and self-injurious behavior, to suicide attempts and completions (deaths). Some early signs of the onset of suicidality are noted below. Please note that these also are consistent with signs of suicidality among the general public:

- Withdrawing or socially isolating oneself from prison contacts,
- Dropping family or others from phone or visitation list,
- Cutting, other types of self-injury,
- Sleep problems or somatic complaints,
- Agitation, anger, and verbal and physical confrontations, and
- Mood changes, anxiety, growing pessimism, and persistent and growing self-criticism, shame (American Association of Suicidology, 2013).

Prisoners showing these signs should be referred for psychological screening and counseling. Passing suicidal thoughts may accompany these behaviors. More serious warning signs may include:

- Obsessing over sentencing change, divorce, or a death,
- Marked personality or mood change,
- Withdrawing from contact with family/friends/attorney,
- Being present-oriented/vague on future,
- Talking/writing/drawing about death, and
- Giving away/disregard for possessions/food (American Association of Suicidology, 2013).

A suicide risk assessment and clinical treatment are necessary when these behaviors are identified. Suicidal ideation also is likely to be present. Suicide precautions should be put in place. As with the general public, signs of high suicide risk and possible imminent, near-term danger to self among prisoners include explicit threats to hurt or kill oneself, attempting to acquire instruments to facilitate the suicide, and voicing a specific suicide plan, such as when, where, or how one intends to carry out the suicide (Rudd et al., 2006). Any of these signs should result in an immediate psychiatric evaluation and in-patient treatment. Prisoners at this juncture will likely have a well thought out suicide plan, rehearsed it mentally, and possibly even practiced it in some way.

How can prisoner suicide threats be understood?

Recognizing suicidality in correctional settings is complicated by the prevalence of coping strategies incorporating allusions to suicide attempts, which may otherwise discourage some from taking talk of suicide seriously. In prison contexts, manipulation, in the form of contingent suicide threats ("If you don't let me do or have X, I'll just kill myself"), may be frequently heard from inmates and ignored by staff. Furthermore, other prisoners may employ suicide threats as a means of emotional release. However, correctional staff should take every threat seriously because it is often difficult to determine if an inmate intends to carry out their threats. Bonner (2001) offers the following typology to help identify those who are using suicidal threats to manipulate correctional or medical staff compared to those who may actually attempt suicide:

- Prisoners who deal with a problem by making threats and/or self-harming until they get an acceptable solution.
- Prisoners who make threats and/or self-harm to relieve overwhelming emotions

- Prisoners who are severely depressed and hopeless and manifest strong intent to die.

Using suicide threats for purposes of self-gain does not preclude suicide risk (Dear, Thomson & Hill, 2000). Based on Bonner's (2001) research, individuals in either of the first two groups have no intent to die and often no actual plan. However, it is important to note that all three groups have suicide risk and few protective factors. While threats may not give way to action, they may foster suicidal ideation, increased comfort level with suicidal behavior, and, over time, contribute to lower resistance to a suicide attempt. Even though some prisoners persistently engage in parasuicidal behavior (cutting or other self-injurious behavior) acts or quasi-attempts with no intent to die; others acquire intent, become more capable, adopt more harmful means, and end their lives (Daniel, 2006). Therefore, all expressions of suicidality must be assessed for risk and danger by a qualified clinician or mental health professional.

How can the risk of prison suicide be reduced?

There is a substantial body of literature on prison suicide prevention available and readers are encouraged to examine these useful resources in efforts to better deepen their understanding of the information (Daniel, 2006; Hayes, 1995, 2013; Marzano et al., 2016; Tartaro, 2018; Tripoldi & Bender, 2007). Within the following bulleted list are some practices from the aforementioned literature that help reduce suicide and life-threatening behavior:

- Screening for suicide risk at intake and after any event negatively affecting a prisoner,
- Training all correctional staff to recognize possible signs of suicide risk,
- Refer potentially suicidal inmates to mental health professionals,
- Involving prisoner peers in suicide prevention/support groups,
- Implement ongoing monitoring and treatment after any suicide attempt,
- Avoid isolating inmates unless constant observation can occur,
- Develop a procedure to respond to a suicide in progress,
- Implement a notification plan for informing authorities and family of suicide attempts or deaths,
- Create a surveillance program to track suicide attempts and deaths,
- Review of the organization's suicide prevention plan if a suicide happens, and
- Communicating information about suicide risk when a prisoner is transferred.

The use of a suicide-resistant design to the prison setting and products is essential in suicide risk reduction. However, despite best efforts, prisoners who may be inclined, have a lot of time to ponder plans and means to carry out their plans. Therefore, it is critical that all staff in contact with prisoners and prisoners themselves learn what to look for, be ready to ask, not take no for an answer, and follow through when suicide risk is suspected. Daigle and Naud (2012) studied suicide in Canadian prisons and found that poisoning and hanging were, by far, the most common methods of inmate suicide. Drowning and deep cutting are additional methods warned about by the Oregon Department of Corrections (2009). A trend of asphyxiation by plastic bag among the general public—a method that could be used easily in prison—is another method seen by the authors in a review of death records. Suicide precautions must not be limited to those who

self-report suicidality or manifest some overt behavior. Rather they must extend to prisoners showing signs. Prison suicides are preventable and those exhibiting initial signs must be taken seriously and put on precautions.

Given the incidence of suicide in prisoners with mental illness and associated problems, it would seem that some proportion of prison suicides could be prevented by keeping individuals with pre-existing serious psychiatric disorders out of prison. Identifying mental illness and suicidality as early as possible in the criminal justice system and diverting those found to be at-risk to evaluation and treatment would seem to be the preferable method for suicide prevention (Marzano et al., 2016). While there has not been an evaluation of such "jail diversion" programs from a suicide prevention perspective, their effectiveness in deterring inappropriate incarceration of individuals with serious mental illness has been demonstrated (Frisman, Lin, Sturges, Levinson, Baranoski, & Pollard, 2006; Sirotich, 2009; Steadman & Naples, 2005).

What about suicide risk at and after release?

Researchers studying inmates released from Washington State Prisons found a high risk for death during the first two weeks of incarceration and that suicides were a leading cause of death, particularly in men under age 45 (Binswanger et al., 2007). The proximity of the suicides to release from prison suggests that these deaths may be related to risk carried over from prison, or because of poor preparation for stressors, following release. As more states pursue policies resulting in early release and less use of parole, policymakers should be aware of suicide risk associated with reentry (Petersilia, 2001). For instance, interviews of former inmates in Colorado identified financial and housing problems, unemployment, inability to access health care and to continue psychiatric medications, and emotional stressors such as fear and anxiety as reentry issues that may trigger suicidality or psychiatric conditions raising suicide risk (Binswanger et al., 2011). A British study found suicide risk on release from prison to comparable to that faced by patients leaving psychiatric hospitals (Pratt, Piper, Appleby, Webb, & Shaw, 2006).

A number of steps can be taken before release to reduce suicide risk. All prisoners should receive a suicide risk assessment prior to discharge. While the prison cannot delay release of those determined to be at risk, referrals can be made to mental health resources in their home communities. Prison medical units can make "warm handoffs" of inmates with serious mental health needs or suicidality by developing post-release transition plans with community providers and schedule same-day intake appointments, where possible (Spillman, Clemans-Cope, Mallik-Kane, & Hayes, 2017, p. 8). Prisons also may have the option under their state mental health law to seek an involuntary psychiatric evaluation of high-risk individuals immediately after release, which may lead to inpatient psychiatric care (Testa & West, 2010). Efforts should be made before release to restore Medicaid and Medicare coverage or to secure such benefits for those who may be eligible. Further, provision should be made to assure the availability of any psychiatric medications. Moreover, parole and probation agencies must be apprised of suicide risk present in those transitioning to their supervision.

But what about the correctional officers?

Although not the primary focus of this article, we would be remiss in not mentioning suicide among correctional officers. Researchers have found that correctional officers exposed to

inmate suicides experience a 36.7% increase in PTSD (Wright, Borrill, Teers, & Cassidy, 2006). In general, 31% of correctional officers have a PTSD diagnosis and 25.7% have depression regardless of suicide exposure (Denhof & Spinaris, 2013). This is important because PTSD and major depressive disorder are among the top four mental illnesses associated with suicide (Bolton & Robinson, 2010). The New Jersey Police Suicide Task Force (2009) discovered that, in their state, correctional officers had double the suicide rate of police officers with a crude rate of 34.8 per 100,000 compared to 15.1 per 100,000. This means that corrections officers have a suicide rate of 19.7 more per 100,000 than the prisoners themselves. Taking a broader look, researchers found that correctional officers have a 39% higher risk of suicide than the general working population (Stack & Tsoudis, 1997). Consequently, a part of any correctional department suicide prevention program must also include correctional officers. This must also include postvention for correctional officers and other prison staff who are affected by the loss of a colleague to suicide (Salvatore & Bartuski, 2017).

CONCLUSION

Prison suicide prevention, like that in other settings, is an ongoing process rather than a stand-alone event. Suicidality can wax and wane among a given population. Reducing suicide risk among prisoners must be embedded in every phase of incarceration from pre-reception to release (see Table 2).

Table 2.

Identifying Suicide Risk During the Stages of Incarceration

Pre-reception	Diversion of at-risk individuals with criminal justice contact from potential incarceration to treatment in the community through crisis intervention training for police officers and mental health courts.
Reception	Screening for suicide risk on arrival and routing at-risk prisoners to other settings as indicated.
Incarceration	Ongoing risk monitoring, maintaining suicide prevention awareness in inmates and staff, eliminating environmental hazards, reducing access to lethal means, and promoting help-seeking and treatment.
Release	Pre-discharge suicide risk screening and referral of at-risk individuals to appropriate community resources at re-entry.

Source: Marzano et al., (2016).

Measures such as these can not only lessen inmate suicide risk and the liability that comes with it but also lighten the prison's responsibility for the care of offenders with serious mental illness and other factors contributing to prison suicides. In addition, correctional facilities should be sure to include training for identifying correctional officers and staff who may be exhibiting mental health symptoms associated with suicide. It is also essential that suicide prevention in a state or

county prison not be isolated from suicide prevention activity in the surrounding community. Prison suicides impact the suicide rate in the county in which they are located. Correctional staff are suicide prevention stakeholders and must be part of the suicide prevention planning in their area. As noted above, prison suicide prevention does not begin and end at intake and discharge. Community resources can lessen risk among incoming inmate; prison programs can lessen risk in former inmates returning to the community.

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