SUICIDE PREVENTION TASKFORCE

SUICIDE IN PRISON

A Report by the
Western Australian
Department of Justice
Suicide Prevention Taskforce
July 2002

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SUICIDE PREVENTION TASKFORCE PERSONNEL

1. STEERING COMMITTEE

Mr Terry Simpson	**Executive Director, Prisons (Chair)**
Dr Chris Henderson	**Director, Health Services**
Dr Ananth Pullela	**Senior Forensic Consultant Psychiatrist**
Prof David Greenberg	**Director, State Forensic Mental Health Services, Graylands**
Prof Sven Silburn	**Director, Centre for Development Health, Institute for Child Health Research, Curtin University**
Mr Robert Harvey	**Executive Director, Community and Juvenile Justice**
Mr Anthony Leech	**General Manager, Public Prisons**
Mr Bill Milroy	**Manager, Policy & Planning, Aboriginal Services**
Mrs Jane Burn	**Legal Officer, Office of Parliamentary Commissioner (Ombudsman's Office).**

2. WORKING PARTIES

Mental Health (Self Harm & Suicide Awareness) Working Party

Dr Ananth Pullela	**Senior Forensic Consultant Psychiatrist (Chair)**
Dr Stephen Patchett	**Director, Inpatient & Community Psychiatric Services, Graylands**
Mr Leslie Harrison	**Principal Clinical Consultant, Operational Services & Sentence Management Directorate, Prison Services**
Mr Stephen Kelly	**Project Manager, Health Services**
Mr Bill Milroy	**Manager, Policy & Planning, Aboriginal Services**
Mr Glenn Ross	**Manager, Forensic Case Management Team**
Ms Teresa McGlynn	**Forensic Case Manager, Hakea Prison**
Ms Tracy Palmer	**Project Officer, Naltrexone Behavioural Program**
Ms Beverley Vetesi	**Mental Health Nurse Specialist, Hakea Prison.**

Environmental (Operational) Working Party

Mr Anthony Leech	**General Manager, Public Prisons (Chair)**
Dr Chris Henderson	**Director, Health Services**
Mr Steve Jenkins	**Project Manager, Justice Reform**
Mr Stephen Kelly	**Project Manager, Health Services**
Mr Steve Newell	**Workforce Planner, Prison Services**
Mr Kevin Bourne-McRae	**State Director, Prison Fellowship of Australia WA Council**
Ms Jann McBride	**Manager, Offender Programs, Operational Services & Sentence Management Directorate, Prison Services**
Ms Vicki Bell	**Manager, Aboriginal Services, Prison Services**
Mrs Jane Burn	**Legal Officer, Office of Parliamentary Commissioner (Ombudsman's Office).**

Identification and Management of At Risk Offenders Working Party

Dr Chris Henderson	**Director, Health Services (Chair)**
Dr Phillip Hames	**Medical Officer, Casuarina Prison**
Prof Sven Silburn	**Director, Centre for Development Health, Institute for Child Health Research, Curtin University**
Mr Guy Hall	**Senior Lecturer in Law, School of Law, Murdoch University**

Mr Leslie Harrison	**Principal Clinical Consultant, Operational Services & Sentence Management Directorate, Prison Services**
Mr Dave Hide	**Deputy Superintendent, Casuarina Prison**
Mr Stephen Kelly	**Project Manager, Health Services**
Mr Graeme Pilton	**Statistical Analyst, Community & Juvenile Justice**
Ms Vicki Bell	**Manager, Aboriginal Services, Prison Services**
Ms Pam Deenan	**Aboriginal Health Worker, Derbarl Yerrigan.**

3. PROJECT TEAM

Mr Stephen Kelly	**Project Manager, Health Services**
Ms Rachele Day	**Psychologist, Forensic Case Management Team**
Ms Megan In de Braekt	**Project Consultant, Prison Services**
Ms Christy Hawker	**Project Officer.**

ORGANISATION OF THIS REPORT

Chapter 1 Introduction

This chapter details the establishment of the Suicide Prevention Taskforce and its *Terms of Reference*. Introductory information is also provided on the three suicide prevention working parties, the data analysis and the literature review. Finally, a background to existing suicide prevention services in Western Australian prisons is provided.

Chapter 2 Literature review

The Taskforce commenced the Suicide Prevention Project with a literature review. The review encompassed over 70 publications, including journal articles (research, case studies, statistics, comparative studies, interstate and international reprints), texts and treatises, various reports (eg, Coronial, selected committees and conferences, criminological) and magazines. The literature was predominantly recent and written by recognised corrections and criminology experts.

Chapter 3 Analysis of suicides in custody

An analysis of 51 deaths in custody by suicide from January 1988 to June 2000 was undertaken. This analysis involved the perusal of medical and prisoner records on file and on computer, along with investigative, Coronial, police and Department of Justice reports to obtain both quantitative data (ie, statistically-analysed) and qualitative data (examining contextual variables).

Chapter 4 Past and current preventative measures

The Department of Justice[1] suicide prevention measures, both past and present, were examined by the Suicide Prevention Taskforce. In particular, a review of the "action sets" identified in the *"Report on Suicide Prevention Strategies for Prisons in Western Australia, December 1998"* by the Department of Justice's Strategic Group on Suicide Prevention Strategies was conducted. The review shows what changes have been made by Department of Justice to lessen suicide following the 1988 report in the intervening years 1988-2001.

Chapter 5 Working parties

Three working parties, supported by findings from the literature review and the analysis of suicide in custody, were established as follows:

- **Working party one (Mental health)** identified and reported on the priorities in dealing with suicide.
- **Working party two (Operational environment)** reported on those factors necessary for a 'healthy prison'.
- **Working party three (Identification and management of at-risk prisoners)** reported on the complex issues surrounding identification, screening, and management of suicidal risk.

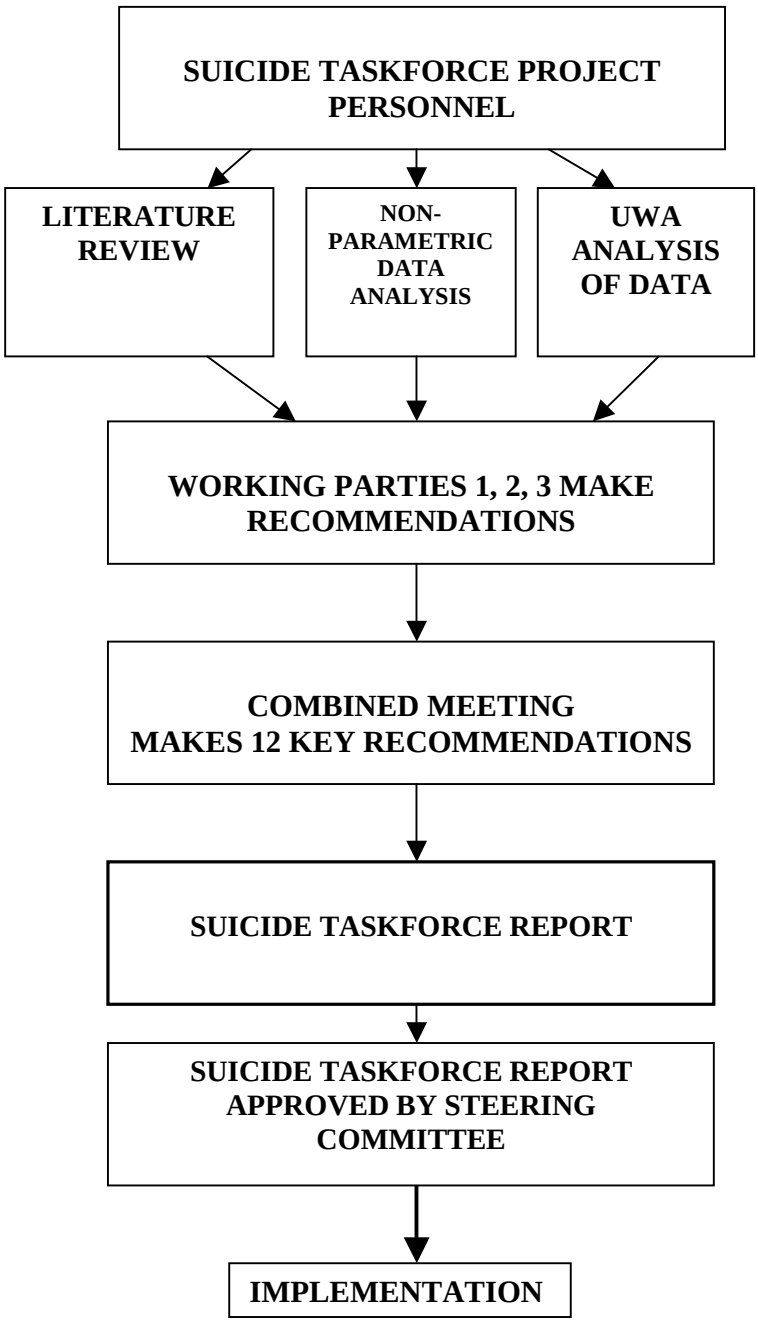
[1] The Department of Justice changed its name from the Ministry of Justice in 2001 during the tenure of the Taskforce. For purposes of consistency, the term Department of Justice is used throughout this report unless reference is made to the title of a document that bears the name Ministry of Justice.

Chapter 6 Concluding remarks

This chapter pulls the important issues together from the preceding chapters. It begins with a discussion of the psychological effects on prisoners of entry into prison and proceeds to provide a synopsis of the major risk and protective factors that are critical to preventing suicide in prison custody.

Note on recommendations: The report contains 'suggested strategies' in chapters 2-5. These strategies were put to the final meeting of working party participants who considered all of them and developed 12 key recommendations. Thus the 'suggested strategies' from chapters 2-5 do NOT necessarily become part of the final Key Recommendations but should receive further consideration as part of the implementation of these Key Recommendations

DIAGRAM OF OPERATION OF SUICIDE TASKFORCE



EXECUTIVE SUMMARY

In response to an unacceptably high prison suicide rate, the Department of Justice, in June 2000, established a comprehensive review to examine the relevant international and Australian literature and conduct a data analysis of recent prison suicides. Through the focus of the Suicide Prevention Taskforce, three working parties were established to separately report on the impact of mental health, the prison environment, and the identification and management of at-risk prisoners. This report documents the findings of the Suicide Prevention Taskforce and provides recommendations for the better identification and management of 'at-risk' prisoners as well as changing the general prison system.

When a person is imprisoned the public admonition of a court hearing and the loss of freedom and privilege that occurs frequently leads to a loss of self-respect and depression that may increase the risk of self-harm or suicide. However, it is neither practicable nor appropriate to manage every prisoner as if they are suicidal, consequently a strategy of screening and assessment has been used to identify so-called "at-risk prisoners" and thereby better manage the incidence of suicide.

Unfortunately, suicide risk prediction generates a large number of false positives, since the predictors are non-specific and suicide itself is a rare event. A similar problem exists for the prediction of dangerousness in prisoners (and in other fields - for example, prediction of earthquakes, and volcanic eruptions.) It is estimated that for every prison suicide there are around 60 incidences of self-harm.[2]

While the use of clinical and actuarial screening systems can be improved in our system, it is unlikely that a totally reliable screening tool will ever be developed for suicide. Therefore, while we will continue to improve screening tools, it will also be important to focus on the extent to which the whole prison environment contributes towards the good mental health of inmates.

The Taskforce set out to investigate how prison custody places prisoners at-risk of self-harm and suicide and how to identify, manage and treat prisoners who are at-risk, particularly those prisoners who present as an acute risk.

Prison suicide is a complex phenomenon that is best understood (and prevented) by an assessment of individual *psychosocial factors.* These factors act to increase the risk of suicide and, in combination with the better management of those *systemic factors* that act to exacerbate suicidal feelings. In general terms, remand prisoners and maximum-security prisoners were found to be at greater risk of suicide than the wider prison population, as were prisoners with a psychiatric illness or a drug or alcohol dependence. However, suicide does not necessarily imply an underlying mental disorder. Early family dislocation, destructive community relationships, death or a relationship breakdown, distressing communications while in prison and bullying, were also identified as significant factors.

[2] McArthur, Camilleri, & Webb "Strategies for managing suicide and self-harm in prisons" No 125, Trends in Crime & Criminal Justice, August 1999.

Whilst suicide 'profiles' are unreliable, a 1999 study revealed a number of commonalities amongst Australian prison suicides:

- 96% of the suicides were male.
- 14% of prison suicides were Aboriginal.
- The mean age for suicide was 29 years.
- The times at which the suicides occurred were spread fairly evenly over the 24 hour period.
- The most likely day of the week for suicides to occur was Sunday.
- Most suicides occur in the months of November and January.
- 25% occurred within the first week of imprisonment.
- 85% occurred in prison cells.
- 48% were on remand at the time of their death.
- The mean time spent in prison before prisoners committed suicide was 15 months.

It is recognised that women experience imprisonment differently from men. For women imprisonment includes a significant increase in family stress. For example: separation from dependent children, children taken into care, or inability to care for older family members. Consequently, it may be necessary to augment women's prison regimes with measures that ameliorate these 'care-giver' stresses.

The report also reviews the significance of Aboriginality as a factor in prison suicides. In comparative terms, in Western Australia between 1986-1997, the standardised suicide rate for Aboriginal males in the general population was almost double the rate for males overall.

However, in the Western Australian prison system the long-term average Aboriginal death rate is significantly lower than the non-Aboriginal rate (2.4 Aboriginal deaths per 1000 prisoners compared to 3.06 non-Aboriginal deaths). It is also significantly lower than the national average (ie minus Western Australia - 2.4 Aboriginal deaths per 1000 prisoners compared to the national average of 3.4 non-Aboriginal deaths per 1000)[3].

Although now over 10 years old, the report of the *Royal Commission Into Aboriginal Deaths In Custody* (RCIADIC), was reviewed along with other relevant research. Recognition and support for Aboriginal culture is noted as being a central issue to addressing the problem of suicide among Aboriginal prisoners. Reasons[4] advanced for the high suicide rates among Aboriginal prisoners include:

- the on-going experience of dispossession;
- social disadvantage;
- modernisation and lack of services;
- alcoholism and the internal breakdown within communities;
- frustration and anger;
- lack of purpose; and
- Pessimism.

[3] Report on an enquiry into deaths in prisons in Western Australia. Ombudsman WA December 2000. www.ombudsman.wa.gov.au or Ombudsmans Office, PO Box Z5386 St Georges Terrace Perth 6831.
page 14.

[4] *RCIADIC, Volume 3, (Chapters 23-25) National Report by Commissioner Elliott Johnston QC*

A quantitative analysis of characteristics applying to prisoners who had suicided in Western Australia , compared with a control group, identified a range of significant variables including:

- Personal characteristics such as emotional state , psychiatric illness and frequency of contact with health professionals
- Background issues such as history of sexual assault and/or early family dislocation
- Prison-related issues such as remand status , sentence length , lack of constructive activity and bullying.

The report finds that if there are enough *protective factors* to offset the *risk factors* and prisoners with mental illness can be returned to health, suicidal behaviours may be reduced. Accordingly, the report recommends improving protective factors across the prison system.

It is evident that many of the stresses that precipitate self-harming and suicidal behaviour are personal events which may be kept private. Successful prevention of suicide is consequently dependent upon the identification of 'at-risk' factors. The framework for this process is in place, through the At-Risk Management System (ARMS) and Prisoner Risk Assessment Group (PRAG) systems that have been introduced in recent years. However, the implementation of these processes requires further involvement of prison staff.

In particular, a number of the existing system-protective factors such as the PRAG, the ARMS, and the *Prisoner Peer Support Scheme* are examined and recommendations made for improvement and enhancement where appropriate.

Several of the 'system-risk factors' are analysed and illustrations are given from prison records.

The report notes that whilst it is important to remove all obvious hanging points from cells, it is almost impossible to "hang-proof" a cell, without making the cell so austere that it can be counter-productive.

Neither is it enough only to tackle the means for committing suicide - the very notion of suicidal ideation must be addressed. The Task Force is concerned that the current management of at-risk prisoners is not attuned to detecting significant changes in behaviour that may indicate a progression toward suicide.

The most gains to be made in prevention of self-harm and suicide in prison are seen to require a cultural change in which the care and well-being of these prisoners becomes a primary focus for all staff. A holistic view of the prisoner as a person must be taken involving a teamwork approach by all prison staff and supported by training and assessment.

The Department of Justice has a duty of care for prisoners and every prisoner suicide is deeply regretted. The report however, makes it clear that such expressions of regret must be followed up by decisive action.

Recent changes include:

Casuarina Prison, Hakea Prison and, since February 2002, Bandyup Women's Prison, each have *Crisis Care Units* to care for prisoners in suicidal crisis.

The Department of Justice has recently implemented a strategy known as the *Integrated Prison Regime.* This entails training and other initiatives aimed at improving the overall functioning of prisons with regard to such matters as prisoner safety, prisoner support, and the development of mutual respect between officers and prisoners. This 'cultural' change process forms a significant

part of the Department's implementation of recent prevention initiatives.

As part of the Integrated Prison Regime, Unit Management and Case Management are being implemented across the State.

The opening of Acacia Prison and major reforms to the adult justice system have collectively reduced the high numbers and eliminated overcrowded conditions in the prisons. This has reduced overall pressures and increased opportunities for all prisoners to be engaged in constructive activities.

Other strategies and activities which now contribute to prevention of self-harm and suicide include:

- More comprehensive assessments for sentence planning
- Improved induction and orientation of prisoners including video's, prisoners brochures and increased support by prisoner peer support teams.
- Increased recreation and schooling (involving more computer purchases and usage),
- Introduction of an anti-bullying policy,
- A streamlined prisoner grievance process,
- Improved notification of Parole decisions.
- Legislative reforms are being drafted to address short sentencing issues and contribute to the long term reduction in imprisonment rates and over-representation of Aboriginals in WA Prisons and
- An Aboriginal Services Strategic Plan is being implemented in all prisons.
- The Forensic Case Management Team (FCMT) name has changed to Prison Counselling Services and will in future report through to Prison management not Health Services.

The recommendations contained in this report provide a framework for such decisive action. The implementation of those recommendations will require resources, commitment and compassion for the care and well being of those in custody.

SUMMARY OF KEY RECOMMENDATIONS

The Taskforce Steering Committee convened a workshop to formulate key recommendations from the work of the:

- Literature review;
- Analysis of suicide in custody data; and
- Three working parties.

The 12 key recommendations are as follows:

1. The enhancement of constructive and supportive relationships between staff and prisoners should continue to be a major priority for the prison system. Particular emphasis should be placed upon improvements to regimes, staff training and rostering arrangements to enhance these relationships.

2. Opportunities should be expanded for prisoner interaction with the outside world, particularly with regard to family and friends.

3. Each prisoner should be provided with the opportunity to participate in constructive activities such as, employment, education and programs that build competency and address offending behaviour.

4. All aspects of prison operations and programs must recognise and be sensitive to the diversity of the prison population in terms of culture, ethnicity, gender and sentencing status.

5. The Department of Justice should consider the reinstatement of a generic social work/social welfare service. This service will complement prison officers' welfare role, with a particular emphasis on supporting prisoners in relation to family, relationship and other significant personal issues external to the prison.

6. Priority should be given to the provision of comprehensive mental health services to prisoners, including:

    - a multi-disciplinary model for screening and assessment of mental illness;
    - adequate mental health treatment and management resources and systems within prisons;
    - sufficient provision of external hospital accommodation for the treatment and management of acute mental illness; and
    - continuity of mental health care from specialist management and treatment facilities, back into the mainstream prison environment, and ultimately into the community.

7. Suicide awareness training should be provided to prison officers and other prison staff.

8. Prison reception and induction processes should be reviewed to reduce uncertainty and stresses associated with suicide and self-harm, and should incorporate a detailed assessment of risk of self-harm or suicide.

9. A consistent and well-researched model of suicide treatment should be developed and implemented in prisons.

10. A thorough evaluation of the current suicide prevention strategy (ARMS/PRAG) should be undertaken.

11. A longitudinal information system designed to identify behaviours indicative of suicide should be developed.

12. A position of *Suicide Prevention Coordinator* should be established. This position will have the task of overseeing implementation of the recommendations of this report and the ongoing development and refinement of suicide prevention strategies. It will also serve as a focus for the system wide ownership of suicide prevention.

CHAPTER 1 INTRODUCTION

History of management of suicide and self-harm in WA prisons

A *Prisoner Support Scheme* started in 1994 was expanded in later years to include *Aboriginal Prisoner Support Officers* who work with selected prisoner groups to teach them to help each other and to attend to Aboriginal issues. This position is now filled in the ten major prisons in Western Australia. Suitable prisoners are recruited to work with the *Prisoner Support Officers* and to assist vulnerable prisoners. This is now known as the Prisoner *Peer Support Scheme*.

Before mid-1997 the primary suicide prevention mechanism in Western Australian prisons was known as the *Special Needs Team* (SNT). This team constituted under Prison Operations with few supportive and no administrative resources, comprised psychologists and social workers. On average, eight full time employees were charged with providing self-harm and suicide prevention services to prisoners across all prisons. In August 1998, the SNT was amalgamated with Prison Health Services and the name changed to become the Forensic Case Management Team (FCMT). The numbers of teams grew. At the same time team strength gradually improved along with the growing prisoner population. However, more first-time prisoners and drug-users in the prison population during this period coincided with an increased number of self-harm and suicides in prisons.

In 1998, of 16 deaths in custody in Western Australian prisons, 12 were by suicide. In October of 1998, the Department of Justice Strategic Management Committee took a new approach in suicide prevention. This group adopted the initiatives set out in *Caring For the Suicidal in Custody* (HM Prison Service, England and Wales 1994). The subsequent development of ARMS in October 1998, required prisons to share responsibility for the management of at-risk prisoners using a consistent and structured approach to suicide prevention. However, even with the introduction of these significant system improvements suicides continued to occur at alarming rates throughout Western Australian prisons in 2000, with a large number in the first 6 months. Interestingly the rate was unusually low for the next 6 months.

The present Suicide Prevention Taskforce was formed to look again at the whole problem of prison suicide, since the ARMS process was clearly not working well enough to reduce the suicide rate.

Establishment of the Suicide Prevention Taskforce

In June 2000, the Department of Justice announced the establishment of a Suicide Prevention Taskforce to investigate, develop and recommend initiatives to address the unacceptably high number of suicides in Western Australian prisons.

The *Terms of Reference* for the Taskforce were as follows:

- Researching current world best suicide prevention practices.
- Researching recent suicides in Western Australian prison custody.
- Examining court and prison management processes and in particular, the effectiveness of the ARMS that has been implemented in Western Australian prisons.

- Review Prison Officer and other staff training.
- Make recommendations on best practice for the management of 'at-risk' prisoners and the prevention of self-harm and suicide in prison.

The *Suicide Prevention Taskforce* was established comprising representatives from:
- Prison Operations;
- Health Services;
- Health Department Western Australia;
- Aboriginal Policy and Services; and
- The Office of the Ombudsman.

About this report

The Suicide Taskforce encompasses three phases: review of existing literature and data, formation of working parties to examine the present system in the light of the literature and data reviews, and development of recommendations for improvement of the system. This report presents the findings from this process.

The report is divided into three main parts:

1. Literature review
2. Data analysis
3. Working parties

There are 10 appendices containing the details (such as tables, and statistical results) that are more conveniently read separately from the main text.

About the Literature Review

A large body of literature on the characteristics of suicidal people is available, but there is still no adequate theoretical understanding of why people suicide; and particularly the connection between those who suicide and the societal factors around them. It is apparent, from the literature, as well as in the findings of this Taskforce, that suicidal behaviour cannot be understood only by looking at factors relating to the individual prisoner but must include systemic factors.

Viewing a suicidal prisoner as a 'patient' is only part of the picture. The prison context may be as important as individual trait factors. Consequently, it is vital to have a mechanism to share information from all sections of a prison in order to build a picture of stress escalation for a particular prisoner.

About the Data Analysis

To supplement the Literature Review and support the working parties in their decision making, information generated from the data analysis of the last 51 suicides in custody (that is, going back to 1988) was made available.

1. Quantitative analysis

Two types of quantitative analysis were done – non-parametric analysis done by the Department of Justice and an independent regression analysis by the Department of Public Health, University of Western Australia.

The data form developed for this study contains 177 variables. The variables included measures such as demography, institution, and prison-related (eg, visits to health professionals, staff response times, number of staff, adherence to procedures and rules), personal and risk factors (such as medical, psychiatric, substance-use, self-harm history, previous convictions and imprisonment's, attempts at suicide).

Further, in view of the paucity of deaths-in-custody studies which employ control groups, the analysis included self-harm and non-self-harm groups matched on demographic variables, in order to detect differences, commonalties, and systemic influences on self-inflicted deaths in the State's prisons.

a) Non-parametric analysis:
The analysis showed significant differences between deceased and matched groups in, factors such as early familial disruption, self-harm history, and relationship difficulties. (See Appendix 7).

(b) Regression analysis:
This quantitative analysis showed a number of significant differences between variables (eg security rating, current sentence length, times seen by a health or allied health professional, family dislocation in childhood, time in medical observation cells, making suicide threats and psychiatric admissions). In addition, a table of "Attributable fractions" showed those odds ratios where a significant number of the suicides involved the variable studied. This type of analysis allows the development of an actuarial suicide risk screening method. (See Appendix 5).

2. **Qualitative analysis**

This analysis revealed a pattern of widespread problems including shortcomings of both the prison system and individuals, over the period studied (1988 – 2000). The main themes included inadequate attention to risk factors (such as psychiatric problems, substance use and self-harm history) and harshness of penalties. The findings point to the need for better and more frequent staff training in risk assessment and management.

Method of analysing data used in the qualitative analysis described in this appendix

The study involved a review of medical files, internal investigation unit reports, coronial reports, and prisoners' records, along with the extraction of information from the Offender Management System and other data systems. Matched groups were used with qualitative findings from the suicides reviewed. Four researchers read the above information and created a comprehensive vignette on each prisoner. From these vignettes, common 'themes' were identified.

About the working parties

The working parties formed a major part of the Suicide Taskforce. The literature review and data analysis revealed some common threads, and from this, it was apparent that some strategies could be developed and implemented.

In order therefore, to expedite the development and implementation of such strategies three strategic working parties were formed. As prison suicide is multifactorial the membership of the working parties was multi-disciplinary and the function and findings of the working parties sometimes overlapped. The working parties examined current mental health services, operational and environmental factors, and the identification, and management of at-risk prisoners.

The terms of reference for the working parties are summarised as follows:

Working party one - Mental health

The view that suicide prevention is everyone's responsibility and not just a health responsibility was adopted. Prison Officers need training and must come to 'own' the problem of suicide. Increased training is also recommended for all mental health professionals.

This working party was therefore charged with the task of developing proposals, practices and procedures for appropriate Mental Health strategies for the reduction of suicide and self-harm.

Working party two – Operational environment

The higher the degree of *personal* ownership by staff of important prisoner management issues the more effective the decisions and outcomes will be. "Case management" helps in the creation of a 'healthy prison' due to shared responsibility and continuity of care. It is important that prison staff rostering systems are compatible with continuity of care objectives. Continuity of care for prisoners is believed to be of assistance in the prevention of prison suicide.

This working party reviewed the operational environment and developed proposals, practices and procedures to allow for increased staff responsibility for the management of prison issues.

Working party three – Identification and management of at-risk offenders

While there are a number of "markers" which can be associated with suicide, their practical application is difficult for two reasons:

Firstly the interaction of the prisoners with the environment constantly changes, so constant reassessment may be needed.

Secondly, the low rate of suicide generates a large number of false positives. Lester and Danto (1993) pointed out that: "if we had a screening device that predicted suicide with 75% accuracy, in an institution of 1,200 prisoners of whom 4 will commit suicide in the next year, 3 of these 4 will be correctly identified. However, we will also identify 299 of the 1,196 non-suicidal prisoners as suicidal."

This working party looked at the environment in which suicidal prisoners are identified, and how they are managed. It included an examination of the role of ARMS, FCMT, counselling, entry screening as well as behavioural information management within the prison.

The third working party developed proposals, practices and procedures for the identification and management of at-risk prisoners.

Recent changes

Casuarina Prison, Hakea Prison and, since February 2002, Bandyup Women's Prison, each have *Crisis Care Units* to care for prisoners in suicidal crisis.

The Department of Justice has recently implemented a strategy known as the *Integrated Prison Regime.* This entails training and other initiatives aimed at improving the overall functioning of prisons with regard to such matters as prisoner safety, prisoner support, and the development of mutual respect between officers and prisoners. This 'cultural' change process forms a significant part of the Department's implementation of recent prevention initiatives.

As part of the Integrated Prison Regime, Unit Management and Case Management are being implemented across the State.

The opening of Acacia Prison and major reforms to the adult justice system have collectively reduced the high numbers and eliminated overcrowded conditions in the prisons. This has reduced overall pressures and increased opportunities for all prisoners to be engaged in constructive activities.

Other strategies and activities which contribute to prevention of self-harm and suicide include:

- More comprehensive assessments for sentence planning
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- Legislative reforms are being drafted to address short sentencing issues and contribute to the long term reduction in imprisonment rates and over-representation of Aboriginals in WA Prisons and
- An Aboriginal Services Strategic Plan is being implemented in all prisons.
- Forensic Case Management Team (FCMT) name has changed to Prison Counselling Services and will in future report through to Prison management not Health Services.

CHAPTER 2 SELECTIONS FROM LITERATURE REVIEW

Note on recommendations: The report contains 'suggested strategies' in chapters 2-5. These strategies were put to the final meeting of working party participants who considered all of them and developed 12 key recommendations. Thus the 'suggested strategies' from chapters 2-5 do NOT necessarily become part of the final Key Recommendations but should receive further consideration as part of the implementation of these Key Recommendations

A comprehensive literature review was done as part of the suicide taskforce. This chapter discusses the main points from that review. It highlights a number of important issues including the wide variation in methods of data analysis and collection; the need for constant review of the problem of suicide; and its complexity. Suicide requires both a multi-factorial analysis and a multi-disciplinary approach since it involves the whole prison system, rather than one part of it. Traditionally health services is seen as having 'responsibility' for suicide prevention, though, as will be seen later, this is clearly not appropriate.

The literature review also revealed that the systemic factors related to imprisonment itself are as important as, or possibly more important than, individual factors. Whilst individual suicide 'profiles' are unreliable, commonalities amongst prisoners who suicide exist.

Common preventive strategies that emerged from the review centred on the need to develop a concept of the 'healthy prison', better risk monitoring of individuals and shared responsibility. However, the diffusion of responsibility in some cases weakens ownership; therefore an overall "suicide coordinator" is recommended.

Variability of reported Suicide Data

There are many problems in the comparison of data on suicide, because it is reported in different ways in different jurisdictions, and because it is a variable phenomenon.

Between jurisdictions:

- Sociological, cultural, political and economic differences between (and within) jurisdictions impact significantly on the comparability of data.
- Enormous differences exist in the various criminal justice systems, concerning statistical collation and analytical methods and definitions of and approaches to suicide.

Problems of interpretation and variation:

- Motives for suicide can only be deduced from secondary evidence and information gathered after the event.
- The complexity of suicide as a phenomenon renders difficult the isolation of contributing factors.

- Prison suicides are statistically infrequent events and this limits the precision of rate estimates, except in large populations.

- Comparisons of actual numbers of suicides can be misleading. Rates per 100 000 prisoners or persons give comparisons that are more meaningful.

- Remands and maximum-security prisoners are at greater risk of suicide so a prison with a high concentration of prisoners in these security categories will generally have a higher level of suicides.

- Suicides and self-harmers are usually seen as distinct groups in terms of composition and motivation. However, more serious self-harm can be a precursor to suicide attempts.

- Demographics and similarities among prison suicide groups need to be related to those of the general prison population.

Complexity of Suicide

Prison suicide is a complex phenomenon. The following points cannot be overemphasised and should inform the theoretical foundations of any prevention program:

- Suicide has no single trigger and no single solution[5].
- A multi-disciplinary approach is required for effective prevention[6] [7].
- Common profiles of prison suicides must be viewed with caution.
- Psychopathology alone cannot explain incidents of prison suicide. Structural analysis of the prison environment is a critical aetiological factor that must be included in understanding of prison suicide[8].

Suicide rates, methods and demographics - general community and prisons

The rate of suicide in a small prison system.

The 'rate of suicide' is often discussed, but it is important to know the pitfalls of using these 'rate of suicide' figures in our small system.

Suicides (in our system) are actually *rare* events, and in WA prisons they happen at *random*, with no correlation between the timing of successive suicides.[9] What does happen is 'runs' of suicides occur by chance. This gives the appearance of significance and attracts much media attention (in fact the Suicide Taskforce was initiated after one such 'run' of suicides in early 2000. Interestingly the latter half of the same year was almost devoid of suicides)

[5] McHugh. M. "Suicide prevention in prisons: policy and practice" British Journal of Forensic Practice, Vol 2, issue 1, March 2000, pp 12-16.

[6] McHugh. M. "Suicide prevention in prisons: policy and practice" British Journal of Forensic Practice, Vol 2, issue 1, March 2000, pp 12-16.

[7] Schniedman.E.S. p 14, in Diekstra.R.F.W., Plat, Schmidtke, Sonneck & *Brill* "*Suicide and Its Prevention The Role and Attitude and Imitation*", 1989.

[8] Holley and Arboleda-Florez inLeibling, A. "Deaths of Offenders" 1998

[9] Dr Chris Henderson, Director Health Services 2000-2001, studied suicide events using non-parametric statistical analysis and found that the 'runs' of suicides over the past 25 years could be explained by chance. Furthermore there was no systematic relationship between the interval between one suicide and the next.

It is a mistake to use *rare and random* suicide events to draw conclusions about the *rate of suicide*. There is simply not enough data in our small system to make reliable estimates of the true rate.

For example, Table 7 in Appendix 4 shows the yearly 'suicide rate' in WA prisons. The rate ranges from 488 (very high by world standards) to 44 (very low by world standards). Does this mean the prison system suddenly manages to prevent suicide from one year to the next? Of course not – it just means that the calculated 'suicide rate' varies a lot in our system because the system is small and suicides are rare.

Furthermore, taking a 'running average' of our data over several years does not help, since the variability of the yearly data means that this calculated average will be unreliable. It is only in large systems, or over long periods of time, that reliable trends can be observed.

This is not to say we should ignore the 'suicide rate' entirely. However, it does mean that a high or low rate in any one year cannot be used to draw absolute conclusions about the effectiveness or otherwise of the prison system.

Furthermore, comparing so-called 'suicide rates' from a small prison system such as in WA with those in large overseas systems tells us very little – simply because we cannot get numbers which make sense from our small system. It is better to compare the national Australian rate (with many more prisoners and statistically far more reliable data) with other large prison systems.

Rate of suicide in the Australian community.

In the Australian general community, suicide increased by 38% during 1980-1998. There was a disproportionate increase in prison suicide of 75% during the same period.[10].

- Western Australia has a higher rate than the national average[11].
- Male suicide is far higher than female suicide[12].
- In Western Australia between 1986 and 1997, the age standardised suicide rate for Aboriginal males was almost double the rate for males overall[13].
- People who have never married suicide at twice the rate of their married counterparts. However, for divorced or widowed persons the suicide rate is higher – three times the married rate for men, and four times for women[14].
- The most frequent method of suicide used by men between 1979-1998 was firearms. Up until 1996, the most common method used by females was poisoning, but since 1997, it has become hanging. Now hanging is the most common method[15].
- As at 1998, 15% of males and 18% of females who suicided had an associated or contributory diagnosis of a mental health disorder[16].

[10] Dalton.V. "Suicide in prisons 1980 – 1998: national overview" No 126, Trends & Issues in Criminal Justice, August 1999, AIC
[11] Australian Bureau of Statistics, Catalogue number 3309.0., suicides 1921 – 1998.

[12] Australian Bureau of Statistics, Catalogue number 3309.0., suicides 1921 – 1998.
[13] Hillman, Silburn, Zubrick & Nguyen. "Suicide in Western Australia, 1986-1997" Youth Suicide Advisory Committee, Perth, May 2000.
[14] Australian Bureau of Statistics, Catalogue number 3309.0., suicides 1921 – 1998.
[15] Australian Bureau of Statistics, Catalogue number 3309.0., suicides 1921 – 1998.
[16] Australian Bureau of Statistics, Catalogue number 3309.0., suicides 1921 – 1998.

Aboriginal male suicides in the Western Australian community.

Comparisons are with the total number of male suicides:

- Stress arising from legal issues was twice as common.
- Drug use was higher.
- Psychiatric illness in Aboriginal male suicides was far lower (5.7% versus 23.6%).
- Stress related to relationship breakdown was slightly lower.
- Unemployment was twice as common.
- The rate of Aboriginal male suicide in the Kimberley region of Western Australia is among the highest recorded anywhere in Australia.
- Hanging was twice as common[17].

Suicide in prison.

- In Australian prisons during 1980 to 1998, suicide accounted for 47% of total deaths[18].
- Nationwide, Aboriginal suicides accounted for 44% of Aboriginal prison deaths between 1980-1998, during which time they comprised 19% of Australia's prison population and less than 2% of the general population[19]. The Aboriginal suicide rate in Western Australian prisons is significantly less than the non-Aboriginal rate, and significantly less than the national prison Aboriginal suicide rate (see Table 4 and footnote 3).
- In Western Australian prisons between January 1988 and August 2000, suicide was the leading cause of death[20].
- In Western Australian prisons between January 1990 and June 1998, 11% of suicides occurred in regional prisons, where 40% of the total prisoner population was located[21].
- In Australian prisons during 1980 to 1998, the majority (94%) of suicides was by hanging[22].
- There is no difference in the suicide rate between publicly and privately run Australian prisons[23].

[17] Hillman, Silburn, Zubrick & Nguyen. "Suicide in Western Australia, 1986-1997" Youth Suicide Advisory Committee, Perth, May 2000.
[18] Dalton.V. "Suicide in prisons 1980 – 1998: national overview" No 126, Trends & Issues in Criminal Justice, August 1999, AIC
[19] Dalton.V. "Australian deaths in custody: 1980-1998" (conference paper) AIC, March 1999.

[20] Dear & Allan, 1998.
[21] Ibid.
[22] Dalton.V. "Suicide in prisons 1980 – 1998: national overview" No 126, Trends & Issues in Criminal Justice, August 1999, AIC
[23] Biles.D. & Dalton .V. "Deaths in private prisons 1990-1999: a comparative study" No 120, Trends & Issues in Crime & Criminal Justice, June 1999, AIC.

The demographics of prison suicides

Taken from figures relating to Australia during 1980-1998 reveal that[24]:

- 96% of the suicides were male;
- 14% of prison suicides were Aboriginal;
- the mean age of suicides was 29 years;
- the most likely day of the week for suicides to occur is Sunday;
- most suicides occur in the months of November and January;
- The time of the suicides were spread fairly evenly over the 24 hour period;
- 25% occurred within the first week of imprisonment;
- 85% of suicides occurred in prison cells;
- 48% of all suicides were on remand at the time of their death; and
- the mean amount of time spent in prison before prisoners committed suicide was 15 months.

Profiles

Three distinct types of prison suicide are identified by Leibling et al[25]. These types are the:

- poor copers/situational;
- long sentence prisoners (eg. intimate homicide or sex offenders); and
- mentally disordered.

(See also Appendix 4 (Table 1)).

Some common findings

Taken from research in various jurisdictions.

- The average age of suicides is between 29 and 32 years.
- Most suicides occur in maximum-security facilities.

[24] Dalton.V. "Suicide in prison 1980-1998:national overview" No 126, Trends & Issues in Criminal Justice, August 1999, AIC.

[25] Liebling, A., Krarup, H. (1993), Suicide attempts and self-injury in male prisons. HMSO, London

- 42% - 79% of prison suicides were on remand at the time of their death.
- There was a mental health disorder diagnosed in 25% - 33% of prison suicides.
- Most prison suicides had previous custodial experience.
- Most prisoners commit suicide by hanging.
- There is a higher likelihood of suicides occurring on weekends or during night time lockdown.

Strategies suggested by these findings

1. *Minimise the number of prisoners given a maximum-security rating, and minimise the placement of medium or minimum-security prisoners in maximum-security institutions.*
2. *Minimise the number and size of maximum-security prisons.*
3. *Focus on a prisoner's first 24 hours in imprisonment.*
4. *Undertake an analysis of jurisdiction-specific prison suicides, suicide attempts and self-harm incidents.*
5. *Construction of a suicide risk assessment system based on each jurisdiction's own empirical data with practical recognition of the inherent limitations of such a system.*

Women prisoners and suicide

Liebling (1994) and Dooley (1990) debunk one of the most common myths about prison suicide - that women are less likely to commit suicide in prison than men. They suggest that the suicide risk profiles on which most prevention practice in United Kingdom prisons is based is seriously flawed.[26]

Ramsay (1987) observed that females in Canadian prisons are more likely to engage in self - destructive behaviour such as slashing and head banging and suggested women should not be considered a low suicide risk[27].

Strategies suggested by these findings

6. *Women should not be considered a low suicide risk.*
7. *Review incidents and attempts of prison suicide and self-harm carried out by women.*
8. *Review current prevention practices for gender blindness.*

[26] Liebling.A. "Suicide among women prisoners" The Howard Journal, vol 33, no 1, February 1994.

[27] Ramsay.R. "Suicide prevention in high risk populations" Canadian Journal of Criminology, July vol 29 (3).

Prison Suicide - Causes, Contributors and Predictors

No single cause of suicide

Despite the vast body of knowledge about suicide, there is no conclusive evidence for a single cause[28] and it seems unlikely that a clear-cut solution for its prevention will be found. It is, therefore, prudent to speak of 'contributors' and 'predictors' rather than 'causes' with respect to suicide.

Self-destructive behaviour in prisons cannot be explained solely in terms of psychopathology, and the social structure of prisons may also be a critical aetiological factor[29].

Traits of Prison Populations

- There are certain traits, which seem to contribute to the incidence of prison suicide. Prisoners are more likely to have experienced:
- family disruption;
- divorce;
- childhood physical and sexual abuse
- school and vocational failure
- organic brain disorders
- substance abuse
- poor impulse control[30].

Prison Environment

Whilst it is inherently difficult to infer motives from prison suicides, a number of studies have found that stresses associated with the institution itself were the main contributors to the act of suicide in prisons[31] [32]. Such institutional stresses include:

- prison regime, punitive responses and length of sentence[33];

[28] McArthur, Camilleri, & Webb "Strategies for managing suicide and self-harm in prisons" No 125, Trends in Crime & Criminal Justice, August 1999.
[29] Holley and Arboleda-Florez inLeibling, A. "Deaths of Offenders" 1998
[30] Howells. K., Hall.G., Day. Andrew. "*The Management of Suicide and Self-harm in Prisons: Recommendations for Good Practice*" Australian Psychologist, November 1999, Vol 34, pp 157 –165.

[31] Lariviere.M. & Polvi.N. "*The Correctional Services of Canada 1996-97 Retrospective report on Inmate Suicides: Prisoner Suicide a Review of the Literature*".

[32] Dooley.E. "Prison suicide in England & Wales 1972 –1987" British Journal of Psychiatry, 1990, p 40-45.
[33] Dooley.E. "Prison suicide in England & Wales 1972 –1987" British Journal of Psychiatry, 1990, p 40-45.

- prison environment not allowing the expression of despair[34];
- over 'medicalising' the problem of suicide, leading to hospitalisation and segregation[35];
- feelings of depression and despair due to various events such as: relationship breakdowns, lack of communication, fear and uncertainty, guilt relating to the offences, receipt of bad news, inability to cope with confinement and finding aspects of imprisonment intolerable[36];
- bad news from home, or the non-arrival of a visitor[37];
- loss of corporeal control and self-determination[38] [39] [40]
- boredom and inactivity[41] [42] [43].

Strategies suggested by these findings

9. Minimise inactivity and boredom.

10. Constructive activity management plan for remandees.

11. Improve opportunities for positive group interaction among prisoners (assists in the creation of an environment more conducive to the display of despair).

12. Maximise prisoner interaction with the outside world, especially in relation to communication with significant others.

13. Location of prison facilities, which make visits easy.

14. Normalise the prison environment.

15. Minimise the use of medical observation cells.

16. Allow some measure of personal control, for example, dress and tattooing.

[34] Liebling.A. "Suicide among women prisoners" The Howard Journal, Vol 33, No 1, February 1994
[35] Liebling.A. "Suicide among women prisoners" The Howard Journal, Vol 33, No 1, February 1994

[36] Liebling.A. "Suicide among women prisoners" The Howard Journal, Vol 33, No 1, February 199
[37] Wool & Dooley, "Attempted suicides in prison" 1987, Journal of Medicine, Science and the Law, vol 27, no 4.

[38] Winkler. G. "Assessing and responding to suicidal jail inmates" Community mental health journal, vol 28, No 4, August 1992.

[39] Holley and Arboleda-Florez in Leibling, A. "Deaths of Offenders" 1998
[40] Gallo and Ruggiero in Leibling, A. "Deaths of Offenders" 1998
[41] Morrison.S. "Custodial suicide in Australia: a comparative study of different populations" Medicine, Science & The Law, 1996, vol 36. No 2.

[42] Rowan. Joseph. "*Suicide Prevention: Debunking the Experts: Potential Suicides Can Be Identified*." American Jails, November/December 1994.

[43] Wool & Dooley, "Attempted suicides in prison" 1987, Journal of Medicine, Science and the Law, vol 27, no 4.

The "Traits and State" effect.

The personality and the prison environment together create a so-called 'traits and state' effect which may exceed an individual's tolerance threshold and result in suicide or self-harm. When a prisoner becomes ill equipped to handle the common stresses of prison, they reach emotional breaking point. The result can be varying degrees of suicidal ideation, contemplation, attempt or completion[44]. This process is varies with each individual and with each situation.

The success of efforts to prevent suicide in prisons depends on the ability and willingness to identify the vulnerability of each prisoner, provide the necessary supervision and support, and offer alternative ways of coping and reducing emotional distress. 'Stressors' differ according to personality types, gender, ethnicity, race, sexual preference and religious beliefs[45]. Thus at-risk screening/assessment systems cannot be relied upon as the main or sole means of preventing suicides in prisons, and it must be balanced by a knowledge of the stressful factors in the prisoners environment.

Strategies suggested by these findings

- Maximise coping tools available to prisoners.
- Comprehensive implementation of case management and devolved prisoner management.
- Continual suicide risk assessment of all prisoners as an inherent part of daily operations (facilitated by case management and continuity of care).
- Comprehensive orientation program for prisoners.
- Training for all staff on prison suicide, with refresher or advanced courses.

Mental Disorders/Psychiatric Illness or Treatment

The literature reveals great variation in the prevalence of mental illness reported in adult correctional systems, ranging from 1% to 77%. This is due largely to the variation in the definition of mental illness[46].

As a guide to the findings in the Western Australian prison system, a survey of prisoners on 23 February 2000 identified 300 prisoners at that time who were "*receiving medication or other treatment for psychiatric disorders*." This figure represented 10% of the total muster on that day.[47]

[44] Bonner in McArthur. M., Camilleri.P. & Webb.H. "Strategies for managing suicide and self-harm in prisons" No 125, Trends in Crime and Criminal Justice, August 1999.
[45] Morrison.S. "Custodial suicide in Australia: a comparative study of different populations" Medicine, Science & The Law, 1996, vol 36. No 2.
[46] Swetz, A., et al. The prevalence of Mental illness in a state correctional institution for men, 8 Journal of prison & Jail Health (1989) pp3-15 In Tomasevski, K. (1992). Prison Health: International standards and national practices in Europe. Helsinki Institute for Crime prevention and Control

[47] Cant, R., Downie, R., Mulholland, T. April 2000 Cohort Analysis of The Custodial Population for the Ministry of Justice p 27

Common findings regarding mental illness and suicide are:

- Prison suicide or self-harm does not automatically indicate impaired functioning or mental disorder[48].

- Most cases where suicide has been related to depression in the USA show exogenous (situational) and not endogenous depression[49].

- One of the major differences between suicides in prison and in the general community is that over 90% of suicides in the general community are found to have a history of psychiatric illness or treatment[50]. By contrast only about a third of prison suicides have a psychiatric history[51].

- There is general agreement that suicide rates are particularly high among prisoners with a psychiatric illness associated with drug or alcohol dependence.

Harding (1990) suggests that properly resourced and managed drug detoxification programs may help prevent suicide. He draws an important distinction between forced withdrawal and structured detoxification. He notes that instances of para-suicide seem to increase after an influx of drugs into prisons.[52]

Strategies suggested by these findings

17. Mental health training for prison officers, including refresher or advanced courses.

18. Improvement and expansion of mental health service provision in gaol.

19. Freely available, appropriately resourced drug rehabilitation programs in all prisons.

20. Listener schemes and prisoner access to counselling, welfare, and psychological and psychiatric services (both in person and by telephone or other means).

21. Quality medical care.

Aboriginal prisoners

The Report of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) (1991) warns that the use of non-Aboriginal approaches in examining Aboriginal mental health may have problems. Whilst conventional psychiatry may be a "value neutral science'; like other disciplines, it possesses ethnocentric bias toward the dominant (majority) culture which limits the understanding of mental illness in indigenous populations[53]. The incorporation of cross-cultural perspective may reduce this bias.

[48] Liebling.A. "Suicide among women prisoners" The Howard Journal, Vol 33, No 1, February 199
[49] Rowan. Joseph. "*Suicide Prevention: Debunking the Experts: Potential Suicides Can Be Identified*." American Jails, November/December 1994.

[50] It should be noted that not every person who receives psychiatric treatment necessarily has a mental disorder, as people may receive treatment and it may be subsequently found that the person has no mental disorder and/or may receive treatment (ie a one off appointment) as part of a routine process.

[51] Dooley and Backett in Liebling.A. "Suicide among women prisoners" The Howard Journal, Vol 33, No 1, February 1994.
[52] Harding.R. Review of suicide and suicide attempts by prisoners in the custody of the Office of Corrections, Victoria", June 1990, p 23.

[53] RCIADIC, Volume 3, (Chapter 23.3.14-15) National Report by Commissioner Elliott Johnston QC

The RCIADIC concluded that Aboriginal deaths in custody occur due to the interaction of various factors. Some factors concerned with the individuals themselves some concerned with the custodial experience and some concerned with the way in which custodians exercise their duty of care[54].

The act of self-destruction does not necessarily imply an underlying mental disorder. Most of the deaths in custody studied by the RCIADIC were attributable to acute situational factors. The interaction of a set of complicated factors significantly increases the likelihood of self-inflicted deaths and injury. Clinical depression is not a necessary precursor to self-inflicted injury or death. The combination of alcohol and social isolation can be devastating for Aboriginal people in a custodial setting.

Precipitating factors in Aboriginal prisoners

- intoxication, including alcohol withdrawal
- anger, aggression and emotional stress
- mental disorder
- previous attempts or threats to commit self-harm
- age and gender (younger adult males appear to be most vulnerable)
- time (many occur within the first few hours or days of admission)
- method of self-harm – hanging
- situational factors such as family disagreements and isolation custody
- either no outward signs of depression, or not depressed at all first time prisoners and remand prisoners.[55]

Strategies suggested by these findings

22. Intoxication screening for all prisoners on reception.

23. Intensive supervision of intoxicated prisoners or prisoners in withdrawal, especially Aboriginal prisoners.

24. Cultural awareness and special needs training for all prison staff, with appropriately adapted management and treatment approaches.

25. Training for staff on alcoholism, drug withdrawal and intoxication assessment.

[54] *RCIADIC, Volume 3, (Chapters 23-25) National Report by Commissioner Elliott Johnston QC*

[55] *RCIADIC, Volume 3, (Chapters 23-25) National Report by Commissioner Elliott Johnston QC*

Female prisoners

The effects of custody upon women are part of the dynamics of female prison suicide and include:

- separation from dependent children or other equivalent family ties;
- loss of tenancies;
- children being taken into care;
- sexist and racist practices; and
- Closer surveillance and control by drugs[56].

Leibling suggests that, for male prisoners aspects of the prison environment such as boredom, bullying and debts may contribute disproportionately to suicidal thoughts. However, for women it may be that imprisonment itself has such dramatic effects on their outside relationships that 'regime features are less directly relevant to the development of suicidal impulses'[57]. Thus, prison solutions need to be augmented by measures which reduce the stress placed on women prisoners' outside relationships.

Strategies suggested by these findings

26. Access to outside agencies.

27. Better managed and more frequent visits.

28. More convenient prison locations in terms of public transport access.

29. Localities close to family members.

30. Qualitative analysis of women's experiences in prison, including self-harm and attempted suicide.

Self-harm and suicide attempts

It has been estimated that for every prison suicide there are 60 incidences of self-harm[58]. However, the self-inflicted physical damage does not correlate with the strength of suicidal intent, nor in with the likelihood of a repeated suicide attempt[59].

The consensus among authors such as Ivanoff, Haycock, Hayes, Toch, Zamble and Pororino is that self-harm reflects a breakdown resulting from crises of hopelessness, fear, self doubt or abandonment. Prisoners are deprived of freedom which in turn denies them access to coping mechanisms that would be used in the community.

[56] ibid
[57] Liebling.A. "Suicide amongst women prisoners" The Howard Journal, vol 33, No 1, February 1994 pp4-5.
[58] McArthur, Camilleri, & Webb "Strategies for managing suicide and self-harm in prisons" No 125, Trends in Crime & Criminal Justice, August 1999.

[59] McArthur, Camilleri, & Webb "Strategies for managing suicide and self-harm in prisons" No 125, Trends in Crime & Criminal Justice, August 1999.

Additional prison stresses, such as noise, lack of autonomy, lack of privacy, harassment, violence, and threats to safety, serves to further tax already limited coping abilities. When stress cannot be reduced, a person may respond in more unusual and desperate ways. Some may ask for help, while others may lash out at others or themselves resulting in self-harm[60].

Dooley (1990) found that 43% of suicides had a previous history of self-harm and 29% had a history of alcohol abuse. Dooley recommends that a history of suicide attempts should be recorded (and where possible investigated) as a matter of routine.[61] Dear and Allan in a study for the West Australian Department of Justice in 1998 found that prisoners most likely to suicide were those on remand with a history of self-harm[62].

The Chief Inspector of Prisons (UK) makes a series of recommendations relating to self-harm. These are as follows:

- All self-harmers should be interviewed within 24 hours of each incident to attempt to find the cause and decide on the best management approach.

- More in depth, qualitative analysis must be done on what triggers suicides and self-harm in custody.

- A thorough reporting, investigative and analytical system is recommended to be a part of every effective suicide prevention system.

- Self-harm signals acute distress, and group work for self-harmers to talk about their self-harm impulses may be an effective way of controlling the behaviour and allowing more adaptive coping mechanisms to develop[63].

Strategies suggested by these findings

31. Past history of suicide attempts to be recorded (and where possible investigated) as a matter of routine.

32. All self-harmers to be interviewed within 24 hours of each incident to attempt to find the cause and decide on the best management approach.

33. Group work for self-harmers to talk about their impulses and encourage the development of more adaptive coping mechanisms.

34. More in depth qualitative analysis to be done on what triggers suicides and self-harm in custody.

35. Development of a thorough reporting, investigative and analytical system as part of a suicide prevention system.

[60] Ivanoff, Andre. (Columbia University) "Background Risk Factors Associated with Self-harm Among Male Prison Inmates" Criminal Justice & Behaviour, Vol 19, No 4, December 1992 426-436.

[61] Dooley.E. "Prison suicide in England & Wales 1972-1987" British Journal of Psychiatry, 1990, 40-45.
[62] Dear.G. and Allan.M. "Analysis of self inflicted deaths in WA prisons between January 1980 – June 1998" September 1998, Report commissioned by WA Department of Justice.
[63] "Suicide is everyones' concern: a thematic review by Her Majesty's Chief Inspector of Prisons." 1999.

Prison suicide prevention approaches

Ethics of suicide prevention

To what extent is an individual prisoner entitled to end his/her own life and what are the associated ethics of suicide prevention strategies? There is a balance between the exercise of the duty of care to prisoners and the preservation of individuality, responsibility and freedoms.[64]

The following should be borne in mind:

- The *Western Australian Criminal Code* does not make the act of suicide or an attempt to commit suicide a crime.
- Prisoners retain the right to accept or refuse medical treatment (assuming mental competence).
- The duty of care owed by prison services requires intervention in a suicide attempt should this extend to subjecting a mentally competent person to measures which may be perceived as degrading and/or humiliating to prevent suicide at any cost.

What is certain is that the duty of care owed by prison services requires that the prison environment not be such that it 'drives' prisoners to commit suicide. It appears from the literature that the discharge of the appropriate duty of care by prison services is not limited to preventing prisoners committing suicide. Duty of care extends to the creation and maintenance of a prison environment, which prevents suicidal ideation. This is the essence of the concept of a 'healthy prison' referred to by the Chief Inspector of Prisons in the UK[65].

Strategies suggested by these findings

36. Further research into the ethical parameters of suicide prevention to inform the policy framework of any prevention program.

37. Custodial imperatives to carry less weight in decision making processes while health, well being, rehabilitation and prisoner self-determination to carry greater weight.

Prevention programs

It is clear that any proposed piecemeal solution to the problem of suicide in prison will not achieve long-term improvement. An effective prevention program must accept the dynamic nature of suicide and, consequently, strive for continuous improvement through ongoing review and vigilance. It should act both at:

(a) The global level across the whole organisation.

(b) An individual level, allowing for identification of individual prisoners at-risk[66].

[64] McHugh. M. "Suicide prevention in prisons: policy and practice" The British Journal of Forensic Practice, Vol 2 Issue 1, March 2000, pp 12-16.

[65] Ethical issues related to suicide prevention in prisons have been presented at a conceptual level, with some unavoidable references to associated legalities, however in no way is this a complete analysis of all of the associated legal issues, and nor was it intended to be.

[66] McHugh. M. "Suicide prevention in prisons: policy and practice" The British Journal of Forensic Practice, Vol 2 Issue 1, March 2000, pp 12-16.

Strategy suggested by these findings

38. Establish a suicide prevention office within the Department of Justice. This will research, evaluate and analyse, and maintain diligence within the prison system. It will be a focus for the system-wide ownership of suicide prevention strategies.

Global suicide prevention

Increasing imprisonment rates in Australia and other countries over the last 20 years has meant that the actual number of prison suicides has increased. However, in addition to this, the rate of prison suicides has increased greater than expected solely by the rise in the prison population in Australia.

Reducing rates of imprisonment and using imprisonment alternatives wherever possible represents a global prison suicide prevention strategy. It is likely that the smaller the prison population, the less the rate of suicides (if stress is related to overcrowding).

Agomoh (1998) agrees that this is the logical starting point from which to tackle reducing the amount of deaths in prisons and alternatives to imprisonment must be more fully explored.[67] This was strongly argued in the Report of the RCIADIC (1991), which said that the ultimate answer to reducing Aboriginal deaths in custody was to reduce the number of Aboriginal people held in custody. The interim report of the Muirhead RCIADIC (1989) also argues that minimising people's contact with the prison system is essential in order to minimise the harm done to individuals because of their contact with the prison system.

Strategies suggested by these findings

39. Reduction in the use of imprisonment.

40. Research on the public returns of imprisonment.

41. Widespread dissemination of information on prison suicide and deaths in custody to increase public understanding.

42. Critical review of the bail system and reduction in trial delays to reduce the number of people on remand and the length of time spent on remand (remands have the highest suicide rate).

The concept of 'healthy' prisons

The Chief Inspector Prisons (UK) undertook a detailed review of the issue of prison suicides, the product of which was a report published in 1999 titled "*Suicide is Everyone's' Concern: A Thematic Review*." In essence, this report concluded that prison suicides and suicidal behaviour is not just a function of individuals' vulnerability and circumstances, but is also influenced by the quality of the prison regimes and staff responses – or the overall 'health' of the prison or prison system.

[67] In Liebling.A. "Deaths of Offenders" 1998.

The report announced that UK prisons will be reviewed based on the extent to which they are 'healthy prisons', as this is seen as central to suicide prevention and rehabilitation. Tests for 'healthy prisons' include:

- the weakest prisoners feel safe;
- all prisoners treated with respect as individuals;
- all prisoners busily occupied and expected to improve their skills and abilities; and
- all prisoners can strengthen links with their families and prepare for release themselves and are given the opportunity to do so.

The report notes that it is not enough that prison staff are simply available, but rather they must be pro-active about engaging with prisoners. Accordingly, staff arrangements must be based on providing continuity of care to prisoners. Unfortunately, staff rosters and shift arrangements frequently fail to meet this basic requirement.

The Chief Inspector Prisons (UK) has also formulated tests for the health of prisons in relation to *prison staff* and these include:

- staff feeling safe;
- staff treated with respect as individuals;
- staff informed and consulted within their sphere of work;
- high expectations of staff;
- staff are well led; and
- Staff respect their own health.

Some of the systemic changes that need to be effected to secure a healthy prison include:

- the emphasis of general measures designed to reduce stress and promote coping mechanisms, rather than concentrate on the recognition of the suicidal behaviour[68];
- direct efforts towards reducing stresses and increasing coping mechanisms in the prison environment, rather than dealing with the issue in terms of some kind of illnesses[69]
- changes in internal cultures and management - a properly managed and motivated service will deliver a high standard despite resource constraints and administrative barriers. This depends on appropriate behaviours being modelled by its leaders[70];
- changing the physical and social environments of prisons and offering opportunities for staff development and training[71];

- reducing the social isolation, segregation and boredom of prisoners, as these factors undermine coping mechanisms[72];

- civilising the system through case management, the modelling of appropriate behaviour by staff, defining the prison officer role in broader terms than custody and security, and engaging prison officers in the treatment and rehabilitation of prisoners[73];

- improving communication between prison staff , especially between correctional and mental health administrators.[74]

- Improving communication between staff and prisoners[75] [76]; and

- increasing opportunities for prisoners to communicate and interact with the outside world, including free access to Samaritan services, visiting welfare groups, with remand prisoners in particular having virtually free access to outside telephones[77].

Strategies suggested by these findings

43. Maximisation of continuity of care (including the minimisation of transfers) and optimal staff allocation including staff rosters and position duties.

44. Increased and improved interaction between staff and prisoners.

45. Improved flow of information among prison staff and with other organisations and groups relevant to suicide prevention.

46. Increased communication between prisoners and the community.

Prisoner accommodation

The literature is divided on the issue of 'double-bunking' as an at-risk management tool. On the one hand, it is said to place intolerable pressure on another prisoner who has an implied duty of care towards his/her cellmate[78]. On the other hand, the isolation of prisoners is said to increase their level of risk[79].

[68] Backett.S.A. "Suicide in Scottish Prisons" British Journal of Psychiatry (1987) 151, 218-221.

[69] Backett.S.A. "Suicide in Scottish Prisons" British Journal of Psychiatry (1987) 151, 218-221.

[70] Edwards and Edwards in Liebling, A. "Deaths of Offenders', 1998.
[71] Howells, Hall & Day. "The management of suicide and self-harm in prisons; recommendations for good practice" Australian Psychologist, November 1999, p 157 –165.
[72] Howells, Hall & Day. "The management of suicide and self-harm in prisons; recommendations for good practice" Australian Psychologist, November 1999, p 157 –165.
[73] Howells, Hall & Day. "The management of suicide and self-harm in prisons; recommendations for good practice" Australian Psychologist, November 1999, p 157 –165.
[74] Winkler G: "Assessing and responding to suicidal jail inmates" Community mental health journal vol 28 No 4, August 1992.
[75] Howells, Hall & Day. "The management of suicide and self-harm in prisons; recommendations for good practice" Australian Psychologist, November 1999, p 157 –165.

[76] Liebling, A., Krarup, H. Suicide attempts and self-injury in male prisons. HMSO 1993
[77] In Liebling .A. & Ward.T. "Deaths in custody:an international perspective" London, Whiting & Birch, 1994.
[78] Harding, R. "Review of suicide and suicide attempts by prisoners in the custody of the Office of Corrections, Victoria", June 1990.
[79] Winkler, G. "Assessing and responding to suicidal hail inmates" Community Mental Health Hournal, vol 28, no 4, August 1992.

The Law Society of New South Wales Human Rights of Prisoners Task Force is opposed to share cell accommodation for prisoners due to the possibility of bullying and sexual assault. It recommends the following policies are implemented in the prison system:

- Separation of non-violent first time prisoners aged less than 25 years.
- Rating and segregation of other at-risk groups.
- Orientation kits for those entering prison.
- Training of staff.
- Survivor counselling.
- Outreach services by rape crisis centres.
- Condoms, protective pairing and permitted homosexual activities.
- More research into sexual assault in prisons.
- Easier access for at-risk prisoners to have protective custody.[80]

In 1999 the New South Wales Minister for Corrective Services announced that the following measures had been taken in New South Wales prisons in relation to the minimisation of sexual assault and bullying in prisons:

- A young prisoners program operates at Parklea and Oberon Correctional Centres with a small number of carefully selected older prisoners as mentors.
- Single occupancy cells and in-cell showers are incorporated in the design of all new gaols, with some shared cells as specifically recommended by the Report of the RCIADIC.
- Prison officers are informed when in training on duty of care considerations and the responsibilities of officers to prisoners.[81]

Strategies suggested by these findings

47. Compatible, appropriate and balanced prisoner cell allocation.

48. CPR training for all prisoners.

Individual level - at-risk screening/assessment procedures

It is evident from the most recent literature, that whilst important, at-risk screening procedures have inherent limitations and cannot be relied on alone. They must be only a part of an effective self-harm and suicide prevention system.

The limitations of at-risk assessment systems outlined in the literature are as follows:

[80] Law Society of New South Wales Journal September 1999, 37 (8) LSJ 56.
[81] Law Society of New South Wales Journal September 1999, 37 (8) LSJ 56.

- Ineffectiveness: In recent years, of those prisoners who committed suicide in UK prisons, only 30% (at the time of their death) were assessed as being at-risk[82].

- Divergence: Imprisonment does not affect all prisoners equally with regard to self-harm and suicide,[83] In order to maximise the effectiveness of at-risk assessment systems, divergent characteristics must be identified.

- False positives: Most psychological screening instruments produce large numbers of false positives. Low frequency events such as prison suicide make the number of false positives unmanageably large[84].

- Endogenous versus exogenous contributions: Screening should not emphasise individual prisoner's problems at the expense of custodial practices and approaches. Prisons are more the problem rather than the individual characteristics of the individuals who occupy them[85].

- As at-risk assessment and management involves changing the 'trait and state' factors there must be on going assessment and support throughout a prisoner's sentence[86].

- At-risk screening procedures are unlikely to assist unless adequate staff resources exist to monitor and support prisoners on an on-going basis, especially at the time of the acute stress[87].

Medical and psychiatric approaches

Medical and psychiatric expertise has an important role to play in self-harm and suicide prevention in prisons. However, many argue that too much emphasis is placed on medical and psychiatric intervention as a major strategy.[88]

Boldt comments that 'the view of suicide as a "mental illness" has contributed much to our understanding of the psychodynamic factors underlying suicide. However, the framework of mental illness has at least three serious drawbacks for suicide prevention[89].

These are:

- Imposition of a severe social stigma on suicidal behaviour. This has the effect of deterring the suicidal person and his or her family from seeking help from both professionals and relatives and friends;

[82] McHugh. M. "Suicide prevention in prisons: policy and practice" The British Journal of Forensic Practice, Vol 2 Issue 1, March 2000, pp 12-16.

[83] Haycock.J. "Comparative suicide rates in different types of involuntary confinement" Journal of Medicine, Science and the Law" 1993, vol 33, no 2.

[84] Howells, Hall & Day "The management of suicide and self-harm in prisons: recommendations for good practice" Australian Psychologist, November 1999, vol 34, p 157-165

[85] Harding.R. "Prisons are the problem: A Re-examination of Aboriginal and Non-Aboriginal Deaths in Custody" Australian & New Zealand Journal of Criminology Vol 32, No 2, 1999, p 108-123.

[86] Howells, Hall & Day "The management of suicide and self-harm in prisons: recommendations for good practice" Australian Psychologist, November 1999, vol 34, p 157-165.

[87] Dooley.E. "Prison suicide in England and Wales 1972 – 1987" British Journal of Psychiatry, 1990, 40-45.

[88] Liebling.A. "Suicide amongst women prisoners" The Howard Journal, vol 33, No 1, February 1994.

[89] M. Boldt, Defining Suicide: Implications for Suicidal Behaviour and for Suicide prevention. In Suicide and its Prevention, The Role and Attitude and Imitation. Eds Diekstra, R.F.W., Maris, M., Platt, S., Schmidtke, A., Sonneck, G. E. J Brill Netherlands (1989) pp 5-13.

- Implication that suicide is largely the product of internal psychological forces, causing focus on individual pathology while neglecting the interaction between individual and society. The focus then becomes the individuals psychological pain and their ability to cope rather than the need to change the environmental realities that cause the pain; and

- hindrance of suicide prevention by defining suicidal behaviour as a problem for mental health professionals[90].

Winkler notes that depending on the history of at-risk prisoners, medication may be an appropriate response and argues that suicidal or self-abusive prisoners who cannot be safely managed in the prison population should be admitted to a psychiatric hospital[91].

Material factors - medical observation cells, surveillance and hanging points

The use of medical observation cells is widely condemned in the literature as degrading and anti-therapeutic for suicidal patients[92] [93], whilst being tolerated by some as a necessary management tool for highly disturbed individuals who are a danger to others[94]. Harding points out that the co-location of medical observation cells with punishment cells can lead to misunderstandings and incorrect impressions about the use of medical observation cells[95].

RCIADIC concludes that the use of electronic surveillance equipment in custodial settings should only be used as a monitoring aid and never as a substitute for human interaction between custodial staff and prisoners.

A working party on deaths in custody in the UK (1996) recommended that close circuit television systems be introduced into all prisoner transport vans and vehicles.[96] The point is made that not only will this allow closer observation of prisoners, it will also provide a useful mechanism in circumstances where misconduct is alleged.

Strategies suggested by these findings

49. Medical observation and punishment cells should not be co-located.

50. Maximise privacy in prisoner accommodation.

51. Research into incidence of suicide in prison and/or police transport vehicles.

52. Minimisation of hanging points.

[90] Ibid
[91] Winkler. G. "Assessing and responding to suicidal jail inmates" Community mental health journal, vol 28, No 4, August 1992.

[92] HM Inspectorate of Prisons for England and Wales. Suicide is Everyone's Concern A Thematic Review, May 1999
[93] Bell.D. "Issues in the prevention of suicide in prison: a submission prepared for the review of suicide and self-harm to the correctional services task force, department of Justice, Victoria" September 1998.

[94] Wool, R., Ilbert,R. (1994). Prison suicides: Theory and practice. P42. In Liebling, A., Ward, T. (1994) Deaths in Custody: International perspectives. Whitney & Birch: London

[95] Harding.R. Review of suicide and suicide attempts by prisoners in the custody of the Office of Corrections, Victoria", June 1990.
[96] Liebling.A."Deaths of Offenders" 1998.

A note on hanging points: The minimisation of hanging points is often stressed, but it is really only a short-term solution, as their removal is likely to be replaced with another common method of suicide[97].

In addition, hanging point removal may prevent highly impulsive suicides, but will not affect the overall suicide problem because it intervenes too late in the progress toward suicide. It is evident from the literature that truly effective suicide prevention strategies prevent the stressors and the suicidal ideation from forming. This is the real issue to be tackled by policy makers.

Other reports

Any suicide prevention program developed by the Department of Justice should pay due regard to the recommendations contained in the following reports:

- Report of the RCIADIC (1991) - see Appendix 1
- The Vincent Committee Report (1988) – see Appendix 2
- The Kirby Report (1998)
- Report by the Western Australian Ombudsman on an Inquiry into Deaths in Prison in Western Australia: December 2000 – see Appendix 3 for more detail including a summary of the recommendations.

  In February 1998 the former Ombudsman of Western Australia commenced an 'own motion' investigation into deaths in prisons in this State (including deaths by natural causes) because of his – and public – concern about an increase in the number of prison deaths in 1997 which looked likely to continue following the suicide of five prisoners in the first six weeks of 1998. The in-depth investigation examined the 47 prisoner suicides between January 1991 and 30 June 2000 (plus a number of deaths by natural causes in the same period) and made more than 100 recommendations on all aspects of prison life. The circumstances of each death were examined in order to identify systemic deficiencies or stress factors which might increase a prisoner's vulnerability and lead to self harm or suicide.

  The Report of the Inquiry was not available publicly when the Taskforce completed its literature review. However, one of the authors of the Report is a member of the Taskforce and was able to provide comment on the results of the research conducted during the inquiry following its tabling in Parliament in December 2000.

Conclusion

Prison suicide is a complex and dynamic phenomenon and approaches to its prevention should be multi-disciplinary, fluid, responsive, holistic and jurisdiction-specific. Prison suicide prevention programs need to be systemic but should be owned, supported and driven by prisoners, prison staff, prison services leadership and the general community.

[97] Isometsa.E. "Suicide" Current Opinion in Psychiatry 2000, 13, 143-147.

CHAPTER 3 ANALYSIS OF SUICIDE IN CUSTODY

Note on recommendations: The report contains 'suggested strategies' in chapters 2-5. These strategies were put to the final meeting of working party participants who considered all of them and developed 12 key recommendations. Thus the 'suggested strategies' from chapters 2-5 do NOT necessarily become part of the final Key Recommendations but should receive further consideration as part of the implementation of these Key Recommendations

Introduction

Over recent years, the Department of Justice has implemented several initiatives to address suicide in prisons. These include the *ARMS*, *Crisis Care Units* (CCU), and the formation of the *Forensic Case Management Team* (FCMT). The FCMT includes a wide range of health service professionals such as forensic psychologists, mental health nurses and occupational therapists. These initiatives were introduced to assist in accurate and timely identification of at-risk prisoners and the provision of appropriate support.

This chapter is an examination of the effect of introducing these initiatives.

As part of this Suicide Taskforce, the Department of Justice analysed all 51 suicides in custody, January 1990 – June 2000, along with a similar number of prisoners matched in terms of demographic and custodial variables. Quantitative and qualitative analyses were undertaken.

Quantitative analysis indicated significant differences between suicides and prisoners in the matched group. Early family dislocation, community self-harm, death/relationship breakdown of significant other during current imprisonment, distressing communication in current imprisonment, and bullying were identified as significant factors.

Qualitative analysis revealed themes that need to be addressed: systems, communication, punishment and operational issues.

Quantitative analysis

Basic data used in quantitative analyses

A standardised data form examining 177 variables was developed using the earlier work of Dear, Thomson, Hall and Howells (1998) who reviewed suicides in WA prisons in 1998. As well as identifying systemic factors associated with increased risk of suicide and self-harm, the data collected included demographic, historical, social and forensic factors thought to be associated with suicide and self-harm. This data form was used to tabulate variables from the records of all suicides since 1990 (51 prisoners).

As a "control" a further 52 released prisoners were extracted from the Total Offender Management System (TOMS). Matched by age, time served and year of release, these prisoners provided a comparison group to determine significant differences between non self-harmers and self-harmers.

Quantitative analysis was done in two ways:

(a) A non-parametric analysis to show differences between the suicide and non-suicide group

The null hypothesis assumed no differences between the Matched group and Deceased group.

The results are presented in "Appendix 7: Non-parametric analysis of data".

The results of the quantitative study failed to support the null hypothesis of no difference between prisoners who suicide and those who do not.

There appears to be significant differences between the deceased group and the matched group. This non-parametric quantitative analysis showed the importance of hopelessness, emotional distress, distressing communications, relationship loss and escalation of concerning behaviours. Use of health services also indicates possible escalation of distress, and suggests a simple 'warning' system based on the number of contacts with health services. Significant differences were identified between the deceased and matched group regarding family dislocation community self-harm, loss of significant other, refused opportunity to communicate, distressing communication, and being bullied.

(b) A logistic regression analysis independently undertaken by the University of Western Australia

In the light of the above findings using non-parametric statistics, it was decided to ask the Department of Public Health (UWA) to conduct an independent statistical analysis. This was based on the same 117 variables but used a different approach to extract the "relative risk" for each variable in contributing to a suicide. The 117 variables were reduced to 50 variables where there was sufficient data to define a "relative risk." Of these 50, the 'attributable fraction' was measured – showing whether each variable was attributed to a significant number of suicides. 12 variables were shown to be present in a significant number of suicides, 27 are ambivalent, and 10 are important in that they are <u>not</u> present in a significant number of suicides (See the Appendix 5 for the full study).

The value of quantitative analysis in WA prison suicide prevention

The results from the two methods of analysis discussed above form a powerful and unique analysis of the suicide 'factors' in WA prisons. They can be used in two ways:

A useful at-risk assessment system can be developed: Because the results are both empirical (that is derived from existing data) and couched in terms of probability (using 'attributable fractions' and 'odds ratios' – see Appendix 5), they fulfil the requirements for the most productive method of suicide assessment (see the Literature Review, and Workshop 3 report).
The large number (117) of variables has been reduced to 50, of which 22 seem to be of value in selecting at-risk individuals. The results however are drawn from a small sample of 51 deaths, and it would be of great benefit to repeat the study in another Australian jurisdiction.

Qualitative Analysis

The results of this study are presented in full in "Appendix 8: Qualitative analysis of data".

Rationale for undertaking qualitative analysis

Not all the information contained in the records is amenable to quantitative analysis. Upon reviewing the records, it was clear that in many instances, there was a failure of the prison system to prevent suicide, and that this could best be analysed by a descriptive approach.

Recognising these failures or problems could only be done by those with extensive knowledge and experience of the prison system, since they could pick instances where the system did not behave as it should. For this qualitative analysis all assessments were done by such experienced staff.

Basic data used in qualitative analysis

The study firstly involved a review of all available information related to the prisoner who committed suicide.

Medical Files, Internal Investigation Unit reports, Coroner reports and files on the Offender Management System were examined. Four experienced staff researchers read the records and created a comprehensive vignette on each prisoner. From these vignettes, common 'themes' were identified. (See Appendix 8).

Results of qualitative analysis

The qualitative findings show widespread systemic inadequacies. The analyses point to the need for increased staff awareness in the case of suicide prone prisoners - particularly of at-risk prisoners in their area, of risk assessment, and current stressors. Operational issues identified, concomitant with penalties imposed reflects an out-dated, punitive prison culture.

Common to the all the themes identified is a lack of coordination, integration, and communication. At times there seems to be a limited understanding of policy, procedure and protocols in the management of prisoners.

Conclusion from quantitative and qualitative analysis

The overall theme from the qualitative and quantitative analysis is a sense of escalation; the prisoner usually gets noticed through behavioural changes and it is only then that preventative measures intervene.

Suicide is everyone's responsibility: Prison Officer, Hospital Officer, Medical Officer, FCMT, the prisoner and their families, are all involved.

However whilst suicide is everyone's responsibility;

"There is always the risk that shared responsibility equates to diminished responsibility overall. The need for a multi-disciplinary approach reflects the fact that the causes of suicide are complex" (McHugh, 2000. p13).

The themes identified may not be, and it is not suggested they are, the primary precursors to a self-inflicted death in custody they do indicate a general malaise throughout the system.

A number of recommendations are therefore made to correct what can only be described as at times the mismanagement of vulnerable and at-risk prisoners and to cement ownership of suicide prevention in prisons.

The recommendations from qualitative and quantitative data analysis are:

- A coordinator responsible for suicide prevention initiatives is appointed. The coordinator shall be responsible for managing the treatment of suicidal and/or at-risk prisoners, maintaining staff awareness through administration meetings, daily debriefs, senior officer meetings etc., and for ensuring that the prison suicide prevention program conforms to guidelines for training, identification, referral, assessment and intervention.

- That there should be a more judicious use and application of punishment with consideration being given to the appropriateness of solitary confinement as a means of punishment. Alternative punishment modalities showed being implemented, particularly in the case of vulnerable, disturbed and other at-risk prisoners.

- That receiving nurses be appropriately trained in suicide and at-risk assessment.

- That all staff engaged in prisoner contact be appropriately trained in the ARMS and that the use of ARMS be continuously monitored.

- That a continuous pro-active approach be adopted in advising prisoners, their relatives, family and friends of the need to report any concern for the wellbeing or safety of a prisoner.

CHAPTER 4 THE CHANGE IN MANAGEMENT OF AT-RISK PRISONERS IN WA PRISONS

Note on recommendations: The report contains 'suggested strategies' in chapters 2-5. These strategies were put to the final meeting of working party participants who considered all of them and developed 12 key recommendations. Thus the 'suggested strategies' from chapters 2-5 do NOT necessarily become part of the final Key Recommendations but should receive further consideration as part of the implementation of these Key Recommendations.

History of at-risk management in WA prisons

The Department of Justice is acutely aware of the problem of suicide in prison. Clearly it is not an easy problem to solve (as this report attests), but considerable effort has already been put into reducing the rate of suicide. Over the last few years, major changes have taken place in WA prisons regarding at-risk management. This chapter reviews these changes to up to 2001only.

The substantial increase in the number of deaths in prison custody since 1966 and particularly over 1998, resulted in the State Ombudsman in February of 1998 announcing an "Own Motion" inquiry. It was expected that the report of that inquiry would be ready by October of the same year. It was also recognised by the Department of Justice that actions to reduce the incidence of suicide needed a multi-disciplinary approach.

Employing a large body of experts, including academics from Edith Cowan University, the Crime Research Centre, Strategic Policy Unit of the Health Department of Western Australia, along with a review of literature, the Department's then Strategic Working Group for Suicide Prevention developed a number of strategies designed to reduce suicide in custody. These included:

- an extended program of prisoner reception and induction;
- the implementation of an ARMS state-wide;
- new facilities and programs to provide intensive and specialised care and support for acute and chronically 'at-risk' prisoners; and
- new provisions for monitoring prisoner punishments and the adjudication of prisoner complaints and grievances.

Before this the responsibility for identifying and managing at-risk prisoners rested with the Special Needs Team (SNT). The latter comprised six psychologists and two social workers State-wide, assisted by Peer Support Officers and a fledgling peer support movement of prisoners trained to support fellow prisoners who may be at-risk of self-harm. Working in a culture that was predominantly custodial, negotiations for relaxing the regime of prisoner management were often long and arduous.

SNT personnel generally had to convince custodial staff that a prisoner was not manipulating the SNT officers simply to gain some favoured placement, but were genuinely at-risk. At the same time, the prisoner was not so at-risk that he/she should be placed in a medical observation cell. SNT personnel were not always able to secure suitable placement. Placement for those prisoners who were at-risk was limited. Usually what happened was that the prisoner was placed in a medical observation cell with little consideration given to 'doubling-up' in a buddy cell. In extreme cases, the prisoner would be transferred to the Casuarina Infirmary.

In August 1998, SNT was incorporated into Prison Health Services and with a name change to Forensic Case Management Team. The manning level was gradually increased to include occupational therapists and mental health nurse specialists.

Practice in suicide management in 2001

The following is an update on the implementation of identified **Action Sets** identified in the *Report on Suicide Prevention Strategies for Prisons in Western Australia, December 1998* and reflects current prevention mechanisms in use in the Department of Justice:

Action set 1: 'Reception and induction of prisoners'

1998
Extended reception, induction, and risk-screening program for remand prisoners and newly-sentenced prisoners will allow for a more comprehensive identification of risk factors, psychiatric signs, needs for detoxification and other treatments, through a 1-2 week assessment, culminating in an individual management plan which will accompany the prisoner, thus ensuring appropriate management.

Further, each prison will, as part of the revised orientation process, encourage prisoners and their families (and other supporters) to seek help if self-harm is indicated. Prisoners' phone calls are to include a warning informing recipients to advise authorities if they have concerns about a prisoner's welfare.

2001
Expanded at-risk procedures are in place at all prisons. The Reception at-risk procedure is followed by a detailed medical at-risk screening and referrals to specialists or to programs if necessary. Those assessed as at-risk by the nurse on initial interview (using the MR012 Form and MR010's for updates) are referred to the FCMT as are all juveniles, those withdrawing from drug use, those who are first-timers, and those who have a self-harm history.

- Induction and risk screening have been expanded at Hakea Prison with the introduction of an assessment and orientation unit. If the sentence received is greater than six months then within 72 hours of arrival a Management and Assessment Plan (MAP) is developed. Thereafter, within 28 days of sentencing an Individual Management Plan (IMP) setting out the sentence plan for the prisoner is formulated. This is an approved plan developed in consultation with the prisoner and spans the prisoner's sentence through to release. It identifies prisoners' needs and contains recommendations for prison placement, security classification and courses that will assist the prisoner to live a pro-social life on release to the community.

- On transfer from Hakea Prison to another prison, a Case Officer for the prisoner at the receival prison is assigned. Details of contacts between the prisoner and the Case Officer are recorded on the Assessment-Oriented Integrated Prison Regime (IPR) program on TOMS. As of June 2001, pilot studies have ended at three of five selected 'IPR' prisons.

- Unit Management is being reformulated to suit specific prisons and selected officers have received training in case management and have assumed the role of Case Officers for prisoners transferring from Hakea (with their IMP) to Casuarina, Bunbury and Albany prisons and in some cases, to prison farms. The fully-fledged program is to be implemented immediately following the pilot scheduled to end June 2001.

- Prisoners are encouraged to tell staff, friends and relatives if confronted by excess stress; moreover, friends and relatives are also assisted if they have concerns about prisoners. However, recorded messages on the ARUNTA system do not yet include advising family or friends that they should advise prison authorities if they have any concerns about an individual. (One reason the recorded message has not yet been changed (4/2002) is that prisoners pay for the calls, and some object to having to pay for the message-length –eg, seven seconds for Hakea).

Action set 2: 'A systems approach to the management of prisoners'

1998

A new at-risk management system with clearer procedures and shared responsibility will improve the quality of prisoner-staff interactions and reduce use of medical observation cells, as well as classify level of risk.

Low-risk prisoners will, in the mainstream, be observed by staff and peer support prisoners, and have access to their usual supports and others such as the Aboriginal Visitors Scheme.

Medium-risk prisoners will require closer monitoring and this will be addressed by the PRAG, comprising health, management and custodial representatives. The PRAG will meet daily to discuss interventions for medium and high-risk prisoners (who are not suitable for the mainstream).

Reformulations within Unit Management will assist Superintendents in implementing management practices required for the medium-risk prisoners. This will include ensuring incoming staff are made aware of prisoners discussed by PRAG.

A greater range of placement and support options will assist in management of prisoners in each risk-category. These will include: phone access, along with other supports and visits; telephone counselling; double-up or 'buddy cell' placement; transfer to medical observation only during the crisis, with television, access to normal clothing, reading and writing materials and graded exposure to outside environs.

2001

- The ARMS represents an integrated approach featuring not only shared responsibility, but also accountability and transparency, through daily meetings of the PRAG. The latter is composed of health professionals and custodial staff. The PRAG after due consultation and deliberation formulates a risk level, and a management plan. This consists of placement, therapy, observation frequency, and involves designated staff and may specify the use of additional resources.

- The ARMS has been expanded to include the attendance of Senior Officers and other staff at PRAG meetings. Unit Managers are responsible for advising officers at the commencement of their shift about safeguards for at-risk prisoners. Overall, this system allows staff who identify signs of stress to log their concerns, thereby initiating a formalised and structured approach to the management of at-risk prisoners.

- The ARMS/PRAG has been operating since October 1998. A review of the operation of ARMS/ PRAG was undertaken at all prisons, commencing March 1999. Appendix 9 presents the findings of this operational review.

Peer Support

1998

Prisoner Support Officers attend to welfare needs and coordinate peer support activities, and will become integrated into the system as staff awareness of this role increases. Supporting at-risk prisoners will also be a part of both Prisoner Support Officers and peer support prisoners' responsibilities, with appropriate training programs provided. Caution must be exercised in placing responsibility upon peer support prisoners in this enterprise.

Serious consideration is to be given to the concepts around prisoner 'befrienders' and their potential role in helping vulnerable prisoners.

2001

- Prisoner Support Officers, averaging 10 in number, have become an integral part of the prison system. They receive periodic training in suicide awareness, in addition to performing their daily welfare role and have an orientation program of 3-4 days on commencement, to familiarise them with metropolitan prison operations and with colleagues in FCMT. They are encouraged to attend FCMT case conferences and other activities, and normally attend all PRAG meetings.

- Prisoners are recognised as a valuable resource in the provision of assistance within the prison community, assisting in the reduction of self-harm and suicide. The Peer Support Program is based on the concept of listening, befriending and providing support to vulnerable prisoners to assist in the identification and reduction of self-harm and suicide.

- The training of Peer Support Prisoners commenced at Casuarina in 1998 and at Hakea, Wooroloo, Riverbank, Bandyup and Bunbury. Currently training is taking place at Albany Regional Prison. The training consists of seven modules, involving: stress management; interacting with others; anxiety and depression; effective listening; peer support; self-harm and suicide awareness. The program takes, on average, seven full days and has been presented for nearly two years. Training is scheduled for Karnet and will continue as a result of the turnover in peer support prisoners.

- Consideration has been given to '3-out cells' and 'befriending rooms', but they have not yet been implemented (as at 4/2002).

Action Set 3: 'Specialised care and support for acute and chronically at-risk prisoners'

1998

The prisoners assessed as high-risk as classified by the PRAG will be placed in crisis care units being developed at both Casuarina and Hakea prisons, and provided with intensive interventions including after care arrangements.

2001

- For prisoners assessed chronically at-risk and those who have self-harmed or have attempted suicide, crisis care units are operating at Casuarina and Hakea Prisons with another under construction at Bandyup Women's Prison, completed 2/2002.

- The Crisis Care Unit (CCU) at Casuarina Prison opened in March 1999. Its purpose is to replace the outdated use of medical observation cells for prisoners in a state of suicidal crisis and to provide them with a safe, short-stay environment and treatment during their stay, along with plans for after-care.

- Staff on hand includes a mental health nurse specialist, two custodial officers and a psychologist. Psychiatrists and other specialists visit when required.

- Prisoners are admitted to the Crisis Care Unit if assessed as moderate or high risk on admission to prison and are unable to be placed in mainstream or doubled up for safety. Members of the FCMT, medical, Unit, or any other staff may refer prisoners for assessment or admission to CCU. Interim placements may be made by prison staff members after-hours. The prisoner is then formally assessed when the Psychologist, Mental Health Nurse Specialist, or in some cases the Psychiatrist, becomes available.

- The unit has a 12-bed capacity, although periodically the capacity is under pressure and prisoners have to be doubled-up. While in their cells, prisoners are under camera surveillance. Resuscitation and other basic emergency equipment are stored in the unit, and, being a wing of the Casuarina Infirmary, other emergency supplies are readily available nearby, as well as extra medical and custodial staff.

- The Crisis Care Unit at Hakea Prison complex opened in January 2001, and operates essentially in the same manner as the CCU at Casuarina Prison.

Action set 4: 'Complaints and grievances'

1998
An internal appeals system is to be developed which will allow prisoners to have grievances resolved more expeditiously, relative to the current practice of communicating with the Ombudsman.

2001
The Prisoner Grievance Process (PGP) is a recent measure designed to lessen the number of grievances prisoners' pass on to the Ombudsman. The objective is to 'facilitate the resolution of prisoner grievances at the lowest possible level and within the shortest possible time.'

- This process, which operates within the guidelines of Unit Management, allows prisoners under any regime to have access to a grievance process to it without fear of harassment. Confidentiality is also maintained for both prisoners and staff.

- It is intended that prisoners will receive a response to their complaint within 24 hours of submitting their grievance form (C95 B). This form contains information concerning grievance details and desired outcome, along with actions taken through the various stages. Ideally, the matter is resolved at the Unit level. If it is not, the Superintendent becomes involved - following that, the manager of PGP acts. A Grievance Review Panel intervenes in the case of unresolved grievances.

- Training at all prisons (both public and private) enables both staff and prisoners an adequate understanding of the process. The process is also documented in pamphlets and manuals available in units, as well as form C95 B. The PGP pilot has been reviewed, with accompanying recommendations mainly concerning the need for improvement in recording, training and 'ownership'. Reviews will continue at regular intervals.

- The intent of the Prisoner Grievance Process is to resolve issues at the lowest level: if the grievance is not 'fixed' at unit level –ie, with the assistance of the Unit Manager and staff- the next person to intervene is the Superintendent. If resolution is still not achieved, the Manager of Prisoner Grievance becomes involved –all within less than 1 week. The highest level involves input by the latter, as well as Director Sentence Management and Manager Metropolitan Prisons.

- The grievance areas encompassed by the PGP are health; conditions; visits; property; programs; education; employment; communications; breaches of procedures; and equity, ie in matters of harassment or discrimination.

- Areas not covered within the PGP include: grievance on behalf of another prisoner; Case Conference decisions; Statutory disciplinary decisions; Acts, Regulations, and Director General's Rules governing prisons; and Offences/Acts of a criminal nature.

- Implementation commenced in November 2000, and training of prisoners, and relevant staff has been completed in all but four prisons: Hakea, Casuarina, Bandyup Women's Prison, and Karnet Prison. Training should be finalised by August 2001.

- Although prisoners continue to send complaints to the Ombudsman, the latter has agreed to encourage prisoners to use the Prisoner Grievance Procedure in the first instance unless the prisoner or the Ombudsman is of the view that the complaint is more appropriate for the Ombudsman to investigate.

- In terms of modifications to punishments, all prisons have (14th May 2001) received new Department of Justice Policy Directives and Director General's Rules. These incorporate various changes for example: provisions for increased reporting and monitoring and observation cell placement to be at the discretion of the Superintendent who should first consult with health staff; improved opportunity regarding religious practices; expanded orientation process are recommended changes.

- Local prison-specific rules are also being altered in order to further improve individual well being. For example, additional phone calls can be provided when necessary. Isolation or solitary confinement periods are, depending upon circumstances, lessened where practicable.

Action set 5: 'Responding to a crisis'

1998

Superintendents will be responsible for reviewing all training requirements of prison-based staff in responding to critical incidents.

2001

- Training requirements for prison-based staff (other than custodial and in some areas Industrial Officers) in responding to crises and other emergencies has not yet progressed beyond information sharing although Training and Specialist Services (TSS), standard emergency and 'First Officer Response' training has been occurring for over 2 years. A meeting between Department of Justice and TAFE to discuss training for prison staff in deaths in custody was held on 02/07/01. This initiative is in the embryonic stage and further meetings are planned.

- The DOJ offers a number of programs for staff, including suicide awareness/prevention, cross cultural awareness, crisis intervention, etc.

Action Set 6: 'Addressing prison stressors'

1998

The Parole Board has agreed to hold meetings on Thursday rather than Friday, with the impending weekend when prisoners may be overstressed by a decision and when staff numbers are minimal. Funding will be available for the Remand Centre to expand recreational computer programs. Reducing boredom is to be addressed through workshops attended by Superintendents and relevant specialists. Superintendents will also review opportunities for expanding prisoner interaction time. An anti-bullying process is also being considered, along with enhanced peer support training and programs aimed at building coping skills, controlling anger and impulsiveness and stress.

2001

Parole Board

- In terms of lessening the stress of negative decisions, the Parole Board, which previously held meetings on Fridays, now meets Thursdays so that prisoners adversely affected may be assisted if necessary.

- Since 1998 prison procedures for advising prisoners of decisions have standard response-time, clarity, and tactfulness. If a decision is considered difficult for a staff member, FCMT is asked to see the prisoner.

Stress Reduction

- Implementation of various measures to reduce stress and boredom has hitherto been prison-specific but now all prisons have expanded recreational, educational, and other activities to overcome stress and boredom.

- In Casuarina Prison many proposed stress-reducing strategies were hindered by the year long lock-down which was a consequence of the Christmas Riot of 1998, but now, for example, prisoners of any status can have access to the oval and the gymnasium. The Recreation Officer there offers a number of innovative measures (other than sport) including team and trust building (through various activities, such as rock-climbing, tactile approaches, round-table games, etc.).

- The building upgrade at Bandyup Women's Prison has included 'passive' activities: Arts and Crafts; Library; Ceramics; Guitar lessons; Gymnasium; Table tennis; Darts; Painting Basketball; Bingo (Saturday); Quizzes (Sunday).

- Most Prison Education Centres have increased numbers of computers available for both educational and recreational programs, and all centres are required to offer accredited programs, in areas of, horticulture, metalwork, cleaning, life-skills and hospitality, along with basic literacy and numeracy.

- As noted above (Action Set 2) The Integrated Prison Regime project encompasses programs to help all prison groups to interact more successfully, including the teaching of negotiating skills, critical reasoning, regulating emotions, assertiveness, value systems, problem-solving, information-gathering, and other topics.

Bullying

- Bullying has been a problem in all prisons for many years. If a victim of bullying is identified they are initially protected, and then action is taken to remove the problem.

- As of Operational Instruction 15 (14/5/01) a prison wide anti-bullying strategy is being implemented. The four principles of the anti-bullying approach include ensuring prisoner awareness of the strategy at induction; identification of bullies; intervention, targeting the bully, and preferably, multi-disciplinary; locally available staff training. Implementation of the strategy is left up to the superintendent of each prison.

Sleep Problems

- Another significant stress for prisoners, is inadequate sleep, which puts pressure on the nurses and doctors to provide sleeping pills. While these are appropriate for short- term (3-5 days) relief, they have significant disadvantages when used long term, and Prison Health Services actively discourages their use.

- A cognitive behavioural program for managing insomnia, "LAMBS" (Learning Activity Modules for Better Sleep) was developed by members of the FCMT.

- The program includes general lifestyle improvement, discussion of common prison sleeping disorders, how to relax, meditation techniques, cognitive behaviour strategies (eg, changing long held beliefs), and education on substance abuse. The program is designed to improve sleep, reduce dependency on sleeping medications and build better coping skills. The latter is particularly important in the reduction of self-harming behaviours.

Action set 7: 'A new statement of policy'

1998

A new comprehensive policy on the care and management of 'at-risk' prisoners will include:
A statement of principles to guide policy and practice; implementation of duty of care; guidelines for 'good practice'; review of policies regarding placements in order to allow maximum number of prisoners safe access to prison services; protocols for risk identification; detailing options for crisis management, as well as for long-term treatment and management.

2001

- The Statement of Policy in 1998 related to the care and management of "at-risk" prisoners. This report is a comprehensive survey of existing methods, and suggestions for new strategies where needed.

Action set 8: 'Clear leadership responsibility and staff accountability'

1998

Specialist service providers are to be accountable to superintendents for the provision of needs related, timely services, and monitoring mechanisms are to be a part of the new agreements.

Prison Health Services and superintendents will develop new arrangements for sharing information relevant to self-harm, in order to optimise management. Prison management currently is attending FCMT Case Conferences.

The further development of the Total Offender Management Solution (TOMS) will also improve intercommunications within the Department.

2001

- Specialist service providers eg, Sexual Assault Resources Centre, have agreements, which meet Department of Justice requirements for monitoring, timeliness, and quality of services.

- Information sharing between Prison Health Services and superintendents has improved over time, particularly with the regular superintendents' conferences, FCMT conferences, and with the Joint Executive Committee consisting of Prison Health Services and the Health Department. Representatives from other sections are invited to the various meetings.

- Forensic Case Management Conferences occur fortnightly at all metropolitan prisons.

- The new computer prisoner management system TOMS (Total Offender Management Solution) improves communication.

Action set 9: 'Enhancing skills and performance'

1998

Prison Officers will receive training in order to appropriately respond to and identify prisoners in distress. An analysis of training needs for all major staff groups within the prisons will be conducted (eg, officers, administrators; medical, industrial, teaching staff, etc). Staff whose work is demanding, and who may be subject to 'compassion fatigue' need to be valued; staff who do not demonstrate appropriate behaviours towards distressed prisoners also need to be identified and given training.

2001

Integrated Prison Regime

- The Integrated Prison Regime (IPR) is a major change strategy to improve current practice in Western Australian public prisons by streamlining and focusing prisoner management regimes. An essential goal underpinning the IPR initiatives is the improvement of relationships between prisoners and prison officers.

- The Cognitive Skills Project is a component of the Integrated Prison Regime. Its aim of which is to provide a basis for promoting a pro-social prison environment through teaching staff and prisoners and understanding of behaviour and social interaction.

- Two cognitive skill programs, both presented by prison officers, have been introduced to Western Australian prisons:

The Reasoning and Rehabilitation (R&R) program for delivery to prisoners.

- The Reasoning and Rehabilitation program frequently referred to as the R&R of Cognitive Skills, is essentially a structured, cognitive behavioural approach to facilitating change in prisoner behaviour.

  The model focuses specifically on the thinking skills which guide (or fail to guide) the behaviour of prisoners. It attempts to replace maladaptive and well-established thinking patterns with cognitive skills that can promote pro-social behavioural choices.

There is emphasis on teaching prisoners to be more reflective rather than reactive, more anticipatory and thoughtful in their responses to potential problems, and more generally flexible, open-minded, reasoned and deliberate in their thinking. Using step-by-step instruction and purposeful repetition, skills building is sequenced and refined as the program unfolds, and skills-use is integrated and made relevant with concrete examples from individual's lives. Application of skills is encouraged through constant use of modelling and reinforcement techniques.

The Interpersonal Skills Training Program (ISTP) to enhance the skills of prison officers and support the introduction of the second program;

- The ISTP for prison officers was developed to encourage positive officer-prisoner interactions within the prison environment. It aims to teach officers how to competently manage and handle prisoners "in-the-moment". The ISTP links staff-prisoner interaction in the living unit or workshop with classroom teaching. Together, all of these experiences should be promoting pro-social behaviour, attitudes and thinking.

- The program aims to help prison staff in making their working environments more manageable and controllable. It aims to "skill" them in situations they will inevitably encounter. It is a modular training package delivered by prison officers to their colleagues. Those who deliver the ISTP training need to be trained in the R+R program as described above.

Action set 10: 'Unit management'

1998

This concept is to be reformulated, with a view to better information sharing, awareness of stresses, staff/prisoner interactions, hand overs, and other issues fostering a better -environment for prisoner management. Superintendents will have increased authority to implement processes, which continue to improve the overall prison environment.

2001

- Unit management is an approach to prisoner and institutional administration that is designed to improve control and relationships, by dividing a large institutional population into smaller, more manageable groups, assisting interaction between officers and prisoners while improving dynamic security. Unit management is, basically, a more personalised and responsive approach to the management of prisoners, with staff in close proximity having decision-making responsibility and authority.
- Several attempts have been made to implement this model, the most significant in 1991, when extensive resources were utilised resulting in a "foundation" of unit management being established at most prison sites. Over the years, however, this early groundwork has largely dissipated. This has occurred through lack of reinforcement and the introduction of hindering factors, (such as twelve hour shifts), which have reduced opportunities for unit based rostering. In addition, an early review of the 1991 strategy noted that staff did not fully understand the model, a situation that largely continues today.

- The Department of Justice recognises that sound unit management creates the environment for effective management of prisoners. It provides a constructive style of prison management with the potential to reduce detrimental effects of imprisonment, and maximise opportunities for positive prisoner outcomes. Unit management moreover, provides the structure to integrate related prisoner management initiatives such as case management, prisoner grievance and anti-bullying. As such the concept of unit management is being revisited. The primary objective in the refocus being the:

    - Expanding the role of unit staff by delegating authority;
    - A unit based communication system;
    - Increased levels of consistency across key areas;
    - Interactive prisoner management;
    - The integration of the structure and process of unit management
    - The use of learning and performance management principles so that the theory fits the site, and its implementation is monitored

CHAPTER 5 SUICIDE PREVENTION WORKING PARTIES

Note on recommendations: The report contains 'suggested strategies' in chapters 2-5. These strategies were put to the final meeting of working party participants who considered all of them and developed 12 key recommendations. Thus the 'suggested strategies' from chapters 2-5 do NOT necessarily become part of the final Key Recommendations but should receive further consideration as part of the implementation of these Key Recommendations

This chapter discusses the findings of the three working parties of the suicide taskforce in 2001. Where possible some of the recommendations have been implemented prior to the publication of this report.

About the working parties

The literature review and data analysis revealed some common threads, and from this, it was apparent that some strategies could be developed and implemented. In order therefore to expedite the development and implementation of such strategies, three strategic working parties were formed. As prison suicide is multifactorial the membership of the working parties was multi-disciplinary and the function and findings of the working parties sometimes overlapped. The working parties examined current mental health services, operational and environmental factors, and the identification, and management of at-risk prisoners.

Working party one - Mental health

It is clear that a strong mental health service is essential to address the problem of suicide in prison. The brief for this working party was to consider all aspects of current mental health services that affect the potential for suicide and self-harm.

Actions to prevent suicide and to alleviate the individual and social conditions placing prisoners at increased risk must be based on an understanding of these risk factors. It is essential that we have a clear understanding of fatal and non-fatal suicidal behaviour, and an understanding of demographics of those at risk. In presenting its report the Mental Health Working Party adapted the framework developed by the National Advisory Council on Youth Suicide Prevention.

Guiding Principles

In undertaking its review the working party has been cognisant of the need to observe the following guiding principles:

- Suicide prevention is a shared responsibility across the prison community – custodial and professional groups alike.
- Suicide prevention requires an integrated approach targeting the whole population, specific subgroups and individuals at-risk (universal, selective, indicated levels of prevention).
- It must be evidenced-based and outcome-focused.
- Interventions must be accessible to those who need them and responsive to the social and cultural needs of the groups or individuals they serve.
- They must be sustainable, to ensure continuity and consistency of service, and evaluation must be an integral part.

The Working Party has identified five priorities:

1. Promoting well-being and resilience, and enhancing protective factors across the entire prison community.

2. Services and support within the prison for groups at increased risk.
3. Services for individuals at high risk
4. Partnerships with Aboriginal people.
5. Progressing the evidence for suicide prevention and good practice.

Action area one: Promoting well being, resilience and enhancing protective factor.

The purpose in this action area is systematically to address aspects of the prison environment to maximise protective factors for all prisoners. Protective factors are those which reduce the likelihood of individuals becoming, at-risk for suicidal behaviour. This includes measures to enhance physical, emotional and spiritual well-being, hope, a sense of connection with family and other people, adaptive coping skills and individual capacities and vocational skills. Such interventions need to be targeted across the entire prison community.

Rationale

There is a strong association between suicide, mental disorders and a wide range of individual, family, societal and other risk factors. It is also generally accepted that suicide rarely occurs in those who have good mental health, good interpersonal relationships, and family and community support. It follows that if there are enough protective factors to offset risk factors, and prisoners with mental illness can be returned to health, vulnerability to suicide may be reduced. Accordingly, it is believed that improving protective factors across the prison communities helps reduce the overall proportion of at-risk prisoners.

Strategies suggested by these findings

- *Improving social structural factors that promote well-being and mental health.*
- *Enhancing factors that protect against the adverse social conditions associated with prison and suicide risk.*
- *Reducing the prevalence of known risk factors for suicide and self-harm.*
- *Increasing custodial and non-custodial staff awareness of early signs and symptoms of mental health problems and mental disorders.*
- *Implementing media strategies that promote good practice in relation to reporting of deaths in custody and coronial inquiries.*
- *Reducing prisoners' access to identified lethal methods of self-harm.*

Action area two: Prison services and support for at-risk groups

The purpose of initiatives in this action area is to improve the ability of a wide range of services, service systems and support networks to meet the needs of groups at increased risk of suicide and self-harm, through prevention, recognition and response.

Rationale

Suicide prevention is best addressed through building on existing services and existing strengths rather than building a separate 'suicide prevention industry'.

Those who provide services and programs to prisoners, including both custodial and non-custodial staff, should all have an awareness of suicide, self-harm and the associated risk factors, and be equipped to act and refer appropriately.

Prisoners contemplating suicide often indicate in some way that they are at-risk. Knowledge and awareness by staff members of risk factors may assist in the identification of those prisoners most in need of interventions and thereby reduce instances of suicide and suicidal behaviours.

Several social and individual factors and conditions are known to be specifically associated with higher rates of suicide. Most notably, the presence of mental health problems and mental disorders is strongly associated with suicide, attempted suicide and suicidal thinking. In addition, prisoners with drug and alcohol problems, a history of child abuse or poor parent-child relationships, those with a suicide in the family and prisoners who have had early entry into the criminal justice system are all at increased risk. It follows that targeted action to reduce such risk factors and build protective factors in individuals and the prison system may help to reduce vulnerability to suicide and suicidal behaviours.

Strategies suggested by these findings

- *Enhanced response within the prison to the full range of needs of groups who are at increased risk of suicide.*
- *Enhanced capacity within the prison to recognise, respond to and refer individual prisoners showing signs of high suicide risk.*

Action area three: Services for individuals at high risk

The purpose of initiatives in this action area is to identify and mobilise effective responses to individual prisoners at particularly high risk to ensure their immediate safety and to ensure their access to appropriate health care and other sources of support.

Rationale

Individuals with mental disorders, particularly some personality disorders, are more likely to be imprisoned. A significant number of people with untreated mental disorders and emotional problems exist in our prisons. Ensuring access to comparable standards of health and mental health care to that available in the community is one of the recommendations of the RCIADIC.

One of the strongest indicators of likely suicide is a previous suicide attempt – particularly suicide attempts in custody. Deliberate self-harm is also associated with increased risk of later suicide attempt.

Individuals having experienced a recent family suicide and those who have previously lost a close family member (eg. parent, sibling) through suicide may become at increased risk of suicide.

The RCIADIC highlighted the fact that legal problems are associated with increased risk of suicide before, during or after trial or imprisonment.

Harmful drug or alcohol use by people with mental disorders compounds the risk for self-harm and suicide, while drug and alcohol use alone increases suicide risk.

Strategies suggested by these findings

- *Availability of an appropriately resourced health and mental health service at all Western Australian prisons to provide a comparable level of service to that available in the community.*
- *Improved emergency response and provision of follow-up treatment and support for incidents of attempted suicide and self-harm.*
- *Increased surveillance and appropriate treatment and support for prisoners identified to be at high risk of suicide, and those with diagnosable mental disorders.*
- *Reducing access to harmful substance and increasing access to treatment and management of harmful drug use in prisons.*
- *Provision of prompt and effective support for prisoners bereaved, or directly affected by suicide.*

Action area four: Partnerships with Aboriginal people.

The purpose of initiatives in this action area is to provide culturally appropriate programs (universal, selective and indicated) which respond to high rates of suicide in Aboriginal prisoners.

Rationale

Recognition and support for Aboriginal culture is a central issue in addressing the problem of suicide among Aboriginal prisoners. The National Aboriginal Health Strategy (1996) defines health as 'not just the physical well being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and it includes the cyclical concept of life-death-life'.

Possible reasons advanced for high suicide rates among Aboriginal prisoners include the on-going experience of dispossession, social disadvantage, modernisation and lack of services, and the internal breakdown within communities, frustration, anger, lack of purpose and pessimism occasioned by these factors.

Strategies suggested by these findings:

- *Shared information about and implementation of life affirming and community based suicide prevention programs grounded in the culture of Aboriginal people.*
- *Increased relevance of existing services and suicide prevention programs to the culture of Aboriginal people.*

Action area five: Progressing the evidence for suicide prevention and good practice

The purpose of initiatives in this action area is to ensure that programs have the greatest chance of benefit and minimum risk of harm by building the evidence base, sharing good practice and providing education and training.

Rationale

Strong emphasis over recent years has been placed on the need for all interventions to be evidence based.

Development of effective programs, practice and services is critically dependent on feedback from consumers (those who use the services and those who have refused them). Consultancy with prisoner groups is a central part of this process.

Reviews of the evidence base for suicide prevention identify the need for further data collection and strategic research to develop and evaluate suicide prevention programs.

Strategies suggested by these findings:

- *Strategic research and evaluation of programs.*
- *Data and information systems.*
- *Education and training resources and initiatives.*
- *Guidelines and protocols.*

Working party two – Operational environment

In 1999, the Chief Inspector Prisons (UK) undertook a detailed review of prison suicides, the product of which was a report entitled *"Suicide is Everyone's' Concern: A Thematic Review."* This report concluded that prison suicides and suicidal behaviour is not just a function of individuals' vulnerability and circumstances, but is also influenced by the quality of the prison regimes and staff responses – or the overall 'health' of the prison or prison system.

Tests for 'healthy prisons' include:

- the weakest prisoners feel safe;
- all prisoners are treated with respect as individuals;
- all prisoners are busily occupied and expected to improve their skills and abilities; and
- all prisoners can strengthen links with their families and prepare for release themselves and are given the opportunity to do so.

Tests for the health of prisons in relation to prison staff include:

- staff feeling safe;
- staff treated with respect as individuals;
- staff informed and consulted within their sphere of work;
- high expectations of staff; and
- staff are well led and staff respect their own health.

To meet the needs for a healthy prison, the Operational Environment Working Party (consisting of Steve Kelly, Kevin Bourne-McRae, Jann McBride, Steve Jenkins, Dr Chris Henderson, Steve Newell and Jane Burn) examined a range of initiatives that, if accepted, would compliment initiatives from other working parties and work towards reducing deaths in custody.

Case management

It is recognised that improved relationships between prisoners and prison officers will follow the introduction of case management by prison officers. A reduction in self-harming behaviour is expected as a consequence of the speedier resolution of institutional stresses identified through the case management process.

Strategy suggested by these findings*:*

- *Case Management is introduced in all prisons.*

Rostering

The introduction of case management will be greatly facilitated through the adoption of Unit-fixed rostering practices. The continuity of prison officers in Units will lead to a greater knowledge of prisoners, their behaviour and relationships with others. This will allow for earlier identification of aberrant or at-risk behaviour and the resolution of crisis situations.

Strategy suggested by these findings:

- *That Prison Services continue to review staffing structures and rosters that better meet the needs of consistent prisoner management.*

Prison officer training

A review of the current sufficiency of the training provided to recruit prison officers would be undertaken. It is likely that a renewed curriculum with increased emphasis on ARMS practices will be introduced. It is expected that there will be an increased training in the management of aggression.

Strategy suggested by these findings:

- *That a review of training requirements for prison officers and other staff who work closely with prisoners both at the recruitment level and ongoing take place.*

Management Structures

The recently introduced Management Model at Hakea of a superintendent and four 'Zone' Managers will provide direction in a more consistent manner. This will allow for greater accountability in the management of prisoners, ensuring that new practices are implemented.

Strategy suggested by these findings:

- *Continue to review and implement management structures that reflect the need to provide direction in a more consistent and accountable manner.*

ARMS/PRAG

The ARMS, which provides for a structured approach to the management of suicidal prisoners, features specific requirements for observation regimes, placement options and follow up practices. This system is overseen at every prison by a multi-disciplinary team, (the PRAG) consisting of prison administration, custodial officers and health service staff. Ongoing training for staff in these areas is required at each institution.

Strategy suggested by these findings:

- *Continue to review PRAG and ARMS and the ongoing training required by staff.*

Communication

In the creation of a 'healthy prison' that includes prisoners in information sessions should be considered. This is to ensure that prisoners are part of the communication process. There may be a prison newsletter and Unit Meetings.

Strategy suggested by these findings:

- *Develop strategies that include prisoners in information sessions.*

Reception

Reception centres in prisons are often the first introduction to the penal system. Efforts have to be made to improve this environment so that it is more conducive to a relaxed exchange of information with the prisoner. This will allow for the recognition of prisoners' needs, fears and problems.

Strategy suggested by these findings:

- *Review the established protocols that operate in Reception areas and implement practices that assist in reducing the impact of imprisonment.*

Prison and unit philosophy

Prison units should be re-defined with each unit having its own unit statement, setting out the aim of the unit. Prisoner profiling will allow the mix of prisoner types to be monitored for each unit.

Strategy suggested by these findings:

- *Each prison and where necessary each unit shall develop roles and function statements that clearly define the aims of that environment.*

Female needs

Women experience imprisonment differently from men and this experience is often shaped by external pressures (for example, separation from dependent children or other equivalent family ties, children being taken into care, etc). Consequently, it may be necessary to augment regime-based solutions with measures that ameliorate these stresses. This might include access to outside agencies, better and more frequent visits, and self-determination in relation to therapeutic intervention for drug abuse, family violence etc.

Strategy suggested by these findings:

- *When strategies in response to suicide prevention are developed, the needs of women prisoners should be specifically included.*

Working party three – Identification and management of at-risk prisoners

Overview

The **Suicide Taskforce** arose after an unusually high number of suicides in early 2000 prompted the need for a re-examination of the way the prison system manages suicide. The management of suicide and suicidal behaviour is difficult, since the underlying causes are multi-factorial. Mental health is important, but so also is the general environment of the prison. The more 'normal' a prison environment becomes, the lower the suicide rate.

However, prison will never be a 'normal' place. People of many behavioural types, including the mentally ill, interact with a strict custodial regime in a stressful environment. This working party examined the assessment, surveillance and data management of prisoners' behaviour. The committee was made up from those with a professional interest in suicide, as well as those who were familiar with the prison system. The breadth of knowledge and experience was wide enough to enable the many facets of the prison system to be examined. The examination found that several areas were in need of review.

Firstly there were some **obvious problems** that were self-evident to all. Then the assessment of prisoners (to determine who was at-risk) focussed on the need to improve mental health, to review the FCMT, ARMS and PRAG.

Next, **surveillance** was considered, with a clear need to develop a common model and language so that the whole prison system could relate to suicidal behaviour. It was evident that this would mean a data system to manage the shared information, which would then feed back to a strengthened case management. The unreliability of clinical judgement was accepted, with the concomitant need to develop a structured **assessment system**, which would enable an actuarial method of defining a probabilistic estimate of suicidal risk. The focus here was the need for regular reassessment of the 'probability of suicide' throughout the sentence.

One of the key methods of surveillance is to increase the available **contacts** between prisoners and members of the security staff and between prisoners and external support people – such as the family, help lines (ie Samaritans) and prison visitors. It is clear from previous work that prisoners prefer to use external contacts to discuss problems and impending suiciders may talk to people who do not have an easy way of letting the prison know about their concerns. There is, at present, no structured or reliable way in which this behavioural information can be used to formulate an effective response.

Regarding the management of suicide, it is clear that there is **no single model** of suicidal behaviour that has been adopted by the prison system. FCMT, mental health, and medical staff tend to use their own models which they have learned or developed during their training. This results in varying assessment methods, diagnoses and predictions of each case and, given that clinical judgement is notoriously poor in suicide management, a flawed management processes. Clearly, it is necessary to develop a consistent working language to which all staff can relate. This implies a standard view of suicide.

There was recognition that prisoners live in an environment without their usual sources of emotional support and this predisposes to unusual behavioural outcomes – suicide being one. A number of practical ideas were suggested by which the environment of a prisoner could be **normalised** to reduce the emotional dislocation within the prison.

Obvious problems

It was clear to the working party that there are some serious defects in the system, which do not allow potentially suicidal prisoners to be identified. These may promote an environment in which suicide becomes a considered choice of action. These obvious problems were dealt with before moving on to consider specific areas of prison operations.

The following were considered obvious systemic problems:

Prison officers' lack of interaction with prisoners
Officers are always present in the prison and represent authority. To the prisoners they are the faces of the prison. Health staff – currently seen as responsible for suicide management - have little contact with prisoners compared with officers who have almost constant contact with them. Since it is clear that one of the most important features of suicide prevention is surveillance, it is vital that officers interact more with prisoners.

Staffing
Rostering of prison officers is a problem, with officers working 12-hour shifts. Consequently, they have little hand-over from one shift to the next and a shift roster of 3-6 days results in an officer, who may have developed a rapport with a prisoner, going on leave for about a week. This will need to be altered, preferably by eight hour staggered shifts, to allow continuity of care by the officers.

It was noted that in a custodial system outside WA it was forbidden to have two officers in a control room, thus forcing an officer to interact with prisoners.

Lack of case management
Case management in the prisons has been discussed for years, but never successfully implemented. What is needed is an effective way of monitoring the whole sentence of a prisoner from admission to discharge in a structured way so that problems can be identified and followed, rather than the present method of ad-hoc crisis management.

Clearly, suicidal behaviour mostly arises as a consequence of a pre-existing predisposition, which may wax and wane, but remains a feature of the prisoner's life in gaol. It is the identification of this predisposition to suicide more than anything else, which allows for the successful management of the prisoners suicidal risk status. It is suggested that the most effective approach be by longitudinal study of the prisoner's behaviour. This implies sensitive observation, adequate data transfer and timely intervention. This, in turn, means a substantial change in some aspects of the system.

Welfare role doesn't work
Years ago there were social workers in prison performing a welfare function. During one of the EBA bargaining rounds it was agreed that prison officers would take on the welfare function and be paid extra for it. In practice, the officers did not perform welfare functions, the social workers became part of FCMT and turned into counsellors, and the prisoners got no welfare.

What this means is there is now no one to look after legitimate welfare needs of prisoners. Prisoners are unduly susceptible to problems in their outside lives which they cannot solve, because they have little contact with the outside world. This increases the stress on prisoners and ultimately raises the potential for suicide. It is recommended that the Department accepts that the welfare role cannot be performed by officers, and reinstate the welfare officer/social worker.

Someone should manage high risk people
The management of the ARMS, responsibility for suicide awareness, prisoner contact, welfare, structured interaction etc needs to be formalised, and needs to be seen to be the responsibility of one person. This is not to say that the person has to do all these things, but they have to ensure that all these things are being done. It is no longer satisfactory to rely on separate people to perform their roles adequately, because clearly they don't, but equally clearly they have to for an effective suicide management system.

Must have a model, must have resources
If the Department of Justice is to be effective in the management of suicide, then we must develop a model of suicidal behaviour which everyone understands, everyone can relate to, and for which there is a common language. At present responsibility for suicide is shared by FCMT (who have individual ideas of what constitutes suicidal behaviour), Mental Health staff (who specialise in the management of the mentally ill) and officers who tend to distance themselves from the suicide issue.

Not surprisingly, staff in the system see suicide in different ways, and what may be suicidal behaviour to one person is not to another. If all behavioural observations were dependent on a common model, with a common purpose and a common language then we could develop the continuum that longitudinal care requires.Resources (dedicated staff responsibility, not just money) must be allocated to the development of this model.

Medical Observation

Medical observation cells are a very poor way to treat suicidal people. The only certainty they provide is the impossibility of committing suicide while in the cell itself. This certainty comes at a price – the likely outcome is that the time in the cell is so unpleasant that it provokes a suicidal crisis on release. Alternatively, it discourages the prisoner from declaring suicidal intent because of fear of being put in the cell.

The placement is a logical response to a legitimate worry by prison officers, who have no suicide training. They do not want to take responsibility for suicidal behaviour and they want to the prisoner to be prevented from suicide until they can be passed on to an 'expert'. If the officers had an alternative to these cells, and if the suicidal prisoner could be handled in a different way - then the cells will be seen for what they are. They are punishment cells, and effectively a sensory deprivation environment. They are the last place an emotionally unstable, suicidal patient should go.

Even if medical observation cells are to be used, their current use is inappropriate. There is a clear instruction (106/99) which describes how the cells are to be fitted out, and in what way prisoners are to be handled. Despite numerous attempts by Prison Health Services to have this instruction enforced, it is ignored, to the detriment of the prisoner's mental state. Essentially the instruction 106/99 allows for soft furnishings, TV, books, family visits and external contact – most of the things that a medical observation cell should have, and which would make it a reasonable environment. If prison health services could control the conditions and the environment under which a patient is put into medical observation – if it were true *medical* observation and not custodial supervision – then the medical observation cells would have a place. At this stage (2000) this is impossible because health services has no effective control over the use of the cells, especially at Casuarina.

It is worth noting that these cells were outlawed in the United Kingdom. The working party recommends that the Department of Justice should find out the UK Justice system managed without medical observation cells.

Intermediate Care

At present, there is no place where the observation of prisoners immediately on discharge from Crisis Care can be done adequately. Prisoners are put straight back into mainstream. Given that suicide is an unpredictable condition, and that the clinical judgement of a pre-suicidal state is notoriously poor, it would seem that outright discharge from CCU is a mistake. The infirmary at Casuarina is now being used as a de facto "Intermediate Care Unit", but a designated facility is needed.

This means the establishment of a unit where prisoners can be observed by trained staff in an environment sensitive to behavioural changes which demonstrate progression either toward normality (and mainstream) or toward suicide (and CCU). The length of stay would be variable and depend on the prisoner's mental state.

Training of all prison staff in suicide awareness

Staff have some formal training in suicide awareness, but compared with CPR training, which must always be current, in practice there is very little. Suicide is as terminal a condition as cardiac arrest, and it is recommended that all staff have a simple, and regularly updated, course in the recognition and treatment of suicidal behaviour.

Strategies suggested by these findings:

1. *Prison officers should have more time to interact with prisoners.*
2. *12-hour shifts should be replaced with 8-hour shifts.*
3. *Case management needs to be developed.*
4. *An effective welfare system needs to be established.*
5. *A manager of high-risk people should be appointed.*
6. *A model of suicide needs to be developed.*
7. *An intermediate care unit must be established.*
8. *Medical observation cells should be abolished or redefined.*
9. *All staff should be trained in suicide awareness.*

Difference between countries

Australia has very conservative rules of deaths in custody, so that every death in prison is seen as a potential unnatural death until proved otherwise by the coroner. True differences between jurisdictions are very hard to find, and interpretation is fraught with danger. For example, the United States of America has different suicide rules for different states – some are extraordinarily lax. For example, in one state a definition of death in gaol is defined by where the life is certified extinct. Since this is often the nearest hospital, there are few deaths in gaol! Some states have very low 'suicide' levels, and very high so-called 'unknown' levels.

Western Australia is said to have one of the highest suicide rates in the world, but comparison with other Australian states belies this. One of the clear findings in Western Australian suicide rates is that they are very variable. There are clusters – which appear to be random - in the data, which skews the rate depending on the baseline time reference. With a small number of randomly clustered events, it is necessary to sum them over a long time span to derive any sensible measure of the average rate. This necessarily means that trying to measure a rate for one year, or derive a change in rate over the last few years is meaningless. Direct comparison with much larger systems (such as UK) is difficult.

Juvenile Justice has no suicides – why?
It would appear attractive to use the (virtually) zero suicide rates in juvenile justice in Western Australia to point to a way to manage suicide in the adult system. Juveniles, with their high incidence of home breakdown, emotional lability, youth and risk-taking, drug-seeking behaviour should present a very high suicide risk if seen in adult terms – any adult with the same behavioural markers would be very prone to suicide.

However, juveniles are only in for a short time, they are heavily supervised, the custodial staff are highly motivated, well trained to observe behaviour and are expected to intervene with the prisoners.

Perhaps the salient point here is that there is a vast difference between the attitude and expectations of the custodial staff in juvenile and adult custody. In the juvenile system communication between staff and offenders is expected to be good. Staff are trained in psychological observation in the juvenile system, and it is both expected and evident that psychological counselling and intervention will be effective. In the adult system the introduction of effective interpersonal staff training is just beginning.

Furthermore the pattern of mental illness among young people is very different from adults. They do not present with major psychotic illnesses until their late teens or early twenties. Chronic mental illness is rarely a problem, unlike in adults. The personality is generally malleable in young people - unlike adults. Since the presence of mental illness is a very important factor in suicide, these differences explain a large part of the low juvenile suicide rate.

Assessment for suicidal risk

The present methods of assessment need to be re-examined to deliver a more accurate and useable rating of prisoners risk status, both on entry and at any time during the prisoner's sentence. It is only with a clear understanding of risk that an effective method of management can be developed and used effectively. The Department of Justice currently manages suicide by responding to suicidal crises and not by pre-emptive measures.

The overall strategy suggested by the committee was to recognise the need for a structured assessment as the prisoner enters the system, and that this assessment needs to be active for the duration of the prisoner's sentence. Several problems with current assessment procedures were identified:

Lack of a proper mental health examination

The risk of suicide is closely tied to the existence of a mental disorder, and mental disorders are common in prison. Furthermore, mental health problems are poorly managed in prison – mainly because there are simply not enough resources available. Before any other consideration of assessment and management, it is axiomatic that those prisoners who have a mental illness be identified, followed up, and properly treated throughout their sentence.

Strategy suggested by these findings:

- *Improve the resources for proper management of mental health in the prison system. This is probably the single change, which will make the biggest difference to suicide management in the gaol system and has the greatest likelihood of reducing suicide incidence.*

Recognise increasing uncertainty versus medical model

Much of the suicide 'problem' falls to the health staff. Since health staff have a poor tool to assess a prisoner, and have very little time during the day to gather information or effect change, it is not appropriate that health services are seen to 'own' suicides.

Health staff are trained to see morbid conditions in a different way to the model of suicide. They see progress in terms of a medical model – history, examination, diagnosis, treatment, prognosis. The progression through these stages is related to increasing certainty of management and decreasing risk.

Suicidal and at-risk behaviour by contrast does not follow this pattern – there is far less certainty of outcome as evaluation progresses, and 'treatment' is not properly addressed except by crisis management (counselling, observation cells and Crisis Care). It should be recognised that suicidal behaviour is far less predictable, and the factors affecting suicidal action are less obvious (and far more personal, individual and variable), than in medical conditions.

Problem of numbers – too many prisoners to assess

Clinical judgement is a poor way to assess at-risk status. Actuarial assessments are more likely to provide valid results. This means the development of questionnaires, structured data management, and a structured entry examination of all, or nearly all, prisoners.

Currently the ability to assess suicide risk suffers from its uncertainty, and so a large number of false positive prisoners are identified. The number of these identified 'positive' (or high risk) prisoners is too great to treat using the current methods. These methods themselves are of not only variable success, but also the ability to recognise a successful treatment outcome is poor.

A good actuarial system should be better than clinical judgement, and should be able to define the prisoners risk status more clearly. While it is suggested later that the ARMS is expanded, it is also obvious that the pool of 'at-risk' prisoners needs to be reduced.

"The major problem associated with risk screening is that most instruments will produce large numbers of false positives, that is, individuals identified as high risk who would not subsequently self-harm."[98] A screening device able to predict suicide with 75% accuracy, in an institution of 1,200 prisoners of whom 4 will commit suicide in the next year would correctly identify 3 suicides. However, it would also identify 299 of the 1,196 non-suicidal prisoners as suicidal.[99] Another disadvantage of at-risk assessments is that they become "little more than a paper exercise if the number of admissions to be processed is excessive in any given period of time".[100]

Structured intake progression – redefine chain of assessment

The committee recommended a far tighter chain of assessment when a prisoner enters the system, with a recognition that assessment starts with the reception officer, and proceeds to assessment nurse, FCMT, mental health nurse, psychiatrist (as needed), unit manager, and custodial officers. This chain of data needs to be preserved in a language everyone can understand, and it needs to be readily available and flexible enough to be altered as circumstance change.

MRO12 form

MRO12 Form is used by intake staff to develop a picture of a prisoner's personality and risk status. The MRO12 Form needs to be re-examined as a functional document in chain of assessment. (This process started in 2001 and is ongoing)

Protocol

A protocol for examination of a prisoner should be developed that allows receiving staff to put together a case formulation for management of prisoner. The current model is ad hoc, depending on interpretation of a prisoner's mental and emotional state by inadequately trained staff, or by staff operating according to disparate and personal views of suicidal risk.

[98] Dooley, (1994)
[99] Lester and Danto (1993)
[100] Evaluation of the Scottish Prison Service, p12

A formal mental state examination by trained staff will allow a structured assessment. This requires a pre-sorting by actuarial systems, because not all prisoners can be examined. Such an examination should occur early in the assessment process, should form the basis for risk assessment, and should be repeated as necessary during the sentence.

Skills

Currently nursing staff and the FCMT develop their skills in suicide management by experience, not by structured teaching. Many disciplines comprise the FCMT (occupational therapy, social work, and clinical psychology, psychology, mental health). The committee suggested the FCMT be refined to a separate discipline with a common working model and close similarity in their clinical skills.

Strategy suggested by these findings*:*

- *Redefine the way in which prisoners are assessed on entry to the prison system.*

Develop a Longitudinal Information System

Many times when reviewing a suicide it becomes clear that the behaviour culminating in suicide is the result of a progression of related events rather than an isolated collection of unrelated events. There are often markers of behaviour which, when put in context of the eventual suicide, become obvious; but when seen in isolation, as they so often are, become lost in the day to day management of a patient.

Currently, the management of behavioural instability and suicidal risk is based on a crisis response to events. The system is now reasonably efficient at managing a prisoner once they have been identified as 'at-risk', but is very poor at management either side of the event. Thus a prisoner in crisis is put into medical observation, transferred to Crisis Care, treated, declared 'fit' and discharged to mainstream. There is some follow up, but it is inadequate given the uncertainty inherent in suicidal behaviour. Not surprisingly suicides are often found to have been examined by trained staff and declared 'non-suicidal' shortly before the suicide. The staff are competent and experienced, and the finding does not belittle the ability of the staff, but it does clearly point to the fact that the clinical judgement is a poor predictor of suicide. Suicidal risk must be seen longitudinally (in time), and events in a patients life should be monitored and related to the whole rather than reacted to in isolation. Staff understand this, but there is no mechanism to allow it to happen.

Behavioural events and at-risk screening

In the current system, there is often asynchrony between behaviour and assessment. A prisoner can have an adverse event in one area of their life, which is not seen by the health staff (a bad visit for example). Alternatively they can be medically ill, unbeknown to the custodial officers, or if the illness is known, the officers do not see its significance (depression and schizophrenia being good examples where pathological behaviour can be mistaken for misdemeanour).

This asynchrony between assessment and behavioural events means that an assessment may take place that defines the prisoner as 'non-suicidal' (on entry for instance), but a subsequent interaction with the prison system (bullying for instance) causes a sudden change of suicidal intent ("trait and state"). Suicidal people are changeable, and, if mentally ill, can be chaotic in their thinking.

Essentially, we are trying to predict what a disturbed and unpredictable person will do next based on periodic examination by professional staff who simply do not have the data, or the clinical tools to make a reliable judgement. Not surprisingly, this can assess suicide risk a very hit-and-miss affair.

Reporting

The working party recommended that the justice system needs to develop a technique for reporting change in the prisoner over time. There is little contact between the functional day of health staff and the functional day of officers. Health staff have a deep-seated reluctance to allow 'confidential' health information to be shared by officers. The significance of this is far reaching, because officers cannot put a prisoner's behaviour into context. However, the ethics of what relevant information can reasonably be shared requires examination. The working party stressed that a common reporting language and system is needed (PRAG attempts this but in effect it works poorly and only in context of high risk prisoners).

Strategies suggested by these findings:

- *A common model for suicide needs to be developed.*
- *A common language for observing suicidal behaviour should exist.*
- *A longitudinal information system is necessary to pass observations between parts of the prison where prisoners are observed prisoners.*

Forensic Case Management Team (FCMT)

The FCMT is currently the mainstay of suicidal risk assessment and management of suicidal and self-harm behaviour. It is made up of staff from different backgrounds, with various ideologies and variable training. There is little standardisation of professional skills, and thus there cannot be a commonality of the understanding of abnormal behaviour.

The FCMT has little intellectual cohesion because of the varying professional backgrounds, resulting in an ill-defined management of risk and inadequate assessment. The working party recommends a review of the FCMT as follows:

- The FCMT need a much tighter structure, with greater professional expertise being concentrated in managing suicidal risk.

- The FCMT needs realigning with custodial staff in order to promote the free interchange of behavioural information. Some of the roles of FCMT should perhaps be aligned to prison management rather than health services in order to facilitate this.

- Reintroduction of social workers within the case management system. The social worker function has been lost, resulting in prisoners adrift in gaol with no ability to control those aspects of their life, which can generate the most disturbing behaviour.

- Allocation of difficult prisoners to skilled staff. In conjunction with a restructuring of the FCMT is the recognition that the skills of the staff should be matched to the risk of the prisoner.

Strategy suggested by these findings:

- *That the FCMT be reviewed, in particular with regard its training, the clinical ability of its staff, and their roles in managing disturbed and suicidal prisoners.*

PRAG AND ARMS

Prisoner Risk Assessment Group (PRAG)

The PRAG attempts to manage a prisoner who has been identified as being at-risk of suicide by appointing a group of staff with the responsibility for oversight of the prisoner. The structure and reporting systems should ensure that the prisoner is seen by the group until such a time as the prisoner is judged 'safe'. While this is a well-organised system, which has been operating for some years, the working party suggested the following changes:

- **System review**

There have been no quantitative studies to test the efficiency of the PRAG as a system. It is recommended that a study be done of those who have been on the PRAG to establish how well it has operated, using such parameters as:

% deaths; and
% seen by a medic.

Whether or not the PRAG has dealt with, and prevented, many suicides is important given its high profile and the effort put into running the system.

- **Data system**

Review the efficacy of PRAG as a system for collecting and disseminating data. How good a 'longitudinal' system is it?

- **Aim of PRAG**

The original aim of PRAG was to show that a prisoner had been identified and managed as suicidal. If it has not already done so, this aim should now change to include active management of prisoners to prevent suicide. Review its efficiency as an assessment method in terms of *probability*, not in terms of *causal factors.* That is the question should be asked in the form: 'is the system designed to assess the probability of self-harm or is it designed to pick out trigger factors (which is unlikely to work)?'

Strategy suggested by these findings:

- *That the PRAG be re-examined, looking at its efficacy, its value as an information system, its aim, and its ability to predict probabilities of behavioural change.*

At Risk Management System (ARMS)

(See also Appendix 9: review of ARMS findings**)**

ARMS was established to devise procedures which moved away from the existing "medical model" for assessing and treating prisoners identified as at-risk of self-harm towards a unit management approach. The working party recommends a review concentrating on the following:

- **Size**

  It is suggested that the ARMS is too small for the numbers of at-risk prisoners, and that the Department of Justice should expand its resources. There is more multi-disciplinary input needed.

- **Improve manual**

  The manual is said to be difficult for officers to understand. Humanise the guidelines, write in non-bureaucratic English, so people can read and understand it.

- **Only used in a crisis – need more resources to address non-crisis**

  Education about the purpose of ARMS.
  Redefine suicide categories in terms of risk

- **Develop checklist for officers**

  Guidance exists for officers (module 5) but apparently, no one reads it. Perhaps a checklist is needed which is more user-friendly.

- **Suicide coordinator– perhaps for each prison and an overall coordinator for Hakea, Casuarina and Bandyup Prisons.**

  There is a need for one person to coordinate management of officers regarding suicide, quality of the ARMS, training etc. While the program has been running for some time, it is often easy to pick up mistakes and omissions that mitigate against its success.

Strategies suggested by these findings:

- *A review of the ARMS, its manual, its resources, and its size.*
- *Appoint a 'suicide coordinator' to ensure that the processes are effective and are followed.*

Surveillance for suicidal intent

The previous section has dealt with assessment of suicidal risk. This chapter addresses the need for continual surveillance of **suicidal behaviour**. At present, a large part of the management and identification of suicide depends on the medical staff. Clearly this can never work, because medical staff do not have the time to spend observing prisoners, nor do they have the ability to accurately judge suicidal risk (clinical judgement is known to be inaccurate in predicting suicide).

Prisoners need watching – not by overt observers, but by placing them in a milieu, which naturally allows observation, and then enabling surveillance to trigger warnings of behavioural abnormality. This is probably the most important issue in this document – even if assessment is perfect, the environment supportive, and the treatment effective, suicides will be missed if pre-suicidal or abnormal behaviour is not observed.

The working party considered the following areas:

Family support vital

The first line of contact for a prisoner is often their family, which provides a normalising and stabilising influence on disturbed behaviour. Particular attention should be paid to:

- Outcare
- Social workers with a brief inside and extending outside of prison gates.

Strategy suggested by these findings:

- *That an examination of Outcare, welfare, and external social work be undertaken with a view to establishing effective supporting links for prisoners.*

Officers need structured interaction

The officers provide the first line of observations in a gaol. Often they are the only way the appropriate staff and systems can be alerted to a pre-suicidal prisoner. Currently officers have a 12-hour roster, which virtually stops continuous relationships with prisoners because officers will work 3-6 days then leave for several days. Those officers on the 12 hour night shift never see the daytime behaviour of a prisoners, yet a lot of suicides occur at night. An eight-hour shift means that two shifts of officers span the prisoner's day, and that hand-overs can occur during that day. Changing the 12-hour shifts has problems because of union and staff resistance, but these shifts do so much to block officer-prisoner interaction that changing them is important.

Unstructured time with the prisoners is vital. Officers rarely have time, or perhaps the inclination, to chat to prisoners. Chatting to prisoners is simple, but is a powerful way to get to know the prisoners problems.

Structured talking sessions. It is suggested that unit meetings, or regular structured conversation sessions be initiated to formally encourage interaction between officers and prisoners. Subtle things like not allowing two officers in control room will force a culture shift from control to behavioural surveillance. It should also be noted that most of the suicides occur in the metropolitan prisons, and very few in the regional prisons where much more informal talking occurs.

Strategy suggested by these findings:

- *Officers have defined times and levels of interaction with prisoners.*

Prisoner support – external and internal

- Introduce social work services.
- Introduce welfare officers.
- Peer support is a valuable service, but sometimes they are seen as stooges, because INTEL uses them for information on prisoner actions. If INTEL were forbidden to use peer support officers, it would allow freer support (but cause security problems).
- Pre-release support vital. 'Gate fever' is a well known problem, and it has been said (by prisoners) that it is far more difficult to get out of prison and to rejoin the outside world than it is to get in.
- Support Outcare service for pre-release planning.

Strategies suggested by these findings:

- *Introduce social and welfare work staff.*
- *Separate peer support officers from INTEL.*
- *Increase pre-release planning.*

Need a common language and a common model

The working party emphasised very strongly that there is currently no common language to define behaviour in our system. Nor is there a common understanding of a model of suicide and at-risk behaviour from which all staff works.

Obviously there are a number of theories of suicidal behaviour, but we need to allow for this in the teaching and examination of suicide. It is no longer reasonable that staff identify patients according to shifting paradigms of behaviour, rather they should identify shifts in behaviour within an encompassing paradigm

Two new initiatives followed from the development of a common model.

1. A new method of handling suicidal prisoners. Essentially this involves **structured treatment** programs to teach suicidal people about their condition. The idea has grown out of a program at Melbourne University and is intended to be a collaborative venture between Melbourne, Adelaide and Western Australian University psychology departments. Western Australian prisons would provide an accessible pilot site and can be linked with a local university. Should Western Australian prisons adopt this pilot, it would be a new development in suicide management. Respected practitioners in the clinical psychology department at each of the three university centres support this proposal.

2. Use **structured logic** to form a longitudinal analysis of the probability of suicidal risk. A number of computer-based data analysis programs exist. The type of data inherent in prison behavioural reporting lends itself to the use of a data sorting technique called 'Ripple down rules'. This technique, developed at the University of New South Wales Computing Department, is used in many applications and currently is operational in a Perth pathology laboratory.

Developing a working model for suicide

The working party strongly identified one of the problems in the system as being the lack of a formal model for suicidal behaviour. This has two parts – on the one hand, staff are treating behavioural problems in an uncoordinated way, depending on their own training and understanding of self-harm behaviour. On the other hand, prisoners behave in different ways according to theories of suicidal risk. The working party suggested a need for the following developments:

- **A unified identifiable model**

A model that structures thinking when dealing with individuals – for example what would promote suicide, what would inhibit suicide, what opportunities are there for intervention? Most current models of suicide in the wider community apply to middle aged white people. In gaol, there is a completely different group of people. A framework of understanding must be developed and used that is applicable to the existing at-risk prison population of young adult males.

- **A common prison language**

Currently the way officers look at suicidal behaviour is very different from the way trained professionals look at it. Little common language crosses the boundaries. Since officers are probably as good as trained professionals at picking up behaviour which is out of context, a common language and a data system is needed.

- **Scale of input**

It is suggested that if a scale of risk of 0 – 5 be developed, then officers can have involvement in say 0,1,2 levels, the FCMT 2,3,4 and psychiatrists and mental health nurses 3,4,5.

- **Continuum of care**

The working party identified a clear need to develop a continuum of responsibility and of care that extended from the fellow-prisoners to the officers to the health staff. This probably means sharing of much more information than occurs at present.

- **A common assessment track**

Assessment has been discussed above, but inherent in a proper assessment is a language that others, including prison officers, can relate to.

- **Investigate data structures for longitudinal assessment**

Look at the way in which different parts of the prison staff can input into a common database (a so-called 'actuarial system') to generate a consistent longitudinal picture of a prisoner's emotional balance and risk of suicide. This database would then have a structured logic system (such as 'ripple down rules' discussed below) to interpret the links and formulate an at-risk probability.

Use a probabilistic model, not a causal model

Throughout this report, it is been stressed that identifying suicide prone prisoners is difficult. The reason is simply that suicide indicators are notoriously unreliable, mainly because they are too non-specific. Lester and Danto (1993) pointed out that "if we had a screening device that predicted suicide with 75% accuracy, in an institution of 1,200 prisoners of whom 4 will commit suicide in the next year, 3 of these 4 will be correctly identified. However, we will also identify 299 of the 1,196 non-suicidal prisoners as suicidal." Therein lies the heart of the problem with managing suicide in prison – to put it simply, using present screening methods (which are mostly based on clinical judgement) we do not know who is a suicide risk. We are overwhelmed with likely candidates, but do not have a structured way of dealing with them.

Broadly, there are two ways of approaching the problem of prison suicide:

One way of reducing the suicide risk is to make the whole prison environment less stressful. This report examines the current system and makes suggestions for changing the prison culture, improving mental health, making the prison more 'normal' and so on.

The second way is to improve the information management and screening of prisoners better to identify those at risk. This means using 'indicators' to identify prisoners. The indicators have been derived from all the past suicides by the WA taskforce and are presented in Appendix 5. The real power of the University of WA study lies in the identification of the significant indicators from the 177 that were studied. However, each separate indicator is not reliable enough to be useful on its own, but combining certain indicators can greatly increase the chances of successful identification of a suicidal tendency, and this is what is proposed here.

The explanation lies in the laws governing probability, which apply to the suicide problem as follows:

Imagine several recreational fishing boats numbered 1,2,3....n trying to catch fish in a fishing competition, each boat being rather poor at hooking a catch. Say the probability of a boat catching a fish (based on previous performance) is P_n where 'n' represents the number of the boat. The probability P_n may be something like 0.9 (pretty accurate - 90% likely to catch a fish) or 0.05 (only 5% likely to catch one). For example, the accuracy may be for 4 boats, P_1=0.5, P_2=0.1, P_3=0.3, P_4=0.5 representing 50%, 10%, 30% and 50% accuracy respectively – or, at best, only as good as tossing a coin (50%). We would not have a lot of confidence in getting a meal from any one of these boats.

However, the situation changes markedly when all boats are fishing together. Then the total probability of a fish meal - P_t - when all are on the water together is:

$$P_t = 1 – (1-P_1)(1-P_2)(1-P_3)(1-P_4)$$

This works out at:

$$P_t = 1 - 0.5 \times 0.9 \times 0.7 \times 0.5$$
$$P_t = 1 – 0.15 \text{ or } 84\% \text{ chance of catching a fish}$$

This is clearly a lot better than each individual boat's chances.

The total probability increases rapidly as the number of individual probabilities are combined. In fact, imagine 6 combined probabilities (ie boats fishing together), each of 0.5 (ie poor fishing records - equivalent to tossing a coin), the chances of success are 98% when they all are out fishing at the same time (ie there is only a 2% chance that 6 boats, each fishing with 50% probability, will not catch a fish).

How does this apply to the prison system? The suicide taskforce examined 177 variables using the records for each suicide over 25 years, and analysed them in 3 ways – qualitative, quantitative (non-parametric) and quantitative (parametric). In Appendix 5, the parametric analysis by UWA shows two important sets of figures. The first is the 'attributable fraction', which lists those 50 factors which were present in several of the suicides. Table 1 shows these factors, and indicates that 11 were significant because they were commonly present. The second important set of figures is the tables of odds ratios for the 11 significant factors (tables 2-12). These odds ratios indicate how 'strong' a parameter each of the 11 factors is.

Thus, we know that we have 11 factors that commonly occur and are strongly linked to suicide. (Just as, in heart disease, commonly occurring factors are smoking, weight, blood pressure, cholesterol etc – all of which frequently occur in cardiac deaths and are strongly linked to heart disease).

If therefore we can combine a score of the 11 factors, then we will vastly increase our chances of indicating a suicidal tendency. Like the example of the boats and the fishing competition above, a combination of the 11 factors is far more powerful than any one or two of them. We do not even have to know exactly what the probability of success of each factor (the boats fishing record). It is sufficient to combine a number of low-probability factors to be reasonably sure that, if several agree, then the combined indication is a much higher probability result.

For example, if each factor were only 25% accurate (probability 0.25), then if 6 of the 11 are present in an individual prisoners assessment there is a probability of

$$P_t = 1 - (1- 0{,}25)^{11} = 0.82 = 82\%$$

that there is in fact a suicidal tendency in this individual.

This illustrates the power of this sort of analysis. It is not only more objective, but also likely to be far more accurate than clinical judgement (known to be poor, and shown to be poor in WA prisons in Appendix 5). (The power can actually be increased by the using 'negative suicide factors'. At the bottom of Table 1, Appendix 5, is a list of 10 further factors that are not associated with suicide. Some of these can be used to indicate a decreased likelihood of suicide when combined with the 11 positive factors).

Current methods of suicide assessment in our prison system are poorly organised, badly integrated, and inaccurate. It is suggested that the sort of probabilistic technique described here, based on the significant factors delineated by the UWA analysis, be used to indicate which prisoners have suicidal tendencies.

Implementing this objective technique is not - in principle - difficult, since all the information is actually (or potentially) available on each prisoner (data for the study was, after all, extracted from the existing records of past suicides). What is needed is a formal method of combining the significant factors and of acting upon the probability of suicide so indicated.

Put simply, if the data can be reliably collected on a number of significant factors, based on the UWA study in Appendix 5, then the likelihood of suicide increases with an increasing number of factors which apply.

Structured Treatment as a Way of Suicide Reduction

The working party examined a new way of treating suicidal behaviour by looking at it as a treatable condition. Those who had been identified as suicidal would be put into a treatment program (in much the same way as the anger management program etc) that addressed their problem. There is a precedent for this in Melbourne, and interest has been shown by University of SA in joining in such an initiative. The treatment program can be developed in conjunction with Western Australian, South Australian and Victorian universities and a proposal is being drafted for consideration by the Department of Justice.

Strategy suggested by these findings*:*

- *The Department of Justice invites a pilot study of a suicide awareness treatment program for prisoners.*

IT Based system – 'Ripple Down Rules'

The development of a common language and a common database for management of suicide risk on a system wide basis implies that a structured data management system be adopted. Given the variety of factors which are necessary to build up a behavioural picture of a prisoner (the actuarial assessment of a prisoner, the mental health assessment, the officers notes, case management, fellow-prisoners observations etc), coupled with the variety of models of suicidal behaviour, the development of an estimate of suicide risk from a suitable database is a complex problem. Currently there are data management techniques which can address this, and which have been used in other fields with success. These are based on artificial intelligence, and fuzzy logic, but more specifically on a method called 'Ripple down rules' which is more structured and can handle complex input. The working party recommends that this data management system be investigated.

Strategy suggested by these findings:

- *Investigation of intelligent software such as 'Ripple down rules' to manage prisoner suicide probability rating.*

General ideas for harm reduction

There are always a number of general areas that can be improved, and the committee generated a long list of ideas which fall into the following categories:

Dormitories

If prisoners live together, the surveillance is of a completely different nature to that in a single or double cell. The chances of a suicidal, depressed or emotionally disturbed prisoner being noticed, and perhaps supported, by their colleagues is vastly increased.

Unit placement

Prisoners are often moved to unsuitable placements because of the exigencies of muster. This clearly causes problems in some areas, and, while efforts are made to place prisoners in compatible environments, they are not always successful. Units are overcrowded and therefore cannot be too specialised. If the numbers lessen, the chance of improved placement increases.

Social environment

The social environment of a prisoner is very important, and this can be helped by case management, and effective social work in addition to the above.

Visits

If a prisoner has a supportive family, they are probably the best antidotes to emotional distress. Visits are especially important in medical observation and crisis care (but the result of a bad visit can also be catastrophic). Currently it is not always possible to allow visits in Medical Observation Cells because of staffing problems, and this should be addressed.

Listeners – prison listener scheme

Another idea to increase contact is to have experienced prisoners as mentors or counsellors to their colleagues. In other jurisdictions, ex-prisoners are employed to visit existing prisoners. In Western Australia, a 'befriending' scheme exists in some prisons.

Samaritans

The Samaritan help line is a valuable resource, which was explored some years ago, but fell by the wayside and is now being re-instated.

Aboriginal Visitors Scheme
The Aboriginal Visitors Scheme works well, but could perhaps be extended.

"Everyone needs a Mum and Dad"
This simple view probably holds a great deal of truth. Dr Ole Ingstrup, visiting consultant on prison management, has said that in Canada the concept has arisen that every young man needs the approval of an older man. There may well be merit in this in our system, given that most of our prisoners and suicides are young males.

Normalising the prison environment
Televisions have a settling influence on prisoners, relieve the boredom and deflect some of the frustration and anger of imprisonment. Officers report a lessening in adverse behaviour during the football season, probably because prisoners are watching television.

Gameboys
'Gameboy' electronic toys also occupy prisoners, probably more than televisions.

Programs directorate – normalising
The programs offered to prisoners are limited to anger, sex and substance abuse, and while they normalise those behaviours could probably be extended to other matters.

Structured day
There is a current push to develop a structured day for prisoners that will see their time being organised around prison activities and thus reducing boredom.

Structured unit meetings
This has been discussed above, but should be reiterated as a way of involving prisoners in a normalised relationship with prison life in that they have some input into their disposition.

Cell colour scheme
Cell colours are uniformly rather drab and some benefit may be gained by brightening up the colours.

Calling prisoners by an honorific
One prison in the United Kingdom introduced a requirement for the officers to call all prisoners by an honorific, apparently with good effect.

Information
While prisoners can benefit from written material, it should be remembered that not all prisoners can read.

Suicide book
A book compiled from stories of prisoners who avoided committing suicide.

Suicide booklet
A short booklet giving simply understood information on what to do if a prisoner has suicidal feelings.

Internal radio
There are funds available to Aboriginal communities to develop a radio broadcast for prisoners. They could introduce health messages as well as playing appropriate music and reduce the feeling of dislocation for Aboriginal prisoners.

Videos, CD ROMs
Using these media to enhance the anti-suicide message.

Strategies suggested by these findings:

The Department of Justice considered the following:

- *Televisions and Gameboys.*
- *'Normalising' behavioural programs.*
- *Structured unit meetings.*
- *Cell colours changed.*
- *Call prisoners by an honorific.*
- *A suicide book, booklet, CD, tapes.*
- *Aboriginal prison radio.*

Suicide coordinator

There is a need for someone to coordinate and oversee the quality of all these methods by which the system assesses, monitors, and handles suicidal prisoners.

CHAPTER 6 CONCLUDING REMARKS

Being remanded or sentenced to imprisonment is stressful, even for those prisoners who have been to prison before. Separation from family and friends with the consequential risk of relationship break-down, loss of income and employment, a sense of being alone in a potentially hostile environment, are all significant stresses. In addition, there is a symbolic loss of identity as a prisoner dons prison clothing and moves from being a free citizen and becomes a 'prisoner'.

Goffman (1961)[101] vividly describes the sense of loss experienced by prisoners when they first enter prison.

> "The inmate, finds certain roles are lost to him by virtue of the barrier that separates him from the outside world. The process of entry typically brings other kinds of loss and mortification as well. We very generally find staff employing what are called admission procedures, such as taking a life history, photographing, weighing, fingerprinting, assigning numbers, searching, listing personal possessions for storage, undressing, bathing, disinfecting, hair-cutting, issuing institutional clothing, instructing to rules and assigning to quarters."

So begins "a series of abasement's, degradations, humiliations and profanation of self".[102] Security searches that require a prisoner to hold his or her body in a humiliating pose, two person cells that deny privacy for the performance of ablutions, the odours of communal living, embarrassment about body image, mail from home being read and censored and visits with family held in public. To this, add the fear of bullying and if a sex-offender, a need to be held in protective custody, away from other prisoners.

Remand imprisonment can sometimes last for up to a year. There is a continuous throughput of remand prisoners, which makes it difficult for prisoners to make friends. The uncertainty of the future combined with the difficulty of building friendships and support make this a particularly stressful time. If there is also a background of mental illness or substance abuse, the stresses are significantly increased.

A risk-screening procedure has been established as a standard part of the prisoner reception process in all prisons. Within 24 hours of being received a prisoner who presents as being at-risk of self-harm is assessed by custodial staff (using an MRO11 form) and/or by health staff (using an MRO12 form).

"The major problem associated with risk screening is that most instruments will produce large numbers of false positives, that is, individuals identified as high risk who would not subsequently self-harm."[103] The magnitude of this difficulty is highlighted by pointing out that a screening device that was able to predict suicide with 75% accuracy, in an institution of 1,200 prisoners of whom 4 will commit suicide in the next year would correctly identify 3 suicides. However, it would also identify 299 of the 1,196 non-suicidal prisoners as suicidal.[104] Another disadvantage of at-risk assessments is that they become "little more than a paper exercise if the number of admissions to be processed is excessive in any given period of time".[105]

[101] "Essays on the Social Situation of Mental Patients and other Inmates,"
[102] .Ibid p 24
[103] Dooley, (1994)
[104] Lester and Danto (1993)
[105] Evaluation of the Scottish Prison Service, p12

The identification of mentally ill prisoners brings a number of definitional problems. Do we include personality disorders? "What do we mean by mentally ill? Findings indicate that personality disorders represent a major risk factor for suicidal behaviour, at a level comparable to major depression and schizophrenia."[106] Do we include substance abuse? It is estimated that between 70 and 80% of the prison population may be substance abusers.

A cohort analysis of the prison population for the Department of Justice in Western Australia (an administrative survey of prisoners conducted on the 23rd February 2000) identified 300 prisoners who were receiving medication or other treatment for psychiatric disorders. This represents 10% of the total prisoner population on that day. However, 20% of those receiving medication or treatment were female. Given that females represented 8% of the prisoner population on that day, they were disproportionately represented in this cohort.

Suicide occurs in the psychiatrically mentally ill. It is apparent that the mentally ill prisoners are generally identified and treated, but the ongoing management of this group that has proved inadequate.

The escalation of indicative behaviours (such as increased visits to health services) requires monitoring. "Before people kill themselves, or attempt to kill themselves, many of them have had a recent contact with a helping agency. Two-thirds of those that contact their general practitioner have received medication, which about half use to poison themselves."[107]

In 1999 the Chief Inspector Prisons (UK) undertook a detailed review of prison suicides, the product of which was a report published entitled *Suicide is Everyone's Concern: A Thematic Review*. The report concluded that prison suicides are not simply a function of an individual's vulnerability and circumstance, but are also influenced by the quality of the prison regimes and staff responses – or the overall "health" of the prison or prison system. The essential theme of this report was "care for and awareness of others…"

To achieve an improvement in the ongoing management of this group will require a cultural change in prison management. Suicide may be too often seen as an FCMT or health responsibility. As reported earlier, the general tendency is to treat suicide as a medical problem and refer the problem to a specialist. This can be taken too far as the ongoing management of at-risk prisoners must always involve a multi-disciplinary approach that includes all prison staff in the management process. However, it has been observed that "the concept of multi-disciplinary working as been open to much misinterpretation. To work as intended requires genuine partnership where the decisions on provision of support are dictated by the individual prisoner's need. There is always the risk that shared responsibility equates to diminished responsibility overall."[108]

In addition, the Department of Justice should consider adopting the concept of a "*Healthy Prison*" from the United Kingdom prison system. Under such a concept the well-being of prisoners may be given greater prominence so that:

- the weakest prisoners feel safe;
- all prisoners are treated with respect as individuals;

[106] Linehan et al (2000)
[107] Stenager and Jensen (1994)
[108] McHugh (2000)

- all prisoners are busily occupied and expected to improve their skills and abilities; and

- all prisoners can strengthen links with their families and prepare for release themselves and are given the opportunity to do so.

To this end the *Key Recommendations* formulated from the literature review, data analysis of recent suicides in prison and the work of the three working parties, are directed achieving this goal.

SUMMARY OF KEY RECOMMENDATIONS

The Taskforce Steering Committee convened a workshop to formulate *Key Recommendations* from the work of the:

- Literature Review;
- Analysis of Suicide in Custody Data; and
- Three Working Parties.

The 12 *Key Recommendations* are as follows:

1. The enhancement of constructive and supportive relationships between staff and prisoners should continue to be a major priority for the prison system. Particular emphasis should be placed upon improvements to regimes, staff training and rostering arrangements to enhance these relationships.

2. Opportunities should be expanded for prisoner interaction with the outside world, particularly concerning family and friends.

3. Each prisoner should be provided with the opportunity to participate in constructive activities such as, employment, education and programs that build competency and address offending behaviour.

4. All aspects of prison operations and programs must recognise and be sensitive to the diversity of the prison population in terms of culture, ethnicity, gender and sentencing status.

5. The Department of Justice should give consideration to the reinstatement of a generic social work/social welfare service to complement prison officers' welfare role, with a particular emphasis on supporting prisoners in relation to family, relationship and other significant personal issues external to the prison.

6. Priority should be given to the provision of comprehensive mental health services to prisoners, including:

    - a multi-disciplinary model for screening and assessment of mental illness;
    - adequate mental health treatment and management resources and systems within prisons;
    - sufficient provision of external hospital accommodation for the treatment and management of acute mental illness; and
    - continuity of mental health care from specialist management and treatment facilities, back into the mainstream prison environment, and ultimately into the community.

7. Suicide awareness training should be provided to prison officers and other prison staff.

8. Prison reception and induction processes should be reviewed to reduce uncertainty and stresses associated with suicide and self-harm, and should incorporate a detailed assessment of risk of self-harm or suicide.

9. A consistent and well-researched model of suicide treatment should be developed and implemented in prisons.

10. A thorough evaluation of the current suicide prevention strategy (ARMS/PRAG) should be undertaken.

11. A longitudinal information system designed to identify behaviours indicative of suicide should be developed.

12. A position of *Suicide Prevention Coordinator* should be established with the task of overseeing implementation of the recommendations of this report and the ongoing development and refinement of suicide prevention strategies as well as serving as a focus for the system wide ownership of suicide prevention.

APPENDICES

APPENDIX 1 SELECTED RECOMMENDATIONS FROM THE RCIADIC

Number	Recommendation
122	• Governments ensure that staff recognise that they owe a duty of care to people in their custody • Standing instructions be issued to officers explaining that each officer owes a duty of care to people in their custody and that as a result of any breach of their duty of care which results in the injury or death of such persons they may be held legally responsible • That Governments should ensure that such officers are aware of their responsibilities and trained appropriately to meet them, both on recruitment and during their service.
123	Police and corrective services establish clear policies in relation to breaches of departmental instructions. Instructions relating to the care of persons in custody should be in mandatory terms and should be both enforceable and enforced. Procedures should be put in place to ensure that such instructions are brought to the attention of officers and understood by all of them, and that officers understand that they will be enforced. Such instructions should be made available to the public.
126	Risk assessment must be carried out on every person prior to that person being placed in a cell.

127	• Establishment of proper liaison systems with Aboriginal health services.
	• Establishment of specific protocols to assess and manage at-risk Aboriginal prisoners, specifically in relation to people with the following:
	  • Intoxicated persons.
	  • known epilepsy or diabetes sufferers
	  • previous history of self-harm/suicide attempts
	  • impaired state of consciousness
	  • angry, aggressive or otherwise disturbed persons
	  • persons suffering from mental illness
	  • serious medical conditions
	  • in possession of or requiring access to medication

129	Use of breath analysis to test alcohol levels on arrival
150	Correctional health care be at least equivalent to the standard available in the community
151	Wherever possible psychiatrists have knowledge and experience of Aboriginals patients.
152	Detailed communication guidelines to be developed and implemented for staff in correctional settings.
153	• Prison medical services should be subject to on-going review • Whatever service delivery model is adopted, medical services staff should be responsible to professional medical service persons rather than to prison administrators.
154	• All prison medical service staff should receive training on Aboriginal culture, lifestyle and health

Number	Recommendation
	• Prison medical service should consult with Aboriginal health groups • Correctional institutions should endeavour to employ Aboriginal persons wherever possible
155	All prison staff should receive training on Aboriginal culture, lifestyle and health
156	All Aboriginal prisoners should be subject to comprehensive at-risk assessment upon recital and should be seen by a medical practitioner within 24 hours of recital
157	Comprehensive medical history records to be kept and to be transferred with prisoners
158	While recognising the importance of preserving the scene of a death in custody for forensic examination, the first priority for officers finding a person perhaps dead should be to attempt to resuscitate and to seek medical assistance.
159	Medical resuscitation equipment should always be readily available.
160	All prison staff should receive CPR training & annual refresher courses.
163	Prison staff to receive regular training in use of the restraints and restraints should only be used as a last resort.
165	All care to be taken to eliminating/reducing self-harm potential of facilities, especially hanging points.
166	Formal mechanisms to be put into place for the exchange of information between prisons and police
167	No lesser standard of care for juvenile detention centres as for adult facilities
168	Prisoners to be located in a prison located as close as possible to family
169	Where (168) not possible, consideration to be given to providing assistance to facilitate visits to prisoner
170	Prison visit facilities should enable relatively normal family interaction to occur in relative privacy
171	Must give recognition to special kinship and family obligations which extend beyond immediate family in Aboriginal culture
172	Aboriginal prisoners to be entitled to regular visits from Aboriginal organisations
173	Introduction of shared communal facilities and living wherever possible
174 & 178	Employment of Aboriginal persons in all classifications
175	Introduction of an initial transition phase for prisoners prior to being introduced into the main prison routine.
175	A prisoner complaints officer at each prison
177	Screening of officers to prevent employment of persons with racist tendencies.
189	Make prison disciplinary procedures more expedient and simple
190	All alleged offences committed by prisoners in custody to be tried by a Magistrate, & if offences against general law the matters should be hear in an open public court
181	Every effort should be made not to place Aboriginal prisoners into segregated or isolated detention
182	Instructions to be issued to officers and enforced that they must interact with prisoners in a humane and courteous way, and any breach of this will be a serious breach of discipline.
183	Provide formal support to enable Aboriginal prisoners to form and maintain support groups within prison

Number	Recommendation
184	All Aboriginal prisoners to have the opportunity to perform meaningful work and access education
186	Prisoners should receive remuneration for all work and education undertaken.

Overall, the Report of the RCIADIC (1991) recommends that the number of Aboriginal people in Australian prisons needed to be reduced, and that this is the most important strategy in reducing the amount of Aboriginal deaths in custody.

APPENDIX 2 SUMMARY OF VINCENT COMMITTEE REPORT RECOMMENDATIONS

Number	Recommendation
2	Prisoners to be closely observed within first hours in custody, especially if alcohol is connected with prisoner
3	Specific cardiac complaint testing should be undertaken on all aboriginal prisoners received into custody & prison diets should be reviewed in connection with preventative measures against heart disease
4	When prisoners are found insensible officers should seek medical assistance immediately
5	Suicide prevention principles should be: • Treat prisoners as humanely as possible • Modern hygiene standards required in all institutions • Facilities reviewed and up-graded • Aboriginal prisoners should share accommodation with other Aboriginal prisoners • Interaction between Aboriginal and non-Aboriginal people should be facilitated
6	Head locks or neck locks should never be used
8	Duty of care thoroughly explained to officers
9	Officers to immediately seek medical care for prisoners if they have any doubts as to the prisoner's condition
10	Establishment of formal communication guidelines between prison medical service and Aboriginal Health Service
11	Prison medical service examine the provision of services by the Aboriginal Medical Service
12	Adequate first aid and CPR training for all officers
14	Specially trained reception officers
15	Transfer of medical information from police to prisons
16	There should be input from Aboriginal groups with regards to the design of new facilities
19	Emphasis should be placed on general preventative measures as a means of combating suicide with the on-going upgrading of facilities and direct supervision
20	Aboriginal visitor scheme should be implemented
21	Employment of Aboriginal persons and training for all officers on Aboriginal culture

APPENDIX 3 THE WA OMBUDSMAN REPORT

Report by the Western Australian Ombudsman on an Inquiry into Deaths in Prison in Western Australia: December 2000

In February 1998 the former Ombudsman of Western Australia commenced an 'own motion' investigation into deaths in prisons in this State (including deaths by natural causes) because of his – and public – concern about an increase in the number of prison deaths in 1997 which looked likely to continue following the suicide of five prisoners in the first six weeks of 1998. The in-depth investigation examined the 47 prisoner suicides between January 1991 and 30 June 2000 (plus a number of deaths by natural causes in the same period) and made more than 100 recommendations on all aspects of prison life. The circumstances of each death were examined in order to identify systemic deficiencies or stress factors that might increase a prisoner's vulnerability and lead to self-harm or suicide.

The Report of the Inquiry was not available publicly when the Taskforce completed its literature review. However, one of the authors of the Report is a member of the Taskforce and was able to provide comment on the results of the research conducted during the inquiry following its tabling in Parliament in December 2000.

The key conclusions in the Report were that: -

- offenders frequently enter prison in a vulnerable state, experiencing remorse for their crime with psychological and psychiatric problems that may be the result of traumatic histories and drug dependencies;
- this vulnerability is often exacerbated by the pressures of prison life, resulting in a greater risk of suicide than the rest of the community;
- prisoner health and welfare is the responsibility of all prison staff and requires the full involvement and commitment of all concerned working together;
- the nature and quality of interactions and relationships between prison officers can be a significant determinant of the 'health' of the prison system and whether prisoners at risk of self harm will be identified and managed in a way that reduces that risk;
- prison services such as health and education were under-resourced;
- prison health services often failed to provide sufficient and appropriate care to prisoners and were frequently over-ridden by prison operational considerations;
- there was a need for improved prison officer/prisoner relations;
- accommodation, access to education, meaningful employment and rehabilitation programs were inadequate;
- the Department's response to recommendations made by the various bodies which are required to investigate prison deaths appeared to lack coordination and commitment;
- there was no specific person in the Department with responsibility for responding to and pursuing recommendations made following the death of a prisoner; and
- the Department appeared to have accepted some of these requirements and deficiencies and had begun to take steps to formulate strategies and provide an environment in which improvements could be made.

The main recommendations in the Report included: -

- increased funding and resources for prison health services which should be provided by a body external to the Department;
- greater effort to encourage the involvement of Aboriginal medical services;
- provision of appropriate accommodation and services for special needs groups of prisoners such as those suffering the effects of substance abuse, those with a psychiatric disorder, and female prisoners;
- additional resources for the Forensic Case Management Team (FCMT) to enable ongoing monitoring of at risk prisoners and provision of self-help strategies, not just crisis care;
- improved facilities and services for female prisoners in regional prisons and increased education, employment and training opportunities for women at all prisons;
- the discontinuation of the use of medical observation cells as currently operated;
- review of selection and recruitment procedures for all prison-based staff to ensure that sufficient priority is given to a high level of communication and interpersonal skills;
- increased involvement of relevant community support organisations such as The Samaritans;
- expansion of the methadone program; provision of drug rehabilitation programs from the beginning of the sentence; and discrete detoxification areas in each prison;
- increased resources for the Prison Pharmacy to enable greater monitoring of prescription levels;
- acknowledgment of the importance of constructive activity in the prevention of suicide and self harm and in the rehabilitation of prisoners, and increased opportunities for education, employment and training at all prisons;
- additional resources for the Parole Board;
- improved procedures for prisoner transfers; and
- incorporation of a statement of prisoner rights in the *Prisons Act*.

The recommendations have been the subject of discussion and negotiation with the Department. A number have been introduced although others are dependent on the availability of funding.

APPENDIX 4 TABLES

List of Tables

Table 1: Types of Prison Suicides

	(1) Poor Copers / Situational	(2) Long Sentence Prisoners (e.g. intimate homicide or sex offenders)	(3) Mentally Disordered
Motivation	Fear / helplessness Distress / isolation	Guilt / No guilt	Alienation Loss of (self) control, fear / helplessness
Age	16 - 25	30+ (average 35) 1	30+
Proportion of Total Suicides	30 – 45%	5 – 20%	10 – 22% [109]
Situation	Acute	Chronic	Varied
History of previous self-injury	High	Low	Medium
Features	Often more typical prison population, i.e. acquisitive offences	Often (76%)[110] on remand, after midnight. Some well into sentence	Psychiatric history present; single, NFA.

Table 2 : Prison Suicide Rates per 100,000 prisoners

COUNTRY/ STATE	Year/s	Suicides in Custody Rate per 100,000 Prisoners
WA	1995	44
	1996	224
	1997	266
	1998	488
	1999	166
Australia	Average 1980-1998	180
UK	1996/97 & 1998/99	126
New Zealand	1996/97	120
	1997/98	150
	1998/99	140
USA	1996	22
	1995	21
Austria	1995	148
Belgium	1995	196
Canada	1992/1993	91
	1993/1994	185
	1994/1995	100
	1995/1996	121
	1996/1997	71
Denmark	1995	115
Finland	1995	92
France	1995	185
Germany	1995	153
Greece	1995	57
Ireland	1995	142
Italy	1995	101
Netherlands	1995	145
Portugal	1995	106
Scotland	1995	284
Sweden	1995	73

Table 3 :Suicides in Custody (UK)

Year	Suicides	Population (000)	Rate/100,000
1988	37	48.9	76
1989	48	48.5	99
1990	50	45.6	110
1991	42	45.9	92
1992	41	45.8	90
1993	47	44.6	105
1994	62	48.8	127
1995	59	51.0	116
1996	64	55.3	116
1997	68	61.1	111
1998	82	65.5	125
1999	91	64.8	140

Table 4: Suicide Rate – Australian General Community – State/Territory – 1998

State/Territory	Rate of suicide per 100,000
NSW	13.3
VIC	12.1
QLD	16.3
SA	16.1
WA	15.2
TAS	12.4
NT	21.3
ACT	9.5

Table 5: Methods of Suicide – Australian General Community 1979-1998

Method	Percentage
Hanging/strangulation	25
Firearms/explosives	23
Cutting/piercing	2
Poisoning	18
Jumping from a high place	4
Domestic gas	1
Drowning	3
Carbon monoxide poisoning	19

Table 6: Manner of Prison Deaths in Australia 1980-1998

Cause	Aboriginal	%	Other	%	Total	%
Self inflicted suicide	53	45	314	48	367	47
Natural causes	56	47	201	31	257	33
Homicide	5	4	57	9	62	8
Accident	3	3	83	13	86	11
Other	2	2	3	1	5	1
Not known	-	-	10	-	10	-
Totals	*119*	*101*	*668*	*102*	*787*	*100*

Table 7: Deaths in Prisons in WA (1/1/1988 – 20/11/2000)

Year	Suicide	Accident	Homicide	Natural Causes	Other	Total No	Rate / 100,000
1988	2			3		5	126
1989	2				1	3	125
1990	1	1		1		3	56
1991	1	2		3	2	8	53
1992	3				1	4	158
1993	2				1	3	96
1994	3		2	1		6	142
1995	1			4		5	44
1996	5				1	6	224
1997	6	2		4		12	266
1998	12			3	1	16	488
1999	4	1		3		8	133
2000	7			3		10	232
Total	49	6	2	13	7	89	165 (average over all years)
As % of all Deaths	*55*	*7*	*2*	*28*	*8*	*100*	-

Table 8: Deaths in WA Prisons by Gender & Aboriginality (01/01/1988 – 20/11/2000)

Year	Females	Males	Aboriginal	Non-Aboriginal	Total
1988		5	2	3	5
1989		3		3	3
1990		3		3	3
1991		8	2	6	8
1992		4		4	4
1993		3		3	3
1994		6	2	4	6
1995		5	1	4	5
1996		6	2	4	6
1997		12	3	9	12
1998	3	13	4	12	16
1999		8	2	6	8
2000*		10	4	6	10
Totals:	**3**	**86**	**22**	**67**	**89**
% of total Deaths:	**3**	**97**	**25**	**75**	
% prison population	**10**	**90**	**33**	**67**	

(* to 20 November 2000 only)

Table 9: Suicide as a Percentage of Prison Deaths in Australia

State/Territory	1995	1996	1998
New South Wales	32	20	50
Victoria	67	14.3	46
Tasmania	0	100	100
Northern Territory	0	0	0
Queensland	77	82	20
Western Australia	20	100	77
South Australia	54	20	67
Australia	**47**	**44**	**50**

Table 10: Deaths of Offenders – Community Corrections – Some Australian States

State	Year/s	No of Deaths	Average Client No	Rate per 1000 Clients
Victoria	1997-98	59	7,081	8.3
Queensland	1997-98	95	14,776	6.4
Western Australia	1997	32	5,900	5.4
South Australia	1997-98	36	8,375	4.3

Table 11: Suicide in Scottish Prisons 1976 –1993

	1976 – 1979	1980 - 1983	1984 - 1987	1988 - 1991	1992 – 1993
Mean annual ADP	4,850	4,830	5,265	4,930	5,447
Mean annual receptions	32,819	32,987	40,036	33,244	34,540
Suicides	14	12	23	20	14
Suicides per 100,000 ADP	72.2	62.1	109.2	101.4	128.5
Suicides per 100,000 receptions	10.7	9.8	15.0	15.0	20.2

Table 12: Suicide Motivation in UK Prisons 1972-1987

Motivation	Percentage of Suicides
Prison situation	40
Outside pressures	15.3
Guilt for offence	12.5
Mental disorder	22.4
Not known	9.8

Table 13: Imprisonment Rates in Australia 1982-1998

1982 - 1998	Rate / 100,000
NSW	160
VIC	80
QLD	178
WA	170
SA	120
TAS	83
ACT	88
NT	470
AUSTRALIA	***138***

APPENDIX 5 SUICIDE PREVENTION IN WA PRISONS

Suicide Prevention in WA Prisons

Analysis of data for the Suicide Prevention Taskforce

Kieran McCaul
Dept of Public Health
University of Western Australia

9380-1274
kmccaul@cyllene.uwa.edu.au

EXECUTIVE SUMMARY

Data were missing for a number of variables. While this is unavoidable in a study where the data are collected from administrative records, it does impact on the power of the study, and it does limit the extent to which multivariate methods can be applied. It is imperative that regardless of what future studies are done, that missing data be kept to a minimum. Unlike disease conditions like cancer or heart disease where cases for study are plentiful, when conducting a study of suicide in prisons, one does not have the luxury of a large pool of cases to sample from. Invariably, even when data are collected on all suicides in a prescribed period, the sample will be small.

It was possible to rank variables in order of their attributable fraction, which is crudely a measure of their importance as predictors of suicide. What is revealing in this ranked list of items is the grouping of similar items. At the top of the list are items that tend to measure characteristics of the prisoner's mental health. They are not all exclusively mental health items, *security rating* and *current sentence length* also rank high, but it does indicate, perhaps not surprisingly, that mental health characteristics are likely to be the most important determinants of a prisoner's risk of committing suicide.

The data contained suicide risk assessments made by medical officers, nurses and psychiatrists. Very few prisoners were assessed has being at high risk. Twenty-one prisoners who later committed suicide were assessed as being of no risk or were not assessed at all. Of 24 prisoners who were assessed as low risk, 17 subsequently committed suicide. Clearly then, current risk assessment practices are either missing prisoners who are at risk or failing to adequately assess the true level of risk.

To progress this work further, the best option would be extend it into other jurisdictions interstate. This would allow more data to be collected on those prisoners who have committed suicide in other States: an immediate increase in the sample size of cases. When selecting controls it would be good practise to sample four or five times as many controls as cases. Increasing the overall sample size of cases and controls would allow a more comprehensive multivariate analysis to be conducted. Improvement in risk assessment should be the main outcome of a study such as this. The main benefit of a good multivariate analysis would be the production of a screening instrument to target high-risk prisoners that would achieve this end.

INTRODUCTION

The following is a brief analysis of some of the data in the prisoner suicide data file. It includes a tabular and univariate logistic regression analysis of some of the important variables in the data as well as an investigation of the extent to which a multivariate logistic regression analysis could be undertaken.

The data set is small in size and this limits the extent to which a multivariate analysis can be done. This is further limited by missing data. These limitations will be discussed as well as some possible strategies for improving the data.

Statistical Analysis

For the analysis I have used logistic regression to estimate an odds ratio (OR). Since suicide can be considered to be a rare event, the odds ratio can be interpreted as a relative risk. So, for example, in Table 17, which examines the effect of age on risk of suicide, there are five age groups and the OR relates the risk of suicide in four of these (22-25; 26-30; 31-35; 36+ years) relative to the first age group (18-21 years). Thus the OR for the 26-30 age group is 1.58, meaning that prisoners in this age group are 58% more likely to commit suicide than prisoners aged 18-21. Another way of stating this would be to say that they are 1.58 times more likely to commit suicide.

For each table of logistic regression results I have also included the number and percentage of cases (died) and controls (alive), 95% confidence intervals for the odds ratios, and the p-value associated with each odds ratio.

A great advantage with logistic regression is that multivariate models of the data can be constructed allowing adjusted odds ratios to be computed. It was not been possible to conduct a comprehensive multivariate analysis because of the relatively small sample size and the level of missing data. Nevertheless, a multivariate model based on a subset of the variables is presented, with a discussion of its limitations.

To provide another way of looking at the data, I have constructed a table of attributable fractions for each of the variables that I have considered in the analysis. These are presented in order of highest to lowest. An attributable fraction is an estimate of the proportion of cases that can be attributed to the factor in question. These need to be interpreted with some caution, because suicide is not a condition for which there is only one cause, but rather there are many causes interacting and combining together. Thus, in Table 1, the attributable fraction for the security rating of the prisoner is 0.83. This would mean that *security rating* had a causal role, either directly or indirectly, in 83% of all suicides. It does not mean that *security rating* was the only cause of 83% of suicides; simply that it was involved in some way in 83% of cases. They are also crude estimates of the attributable fraction, unadjusted for the effects of other factors.

Missing data and other coding issues

Data were missing for a number of variables. While this is unavoidable in a study where the data are collected from administrative records, it does impact on the power of the study, and it does limit the extent to which multivariate methods can be applied. For example, *Family dislocation in childhood* that comes out in the univariate analysis as strongly associated with suicide (Table 8), is missing for 58 individuals out of 103. Similarly, *occupation* (coded as employed or unemployed) seems to be important, but is recorded for only 53 individuals (Table 20).

Generally, and not surprisingly, the most complete data are usually on those items that relate most directly to aspects of the prisoners time in prison, their conviction history, sentence length, etc. Unfortunately, as will be clear later, while these factors have some role in predicting suicide risk, the most important factors relate to the prisoners mental health; data on these factors are poorly recorded.

The use of the category ‘na’ which I assume means ‘not applicable’ is also a source of missing data. In some instances it is difficult to see why it is used. For example, for the *Total number of prison transfers,* 19 prisoners were coded ‘na or unknown’. For the *total amount of time in prison in previous incarcerations* 35 prisoners are coded ‘na’. These are probably those prisoners who have never been in prison before, but they should be coded as such. In some cases, it’s difficult to determine why a response would be not applicable and so I have assumed that the response is unknown. This only adds to the problem of missing data.

Consistency between variables is problematic. For example, 49 prisoners are identified as having a community history of self-harm. However, under *Method of self-harm in the community,* 50 are identified as having no history, and under *Amount of times self-harm in community,* 51 are identified as having no history. While the discrepancies are small there are, nevertheless, worrying.

It is imperative that regardless of what future studies are done, that missing data be kept to a minimum. Unlike disease conditions like cancer or heart disease where cases for study are plentiful, when conducting a study of suicide in prisons, one does not have the luxury of a large pool of cases to sample from. Invariably, even when data are collected on all suicides in a prescribed period, the sample will be small. Any loss of data because of missing information or erroneous coding will have catastrophic consequences for the statistical power of the study.

RESULTS

The data are in three groups: no self-harm (n=41, 39.8%); self-harm (n=11, 10.7%); and deceased (n=51, 49.5%). The third group comprises the cases, and the remaining 52, the controls. The total sample size is therefore 103.

Attributable Fractions

The data items used in this analysis are shown in Table 1 in rank order of attributable fraction. The confidence intervals for these attributable fractions (not shown) are very wide indicating a large degree of uncertainty in these estimates. For this reason the absolute rank order of each of these items should not be given too much credence. Nevertheless, what is revealing in this list of items is grouping of similar items. At the top of the list are items that tend to measure characteristics of the prisoner's mental health. They are not all exclusively mental health items, *security rating* and *current sentence length* also rank high, but it does indicate, perhaps not surprisingly, that mental health characteristics are likely to be the most important determinants of a prisoner's risk of committing suicide. At the bottom of the ranked list there tend to be those items that relate to the prisoners term of imprisonment or past history.

I have chosen to present these data items sorted by attributable fraction because it is a way of highlighting what are the most important variables. Normally this would be done with a multivariate analysis however, because of the small sample size and the extent of missing data in many variables, a full multivariate approach to the analysis of these data is not possible.

So when reading Table 1, the reader should keep in mind that these data are ranked in order to highlight, albeit crudely, what variables are likely to be important and therefore what data should be collected in a future study. To this end, I have spilt the Table 1 into three parts. The first part contains all those data items – there are 11 in all - that produced an attributable fraction greater than 50%. The second part contains those that crudely explained between 25% and 50% of suicide case and, in the last section, those that explained fewer than 25% of cases.

Table 1: List of factors in order of attributable fraction (AF).

Factor	AF
The following factors are considered significant (AF > 0.5)	
did prisoner demonstrate emotional distress during imprisonment	0.84
security rating of prisoner	0.83
current sentence length	0.83
Was the prisoner seen by a psychiatrist/psychologist/other health professional	0.78
was the prisoner engaged in constructive activities	0.78
total amount of time spent in prison in previous incarceration periods	0.66
family dislocation in childhood	0.63
last time prisoner saw a nurse	0.57
in medical observation prior to death	0.57
did prisoner threaten to commit suicide	0.54
deceased ever in psychiatric facility	0.52
THE FOLLOWING FACTORS ARE CONSIDERED NON-SIGNIFICANTS (AF < 0.5)	
on medication	0.49
was mental health disorder diagnosed	0.47
denied opportunity to communicate significant other	0.46
previous conviction history	0.44
usual occupation prior to incarceration	0.43
risk of suicide psychiatrist/psychologist placed him/her at	0.43
history of self harm in custody	0.42
previous conviction types	0.41
last time saw MO	0.41
previous convictions/offences burglary/theft	0.37
type of current imprisonment offence/s or alleged offence/s against the person	0.35
were actions recommended	0.34
death/relationship breakdown of significant other	0.33
was prisoner given psychological diagnosis	0.32
suffer from any medical condition?	0.3
history of self harm in community	0.29
did prisoner experience failure/disappointment	0.29
offender status at death	0.28
amount of sentence served or time spent on remand at death	0.28
times deceased seen by mo	0.27
did the prisoner report being bullied or stood over in current period of imprisonment	0.26

Table 1: List of factors in order of attributable fraction (AF) (cont.).

Factor	AF
risk of suicide placed by nurse	0.25
deceased had family links/support immediately prior to death	0.24
previous convictions/offences justice procedure/good order	0.24
any prison infractions during current period of imprisonment	0.23
placed in punishment during current imprisonment?	0.23
denied opportunity to communicate with significant other	0.22
THE FOLLOWING FACTORS ARE CONSIDERED SIGNIFICANT SINCE THEY APPEAR TO BE UNRELATED TO THE SUICIDES (AF < 0.20)	
times seen by nurse	0.20
if ARMS/PRAG applied level of risk	0.19
evidence deceased being stood over	0.19
types of prison infractions	0.15
age at death	0.14
did he/she pick fights	0.12
total number of prison transfers in current period of imprisonment	0.10
type of current imprisonment offence/s or alleged offence/s robbery/extortion	0.09
geographic proximity of family/significant others to deceased's incarceration lo	0.08
escape attempts	0.07
did imprisonment involve significant loss of status	0.04

Having made a decision about which variables are most important, we can now explore these further. The following section computes the odds ratios for each of the 11 variables that appeared in the top section of Table 1 using logistic regression. For each of these variables we will be able to estimate to what degree they increase the risk of suicide among exposed prisoners.

Logistic regression

Univariate logistic regressions have been conducted on all the variables listed in Table 1, but only those that appeared in the top section are considered here. The remainder are in appendix of this report. The top 11 variables according to attributable fraction in Table 1 were:

- did the prisoner demonstrate emotional distress during imprisonment;
- security rating of the prisoner;
- current sentence length;
- was the prisoner seen by a psychiatrist/psychologist/other health professional;
- was the prisoner engaged in constructive activities;
- total amount of time spent in prison in previous incarceration periods;
- family dislocation in childhood;
- last time prisoner saw a nurse;
- in medical observation prior to death;
- did prisoner threaten to commit suicide;
- ever in psychiatric facility.

The univariate results for these variables are presented in the next eleven tables below.

Table 2 that of those who demonstrated emotional distress during their imprisonment, 44 out of 55 (80%) committed suicide. Of those who did not demonstrate emotional distress during their imprisonment, 6 out of 41(14.6%) committed suicide. Clearly a greater proportion of prisoners demonstrating emotional distress during their imprisonment commit suicide than prisoners who are not emotionally distressed. They are at greater risk of committing suicide and the magnitude of this increase in risk is estimated by the odds ratio of 23.33: prisoners who are emotional distressed during imprisonment are more than 23 times more likely to commit suicide than a prisoners who do not. This is highly statistically significant (P<0.001).

(NOTE: normally I would not present percentages to the second decimal point, but this is the way that they have been calculated in my statistical package and I have used them as is, rather then edit them to one decimal point.)

Table 2: Did prisoner demonstrate emotional distress during imprisonment?

	Alive	Died	OR	95% CI		p-value
No	35	6	**1.00**	-	-	
	85.37	*14.63*				
Yes	11	44	**23.33**	7.85	69.35	**<0.001**
	20.00	*80.00*				

Total	46	50
	47.92	*52.08*

Security rating of prisoner

In

Table 3, it can be seen that the risk of committing suicide is higher for medium and maximum security prisoners than for minimum security prisoners. Both medium and maximum severity prisoners are about 10 times more likely to commit suicide than minimum security prisoners (P=0.003).

Table 3: Security rating of prisoner

	Alive	Died	OR	95% CI		p-value
maximum	21	37	**10.13**	3.08	33.27	**<0.001**
	36.21	*63.79*				
medium	6	10	**9.58**	2.21	41.55	**0.003**
	37.50	*62.50*				
minimum	23	4	**1.00**	-	-	
	85.19	*14.81*				
Total	50	51				
	49.50	*50.50*				

Length of current sentence

Compared to prisoners with a short prison sentence (less than 6 months), prisoners on remand are 9.5 times more likely to commit suicide (p=0.006), whereas prisoners with a longer sentence (greater than 2 years) are more than 15 times more likely to suicide (p=0.002).

Table 4: Length of current sentence

	Alive	Died	OR	95% CI		p-value
<6 months	12	2	**1.00**	-	-	
	85.71	*14.29*				
6mth-2yr	15	4	**1.6**	.25	10.27	**0.620**
	78.95	*21.05*				
>2yr	7	18	**15.43**	2.73	87.28	**0.002**
	28.00	*72.00*				
Remand	17	27	**9.53**	1.89	47.93	**0.006**
	38.64	*61.36*				
Total	51	51				
	50.00	*50.00*				

Was prisoner seen by psychiatrist, psychologist or other health profession

Prisoners who had seen a psychiatrist or psychologist (Table 5) were nearly 12 times more likely to commit suicide than a prisoner who had not ($p<0.001$).

Table 5: Was prisoner seen by psychiatrist, psychologist or other health profession

	Alive	Died	OR	95% CI		p-value
No	31	7	**1.00**	-	-	
	81.58	*18.42*				
Yes	15	40	**11.81**	4.29	32.50	**<0.001**
	27.27	*72.73*				
Total	46	47				
	49.46	*50.54*				

Was the prisoner engaged in constructive activities?

Whether or not a prisoner was engaged in constructive activities can also be seen to be an important risk factor. In Table 6 we can see that those that were not engaged in such activities were nearly 10 times more likely to commit suicide than those that were ($p<0.001$).

Table 6: Was the prisoner engaged in constructive activities?

	Alive	Died	OR	95% CI		p-value
Yes	18	5	**1.00**	-	-	
	78.26	*21.74*				
No	13	35	**9.69**	2.99	31.47	**0.000**
	27.08	*72.92*				
Total	31	40				
	43.66	*56.34*				

Total amount of time spent in prison in previous incarceration periods

The relationship between the total amount of time previously spent in prison and the risk of suicide is not strictly linear as can be seen in 7. If those prisoners who have never been in prison before are used as our reference level, then we can seen that prisoners who have previously spent up to 12 months in prison are over 6 times more likely to commit suicide and prisoners with a total prior imprisonment of more then 3 years are over 12 times more likely. Prisoners with a total time between 1 and 3 years are only just over 2 times more likely to commit suicide. Table 7: Total amount of time spent in prison in previous incarceration periods

	Alive	Died	OR	95% CI		p-value
Zero	23	9	**1.00**	-	-	
	71.88	*28.12*				
<12 months	9	22	**6.25**	2.09	18.64	**0.001**
	29.03	*70.97*				
1-3yr	8	7	**2.24**	.63	7.99	**0.216**
	53.33	*46.67*				
>3yr	2	10	**12.78**	2.33	70.12	**0.003**
	16.67	*83.33*				
Total	42	48				
	46.67	*53.33*				

Family dislocation in childhood

Family dislocation was a significant factor associated with the risk of suicide (Table 8). Prisoners with a major history of family dislocation were over 10 times more likely to suicide than prisoners with no such history, while prisoners with some history were 4 times more likely to suicide.

Table 8: Family dislocation in childhood

	Alive	Died	OR	95% CI		p-value
Yes, major	1	12	**10.5**	1.08	102.48	**0.043**
	7.69	*92.31*				
Yes, some	3	14	**4.08**	.82	20.38	**0.086**
	17.65	*82.35*				
None	7	8	**1.00**	-	-	
	46.67	*53.33*				
Total	11	34				
	24.44	*75.56*				

Last time prisoner saw a nurse

Recent consultation with a nurse was also significantly associated with suicide. Prisoners who had seen a nurse in the last week were over three and a half times more likely to commit suicide than prisoners who had not had such a recent consultation (Table 9).

Table 9: Last time prisoner saw a nurse

	Alive	Died	OR	95% CI		p-value
>1 wk	19	10	**1.00**	-	-	
	65.52	*34.48*				
<1 wk	19	36	**3.60**	1.40	9.27	**0.008**
	34.55	*65.45*				
Total	38	46				
	45.24	*54.76*				

Was the prisoner under medical observation?

If a prisoner had been under medical observation then they were over 10 times more likely to commit suicide (Table 10).

Table 10: Under medical observation?

	Alive	Died	OR	95% CI		p-value
No	38	18	**1.00**	-	-	
	67.86	*32.14*				
Yes	6	30	**10.56**	3.73	29.88	**<0.001**
	16.67	*83.33*				
Total	44	48				
	47.83	*52.17*				

Did the prisoner threaten to commit suicide?

If a prisoner had threatened to commit suicide they were over 27 times more likely to actually commit suicide than a prisoner who had not made such threats (Table 11).

Table 11: Did the prisoner threaten to commit suicide?

	Alive	Died	OR	95% CI		p-value
No	44	16	**1.00**	-	-	
	73.33	*26.67*				
Yes	2	20	**27.5**	5.77	131.14	<**0.001**
	9.09	*90.91*				
Total	46	36				
	56.10	*43.90*				

Was the prisoner ever in psychiatric facility?

If prisoners had ever been in a psychiatric facility their risk of committing suicide was over 26 times higher than the risk experience by prisoners with no such history.

Table 12: Ever in psychiatric facility?

	Alive	Died	OR	95% CI		p-value
No	44	20	**1.00**	-	-	
	68.75	*31.25*				
Yes	2	24	**26.4**	5.68	122.68	<**0.001**
	7.69	*92.31*				
Total	46	44				
	51.11	*48.89*				

Multivariate Logistic regression

If we take the eleven variables discussed above, we can construct a multivariate model that will provide us with odds ratios that are adjusted for the other factors in the model. The rationale for doing this is that the odds ratios presented above are crude estimates and are subject to confounding influences of other variables. A multivariate model will allow us to estimate odds ratios that are adjusted for these confounding effects.

Taking the 11 variables above and entering them together into a logistic regression resulted in a extremely poor model because, after missing data were excluded, there were only data for 16 prisoners left to construct the model.

Family dislocation was missing for 58 prisoners and *engaged in constructive activities* was missing for 32 prisoners. If we exclude these variables from the model, we are left with data for 56 prisoners – still not adequate to construct a robust model.

After variables were excluded, basing decisions more on the size of standard errors and p-values, the following model (Table 13) was arrived at. This model contains the following variables:

- did the prisoner demonstrate emotional distress during imprisonment;
- security rating of the prisoner;
- did prisoner threaten to commit suicide;
- ever in psychiatric facility.

Table 13: Multivariate logistic regression results.

		OR	95% CI		p-value
Distress	No	**1.00**			
	Yes	**8.92**	1.69	47.19	**0.010**
Security Rating	Minimum	**1.00**			
	Medium	**6.04**	0.31	118.94	**0.237**
	Maximum	**22.70**	1.88	274.23	**0.014**
Threats	No	**1.00**			
	Yes	**9.37**	0.88	99.42	**0.063**
Psychiatric Facility	No	**1.00**			
	Yes	**14.87**	1.23	179.78	**0.034**

Table 2, now has a reduced odds ratio of 8.92. Similarly, the odds ratio associated with making suicidal threats has reduced, as has the odds ratio associated with previous contact with a psychiatric facility. The adjusted risk associated with security rating has now more than double for those rated as maximum security (previously 10.13, now 22.7) and the risk associated with medium security prisoners has reduced to 6.04 (previously 9.58). So before adjustment, there was little difference between the risk of suicide for either medium or maximum security prisoners. After adjustment for suicidal threats, history of contact with a psychiatric facility and emotional distress however, there is now a great disparity between the maximum and medium security prisoners.

What this multivariate model is now telling us is that prisoners in maximum security are over 22 times more likely to commit suicide regardless of whether or not they have shown signs of distress, or threatened suicide or had a history of being in a psychiatric institution. Similarly, prisoners with a history of being in a psychiatric institution are over 14 times more likely to commit suicide than prisoners who have not been in such an institution, regardless of there security rating or whether or not they have shown signs of distress, or threatened suicide. The odds ratios in Table 13 are therefore interpreted as the effect of each variable independent of the effects of the other variables in the model.

The point of this multivariate analysis was to illustrate the potential that such an analysis offers in its ability to tease out important effects. This is still a very crude analysis however, if there were more data and less missing data, a more comprehensive model could be constructed. It should be noted that only data from 75 prisoners were used in the above regression, data for the remaining prisoners were missing. This represents a 25% loss of information.

The adjusted odds ratios above also assume that each effect is independent of the other. With more data it would be possible to test this and to model interactions between variables this creating a model of the data that would provide greater insight into the problem of suicide in prisons.

Finally, and this is the most important reason for conducting a good multivariate analysis, it is possible to use the results of a multivariate analysis to create a screening instrument to target high-risk prisoners. As we will see in the next section, the ability of medical staff to assess the risk level of prisoners is currently very poor.

Risk assessments

Contained in the data set are suicide risk assessments made by medical officers, nurses and psychiatrists. In each of these there are a large number of prisoners coded 'na' which we will assume to mean that no assessment was carried out. Given this, we can see that for the prisoners in this data set, medical officers assessed only one as high risk and one as medium risk (Table 14). Both subsequently committed suicide. Twenty-four prisoners were assessed as low risk of whom 17 subsequently committed suicide. The majority of prisoners, however, were assessed as being of no risk or were not assessed at all. Twenty-one prisoners who later committed suicide were in these categories.

Table 14: Medical Officer's suicide risk assessment

Risk	Alive	Died
High	0	1
	0.00	*100.00*
Medium	0	1
	0.00	*100.00*
Low	7	17
	29.17	*70.83*
No discernable risk	17	6
	73.91	*26.09*
NA	23	21
	52.27	*47.73*

A greater proportion of prisoners had their suicide risk assessed by nurses (

Table 15. However, 29 prisoners who subsequently committed suicide were either not assessed or were assessed as being of no discernable risk.

Table 15: Nurse's suicide risk assessment

Risk	Alive	Died
High	0	2
	0.00	*100.00*
Medium	0	0
	0.00	*0.00*
Low	7	14
	33.33	*66.67*
no discernable risk	23	22
	51.11	*48.89*
NA	18	7
	72.00	*28.00*

Psychiatric or psychological assessment of suicide risk resulted in no prisoner being assessed above the low level of risk (Table 16). Twenty-four prisoners who later committed suicide were assessed as having a low level of risk. The remaining 23 were either not assessed or were assessed as being of no discernable risk.

Table 16: Psychiatrist's / psychologist's suicide risk assessment

Risk	Alive	Died
High	0	0
	0.00	*0.00*
Medium	0	0
	0.00	*0.00*
Low	7	24
	22.58	*77.42*
no discernable risk	9	3
	75.00	*25.00*
NA	32	20
	61.54	*38.46*

Clearly then, current risk assessment practices are either missing prisoners who are at risk or failing to adequately assess the true level of risk.

RECOMMENDATIONS

Categorising data.

Some of the variables contain time intervals (for example: amount of sentence served; proximity of last transfer to death) and these have been coded in categories. It is preferable to collect the relevant dates and calculate these intervals during the analysis.

Similarly, when the number of events of a particular type is of interest (for example: number of previous conviction), then the number should be recorded rather than categorized.

Coding 'Not Applicable'

A number of data items had significant numbers of prisoners coded with the response 'not applicable'. At times it was difficult to see why a response would be not applicable. In other instances it was difficult to distinguish between unknown and not applicable. The net result of coding data like this is that it results in missing data.

Increasing the number of controls

Because the sample size is severely hampering analysis of this data, an option is to increase the sample size. Obviously the sample of cases is limited to what is available, but the control sample could be enlarged. Currently there is approximately one control per case. This could be increased to four controls per case and this would result in an increase in statistical power.

The absolute number of cases is, however, a limiting factor. If data are missing for cases, then these cases will be excluded from a multivariate analysis. A cursory examination of the missing data reveals that where data are missing they are missing for about twice as many controls as cases. For example, for *family dislocation*, data are missing for 58 prisoners – 17 cases and 41 controls.

So even increasing the number of controls may not necessarily provide a better data set for analysis. If the data that is missing for the cases could be retrieved from the prison administrative records, then this would obviously reduce this problem.

Another option is to extend the study into other States thus increasing the number of cases. This would be the better option. It is likely that missing data are going to plague any study relying on administrative records. So, while extending the study to other States might be more expensive, it would more than likely result in better data set.

Final comments

While this analysis has been only very cursory, some indications are already evident as to what the most important variables are likely to be in any attempt to predict suicide risk.

- The odds ratios associated with some of the factors measured in this study are very large. If we were study breast cancer for example were would be looking at factors that typically produce odds ratios of around 1.5 to 2.5. Odds ratios greater then 3 are usually considered to be very important. In this study we are seeing odds ratios in the range of 10 to 25. These are indicative of very strong risk factors.

- As has already been mentioned, the variables that appear near the top of Table 1 are largely measuring some aspect of the prisoner's mental health. Clearly then, and not surprisingly, these variables will be the most important in assessing risk. Unfortunately, they tend also to be the variables that contain the most missing data.

- The variables describing aspects of the prisoner's term in prison (for example, their present conviction, previous convictions, and periods of imprisonment both current and previous) can all be obtained without any significant loss due to missing data. However, these data in general do not appear to be that important as predictors of suicide risk.

- The assessments of suicide risk current performed by medical officers, nurses, psychiatrists or psychologists, do not appear to be particularly sensitive with most prisoners who later commit suicide being assessed as being of no discernable risk or not being assessed at all.

- A study such as this, performed on a large group of prisoners would have the potential to create a more discriminating risk assessment instrument. The importance of complete data cannot be over-stressed, however. Because of the limited pool of cases – prisoners who have committed suicide – any loss of information because of missing data can severely limit a statistical analysis.

- To progress this work further, the best option would be extend it into other jurisdictions interstate. This would allow more data to be collected on those prisoners who have committed suicide in other States: an immediate increase in the sample size of cases. When selecting controls it would be good practice to sample four or five times as many controls as cases. This would increase the power of the study and further diminish the impact of missing data.

APPENDIX

In the following pages are the results of the univariate logistic regressions conducted on the remaining variables considered in the data set. They are presented for completeness, although some are clearly not statistically significant: their p-value is greater than 0.05.

Table 17: Prisoner's age

age	Alive	Died	OR	95% CI		p-value
18-21	13	11	**1.00**	-	-	
	54.17	*45.83*				
22-25	14	14	**1.18**	.40	3.52	**0.764**
	50.00	*50.00*				
26-30	6	8	**1.58**	.42	5.95	**0.502**
	42.86	*57.14*				
31-35	6	7	**1.38**	.36	5.34	**0.642**
	46.15	*53.85*				
36+	13	11	**1.00**	.32	3.11	**1.000**
	54.17	*45.83*				
Total	52	51				
	50.49	*49.51*				

Table 18: Deceased had family links/support immediately prior to death

	Alive	Died	OR	95% CI		p-value
Yes	32	25	**1.00**			
	56.14	*43.86*				
Some	4	8	**2.56**	.69	9.48	**0.159**
	33.33	*66.67*				
None	7	11				
	38.89	*61.11*	**2.01**	.68	5.94	**0.206**
Total	43	44				
	49.43	*50.57*				

Table 19: Geographic proximity of family/significant others to deceased's incarceration location

	Alive	Died	OR	95% CI		p-value
Facilitated Visits	35	23	**1.00**			
	60.34	*39.66*				
Interstate	3	4	**2.03**	.42	9.92	**0.382**
	42.86	*57.14*				
Prevented Visits	0	13				
		100.00				
Total	38	40				
	48.72	*51.28*				

Table 20: Usual occupation prior to incarceration

	Alive	Died	OR	95% CI		p-value
Employed	19	18	**1.00**	-	-	
	51.35	*48.65*				
Unemployed	1	15	**15.83**	1.89	132.47	**0.011**
	6.25	*93.75*				
Total	20	33				
	37.74	*62.26*				

Table 21: Offender status at death

	Alive	Died	OR	95% CI		p-value
sentenced	34	24	**1.00**	-	-	
	58.62	*41.38*				
remand	18	27	**2.13**	.96	4.70	**0.062**
	40.00	*60.00*				
Total	52	51				
	50.49	*49.51*				

Table 22: Type of current imprisonment offences or alleged offences

	Alive	Died	OR	95% CI		p-value
Single	28	30	**1.00**	-	-	
	48.28	*51.72*				
Multiple	22	21	**.89**	.40	1.96	**0.774**
	51.16	*48.84*				
Total	50	51				
	49.50	*50.50*				

Table 23: Type of current imprisonment: offence/s or alleged offence/s against the person

	Alive	Died	OR	95% CI		p-value
No	37	24	**1.00**	-	-	
	60.66	*39.34*				
Yes	14	27	**2.97**	1.30	6.78	**0.010**
	34.15	*65.85*				
Total	51	51				
	50.00	*50.00*				

Table 24: Type of current imprisonment: offence/s or alleged offence/s robbery/extortion

	Alive	Died	OR	95% CI		p-value
No	47	43	**1.00**	-	-	
	52.22	*47.78*				
Yes	4	8	**2.19**	.61	7.78	**0.227**
	33.33	*66.67*				
Total	51	51				
	50.00	*50.00*				

Table 25: Type of current imprisonment: offence/s or alleged offence/s traffic offences

	Alive	Died	OR	95% CI		p-value
No	33	43	**1.00**	-	-	
	43.42	*56.58*				
Yes	18	8	**0.34**	.13	.88	**0.026**
	69.23	*30.77*				
Total	51	51				
	50.00	*50.00*				

Table 26: Amount of sentence served or time spent on remand at death

	Alive	Died	OR	95% CI		p-value
<3 months	29	21	**1.00**	-	-	
	58.00	*42.00*				
>3mth	22	30	**1.88**	.86	4.13	**0.115**
	42.31	*57.69*				
Total	51	51				
	50.00	*50.00*				

Table 27: Total number of prison transfers in current period of imprisonment

	Alive	Died	OR	95% CI		p-value
less than 5	42	28	**1.00**	-	-	
	60.00	*40.00*				
5-10	4	6	**2.25**	.582	8.70	**0.240**
	40.00	*60.00*				
Total	46	34				
	57.50	*42.50*				

Table 28: Previous conviction history

	Alive	Died	OR	95% CI		p-value
No	27	15	**1.00**	-	-	
	64.29	*35.71*				
Yes	23	35	**2.74**	1.20	6.23	**0.016**
	39.66	*60.34*				
Total	50	50				
	50.00	*50.00*				

Table 29: Previous conviction types

	Alive	Died	OR	95% CI		p-value
None	27	16	**1.00**	-	-	
	62.79	*37.21*				
Single	6	6	**1.69**	.46	6.13	**0.426**
	50.00	*50.00*				
Multiple	16	27	**2.85**	1.19	6.83	**0.019**
	37.21	*62.79*				
Total	49	49				
	50.00	*50.00*				

Table 30: Previous convictions/ offences: burglary/theft

	Alive	Died	OR	95% CI		p-value
No	36	23	**1.00**	-	-	
	61.02	*38.98*				
Yes	12	26	**3.39**	1.43	8.02	**0.005**
	31.58	*68.42*				
Total	48	49				
	49.48	*50.52*				

Table 31: Previous convictions/ offences: procedure, good order, etc

	Alive	Died	OR	95% CI		p-value
No	41	32	**1.00**	-	-	
	56.16	*43.84*				
Yes	7	17	**3.11**	1.15	8.41	**0.025**
	29.17	*70.83*				
Total	48	49				
	49.48	*50.52*				

Table 32: History of self harm in the community

	Alive	Died	OR	95% CI		p-value
No	32	21	**1.00**	-	-	
	60.38	*39.62*				
Yes	10	18	**2.74**	1.06	7.08	**0.037**
	35.71	*64.29*				
Total	42	39				
	51.85	*48.15*				

Table 33: History of self harm in custody

	Alive	Died	OR	95% CI		p-value
No	39	22	**1.00**	-	-	
	63.93	*36.07*				
Yes	7	23	**5.82**	2.15	15.75	**0.001**
	23.33	*76.67*				
Total	46	45				
	50.55	*49.45*				

Table 34: Suffers from any medical condition?

	Alive	Died	OR	95% CI		p-value
0	20	15	**1.00**	-	-	
	57.14	*42.86*				
Single	19	17	**1.19**	.47	3.04	**0.712**
	52.78	*47.22*				
Multiple	7	17	**3.24**	1.07	9.78	**0.037**
	29.17	*70.83*				
Total	46	49				
	48.42	*51.58*				

Table 35: Addicted to drugs?

	Alive	Died	OR	95% CI		p-value
No	10	13	**1.00**	-	-	
	43.48	*56.52*				
Yes	35	33	**0.73**	.28	1.88	**0.508**
	51.47	*48.53*				
Total	45	46				
	49.45	*50.55*				

Table 36: On medication

	Alive	Died	OR	95% CI		p-value
No	28	14	**1.00**	-	-	
	66.67	*33.33*				
Yes	15	28	**3.73**	1.52	9.16	**0.004**
	34.88	*65.12*				
Total	43	42				
	50.59	*49.41*				

Table 37: Times deceased seen by MO

	Alive	Died	OR	95% CI		p-value
<=5 times	37	27	**1.00**	-	-	
	57.81	*42.19*				
>5 times	8	18	**3.08**	1.17	8.13	**0.023**
	30.77	*69.23*				
Total	45	45				
	50.00	*50.00*				

Table 38: Last time they saw MO

	Alive	Died	OR	95% CI		p-value
0	4	3	**1.00**	-	-	
	57.14	*42.86*				
<48 hr	4	14	**4.67**	.72	30.11	**0.105**
	22.22	*77.78*				
<1 wk	6	12	**2.67**	.45	15.96	**0.283**
	33.33	*66.67*				
>1 wk	22	17	**1.03**	.20	5.23	**0.971**
	56.41	*43.59*				
Total	36	46				
	43.90	*56.10*				

Table 39: Number of times they saw nurse

	Alive	Died	OR	95% CI		p-value
<=5 times	24	20	**1.00**	-	-	
	54.55	*45.45*				
>5 times	21	27	**1.54**	.68	3.51	**0.302**
	43.75	*56.25*				
Total	45	47				
	48.91	*51.09*				

Table 40: Suicide risk assessed by nurse

	Alive	Died	OR	95% CI		p-value
No risk	41	29	**1.00**	-	-	
	58.57	*41.43*				
Low to High	7	16	**3.23**	1.18	8.85	**0.022**
	30.43	*69.57*				
Total	48	45				
	51.61	*48.39*				

Table 41: Suicide risk assessed by psychiatrist, psychologist, or other health professional

	Alive	Died	OR	95% CI		p-value
No risk	41	23	**1.00**	-	-	
	64.06	*35.94*				
Low to High	7	24	**6.11**	2.28	16.36	**0.000**
	22.58	*77.42*				
Total	48	47				
	50.53	*49.47*				

Table 42: Were actions recommended?

	Alive	Died	OR	95% CI		p-value
No	2	4	**3.23**	.55	18.90	**0.193**
	33.33	*66.67*				
Yes	4	15	**6.06**	1.81	20.24	**0.003**
	21.05	*78.95*				
NA	42	26	**1.00**	-	-	
	61.76	*38.24*				
Total	48	45				
	51.61	*48.39*				

Table 43: If ARMS/PRAG applied level of risk

	Alive	Died	OR	95% CI		p-value
NA	46	34	**1.00**	-	-	
	57.50	*42.50*				
No, Low to High	2	10	**6.76**	1.39	32.89	**0.018**
	16.67	*83.33*				
Total	48	44				
	52.17	*47.83*				

Table 44: Was mental a health disorder diagnosed

	Alive	Died	OR	95% CI		p-value
No	34	20	**1.00**	-	-	
	62.96	*37.04*				
Yes	10	29	**4.93**	1.99	12.20	**0.001**
	25.64	*74.36*				
Total	44	49				
	47.31	*52.69*				

Table 45: Was the prisoner given a psychological diagnosis?

	Alive	Died	OR	95% CI		p-value
No	34	22	**1.00**	-	-	
	60.71	*39.29*				
Yes	11	21	**2.95**	1.19	7.30	**0.019**
	34.38	*65.62*				
Total	45	43				
	51.14	*48.86*				

Table 46: History of substance abuse?

	Alive	Died	OR	95% CI		p-value
Yes, current	31	22	**0.47**	.12	1.88	**0.287**
	58.49	*41.51*				
Yes, last 2 years	4	15	**2.5**	.467	13.39	**0.285**
	21.05	*78.95*				
Yes, more than 2 years	4	5	**0.83**	.13	5.17	**0.845**
	44.44	*55.56*				
Never	4	6	**1.00**	-	-	
	40.00	*60.00*				
Total	43	48				
	47.25	*52.75*				

Table 47: Any prison infractions during current period of imprisonment

	Alive	Died	OR	95% CI		p-value
No	36	26	**1.00**	-	-	
	58.06	*41.94*				
Yes	11	18	**2.27**	.92	5.59	**0.076**
	37.93	*62.07*				
Total	47	44				
	51.65	*48.35*				

Table 48: Types of prison infractions

	Alive	Died	OR	95% CI		p-value
None	35	31	**1.00**	-	-	
	53.03	*46.97*				
Minor	6	8	**1.51**	.47	4.82	**0.491**
	42.86	*57.14*				
Major	3	3	**1.13**	.21	6.01	**0.887**
	50.00	*50.00*				
Both	3	7	**2.63**	.63	11.08	**0.186**
	30.00	*70.00*				
Total	47	49				
	48.96	*51.04*				

Table 49: Placed in punishment during current imprisonment?

	Alive	Died	OR	95% CI		p-value
No	45	30	**1.00**	-	-	
	60.00	*40.00*				
Yes	1	10	**15.0**	1.82	123.34	**0.012**
	9.09	*90.91*				
Total	46	40				
	53.49	*46.51*				

Table 50: Ever made escape attempts?

	Alive	Died	OR	95% CI		p-value
No	46	42	**1.00**	-	-	
	52.27	*47.73*				
Yes	1	4	**4.38**	.47	40.78	**0.194**
	20.00	*80.00*				
Total	47	46				
	50.54	*49.46*				

Table 51: Ever picked fights?

	Alive	Died	OR	95% CI		p-value
No	39	35	**1.00**	-	-	
	52.70	*47.30*				
Yes	4	9	**2.51**	.71	8.87	**0.154**
	30.77	*69.23*				
Total	43	44				
	49.43	*50.57*				

Table 52: Death or /relationship breakdown of significant other

	Alive	Died	OR	95% CI		p-value
No	23	19	**1.00**	-	-	
	54.76	*45.24*				
Yes	11	23	**2.53**	.99	6.48	**0.053**
	32.35	*67.65*				
Total	34	42				
	44.74	*55.26*				

Table 53: Denied opportunity to communicate with significant other

	Alive	Died	OR	95% CI		p-value
No	32	29	**1.00**	-	-	
	52.46	*47.54*				
Yes	6	15	**2.76**	.94	8.06	**0.064**
	28.57	*71.43*				
Total	38	44				
	46.34	*53.66*				

Table 54: Distressing communication during current incarceration?

	Alive	Died	OR	95% CI		p-value
No	31	20	**1.00**	-	-	
	60.78	*39.22*				
Yes	6	24	**6.2**	2.16	17.83	**0.001**
	20.00	*80.00*				
Total	37	44				
	45.68	*54.32*				

Table 55: Did imprisonment involve significant loss of status?

	Alive	Died	OR	95% CI		p-value
No	47	47	**1.00**	-	-	
	50.00	*50.00*				
Yes	1	3	**3.00**	.30	29.90	**0.349**
	25.00	*75.00*				
Total	48	50				
	48.98	*51.02*				

Table 56: Did prisoner experience failure or /disappointment?

	Alive	Died	OR	95% CI		p-value
No	47	35	**1.00**	-	-	
	57.32	*42.68*				
Yes	1	15	**20.14**	2.54	159.79	**0.004**
	6.25	*93.75*				
Total	48	50				
	48.98	*51.02*				

Table 57: Did the prisoner report being bullied or stood over in current period of imprisonment?

	Alive	Died	OR	95% CI		p-value
No	36	28	**1.00**	-	-	
	56.25	*43.75*				
Yes	6	16	**3.43**	1.19	9.90	**0.023**
	27.27	*72.73*				
Total	42	44				
	48.84	*51.16*				

Table 58: Evidence deceased being stood over?

	Alive	Died	OR	95% CI		p-value
No	41	36	**1.00**	-	-	
	53.25	*46.75*				
Yes	6	15	**2.85**	1.00	8.11	**0.050**
	28.57	*71.43*				
Total	47	51				
	47.96	*52.04*				

APPENDIX 6 GLOSSARY OF TERMS & ABBREVIATIONS

TERMS

Attempted Suicide: A non-habitual act with a non-fatal outcome that is deliberately initiated and performed by the individual involved and causes self-harm (or without intervention by others will do so), or consists of ingesting a substance in excess of its generally recognised therapeutic dosage.[111]

Suicide: An act with a fatal outcome deliberately initiated and performed by the deceased in the knowledge or expectation of its fatal outcome.

ABBREVIATIONS

ARMS	*At Risk Management System*
CCU	*Crisis Care Unit*
FCMT	*Forensic Case Management Team*
IMP	*Individual Management Plan*
MAP	*Management and Assessment Plan*
PRAG	*Prisoner Risk Assessment Group*
RCIADIC	*Royal Commission Into Aboriginal Deaths In Custody*
SNT	*Special Needs Team*
TOMS	*Total Offender Management System*

APPENDIX 7 NON-PARAMETRIC ANALYSIS OF SUICIDE DATA

AIM OF ANALYSIS

This non-parametric analysis was carried out to determine whether there was any difference between the suicide and non-suicide groups. The results showed that there was indeed a difference, and the Suicide Taskforce proceeded to ask UWA Department of Public Health to undertake and independent and more detailed study of the variables. (See Appendix 5 for this study.)

METHOD

The data form developed for this study contains 177 variables, ranging from demographic (eg, age, ethnicity, schooling, religion,), through time, place, institution, and prison-related (eg, visits to health professionals, staff response times, number of staff, adherence to procedures and rules), to personal and risk factors (such as medical, psychiatric, substance-use, self-harm history; previous convictions and imprisonment's, attempts at suicide).

Further, in view of the paucity of deaths-in-custody studies which employ control groups, the analysis included self-harm and non-self-harm groups matched on demographic variables, in order to detect differences, commonalities, and systemic influences on self-inflicted deaths in the State's prisons.

Sample groups used

Matched Group (Nil SH Hx)	Matched Group a (Self-Harm Hx)	Deceased	Total N
41	**11***	**51****	**103*****

***** *Matched Group 'a' was excluded from the statistical analysis as sample size was not sufficient for comparison.*

*** Two cases in the Deceased group were excluded from analysis on the basis of gender (female), thus n=49 for analytical purposes.*

**** Analysis sample N=101.*

RESULTS

Significant differences were found between prisoners in a matched group and prisoners deceased. Significant differences were explained in terms of non-parametric tests (Mann-Whitney U-test), which, owing to relatively small sample-size, could not be used to indicate direction.

Between the Matched Group (matched on length of sentence, security rating, age) and the Deceased Group differences were found relating to: education and trade qualifications; community sexual assault history; psychiatric admissions; expressing suicidality; bullying; and custodial issues such as prior convictions, time spent in prison, and number of times imprisoned.

Significant differences between these groups also existed in contacts with health and allied health staff (eg, psychiatrists, psychologists, mental health nurses), including number of times seen by various professionals, as well as time spent in medical observation cells.

Other differences were in expressions of emotional distress and helpless/hopelessness, experiencing failure or disappointment, and an escalation of concerning behaviours. Chi-Square testing showed: early family dislocation occurred more in the Deceased Group; the Deceased Group were more likely to have a history of self-harm in the community, more likely to have experienced loss or relationship breakdown, subjected more to denial of opportunity to communicate with significant others, and had more distressing news, relative to the Matched Group. Bullying was also relatively more frequent for the Deceased Group.

The Mann-Whitney U Test

The Mann-Whitney U test was employed to test for differences between groups 'Matched' and 'Deceased' on variables investigated in the study. In order to control for Type 1 error due to repeated testing, the alpha level of significance was interpreted with $p<.01$.

Demographic

A significant difference between the level of education/trade qualifications for the Matched and Deceased group was identified, $\underline{U}(N=90) = 337.5$, $p<.01$.

Sexual Assault History

A significant difference between community sexual assault history between the Matched and Deceased group was identified, $\underline{U}\ (N=85) =712.5$, $p<.01$.

Psychiatric Placement

Instances of placement in a psychiatric facility were significantly different between the Matched and Deceased groups, $\underline{U}(N=85) =479$, $p<.01$.

Self-Harm Issues

Expressions of suicidal ideation were significantly different between the Matched and Deceased groups, *U*(N=81) = 442.5, *p<.01*.

Bullying

Instances of bullying expressed by prisoners were significantly different between the Matched and Deceased groups, *U*(N=86) =658, *p<.01*.

Custodial Issues

Custodial issues, including: the security rating of prisoners in current imprisonment, current sentence length, previous conviction history, total number of previous times in prison and total amount of time spent in prison in previous imprisonment periods were significantly different between the Matched and Deceased groups.

Respective differences as indicated by Mann-Whitney are: *U*(N=90) =615.5, *p<.01;*
U(N=89) = 599.9, *p<.01; U*(N=88)=676.5, *p<.01; U*(N=85) =584.5, *p<.01;*
U(N=83) = 537, *p<.01*.

Health Services

Contact with Health Services whilst incarcerated were significantly different between Matched and Deceased groups.

Differences included:

- the last time the prisoner was seen by the Medical Officer prior to release;
- the risk of self-harm considered by the Medical Officer;
- the last time the prisoner was seen by a nurse prior to release; and
- the risk of self-harm considered by the nurse.

Respective differences as indicated by Mann-Whitney are: *U*(N=77) = 389.5, *p<.01; U*(N=80)= 494, *p<.01; U*(N=79) =373.5, *p<.01; U*(N=80)=491.5, *p<.01*.

Contact with psychologists/psychiatrists and other health professionals whilst incarcerated was similarly different between the Matched and Deceased groups.

Differences included:

- the number of times during the current imprisonment that the prisoner was seen by psychologists/psychiatrists or other health professionals;
- the last time the prisoner was seen by a psychologist/psychiatrist/other health professional prior to release; and
- the assessed risk of suicide.

Respective differences as indicated by Mann-Whitney are: *U*(N=82) = 356.5, *p<.01;* U(N=82) = 144.5, *p<.01; U*(N=82) = 502.5, *p<.01*.

The referral source (prisoner, psychologist/other health professional, prison officer, other staff) for an appointment with psychiatrist/psychologist/other health professional was significantly different between the Matched and Deceased groups, *U*(N=81)= 294, *p<.01*.

Medical Observation

Placement and amount of time spent in medical observation during imprisonment period were significantly different for the Matched and Deceased groups; *U*(N=85) = 446, *p<.01*, and *U*(N=85) =478, *p<.0*, respectively.

Antecedent Circumstances

Prisoner's experience of failure/disappointment, and expression of emotional distress, were significantly different between the Matched and Deceased group. Respective differences as indicated by Mann-Whitney are: *U*(N=85) =628.5, *p<.01;* and *U*(N=86) =291.5, *p<.01*.

Expressions of hopelessness/helplessness were significantly different between the Matched and Deceased group, *U*(N=)=60.527, *p<.01*.

Escalation of behaviour prior to release was significantly different between the Matched and Deceased group, *U*(N=85) =74, *p<.01*.

Chi-Square

Chi-Square tests were employed to examine the nature of relationship between variables determined to exhibit significant differences (as identified by Mann-Whitney U). Small sample size precluded investigation of a number of significant variables. Variables identified to significantly differ between Matched and Deceased groups (with sufficient sample size for chi-square analysis) have been reported.

Early Family Dislocation

A significant difference between experience of family dislocation in childhood was identified between the Matched and Deceased group. As indicated below, the Deceased group is more likely to experience family dislocation in childhood than the Matched group. This observation must be interpreted with caution, as the number of 'unknowns' is large.

Family Dynamics	Matched Group	Deceased Group	Total
Major family dislocation in childhood	0	12	12
Some family dislocation in childhood	3	14	17
No family dislocation in childhood	5	6	11
Unknown	33	14	47
Total	41	46	87

$\chi 2(3, N=87) = 26.69$, $p<.01$. Strength of relationship as measured by Cramer's V .554.

History of Self-Harm In Community

A significant difference between the Matched and Deceased group was identified regarding history of self-harm in the community. Chi-Square indicates that prisoners in the Deceased group are more likely to have a history of community self-harm than prisoners in the Matched group.

Community Self-Harm History	Matched Group	Deceased Group	Total
Yes	3	17	20
No	28	21	49
Unknown	7	10	17
Total	38	48	86

$\chi 2(2, N=87) = 10.30$, $p<.01$. Strength of relationship as measured by Cramer's V .346.

Death/Relationship Breakdown of Significant Other During Current Imprisonment Period.

Experience of a relationship breakdown or the death of a significant other during imprisonment was found to be significantly different between the Matched and Deceased group, with prisoners in the Deceased group experiencing loss more than prisoners in the Matched group.

Death/Relationship Breakdown	Matched Group	Deceased Group	Total
Yes	6	23	29
No	18	17	35
Unknown	13	9	22
Total	37	49	86

$\chi 2(2, N=86)=9.23, p<.01$. Strength of relationship as measured by Cramer's V .328.

Denied Opportunity to Communicate with Significant Other in Current Imprisonment Period.

A significant difference regarding reported denial of communication opportunity with a significant other was identified between the Matched and Deceased group, with prisoner's in the Deceased group denied communication opportunity.

Denied Opportunity to Communicate	Matched Group	Deceased Group	Total
Yes	2	14	16
No	25	28	53
Unknown	10	7	17
Total	37	49	86

$\chi 2(2, N=86)=8.18, p<.05$. Strength of relationship as measured by Cramer's V .308.

Distressing Communication during Current Imprisonment Period

Prisoners in the Deceased Group indicated significantly different instances of distressing communication during current imprisonment than those in the Matched group.

Distressing Communication	Matched Group	Deceased Group	Total
Yes	3	23	26
No	24	19	43
Unknown	10	7	17
Total	37	49	86

$\chi 2(2, N=86)=15.11, p<.01$. Strength of relationship as measured by Crammer's V .419

Evidence of Prisoners Being Bullied

Evidence that prisoners in the Deceased group were being bullied was significantly greater than for the Matched group, indicating, the Deceased group had higher instances of being bullied.

Evidence	Matched Group	Deceased Group	Total
Yes	4	15	19
No	33	34	67
Total	37	49	86

$\chi 2(1, N=86)=3.72, p<.05$. Strength of relationship as measured by Crammer's V .236.

APPENDIX 8: QUALITATIVE ANALYSIS OF SUICIDE DATA

Note: This section uses information from individual cases in order to illustrate the discussion. As far as possible, all details which may identify a case have been excluded.

Introduction

This appendix uses a different approach to the rest of the report. Essentially, it is an examination of the interactions between the system, the staff, and the prisoner. It focuses on the human face of prisons.

Why this appendix was needed.
During the 18 months of the operation of the Suicide Taskforce, it became obvious that collecting and analysing data would not be enough to give a full picture of prison suicides. Those who read the records of the suicides found instances where problems were obvious, but the data analysis missed them, because they were not the sort of things which are easily quantified.

Therefore, experienced staff from FCMT was asked to review the records specifically to look for the sort of problems discussed here (more details at the end of this Appendix).

A major reason for presenting the data here is to make the report more accessible to readers. Those who are comfortable with figures and systems thinking will readily accept the format of the main body of the report. However, not all readers relate to this type of presentation, and it is hoped that this appendix will reinforce the idea that all the figures and abstractions have a very tangible basis – people dealing with people – which is emphasised here.

This appendix concentrates on the difficulties the prison system has had in handling its prisoners in the past, with the intention of developing a realistic level of surveillance and type of management of suicidal prisoners which is more effective in reducing the suicide rate than current methods.

Prisoners
We know that there is a very high proportion of mental illness amongst prisoners – 70% have, (or have had, in or out of prison) a mental illness, while 15% of prisoners are seriously mentally ill. An estimated 35% are depressed or suffering an anxiety disorder. Some have behavioural disorders (which are not mental illnesses, but manifest as seriously disruptive ways of dealing with society). We know that about 70% of prisoners enter gaol with either an active drug habit or a past habit. We know that the majority of prisoners have had a problematic upbringing, with violence, sexual abuse, and poor parenting being predominant. Many grew up in broken homes, and many have current dysfunctional relationships and again live in broken homes.

Many of the personality characteristics that lead to criminal behaviour are common to those with a high risk of suicide. Therefore, it is likely that those who are imprisoned have a high suicide risk.

Are all suicides preventable?

Even if all the recommendations are implemented, and the system as a whole improves greatly, it must be recognised that some prisoners will commit suicide. These will probably be either the seriously ill or the persistent suicide attempter. In the latter case the surprising thing is not the suicide, but the fact that it did not occur much earlier. These are often complex and difficult cases. For example:

> *An extensive history of prison self-harm and suicide attempts. Committed an act of self-harm. In medical observation 18th August. Single cell IOU suicided one day later.*

> *In prison 3 days. On admission reported to nurse an extensive history of suicide attempts. Had been raped, was facing extradition to NSW.*

Or the prisoner who becomes progressively uncontrollable – as often happens – but in this instance finally including suicide:

> *Long time poly-substance abuse. Brain damage, poor appetite, poor sleep, anxiety, depression. Gradually became labile, aggressive, overdosed on heroin, slashed, sent to obs. Placed on ARMS; slashed. Fighting with staff. Suicided.*

Or those where ordinarily suicide would not be suspected, and there is great difficulty in predicting that the prisoner is likely to commit suicide:

> *Loss of privileges, day room, for 7 days as a result of arguing with officers. Prisoner at time was in Close Supervision.*

> *Was to be moved to a lower standard of accommodation (dormitory) because he refused to return a swivel chair, which was in his cell (a shared cell) to unit office. Prisoner was intellectually handicapped.*

> *Previous prison infractions: had received severe punishments. Nike shoes, unlawful possession from sister during visit (48 hours confinement to sleeping quarters and non-contact visits); gave another prisoner his ARUNTA pin so he could use the phone (28 days loss of privileges).*

> *Losing canteen spend for a week after being found in possession of a pair of kid's scissors when he was allowed access to razor sharp hedge clippers for gardening.*

> *Thought his past could "catch up with him" as DNA testing was beginning.*

Custodial officers

Most officers are ordinary people trying to do the 'right thing' by the prisoners while remaining in control of many difficult and some very dangerous people. Being a prison officer is not an easy job, and there are many more opportunities to get it wrong than right, especially with the range of prisoners personalities.

The number of prisoners with personality and conduct disorders is proportionally much higher than in the community and the more the quality of the interaction between the prisoner and the custodial officer can be improved, the less the risk of suicide. In some cases, the personality of a single prisoner undergoes rapid changes related to (for example) mental illness, legal matters, outside or inside relationships.

> *Was attempting to retrieve possessions from Cash Converters on the day he died. Couldn't get property back, was teary and agitated. Experiencing serious relationship problems with defacto. Within 24 hours before suicide lost temper, slammed doors, up-ended tables, bashed things with pool cue.*
>
> *Twenty-one years of age, withdrawing from heroin/methadone. Two days in prison. Seen by Chaplain who said deceased was emotionally upset and crying. Seen by SNT social worker who found deceased to be mildly depressed but not suicidal. Mother had communicated concerns to the prison about deceased's state of mind. Was denied telephone call to family on day of suicide.*
>
> *Deceased had an extensive history of self-harm including slashing, self-immolation, self-stabbing and the ingestion of poison. On receival in January was assessed as vulnerable and at-risk of suicide. Placed in medical observation, frequently transferred between medical observation, mainstream and infirmary. Later it was noted deceased had marks on his neck consistent with attempted hanging. In November reported to prison officer he was "stressing out." When asked what was wrong replied "I'm going to neck myself after my court case." When asked if he was joking replied "No I'm f... serious." Later denied suicidal ideation. Attended court in November was unprepared due to lateness of notification (afternoon). Significant disappointment in court and yelled out, "I might as well go back to gaol and hang me f.... self." At 4pm was interviewed by unit Senior Officer and asked if he had thoughts of self-harm the deceased replied "Boss, I give you my word that I will not do anything." The deceased was found hanging at 10.40pm.*

Written here, a long time after the event, the problems are obvious in all the above cases. However, in real life problems like these are not obvious, or easy to deal with. The custodial officers, up to now, have not had specialised training to deal with this range of interpersonal problems in prison. However officer training is now to be augmented by 'T3', a training program from Canada which is designed to vastly increase the repertoire of techniques officers can use to deal with prisoners, thereby reducing the inevitable conflict between them.

This is one of the most proactive and valuable initiatives the Department of Justice has undertaken in recent years, and is destined to shift the whole prison culture away from punishment toward rehabilitation. There is little doubt that the more constructive the relationships between officers and prisoners, the more supportive the prison environment becomes. What is needed is a system whereby normal community standards of decency between human beings is upheld, but modified to suit the gaol environment.

The 'system'

Not all problems are interpersonal however. The 'system' itself can often create difficulties, simply because it is a large, and inevitably impersonal, entity. Similar problems are seen in all regimented systems – police, armed forces, schools, government etc – where the individuals needs can get overlooked.

Some of the examples discussed here show these inevitable faults and demonstrate where the 'system' can be improved. The work of the Suicide Taskforce, culminating in this report, is designed, among other things, to suggest changes in the way the 'system' operates to reduce its negative effects on prisoners.

The following five examples demonstrate where events perhaps had a negative impact on a prisoner's view of himself or the way in which he saw himself being treated. The 'system' was discussed in Working Party 2 (Operational Environment, Chapter 5), where it was recognised that the more contact officers have with prisoners, and the more officers know prisoners personally, the less likely it is that prisoners will feel ignored or alienated by 'the system'.

> *An unfavorable Parole Board decision was phoned through to the Unit. The prisoner first heard of the decision in June when formal notification arrived in the post. The Coroner found that, in retrospect, "it appears that the breakdown in the system of notifying prisoners of the outcome of Parole Board decisions was a factor, although perhaps not the final factor, in the events leading to the death of the deceased…"*
>
> *Deceased had submitted interstate prison transfer request. This request was not dealt with at unit conference*
>
> *The deceased asked what gratuities he had available. The prison officer told him none, as an internal transfer voucher had been prepared pending his transfer to Albany. This was the first the prisoner heard of the transfer.*
>
> *A decision had been taken to postpone the Visiting Justice Hearing but it had been neither recorded nor conveyed to the prisoner.*
>
> *Was resistant to transfer from Greenough Regional Prison to Canning Vale Prison, (scheduled for the day following DIC); reported he had enemies there; had family in Geraldton area.*
>
> {The individual needs of this prisoner and the need to transfer him to a maximum security gaol are clearly at odds here because it is not clear how much leeway a prisoner has to oppose the needs of the system. }

Often reading suicide reports, it becomes clear that it is not one single thing which led to the suicide, but a number of things. Sometimes things go wrong in small ways that perhaps have important consequences:

> *Psychologist asked for the medical file but it was filed under previous name and therefore couldn't be found.*

A prisoner's alias is always known, and it must be accepted that these things happen in the best regulated systems. The key here is to make system 'fail safe' without making it cumbersome.

Some systemic issues were instances of misapplication or non-application of policy and procedure and sometimes there are gaps in policy and procedure.

Unlock occurred at 8am. Prisoner was discovered dead by another prisoner at 9.20am. It was later found that Standing Orders regarding morning unlock were not in accordance with circular to superintendents 32/1997 and 48/1997 requiring all standing orders to be altered to adhere to circular requirement of ensuring prisoner is alive at morning unlock. Circulars were dated 24th March and 6th May 1997 respectively.

Obviously, there is a failure of the rules here. However, as any good manager knows, merely having many rules does not make a system work. For practical purposes there is a limit to the number of rules staff can keep up with. The underlying problem is not obedience to the rules, but the willingness of staff to behave in accordance with the spirit of the rules. Encouraging staff to do this is a far harder task than making rules for every circumstance (which is what tends to happen when things go wrong – the bureaucratic solution), for it requires good morale, and motivated staff with pride in their work and loyalty to the system.

The new Unit Management initiative, now being implemented, is designed to give prison officers a greater understanding of and part in, the management of the prisoner. This will directly address the underlying problem of prisoner/system conflicts. Incorporated in this is a shift of the responsibility for managing suicide from health to the whole prison staff.

Case management issues – improving case management:
Where the information is available, accessing it might also be a problem:

FCMT failed to make entries on daily FCMT catalogue. Officer on duty in Unit on night of deceased's suicide neglected to read ARMS form before shift commenced.

On being received in prison on 4th September…was assessed as being at low risk. It was recommended that he receive psychological counselling concerning his recent serious suicide attempt. The information regarding…previous suicide attempt was available on his unit file. Duty Officer did not access this information. Neither did the Duty Officer the next day.

The issue here is not to point the finger at the individuals involved (though they were probably made aware of the issues afterwards), but to develop a system which is 'fail safe'. The greater involvement of the officers has already been discussed; the aim is to change the amount of responsibility they have for prisoners.

Finally, there is a need for a Suicide Prevention Coordinator to be appointed. This person will have the task of making sure all the procedures relating to suicide surveillance are in place and are being followed. The Taskforce recognises that there is now a need for this position to be formally defined, since in practice procedures are not always followed:

Diagnosed schizophrenic. Seen by FCMT 2 days prior to suicide ("settled, but referred to MHNS"). Suicided. No progress note entries between next 14 days, last ARMS entry two months before. Doubled up with unstable type who had slashed day before. Received a further 9 years sentence within 48 hours prior to suicide.

Had been depressed and suicidal which was noted on file. The Doctor marked him for review. This consultation did not occur. A halt date for antidepressant was placed on the medical chart, which was exceeded by four days. No recall system was in place, no follow up was done and ten days later…suicided.

Communication issues

Prisoners are seen by, and interact with, many people. Suicidal behaviour - unfortunately perhaps - does not always present itself conveniently during an interview with a psychiatrist, psychologist, or nurse. Nor does the prisoner's behaviour become obvious to a unit officer. More often than not, suicidal behaviour is lost in the 'noise' of similar behaviour in other prisoners, or is hidden, or the prisoner is so erratic as to be seen differently by different people.

Working Party 3 (Chapter 5) discussed at length the problem of the different observers communicating with each other. It seems that one of the pillars of effective suicide prevention depends on putting the pieces of the behavioural jigsaw together. Rather like a weather map, a prisoner's behavioural picture is built up from isolated observations of behaviour by different people. This, when added to the background family, mental, and medical history of the prisoner, forms a much clearer assessment than any individual can. While this 'behavioural map' is not likely to be perfect, using actuarial information as well as observations by staff delivers a probability rating that the system can use.

> *Chronic Paranoid Schizophrenic, seven transfers in 57 days, seen by Health Service staff on at least 65 occasions. Recommended remaining in a metropolitan prison to facilitate close psychiatric monitoring. Attacked control room with broom, the day before suiciding. Twice asked for telephone calls on day of suicide and was refused.*

This seems so obvious now, but it was only by correlating the data (after the event) that the high-risk nature of this behaviour became evident. Interestingly what also became evident was the fact that the abnormal behaviour was escalating up until the suicide, but this was not seen at the time – because there was no mechanism to look for it.

The next few examples demonstrate the issues with communication. Perhaps some, or all, of this information would have alerted someone to intervene and prevent a suicide. One of the important areas addressed by this report is the way in which communication can be made easier.

> *Made threats to kill himself to prisoners, including the night before he hanged himself.*

> *The deceased's cellmate knew of his intention to suicide but did not inform staff.*

> *The deceased told his mother that if she did not provide surety, he would suicide. His mother did not inform prison authorities of the threat.*

> *A prisoner, who was a friend, did not pass on to staff information about a threat the deceased made on the day of his death to suicide.*

> *The deceased made several telephone calls, the last of which was to his brother in which he asked him to say goodbye to everyone.*

> *He told some prisoners he felt like hurting himself, or even electrocuting himself, but they did not pass this on.*

This information – where prisoners talk to their friends or their family – is often very significant. At present, we do not have any formal means of incorporating it into a structured format that can be used to update the risk factors on a prisoner. This report recognises the importance of setting up such a longitudinal system. This will involve the development of a 'probabilistic-actuarial' system, which will, in effect, give a current assessment of the probability of a prisoner being at risk of suicide. The salient point here is getting people to pass on the essential types of information (in practice this is most likely to happen by logging it into a computer program where it is collated into a suicide risk probability).

Clinical Judgement

It is well known that assessing suicide risk by clinical interview is unreliable. Even the most experienced clinician, is not able reliably to estimate whether a person will commit suicide. This is not surprising, for it happens in other areas of medicine – cardiac risk being the best known. Although an insurance company can tell you how many high-risk cardiac patients will suffer a heart attack in a year, they cannot predict when this will happen to any individual. It is the same with suicide, and is the basis for the suggestion that the prison system broaden its focus to include more 'hard data' in the assessment of suicide risk.

> *Prisoner presented with an extensive 3 year history of prison self-harm and suicide attempts and the Risk Management Alert System recording alerts for escape, self-harm, risk to others, drug and other risk alerts…was determined by receiving nurse to be 'no identifiable risk – these prisoners present with good coping skills and show no identifiable psychosocial risk factors.'*
>
> *July 17th seen by Dr recorded in medical progress notes "was depressed, felt useless, worthless, and hopeless and would end it all". Dr concluded consultation recording "Paranoid Schizoid Personality Disorder and Depression; recommended mood is monitored when medication was issued". Suicided two days later.*
>
> *Interviewed by FCMT who recorded difficulty in engaging "in intelligent conversation" due to neurological damage. No at-risk assessment was undertaken.*
>
> *Suffered from severe anxiety and depression; diagnosed anti-social personality. Had previously been hospitalised in Graylands for depression. Assessed by psychologist 3 days before suicide. Assessment stated that the deceased's suicidal threats were not genuine.*

Patients will often say they will definitely not commit suicide, or refuse treatment, or be transferred out of the Crisis Care Unit, then suicide shortly afterward:

> *Conveyed by Police ... and transferred to prison custody. Became unconscious, recovered and was taken to prison. Upon arrival at prison the prisoner was taken to hospital. The cause of the prisoner's unconscious was state was found to be an overdose of Tryptanol. The prisoner refused medical treatment and demanded to be taken back to the prison. The prison officer accompanying returned the prisoner to prison but did not refer the case to the doctor, or the Superintendent since he appeared to be recovered.*
>
> *Long history of poor coping, suicidality, drug use, offbeat religious views, suspected schizophrenia. A visitor concerned about his suicidal talk informed a welfare officer and as a result the deceased was placed in medical observation for three days. Was released into mainstream and committed suicide.*

The point about these cases is that, despite what the prisoner says, and despite appearances at the time of assessment, the risk of suicide remains high.

High Risk prisoners

Finally, the longitudinal management of prisoners must include adequate treatment for mental illness (Working Party 1, Chapter 5), which is presently not adequate, and drug addiction, which is not yet adequate. These two factors are both associated with high suicide risk – and are often combined in one person, making the risk even higher. Stories like the following occur with great regularity and emphasise the importance of drug addiction and mental illness:

> *Age 19. First time in prison. Longstanding heroin user, history of depression. New to system. Admitted 15.25 hrs and placed in a single cell. Discovered 22.35 hrs.*
>
> *Was withdrawing from heroin, first time in custody as an adult, was not assessed as at-risk. Suicided approximately 24 hours following his admission to prison.*
>
> *In Graylands for one month. Doctor noted suicidal after discharge. Reported being stood over. Flashbacks, nightmares. Complained of headaches and sleeplessness during 57 days in prison. Could not accept he murdered someone close. Suicided in single cell.*
>
> *Received 20.30 hrs. On reception it was noted he was in withdrawal from heroin, had experienced significant family breakdown, had a history of prison self-harm. He was subsequently assessed to be at no risk. Found hanging 22.45 hrs the next day.*
>
> *Both men in the two out cell were withdrawing from heroin and were on a withdrawal regime. One suicided.*
>
> *Received into prison in January, suicided same month. In withdrawal from heroin, amphetamines and benzodiazepines. Experienced significant disappointment prior to suicide (being remanded in custody rather than bailed).*
>
> *Received on remand. The nurse noted it was better to let him get over his agitation (due to alcohol withdrawal) than complete documentation. He was experiencing delirium tremens. Psychologist recommended placement in double up accommodation with deceased's brother however deceased declined. Placed in two out accommodation on his own and was found hanging at 11.14pm.*
>
> *First timer; 22 years of age; attempt hanging when 13; in prison 14 days; Chronic alcohol abuse; poor relationships; chronic pain/headaches; loss of girlfriend; fitting/blackouts.*

The Department recognises the mental health problem and the drug problem and is making progress on both fronts. However, both are resource intensive and expensive, and take time to address.

Apart from increased psychiatric services, the Crisis Care Units in Casuarina, Hakea and Bandyup provide the mainstay or acute suicide management. It is now recognised that, given the instability of suicidal people, and the unreliability of clinical judgement, it is imperative that some kind of increased surveillance be developed to follow up prisoners after discharge from Crisis Care (an "Intermediate Care Unit").

Was placed in medical observation. Was released to a normal cell at 4.35pm, found hanging at 8.45pm.

The inevitable suicides: "All suicide is preventable" ....?
Each one of these cases could have been prevented if only we had the benefit of hindsight – which we didn't.

However, focussing on the completed suicides does not take account of the vastly greater number of cases where someone *did* recognise the problem, and the suicide *was* prevented. It is clear that looking for suicides is looking for a needle in a haystack of conflicting and confusing abnormal behaviour. However, with some changes to the present system the probability of identifying high-risk prisoners will become greater.

Conclusion
If the issues discussed here can be addressed, then there will be the development of an environment where

- Prisoners feel safe
- There are good lines of communication
- Staff are skilled to handle difficult problems

Then the prison will become a 'healthy environment'. Then inevitably the suicide rate will be lowered, as many cases which would have suicided will have the opportunity to access support during the critical time when the decision to act is made.

APPENDIX 9: ARMS REVIEW FINDINGS

Health primarily seen as responsible:

One of the key the findings of the ARMS Review was that there was a tendency across prisons to view self-harm and suicide as a health responsibility and this frequently led custodial staff to refer at-risk prisoners to health services without consideration being given to appropriate custodial management strategies. In one prison the 'preference [is] to refer the majority of matters pertaining to at-risk prisoners on to Health Services staff, predominantly FCMT. This [was] interpreted as a lack of knowledge and confidence in the ARMS and the requirements and responsibilities of Unit Managers under it.' Similar practices occurred in other prisons, where it was reported that 'the opening of PRAG forms was a function more suited to FCMT staff members. Custodial staff reported that they had not been trained in this specialist role. At another prison, prisoners identified during the reception process as perhaps being of concern did not have an ARMS form opened by the reception officer but instead were directed immediately to the nurse on duty. Whilst at another prison officers reported that they did not complete the MR011 Reception Assessment Form because members of the nursing staff undertook the risk assessment process.'

These practices do not necessarily reflect a lack of concern on the part of custodial staff but rather a belief that self-harm and suicide require specialist knowledge and the primary responsibility lies with the FCMT. Whilst involving the FCMT as soon as possible is in itself commendable, it does not imply that custodial may therefore move their attention elsewhere. Custodial officers have a continuing responsibility to remain actively involved in the management of at-risk prisoners. When the PRAG review team interviewed staff at Casuarina Prison, they considered that nursing and custodial staff both showed a significant lack of understanding of suicidal and self-harming behaviours. This is despite Casuarina prison being the major prison for the management of at-risk prisoners. A census that was undertaken of prisoners subject to management by PRAG teams that showed there were 82 PRAG prisoners identified in prisons across Western Australia. Of these, 41 were at Casuarina including 6 of the 9 prisoners designated as being at high risk.

ARMS Process

ARMS forms were often imperfectly completed and a number of criticisms have been levelled, particularly at the metropolitan prisons, including:

The completion of the initial assessment seems to have been overlooked and the assigning of specific responsibilities for elements of the Risk Management Plan not undertaken.

Whilst the modifications themselves are documented, the responsibilities for carrying out the modifications are generally unassigned and there is a paucity of information to support what is to occur.

There is no individual management plan recorded.

A number of comments made are repetitive.

The support record complies with all formal requirements without providing a great deal of insight into the prisoner's behaviour and demeanour.
Difficulties have been experienced with nursing staff who adopt a conservative position wherein they tend to assign a low risk status to many prisoners.

Documentation in the PRAG forms in the units was at times deficient. Prisoners often turned up at a medical observation cell or the CCU without a PRAG form.

Knowledge of the ARMS manual was not high aside from knowledge of its location.

There was great variance in the quality of interim management plans – sometimes very good and other times none at all.

There was uneven compliance with the requirements of this section of the form.

Modifications to Risk Management Plans have not been completed in all cases.

Some of the comments provide valuable information whereas (the majority) simply evidence that a record has been made.

Overall it would appear that whilst there is technical compliance in the application of the ARMS, an attitude of lip service predominates and the process is implemented with a minimum of effort on behalf of staff. As remarked by the review team 'it may now be time to address some of the qualitative issues.'

To address this the review team has identified the need for additional training of staff at all levels in suicide and at-risk assessment and in the application of the ARMS.

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