

Using Trained Inmate Observers for Suicide Watch in a Federal Correctional Setting: A Win–Win Solution

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This study examined the impact of using inmate observers for suicide watch within a federal correctional–mental health setting. Results indicate a significant decrease in the mean number of hours inmates remained on suicide watch ($p = .036$) following the implementation of the Inmate Observer Program (IOP). Overall, suicidal inmates with a diagnosis of psychotic disorder remained on suicide watch significantly longer ($p = .004$) than did inmates in other diagnostic groups. The psychotic group, however, had a significant decrease in mean hours on suicide watch ($p = .001$) following the implementation of the IOP. Also, individuals with personality disorders had significantly fewer watches ($p = .033$) when inmate observers were used. Initial findings suggest that the use of inmate observers reduces the length of time that suicidal peers remain on watch without compromising standard of care.

Keywords: prison, suicide, suicide watch, inmate observer

Within the United States, suicide is the 11th leading cause of death, accounting for 29,350 deaths in 2000 (Centers for Disease Control, 2002); these figures equate to one completed suicide every 17.5 min. Both the surprisingly high number of completed suicides and the human tragedy associated with self-inflicted deaths motivate researchers to better understand the correlates of this behavior. For example, one of the most well-researched predictors of suicide is a sense of hopelessness concerning the future (Brown, Beck, Steer, & Grisham, 2000), including the inability to cope with distress and to define life problems in a way they can be solved (Dixon, Heppner, & Anderson, 1991). Further, individuals with low self-esteem or low self-efficacy are also more likely to endorse suicidal ideation (Dieserud, Roysamb, Ekeberg, & Kraft, 2001). In addition to cognitive corre-

lates of suicidal ideation, several psychological disorders are associated with greater risk of suicide, such as alcoholism, schizophrenia, mood disorders, and certain personality disorders, for example, borderline personality disorder (Carson, Butcher, & Mineka, 2000). Finally, there is evidence of both biological influences, such as reduced dopaminergic activity at D_2 receptors (Pitchot et al., 2001), and a genetic predisposition to suicidal behavior (Turecki, 2001).

Though the same predictors of suicide in the general population apply to a correctional setting, additional attention has been given to accurate assessment of risk in prisons. For example, inmates who lack close friends outside prison or do not take part in recreational, vocational, or hobby activities are at an increased risk of suicide (Cooper & Berwick, 2001). Assessing support systems, both in and out of the prison milieu; activity levels; and perceptions about hopelessness relating to their incarceration (Bonner, 2000) is essential in risk assessment of inmates. Individuals who are incarcerated are more likely to suffer from a mental illness (Dimond, Wang, & Holzer, 2001), which can also increase the risk for suicide. In total, the combination of personality factors and the stress of being incarcerated highlights the complexity of suicide risk assessment in prisons.

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The views presented in this article are those of the authors and are not endorsed as an expression of the policies or views of the Federal Bureau of Prisons.

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Because of an increased percentage of completed suicides in prison settings, there is greater responsibility for mental health professionals working in correctional settings to both assess risk and develop programming to prevent or reduce suicide attempts (Correia, 2000).

Ivanoff, Jang, and Smyth (1996) cited that the percentage of individuals committing suicide in prison is much higher than in society at large, leading researchers to identify prison suicide as a "serious public health problem" (Haycock, 1991, p. 81). Similar to society as a whole, increased depression and hopelessness contribute to increased suicidal ideation in a prison population (Ivanoff et al., 1996). However, social stressors that may lead to a sense of hopelessness are amplified, which may contribute to an increased risk of suicide in this population. For example, protective factors, such as family, employment, leisure time, and having children living in the home (Sanchez, 2001), are not immediately present for individuals who are incarcerated. Further, the most common sources of distress for incarcerated individuals (relationships, family, and discharge concerns) are difficult to manage while in prison (Dexter & Towl, 1995). Certainly prison is a stressful environment, and as the severity of distress and worry increases, so too does suicidal ideation of inmates (Cooper & Berwick, 2001). Individuals with ineffective coping strategies are more likely to endorse suicidal ideation (Eidhin, Sheehy, O'Sullivan, & McLeavey, 2002). Stress that may be benign for some is overwhelming to others, placing the latter group at a greater risk for suicide.

From a legal perspective, suicide prevention in prison involves a standard of care for detecting risk of suicide among inmates and then taking "reasonable preventive measures" (Hanser, 2002, p. 461) to deter suicide attempts once this risk has been detected. For example, in his discussion of legal liability, Hanser (2002) cited previous litigation in the assertion that prison officials must search inmates and restrict access to potentially harmful items, in addition to providing a modicum of supervision. This supervision must rise to the level of "marginal protection" (Hanser, 2002, p. 469) or a reasonable attempt to prevent suicide attempts. Successful tort claims relying on 42 United States Code, Section 1983, rely on faulty detection, poor

training in suicide assessment, or bad decision making once risk has been detected. From a risk management perspective, prisons are mandated to act once suicide risk has been detected. However, little direction has been given to direct proper action. A common prison practice is to place suicidal inmates in observation rooms, after removing any item that may be used for the purpose of self-harm. It is not unusual, even within a hospital setting, for observation to consist of 15 min "checks," thereby leaving the suicidal individual unobserved for a vast majority of the time.

A "community care model" within a correctional setting encourages "supportive relationships at all levels" using line staff, medical staff, and peers to reduce levels of suicide (Biggar, 1996, p. 207). In addition to providing a community standard of care to suicidal persons, a team approach to suicide prevention uses the skills of multiple individuals (staff and non-staff), provides opportunities for training of these individuals, and may improve the "management of vulnerable inmates" (Cutler, Bailey, & Dexter, 1997, p. 65). Regardless of the method of prevention, the most important factor is to provide protection to the inmate from self-destructive thoughts and impulsive behaviors in the least restrictive manner possible.

The recognition of suicide in prison as a source of serious concern has led the Federal Bureau of Prisons (BOP) to create and maintain an active Suicide Prevention Program throughout all institutions (Federal Bureau of Prisons, 2004). Because of the attention that suicide prevention has been given within the BOP, the number of suicides for inmates in Federal custody has fallen to between 12–16 per 100,000, which is lower than the percentage for adult men in American society. Important components of the BOP Suicide Prevention Program are continual training of staff at all levels concerning risk factors and early indications of suicidal behavior and the importance of actively communicating information to facilitate proactive intervention.

The BOP Suicide Prevention Program and specifically the Inmate Observer Program (IOP) described in this article go beyond a minimum standard of protection by providing direct and constant observation while an individual is judged to be suicidal. Rather than developing a

program to avoid legal implications of “deliberate indifference” (Hanser, 2002, p. 460), the BOP takes a proactive approach that includes tracking of trends in self-injurious behavior, development of at-risk profiles, staff training, and constant refinement of the suicide watch process.

Despite the attention given to the topic of suicide, there is a paucity of empirical research that has been completed to assess the process of observing individuals who have been placed on suicide watch. A vast majority of published research examines proper assessment, including development of assessment tools, and mechanisms for prevention of suicidal behavior. When individuals are found to be suicidal, the question of how to ensure their safety during active periods of suicidal ideation has not been sufficiently researched. Most interventions within a prison setting involve removal of the suicidal person from the general population and placement in a relatively secure and isolated environment, where visibility is increased and access to objects that could be used for self-harm is minimized (Felthaus, 1997). However, there is a lack of research evaluating the isolation process for acutely suicidal inmates in a suicide watch room (Bell, 1999). Additional empirical exploration is needed to define who is placed on suicide watch in a prison setting, how long they remain on watch, and what the effects of using trained inmates to observe acutely suicidal peers are.

The purpose of the present study is to analyze the effects of using inmate observers for suicide watch within a correctional setting. Data presented provide demographic characteristics of inmates at risk for self-harm. It is anticipated that findings will help researchers and practitioners understand the dynamics of suicidality within corrections. Finally, information gleaned from this research will hopefully fill a gap in the current literature base and provide an example of a community oriented approach to suicide prevention.

Method

Participants

Over the course of the study period (24 weeks), 82 suicide watches were initiated,

which were accounted for by 37 individuals (mean age = 34.38 years, $SD = 10.06$). The sample included 18 African American participants, 10 Caucasian participants, and 9 Hispanic participants. A majority of the sample (51.4%) had been given a primary diagnosis involving some form of psychosis (e.g., schizophrenia, schizoaffective disorder, major depressive disorder with psychotic features). Additional primary diagnoses included the following: personality disorder (24.3%), mood disorder (13.5%), malingering (5.4%), or other (5.4%; e.g., factitious disorder). Twenty-seven percent of the sample were undergoing a forensic evaluation (e.g., competency to stand trial, restoration to competency, criminal responsibility). The remainder were either federally sentenced individuals who developed an acute psychiatric concern requiring hospitalization (62.2%) or individuals who were adjudged mentally ill and dangerous in Federal court, requiring their indefinite commitment to a Federal Medical Referral Center (10.8%). Finally, for a summary of the offenses leading to the detainment of each participant, please refer to Table 1.

Procedure

This study was conducted at a Federal Bureau of Prisons Medical Referral Center, which provides mental and physical health care for inmates incarcerated in the Federal penal system. Over the course of their hospitalization, inmates assessed to be acutely suicidal were placed on suicide watch in an inpatient restricted housing unit. While on suicide watch, individuals are observed simultaneously through four mechanisms: (a) constant surveillance using closed-

Table 1
Participant Offense Type and Frequency of Offense

Offense type	Frequency
Crimes against person	9
Crimes against property	2
Drug offense	10
Threatening a government official	6
Felon possession firearm	5
Illegal alien	4
Total	37

circuit TV; (b) rounds conducted by nursing staff, every 15 min; (c) rounds by correctional staff, every 15 min; and (d) direct observation. The fourth of these mechanisms is the focus of the present study. Prior to the initiation of the IOP, suicide watches were assigned to institution staff as an overtime post. Following the initiation of the IOP, carefully selected and trained inmates were used to provide constant observation of individuals placed on suicide watch.

Inmates requesting to participate in the IOP were screened by unit team, correctional service, and mental health staff for a history of institutional misconduct that would prohibit participation. All acceptable candidates were invited to a 4-hr initial training session in which the IOP was described in full. Information was provided on the basic job assignment of observing suicidal peers, recording log entries at 15-min intervals, and handling emergencies. Training was provided by a psychologist on types of persons who frequently become suicidal and common behaviors of different diagnostic groups. Basic communication skills, active listening skills, and issues relating to confidentiality were also included in this initial training. It should be noted that inmate observers were instructed that their job was to observe and not to counsel. Also, inmate observers did not have access to patient records or any other confidential information. Follow-up training and debriefing have been provided on at least a quarterly basis.

The present study evaluated the impact of the IOP on the suicide watch process. The evaluation of this program was divided into two consecutive 12-week intervals, separated by the initiation of the IOP. Thus, the first time period consisted of using staff for constant observation of suicidal inmates, and the second time period consisted of using trained inmate observers. Suicide risk assessment and clinical decisions to initiate or discontinue suicide watch were conducted by a licensed psychologist or psychiatrist both pre- and post-IOP and remained constant and independent of this research study. Suicide watches were tracked using an e-mail notification system, which is used to notify the Suicide Prevention Program Coordinator when inmates are placed on suicide watch and when watches are discontinued. In the case of missing

data, inmate medical records were reviewed to determine when suicide watches were initiated or discontinued. After data from the e-mail notification system and medical records were consolidated, there were no missing data.

Results

Prior to evaluating the effects of the IOP on trends in suicide watches, separate one-way analyses of variance were conducted to analyze group differences in the number of hours on suicide watch for the following independent variables: ethnicity, primary diagnosis, and the reason for hospitalization. The means and standard deviations for these three independent variables are presented in Table 2.

Because three separate analyses were conducted, Bonferroni correction was used to maintain the familywise error rate at $\alpha = .05$. Of the three analyses of variance, only one yielded statistically significant results, which was primary diagnosis, $F(4, 76) = 4.18, p = .004$. We conducted post hoc contrasts to assess differences between the five diagnostic categories. Because there were no significant differences between four of the diagnostic groups (mood, personality, malingering, and other), these groups were collapsed for the purpose of this contrast, resulting in a comparison between individuals diagnosed with a psychotic disorder versus the remaining four categories. In these

Table 2
Mean Number of Hours on Watch as a Function of Ethnicity, Diagnosis, and Reason for Hospitalization

Variable	<i>M</i>	<i>SD</i>	<i>n</i>
Ethnicity			
African American	85.75	97.27	39
Caucasian	73.13	70.64	21
Hispanic	117.13	144.8	21
Diagnosis			
Psychotic	145.59	141.15	31
Mood	92.60	67.80	7
Personality	50.89	54.45	37
Malingering	46.52	46.80	3
Other	51.94	31.16	3
Reason for hospitalization			
Study	70.13	68.21	15
Sentenced	94.69	114.41	60
Indefinite commitment	101.06	105.35	6

analyses, individuals who were diagnosed with a psychotic disorder were found to remain on suicide watch significantly longer than individuals with other mental illnesses, $t(76) = 2.97$, $p = .004$. The post hoc contrasts presented in Table 3 yielded no additional statistically significant findings.

To analyze the possible relationship between age and length of suicide watch, we calculated a Pearson correlation between these two variables. The results were not statistically significant ($r = -.085$, $p = .449$). Thus, no relationship was found between an individual's age and the length of stay on suicide watch.

A major goal of this study was to explore the effects of using trained inmate observers on the frequency of and number of hours on suicide watch. To explore these issues, we conducted separate statistical analyses. First, a chi-square statistic was calculated, comparing the number of watches in the 12 weeks prior to the initiation of using trained inmate observers to the 12 weeks following. Although it is important to note that the number of suicide watches dropped by 31.25%, from 48 pre-IOP to 33 post-IOP, this difference was not found to be statistically significant, $\chi^2(1, N = 81) = 2.78$, $p = .096$.

A second manner of analyzing the effects of using trained inmate observers was provided by comparing the mean number of hours on suicide

watch pre- and postinitiation of the IOP. The mean stay on watch was 108.88 hr ($SD = 126.06$) for the pre-IOP sample and 64.05 hr ($SD = 59.82$) for the post-IOP sample. Because the standard deviations of the two samples were significantly different, $F(1, 81) = 12.30$, $p = .001$, Levene's test was used to reduce the number of degrees of freedom, which conservatizes this analysis. The resulting t test was statistically significant, $t(71.55) = 2.14$, $p = .036$. Thus, there was a significant decrease in the mean number of hours on watch following the implementation of the IOP.

A final analysis was conducted to compare change in length of suicide watch pre-IOP with post-IOP for the separate diagnostic categories. The malingering and other diagnostic groups had to be removed from this analysis. Individuals in these categories either fell in the pre-IOP or post-IOP group. Without individuals in both of these groups, any comparison would be meaningless. Thus, a two (pre-IOP vs. post-IOP) \times three (psychotic disorder vs. mood disorder vs. personality disorder) analysis of variance was used. There was a significant interaction, $F(2, 75) = 8.71$, $p < .001$, warranting the need for analyzing simple main effects. The means for each diagnostic group, separated by pre-IOP and post-IOP, are graphically presented in Figure 1.

Because there were significant differences in the variances of the two samples, the resulting t tests were again conservatized through the use of Levene's test. The only significant simple main effect was for individuals receiving a psychotic diagnosis, $t(22.65) = 22.65$, $p = .001$. Thus, there was a significant decrease in the mean hours on suicide watch for this group following the implementation of the IOP as shown in Table 4.

It is interesting to note that there was not a statistically significant decrease in the mean number of hours on suicide watch for the personality disorder group. Although this decrease was not observed, the number of individuals on watch in this group dropped from 25 in the pre-IOP sample to 12 in the post-IOP sample. This represents a 52% decrease, which is statistically significant, $\chi^2(1, N = 37) = 4.57$, $p = .033$. Thus, though the mean number of hours for this group did not decrease, there were a significantly lower number of individuals with

Table 3
Analysis of Variance Table Comparing Mean Number of Hours on Suicide Watch for the Independent Variables

Variable	<i>F</i>	<i>df</i>	<i>p</i>
Ethnicity			
Between groups	0.98	2	.379
Within groups		78	
Total		80	
Diagnosis			
Between groups	4.18	4	.004
Within groups		76	
Total		80	
Reason for hospitalization			
Between groups	1.00	74	.568
Within groups		6	
Total		80	

Note. Inmates with a psychotic disorder ($n = 31$) were on suicide watch significantly longer ($M = 145.59$ hr, $SD = 141.15$ hr) than were inmates who were not psychotic ($M = 56.53$ hr, $SD = 55.57$ hr; $p = .004$).

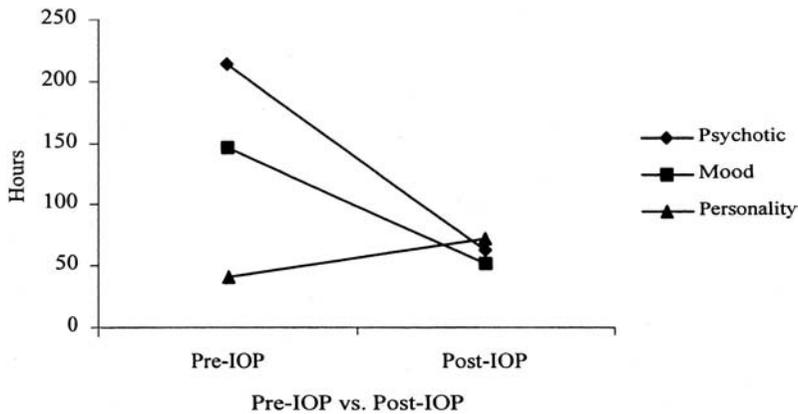


Figure 1. Mean number of hours on suicide watch as a function of diagnostic category and whether it was before or after initiation of the Inmate Observer Program (IOP).

personality disorders placed on suicide watch following the implementation of the IOP.

Discussion

With the identification of suicide in prison as a problem warranting further clinical and empirical attention (Haycock, 1991), examining the effects of innovative programs addressing this concern will continue to be of utmost importance in a correctional setting. Although the results of this study cannot be generalized outside of a federal medical center context, the potential positive effects of an IOP in similar environments such as state prison or county jail is hopeful.

Table 4
Analysis of Variance for Interaction Between Time (Before or After Implementation of the IOP) and Diagnosis (With Significant Simple Main Effect)

Variable	F	df	p
Time	7.06	1	.01
Diagnosis	6.83	2	.002
Time × Diagnosis	8.71	2	<.001
Error		75	
Total		80	

Note. For inmates with a psychotic disorder, before implementation of the Inmate Observer Program (IOP; $n = 17$), they spent significantly longer on suicide watch ($M = 213.92$ hr, $SD = 151.32$ hr) than they did after implementation of the IOP ($n = 14$; $M = 65.38$ hr, $SD = 14.78$ hr; $p = .001$).

Questions remain as to why such a program would have a drastic effect on suicide watches in a correctional setting. Prior to the initiation of the IOP, suicidal inmates were directly monitored by staff members. Thus, inmates on suicide watch had unfettered access to staff. One possible explanation for a reduction in the number of hours individuals spent on suicide watch is the elimination of direct attention provided by staff. Past studies have cited up to 50% of self-inflicted injuries in a prison mental health setting that were manipulative in nature (Franklin, 1988). There are fewer opportunities for staff manipulation if suicidal inmates are directly observed by peers. Further, the IOP allows for contact between the suicidal inmate and the observer. Such contact between peers has been suggested as a helpful strategy in reducing self-injurious behavior among inmates (Rakis & Monroe, 1989). As noted in the Results section of this article, there was a significant decrease in the number of hours individuals with a psychotic disorder spent on suicide watch following the initiation of the IOP. Several of these individuals were actively delusional while on watch. The use of an inmate observer (rather than an authority figure) may provide a safer venue for the suicidal inmate to converse and identify with a peer. Finally, prison is a stressful environment, in which suicidal ideation is more common than in society as a whole (Ivanoff et al., 1996). The support of a peer who is coping more effectively may serve as an encouraging

protective factor for the suicidal inmate. Through social modeling, triggers for suicidal and parasuicidal behavior may be normalized, thereby reducing the need for a continued stay on watch. If these findings are replicated in future research, a next step would be to explore in greater depth the relationships among these variables.

Perhaps even more important, anecdotal evidence suggests that inmate observers realize personal gain by having an opportunity to give back to the community in which they live. Inmate observers are able to display social interest, which is defined as “the willingness to participate in the give and take of life and to cooperate with others and be concerned about their welfare” (Dinkmeyer, Dinkmeyer, & Sperry, 1987, p. 64). Social interest has been shown to be a predictor of “offender outcome as demonstrated by employment status, new felony arrests, and reincarceration status” (Daugherty, Murphy, & Paugh, 2001, p. 465). Thus, opportunities to encourage development of social interest could have important repercussions for the rehabilitation of offenders. Additionally, inmate observers have an opportunity to discover and demonstrate self-efficacy, by joining with an “adversarial” system in an effort to “do good” in their community. By being a suicide watch observer, inmates are given an opportunity to act in a prosocial, helpful, healthy manner, which is antithetical to the antisocial culture prevalent in prison society. Future research should be designed to provide a focus on elucidating the effects of being a participant in an IOP, especially in regard to the development of social interest and pro-social behavior.

Finally, because of the use of inmate observers, as opposed to staff members, there is tremendous cost savings to the institution. For example, the IOP realized a cost savings in one year of over \$300,000 in overtime pay alone. Additionally, many peripheral resources were saved by more rapidly placing inmates in a less restrictive environment. These results were obtained while maintaining a high quality of clinical care and protection for the suicidal person.

Suicide in prison continues to be a major concern for prison officials and to the mental health community as whole. Innovative programs such as the IOP foster sensitivity and responsibility for “community care” (Biggar,

1996, p. 207) while providing potential benefit to administrators, inmate observers, and the suicidal or parasuicidal inmates themselves. Therefore, as one component of a multitier approach to suicide prevention, the use of inmate observers provides correctional institutions with a cost-effective mechanism while ensuring the safety of at-risk inmates. The mutual benefit experienced by all who join in this process comprises the win-win solution of using trained inmate observers for suicide watch.

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