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Suicide in Scottish Prisons

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A consecutive series of prison suicides in Scotland between 1970 and 1982 was examined. The initial phase of imprisonment was found to be the most vulnerable stage of confinement, with almost two-thirds of the deaths having taken place within the first month. A disproportionately high number were found to be on remand. A history of some form of psychiatric involvement was common, and a third of the group had received previous psychiatric inpatient treatment. In contrast to results from general population studies, there was little evidence to link suicide with a history of depressive illness. A record of problems with either alcohol or drug dependence was found in almost half the cases. The importance of general measures designed to reduce stress and promote coping mechanisms is emphasised.

Considerable concern has been expressed about the number of suicides and parasuicides which take place in prison. There is disquiet that such an event could take place in an environment in which there is a high level of surveillance, and there is a possibility that the prison regime itself may be seen to be instrumental in the process. While few would deny that imprisonment is an unpleasant experience, society accepts responsibility for it in the belief that it will deter future criminal activity. However, the punitive aspect becomes unacceptable if it is thought to be a causal factor in a prisoner's death.

In 1982 the suicide of a young man in a remand centre near London was followed by an inquest verdict which described a 'lack of care' on the part of the prison department. This was the stimulus for the newly formed Inspectorate of Prisons to undertake both an Inquiry into this death and a more general study of the adequacy of arrangements for the prevention of suicide. The report (Home Office, 1984) considered the prevention procedure and summarised the views of a number of interested bodies. Examination of a sample of suicides showed that about two-thirds of them were regarded as having psychiatric problems, with a smaller proportion (not specified) having been patients in psychiatric hospitals. This supports the earlier finding by Topp (1979), who also examined prison suicides in England and Wales. He found that, while in custody, 69% had seen doctors for complaints with a psychiatric connection and 39% were receiving treatment as a consequence. Despite this, the risk of suicide had been recognised in only 15% of the deaths. The Inspectorate of Prisons acknowledged the importance of general measures to reduce suicide, at the same time emphasising the central role that the prison medical officer should have in 'individual prevention'. The medical nature of the task resulted from an understanding that suicide was often associated with mental illness, alcoholism, and drug abuse, and that it required a doctor to identify these conditions and recommend treatment.

A more recent report (Scottish Home and Health Department, 1985) reviewed the suicide precautions in the Detention Centre and Young Offenders Institution at Glenochil in Scotland. This review followed a series of five deaths which had occurred between 1981 and 1985 and which had been the source of increasing public alarm. Recognising the vulnerability of some of the young offenders, many of the recommendations made and provisionally accepted by the Secretary of State could be considered as general measures designed to make the environment more humane and caring.

Problems are encountered when international comparisons are made. Tuskan & Thase (1983) illustrated this when they drew attention to the wide discrepancies that exist between prison suicide rates in different countries. Variations in reporting methods and inmate populations have been suggested to explain these differences.

The United States Bureau of Prisons administers 35 different forms of penal facility, ranging from maximum security penitentiaries to community treatment centres. County jails are the most widely used form of confinement and are the source of the majority of studies into prison suicides (Smialek & Spitz, 1978; Fawcett & Marrs, 1973; Danto, 1973; Helig, 1973). Even these jails differ from one county to the next, which further complicates comparisons either between them or with state or federal facilities. The studies themselves have varied considerably, both in size and objectivity. While some have defined what they consider to be the characteristics of the

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suicidal inmate, others have demonstrated that these descriptions are not specific enough to accurately identify the individual and intervene effectively. In this respect it is unfortunate that the most detailed and comprehensive study in this area examined suicide in four maximum security penitentiaries in Canada (Burtch & Ericson, 1979); while data presented in this study are impressive by comparison, it is doubtful that consideration of such a specialised form of imprisonment can contribute to our understanding of suicide in other, more widely used penal institutions.

The present study set out to describe the characteristics of a group of prisoners who committed suicide. In view of the reported association between mental illness and suicide in the general population, it was of particular interest to consider the psychiatric contact, and where possible the diagnoses, of a group of prison suicides.

Method

This study examined a consecutive series of deaths classified as suicide in the Annual Report on Scottish Prisons. In Scotland this process of classification starts with the notification of all deaths which have taken place in custody to the Procurator Fiscal. A report is then sent to the Crown Counsel, who act on behalf of the Lord Advocate and decide which of these deaths will proceed to a Fatal Accident Inquiry. Having heard the evidence the Sheriff, who presides over this Inquiry, is asked to give an opinion on the cause of death. Over the years there has been some inconsistency in these determinations: of those deaths subsequently classified in the Annual Report as suicide there have been some in which a specific reference had been made in the Enquiry that the death was due to suicide; others have been less specific, but have resulted in the same classification.

The Scottish Home and Health Department made available, where possible, the prison records, medical files and Fatal Accident Enquiry reports on each of these deaths. In addition, the Information Services Division of the Scottish Health Service provided data on those individuals who had received in-patient treatment in psychiatric hospitals in Scotland. No corresponding information was available for those who may have had in-patient treatment outside Scotland.

In common with other studies (Fawcett & Marrs, 1973; Esparza, 1973) there were many instances in which the files were not complete. When information on areas of social or psychological importance was recorded both the quantity and quality varied considerably, and many items may have been under-reported.

Suicide rate

The estimation of the suicide rate in a changing population, as found in prisons, requires modification before it can be compared to the rate in the general population. Such a situation has been described for in-patients in a psychiatric hospital (Copas & Robin, 1982). Unfortunately the relevant data necessary to make a similar adjustment for this study were not available. In common with other studies (Topp, 1979; Home Office, 1984) the rate was calculated using the mean daily average prison population for the period in question.

Results

General features

Between 1970 and 1982 there were a total of 33 deaths in Scottish prisons recorded as suicide. All were male prisoners. Suicide was the single largest cause of death, and accounted for 37% of the total. Using the mean daily average prison population (1970–1982), the suicide rate was found to be 51.8 deaths per 100 000 per year. The ages ranged from 14 to 59 years, with a mean age of 28.6 years. Eighteen were single, nine married, and six divorced or separated. Eleven of the group were 'under observation' at the time of their death, with four of these having been identified specifically as a suicide risk.

The early phase of imprisonment appeared to be the most vulnerable stage of confinement. Four deaths occurred in the first 24 hours, thirteen within the first week, and twenty in the first month. Two deaths took place within days of the prisoner's intended release. At the time of death fourteen had been sentenced and nineteen were on remand; of the latter group approximately two-thirds were untried, while the remainder were awaiting sentence or further reports prior to sentence. During the period under consideration the percentage of the total prison population classified as 'on remand' varied between 12.2% and 16.9%, with a mean of 14.1%.

Previous criminal involvement was common. Twenty-nine had a criminal history and 24 had experience of imprisonment. Of those that had been convicted, the majority were serving short sentences for non-violent crimes such as theft. The longest sentence being served was four years.

Psychiatric history

Fifteen members of the group had a record of a previous parasuicidal episode, and in half the cases of two or more. Thirteen had given some indication of suicidal intent in the period immediately before the death. This involved self-inflicted injury in seven cases; in the remaining six cases there was some verbal communication, either to a fellow inmate or to a Prison Officer.

Twenty had a history of psychiatric contact, and for seven this had been within the month prior to the suicide (in some instances this was for the purpose of a psychiatric report). During this period there was only one recorded case in which a depressive illness had been identified and treatment commenced.

Eleven were identified as having received in-patient treatment in psychiatric hospitals in Scotland before their imprisonment. These eleven cases accounted for a total of twenty-four separate admissions (Table I). Depressive disorder had been diagnosed in only two instances.

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TABLE I
Psychiatric diagnoses of those prisoners who had received in-patient psychiatric treatment

Case no.	*ICD–9*[1]	*Discharge diagnosis*	*No. of admissions*
1	311.9	Depressive disorder (not elsewhere classified)	1
	307.9	Special symptoms or syndromes (unspecified)	1
2	295.9	Schizophrenia (unspecified)	2
	303.2	Alcohol dependence syndrome	1
3	300.4	Neurotic depression	1
4	301.9	Personality disorder (unspecified)	2
	301.7	Personality disorder (sociopathic)	1
5	295.9	Schizophrenia (unspecified)	2
6	303.9	Alcohol dependence syndrome	3
	301.7	Personality disorder (sociopathic)	1[2]
7	301.7	Personality disorder (sociopathic)	1[2]
	301.6	Personality disorder (asthenic)	1[2]
	304.1	Drug dependence (barbiturate)	1[2]
8	304.9	Drug dependence (unspecified)	1
	303.9	Alcohol dependence syndrome	1
	965	Poisoning	1
9	304.9	Drug dependence (unspecified)	1
10	312	Conduct disorder	1
11	301.6	Personality disorder (asthenic)	1

1. Diagnosis classification according to the International Classification of Diseases (World Health Organization, 1978).
2. Self-inflicted injury on admission.

It had been documented in the records of fifteen of the group that they had either an alcohol or drug-related problem. While the majority of deaths for the group as a whole occurred during the initial period of imprisonment, this was particularly apparent for those prisoners with these problems: nine of these fifteen deaths took place within the first week. Examination of the medical files of this subgroup provided evidence which suggested that a third of them were experiencing withdrawal symptoms at the time of, or immediately before, the suicide.

Discussion

Any conclusions that can be drawn from these data must be qualified by the fact that the study considered only those deaths which had been officially classified as suicide. Apart from noting the numbers involved, no attempt was made to examine critically the other prison deaths.

Studies by both Robins *et al* (1959) and Barraclough *et al* (1974) have shown that in the general population mental illness can be identified in virtually all suicides. Depressive illness was the most common diagnosis, and a previous history of the same illness was found in almost half the cases. If a similar situation exists for those suicides in prison, it follows that any attempt at prevention should involve the early diagnosis and treatment of this illness.

The suicide group in this study had experienced a considerable amount of psychiatric involvement, with some of this contact taking place in the period immediately preceding the death. In addition, one in three had a history of psychiatric in-patient treatment. There was little evidence that depressive illness at the time of death, or a previous history of this illness, was common; in only one case from the prison records and two from the in-patient group could this diagnosis be found. This suggests that factors other than depressive illness may be important in those suicides which take place in prison.

An alternative approach is to view these deaths as the result of varying degrees of stress rather than formal illness. Support for such a situation can be found in the study by Gunn *et al*, (1978), which examined the prevalence of psychiatric disorder in prison. They examined a sample of prisoners with a combination of psychiatric interviews and questionnaires. The results showed that a high degree of disturbance and psychological discomfort was experienced by the prison population as a whole. The level of this distress appeared to be maximal during

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the initial phase of imprisonment and, although remaining comparatively high, diminished with the passage of time. This change was attributed to a subsequent adjustment to prison life.

Prison suicides follow a similar pattern. This study, in common with many others, found that the majority of deaths occurred shortly after admission to prison. This is the time when the stress factors are most numerous and when the prisoner faces the greatest amount of uncertainty. It could be argued that this results in a continuum of distress, rather than a specific illness with a recognisable constellation of symptoms. In this situation the suicide may take place if, and when, a critical threshold is exceeded. The threshold varies, and is dependent on a balance between the factors themselves and the individual's resources to cope with them. One of the stress factors identified by this study was the symptoms associated with withdrawal from either drugs or alcohol.

Coping mechanisms which might be used by the prisoner have recently been discussed in a review by Coid (1984). He described the way the prison subculture may facilitate the prisoner's adjustment to prison life. In the first place, membership of this group may itself lead to a reduction in the feeling of isolation. In addition, by standing in opposition to the prison staff and management, and by the creation of an 'us' and 'them' situation, the prisoner may regain a feeling of control. This in turn may restore some of his self-esteem and promote a sense of autonomy. The problems arise because acceptance to such a group is neither an immediate process nor equally available to all prisoners. Some will be denied membership owing to the nature of their offence, or aspects of their mental state or personality. As a result of this exclusion they may remain in a vulnerable state. The combination of the clustering of stress factors, and the inadequately developed coping mechanisms, may help to explain the timing of the suicides and the period of adjustment noted by Gunn *et al* (1978).

Finally, it is important to remember that suicides, whether they take place in or outside prison, are rare events, and that it is difficult to predict such an event. This study supports the suggestion that the suicidal prisoner presents with few characteristics which would assist the process of identification. While alcohol and drug related problems may be associated, an identifiable depressive illness does not commonly precede the suicide.

When considering the prevention of suicide in prison it may be more appropriate to emphasise general measures designed to reduce stress and promote coping mechanisms, rather than concentrate on the recognition of the suicidal prisoner. The prison Medical Officer undoubtedly has an important role to play in this. Nevertheless, he will require support from many different areas if the necessary changes are to be made.

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