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## Educating and Training the Next Generations of Security Staff in Suicide Risk Assessment in Correctional Settings: Development of Cultural Competencies

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# Educating and Training the Next Generations of Security Staff in Suicide Risk Assessment in Correctional Settings: Development of Cultural Competencies

## Abstract

Cultural competence in suicide risk assessment has become a necessity given the demographic diversity in the U.S. corrections population and the increasing rate of suicidal behavior in jails and prisons. With few exceptions, little attention has been paid to the cultural training of both clinicians and security staff, and the development of cultural competencies in this field. This paper will focus exclusively on examining the case for cultural competence when conducting a suicide risk assessment in a correctional setting. The author reviews factors that are key in the education and training of culturally informed jail-based therapists and corrections officers, including best practices for educating correctional officers, who are the first line responders to suicide attempts in corrections settings. These factors include understanding the interpersonal theory of suicide, the cultural model of suicide, and the trauma informed care approach in corrections. The author offers future practice recommendations that are based on well-established cultural competencies in the field of suicidology.

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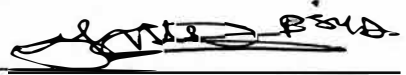
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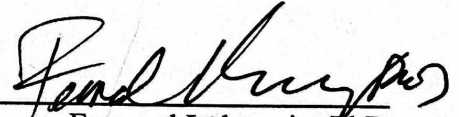
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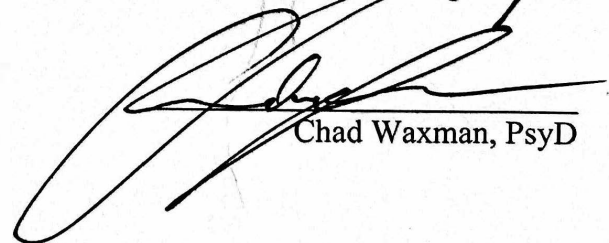
IN PARTIAL FULLFILLMENT  
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DOCTOR OF PSYCHOLOGY

BY  
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## **Personal Introduction**

During my time as a student at the University of Denver's Graduate School of Professional Psychology, I have had the opportunity to work in a variety of settings and subsequently developed a passion for working with forensic populations. I gained experience in responding to crises within a variety of facilities and observe, first-hand, how suicidal inmates are handled and helped. Additionally, the Graduate School of Professional Psychology provided the opportunity for an in depth, year-long, multicultural course sequence, which taught me the importance of the interaction of culture with mental health. My passion for suicide assessment and understanding cultural differences inspired my doctoral paper, as I learned of a significant gap in the research – namely, the lack of culturally alert suicide assessment in correctional settings.

## **Abstract**

Cultural competence in suicide risk assessment has become a necessity given the demographic diversity in the U.S. corrections population and the increasing rate of suicidal behavior in jails and prisons. With few exceptions, little attention has been paid to the cultural training of both clinicians and security staff, and the development of cultural competencies in this field. This paper will focus exclusively on examining the case for cultural competence when conducting a suicide risk assessment in a correctional setting. The author reviews factors that are key in the education and training of culturally informed jail-based therapists and corrections officers, including best practices for educating correctional officers, who are the first line responders to suicide attempts in corrections settings. These factors include understanding the interpersonal theory of suicide, the cultural model of suicide, and the trauma informed care approach in corrections. The author offers future practice recommendations that are based on well-established cultural competencies in the field of suicidology.

## **Introduction**

Suicide is an increasing problem in local jails and prisons (Horon, Williams, McManus, Roberts, 2018). Incarceration often comes with feelings of shame, embarrassment, guilt, and a lack of connection to their support systems. Those who are incarcerated are taken away from their homes and placed into a structured and stressful environment with a wide variety of personalities, backgrounds, races, ethnicities, and cultural identities. The general public tends to see the role of prisons and jails as only for securing offenders; however, the responsibilities of the correctional system extend beyond that and must include providing appropriate care to all inmates, including those with mental illnesses.

Correctional settings, including the federal, state, and local level, all operate under strict rules and regulations, including expectations for their employees. It is common for roles and expectations to conflict with each other, particularly for security staff in these environments (Dvoskin & Spiers, 2004). While their primary goal is the safety and security of the institution, it is common for security staff to be the first ones who come in contact with an inmate who might be experiencing a mental health crisis. Mental health staff in corrections must rely on the information provided by security staff to get a comprehensive picture of the inmate's functioning, given security staffs' consistent contact with the inmates.

Correctional officers receive extensive training on policy and procedures of that particular institution upon getting hired. Given the large number of mentally ill individuals who are incarcerated, it is clear that specialized training in mental health would benefit security staff across all settings. Correctional officers spend more time with inmates than any other staff and see inmate behavior most often, including potential suicidal behavior (Dvoskin & Spiers, 2004).

There are numerous factors that dictate how a person might display suicidal behavior. Cultural identity plays a large role in how a person exhibits suicidal symptoms and potentially the manner of suicide attempts. With the wide range of racial and ethnic identities in correctional settings, it is imperative that security staff have at least a basic understanding of the relationship between culture and suicide, in order to better understand and intervene in suicidal behavior.

### **Literature Review**

Suicide is a preventable death that affects individuals, their families and communities across the lifespan, regardless of race, ethnicity, age, gender, socioeconomic status, or sexual orientation. Suicide is the third leading cause of death in United State prisons and the second leading cause of death in jails (Daniel, 2006). In addition, it is a major public health burden nationwide, costing on average \$1.3 million for each suicide, totaling \$93.5 billion (Suicide Prevention Resource Center, 2015). Most of this cost is due to lost productivity, while the remaining is due to medical treatment. (SPRC, 2015). Suicide prevention efforts in prisons are hindered by many of the same obstacles of those in the general population. Barriers to suicide risk assessment and prevention in correctional settings include stigma, perceptions that prisoners are being manipulative, and imprecise risk assessment frameworks. Additionally, there is a lack of information on cultural factors which may influence suicidality.

Many psychologists have voiced their concerns regarding the need for integrating cultural competence in psychology (Sue, 2001, Chu et. al, 2010, Horon et. al, 2018). Unfortunately, the question of what it means to be “culturally competent” is a complex one to answer. Sue (2001) discusses three components of cultural competence: belief/attitude, knowledge, and skill. A person’s beliefs/attitudes include being aware of their own heritage, recognizing limits of

competency, aware of their own biases and stereotypes, and respecting the beliefs of others. Knowledge focuses on being aware of how culture affects perceptions, and being as knowledgeable as one can be regarding cultural differences. The skill component includes an ability to determine and use culturally appropriate intervention strategies when working with diverse populations. This component also entails attending updated trainings on best practices (Sue, 2001, Sue & Sue, 2019).

Having awareness of cultural differences is an important component of cultural competency. It is imperative to examine personal diversity related beliefs and values in order to recognize any biases or prejudices. These can create barriers in learning about and working with culturally diverse populations (Sue & Sue, 2019). When working with individuals who are in a mental health crisis, particularly ones who are displaying suicidal behavior, having a good working alliance between inmate and staff member is necessary. The inmate needs to feel safe and comfortable disclosing information to a staff member; this is more likely to happen if they do not experience prejudice or discrimination from the staff member.

### *Diversity in Prisons*

Correctional settings within the United States house inmates who come from a variety of races, ethnicities, religions, and sexual orientations. According to the Bureau of Prisons, almost 40% of inmates are Black, nearly 33% identify as Hispanic, approximately 2% are Native American, and about 2% are Asian American (BOP, 2019). Christianity and Islam are the two most common religions practiced by inmates. However, there are those who practice Wicca, Buddhism, Judaism, Hinduism, and Jehovah's Witnesses (BOP, 2019).

The safety and security of the institutions and those who live and work there is the primary concern of security staff. One of the primary sources of violence in corrections comes



from gang activity (Noll, 2011). Gang culture is a common problem in corrections and these gangs are often race-based (Noll, 2011). Both inmates and correctional officers operate within the racial categorization of gangs in correctional settings. It is common for either institutional segregation or self-segregation by the inmates to create separation by racial groups (Noll, 2011). Often, racial categories are used to structure the daily interactions between prisoners and staff to promote safety. With this comes an enormous amount of peer pressure from current inmates to incoming inmates to join with their own racial groups for power and protection (Noll, 2011).

During the intake process when first arriving to a facility, inmates are usually asked what their “affiliation” is (Noll, 2011). It is understood by the inmate that not being affiliated with a racial group or gang is unacceptable and unsafe. This process and experience is different among White inmates, who are not automatically assigned to a specific gang based on their race. The most common gangs which White individuals tend to belong to fall within White Supremacy groups, such as the Aryan Brotherhood, the Nazi Low-Riders, the Skinheads, and the Woods (Noll, 2011). Since there is little choice when it comes to being affiliated with a gang, White individuals will likely join a White Supremist gang for safety and this can enhance racial tensions within a facility (Noll, 2011).

### *Suicide in Prisons*

Providing effective trainings that include suicide risk assessment is essential given the high risk population of inmates. Prisons have a high concentration of high-risk individuals and the act of imprisonment is stressful, demeaning, and isolating, all of which put a person at risk for suicidal behavior. Despite the prevalence of suicide in jails and prisons, there seems to have been less concern for incarcerated populations compared to others (Pompili, Lester, Innamorati,

Del Casale, Giardi, Ferracuti, and Tatarelli, 2009). Those who are incarcerated are often labeled as “criminals,” and therefore seen as less important than those in the general population. In recent years, however, there have been an increase in number of lawsuits in prison settings and psychiatric hospitals, which have caused a financial burden and raised the concerns of staff in those settings (Pompili, et al, 2009).

As stated previously, suicide is the third leading cause of death in prisons and the second in jails (Torrey et. al, 2010). Those in urban jails have a higher suicide rate than those in rural communities, and the overall suicide rate in jails is nine times higher than that of the general population. The high-risk period for suicide in jails is during the first 24 to 48 hours (Daniel, 2006). There is also an issue of underreporting suicides in correctional settings, so the numbers could actually be higher (Daniel, 2006). Many inmates who attempt suicide but who do not die immediately after their attempt are not classified as suicides due to fear of litigation (Daniel, 2006). Eight to fifteen percent of prisoners have a serious and persistent mental illness, and many have co-occurring disorders. Symptoms of disorders (i.e., mood, psychotic, personality, and depressive) can manifest prior to or during incarceration (Daniel, 2006).

Torrey et al. (2010) found that across 44 states, any given prison or jail in each state holds more mentally ill individuals than the largest psychiatric hospital in the same state. Within correctional settings, there are a host of psychosocial stressors such as undesired unit placement, work assignment, disciplinary confinement, interpersonal conflicts, legal processes, and parole setbacks. Additionally, the severity and type of crime may also be a risk factor. This can be explained by feelings of guilt, shame, or stigma attached to the crime, particularly sex offenses.

Pompili, et al. (2009) discussed several other environmental factors which might increase suicide risk. These include inadequate psychological services at the time of intake and

throughout incarceration, poor communication among staff, limited staff direction to respond to suicide incidents, and limited staff training and direction in suicide prevention. This deficit illustrates the importance of adequate training in suicide prevention, especially among security staff. It is difficult for clinical staff to engage in services when a person is first brought into the facility. Security staff are the ones who spend the most time with the individual and could be the ones to intervene if they see problematic behavioral signs. It is important for all staff to be aware of the warning signs, and how best to intervene so there is not a lack of communication or wonder of who should respond.

### *Defining Suicidal Terms*

Important attempts have been made to refine definitions of key suicide-related constructs in order to improve measurement and standardization (Silverman, Berman, Sanddal, O'Carroll, & Joiner, 2007). Suicide-related behaviors can be classified as "ideations, (i.e., thoughts), communications, and behaviors." Further, suicide-related behaviors are self-initiated and can vary in terms of the intensity of intent to die, and the extent of physical injury sustained (Silverman, et al., 2007). Additionally, if there is no actual intent to die, the term "self-harm" is used to describe the behavior, such as cutting for emotional regulation. A "suicide attempt" involves self-initiated potentially injurious behavior, having the intent to die, and a non-fatal outcome. When the outcome is fatal, that is when the term "suicide" is used (Silverman, et al., 2007).

### *Risk & Protective Factors*

A *risk factor* is defined as a characteristic of a person or their environment that increases the likelihood they will engage in suicidal behavior. Major risk factors include: prior suicide attempts, substance use, diagnosed or undiagnosed mental illness, having access to lethal means,

social isolation, and a lack of access to behavioral health care (Suicide Prevention Resource Center, 2015). These factors can vary across age groups, culture, sex, and sexual orientation. For example, middle-aged Caucasian men have the highest rate of suicide across all groups (SPRC 2015).

In contrast, a *protective factor* is a personal or environmental characteristic that helps protect individuals from suicidal behavior. Some examples include, social connectedness, sense of purpose, cultural or religious beliefs, and access to effective behavioral health care (SPRC, 2015). Defining suicide related terms, including risk and protective factors, is important when training staff in suicide risk assessment. Those who are working with high risk populations, like security staff in corrections, need to be aware of what puts a person at risk, along with what can be used to protect them. Trainings should focus on ways inmates can engage with their protective factors while they are incarcerated, such as a person's cultural practices.

When a person is incarcerated, they arrive at the facility with a host of risk factors that most people in the general community do not experience. Some common risk factors that are shared by both who are in the general community and incarcerated individuals are drug abuse, unemployment, interpersonal conflicts, and mental illness (Gupta & Girdhar, 2012). More than half of inmates who attempt suicide in prison are between the ages of 25 and 34. Commonly, they are single and have no family support or employment. Furthermore, upper socioeconomic status and high degree of social integration prior to incarceration tend to increase the risk of suicide in prison. This correlation is interpreted as being related to a high degree of guilt and shame that these individuals commonly experience upon being incarcerated (Gupta & Girdhar, 2012). These feelings and dynamic can be particularly salient among minority ethnic groups with more collectivistic cultural beliefs.

Naturally, many psychosocial stressors come with incarceration. These can include undesired unit placement, work assignment, confinement, legal processes, parole setbacks, chronic medical conditions, and interpersonal conflicts (Gupta & Girdhar, 2012). Interpersonal conflict might include marital separation, divorce, or the death of a loved one while incarcerated. The death of a loved one is particularly difficult as showing evidence of grieving might be seen as a sign of weakness and vulnerability among inmates (Gupta & Girdhar, 2012). This dynamic reflects the complex relationship between culture and suicidal behavior, as grieving behavior may vary across cultures and not feeling safe to grieve in a certain way can increase risk.

Pre-trial inmates are at a high risk for suicide, in particular young, unmarried individuals who have been arrested for minor offenses. Most of these individuals are typically intoxicated at the time of their arrest and are at the greatest risk for suicide within the first few hours of their arrest. Another risky time is shortly before their court appearance, particularly when they anticipate a guilty verdict and harsh sentencing (Gupta & Gindhar, 2012). Those who complete suicide after being sentenced are usually older and have violent offenses. The risk for suicide attempts tends to increase after being incarcerated for an extended period of time (Gupta & Gindhar, 2012).

### *Myths about Suicide*

Joiner (2010) described several “myths” regarding suicide and their importance when it comes to understanding suicidal behavior. These myths can be detrimental in understanding and preventing suicide, especially in correctional environments. Incarcerated persons have a tendency to be viewed as manipulative, especially when it comes to expressing suicidal ideation.

Joiner (2010) discussed the myth that if a person wants to die by suicide, they cannot be stopped. He used the example of the Golden Gate Bridge, one of the most common places in the

world to commit suicide. Joiner cited a published study that reported 95% of the people who were restrained and prevented from jumping went on the live productive lives. Joiner stressed that this finding shows preventing a person from committing suicide does not necessarily mean they will find another way. He also explains it is common for those who choose suicide to still be ambivalent about the act. Simple interventions such as removing the means of suicide, increasing mental health contact, or even a mere conversation can change a person's mind. Understanding this is imperative when it comes to preventing suicide, particularly for security staff who spend more time with inmates than anyone else. Simple interventions can make a huge difference in stopping suicidal behavior, and these interventions do not necessarily have to be done by mental health staff.

One of Joiner's myths is the idea suicide is a cry for attention. This is a common idea in correctional settings, where there are a high number of individuals who have been diagnosed with personality disorders or who are seen as manipulative. It is a common thought that an inmate will "feign" suicide in order to be removed from general population and be housed alone or get "special treatment" from staff. This myth can be detrimental when it comes to helping those contemplating suicide. If staff think of it as just a way to get special treatment, then the threats will not be taken seriously. Joiner explains it is common for a person to have a plan and then decide otherwise. When a person discusses suicide, they are likely reaching out to others regarding their pain in order to see what kind of social ties they have and if others can be helpful. Security staff in corrections need to understand how important interventions are, every time someone discusses suicide. This includes self-injurious behavior, which is also extremely common in corrections, which have a large population of inmates diagnosed with Borderline

Personality Disorder. This behavior is not commonly a cry for attention, instead self-injury is a way for them to control their own negative emotions and moods.

### *Theories of Suicide*

Prinstein (2008) discussed the issue of a lack of examination of theoretical models that might help understand suicidal behavior. There have been multiple theories proposed to explain suicidal behavior. For example, Aaron Beck posited that depression is highly associated with suicide, and the critical link between the two is hopelessness (Beck, 1986). He went on to develop the Beck Hopelessness Scale. E.S. Shneidman (1993) explored the thinking processes of suicidal patients, concluding that all suicides are a direct result of intense psychological pain, or *psychache*. Binswanger focused on the unconscious and its connection to suicidal behavior (Lester, 1994). However, there is no overarching theory that can comprehensively explain the known facts about suicide, making research and prevention difficult. Two important theories of suicide are discussed below: The Interpersonal Theory of Suicide and the Cultural Model and Theory of Suicide.

### *Interpersonal Theory of Suicide*

Joiner et al. (2010) proposed the *Interpersonal Theory of Suicide*. Essentially, this theory posits that people want to die by suicide “because they can and because they want to.” Within this theory, there are three concepts that are central to suicidal behavior, which are *thwarted belongingness*, *perceived burdensomeness*, and *acquired capability for suicide*. The relationship between these three concepts indicate a “causal pathway” for the development of suicidal behavior, both lethal and non-lethal (Joiner, et al., 2010). All of these characteristics are common among incarcerated individuals.

Social isolation and other forms of social disconnection are strong and reliable predictors of suicidal behavior. Baumeister and Leary (1995) discussed the importance of human connection, stressing there is a fundamental need to belong. Humans are social beings and have a need to interact and connect with other people. Thwarted belongingness is when the human need for connection is not met. Further, this theory explains thwarted belongingness as having two important dimensions: loneliness and the absence of reciprocally caring relationships (Joiner et al., 2010). Incarceration is extremely isolating. Individuals are taken away from their support systems and placed in a controlled environment with little positive interaction. Commonly, the incarcerated individual is not allowed visitations with their families, or might be placed far enough away that their families cannot make it to visit them.

Joiner, et al. (2010) discussed some observable behaviors of those who might be at risk of experiencing thwarted belongingness, one of those is being residing in a single jail cell without a cellmate. When housed alone, a person will likely experience loneliness and a lack of caring from others. Security staff are supposed to be constantly observing the housing units in correctional settings. By having an understanding of this concept, staff can be more aware of people who are housed alone, look for the signs, and intervene accordingly. This factor is dynamic, not static, so if an individual's environment or emotional state changes to meet the need of belonging, this factor can decrease (Joiner, et al., 2010).

The interpersonal theory of suicide states thwarted belongingness will be more likely to lead to suicidal thoughts if the person experiences perceived burdensomeness in addition. Perceived burdensomeness is when a person feels like a burden to their support system or that they are expendable. For example, if a person is homeless, incarcerated, unemployed, or chronically ill, they may feel like a burden. Looking specifically at incarceration, these



individuals might feel like a burden to their family due to shame or embarrassment, making them travel to visit them, or depending on them for financial support.

Lastly, the interpersonal theory of suicide assumes the desire to die by suicide per se is not fatal, because dying by suicide may be painful and difficult to complete. Therefore, a person needs an acquired capability for suicide. A person must lose some of the normal fear associated with suicidal behavior and potential death (Joiner, et. al, 2010). Regarding training, understanding this acquired capability is important in order to look for signs of a person building up their determination and fortitude to complete suicide. This could mean self-harming behaviors or engaging in other risky behaviors. Further, asking someone the question, “Do you think you have the capability or courage to kill yourself?” is important. Any other answer than “no” should be regarded as a risk for suicidal behavior (Joiner, et al., 2010).

#### *Cultural Theory and Model of Suicide*

In addition to the interpersonal factors related to suicide, understanding how an individual’s cultural identity affects suicidality is also important and lacking in current research, particularly in corrections. The Cultural Theory and Model of Suicide was proposed to include cultural components in suicide assessment. It is important for staff working in this environment to be aware of the unique challenges that ethnic minorities struggle with when it comes to suicidal behavior.

In 2010, Chu, Goldblum, Floyd, & Bongar conducted a study looking at suicide across different minority groups and culturally specific factors. They found four common cultural components of suicide risk: *cultural sanctions*, *idioms of distress*, *minority stress*, and *social discord* (Chu, et al., 2010). With this information, Chu and his research partners proposed the Cultural Model of Suicide, which has three principles: a) culture affects how suicidal behavior is

expressed; b) culture affects the types of stressors that lead to suicidal behavior; and c) cultural meanings associated with stressors and suicide affect the development of suicidal tendencies, pain threshold, and suicidal act (Chu, et al., 2010).

The term *cultural sanctions* is defined as messages of approval or acceptability supported by a given culture. This includes how acceptable suicide is as an option, based on the shame associated with certain life circumstances (Chu, et al., 2010). For example, viewing suicide as unacceptable or immoral have been shown to predict lower suicide rates among African Americans and Latinos (Chu, et. al, 2010); while suicide in homosexual populations is seen as more acceptable and perhaps necessary (Molloy, McLaren, and McLachlan, 2003).

Further, cultural sanctions can explain which life events are considered shameful. For example, among Asian American individuals, bringing shame to your family is seen as unforgivable and suicide can be an honorable or acceptable “way out” for those who believe they have brought shame to their families (Chu, et. al, 2010). The idea of cultural sanctions is important when working with incarcerated individuals. Recent incarcerations or arrests can be seen as shameful or unacceptable by some, which can increase their risk of suicidal behavior; particularly within the first 48 hours when the risk is the highest. Simply asking the individuals about their family and their level of support can provide clues as to whether this is a particular risk factor for that person.

Second, understanding *idioms of distress* is imperative in suicide assessment. Idioms of distress are cultural variations in the manifestation of psychological symptoms. These include likelihood to express suicidality, expression of suicidal symptoms, and means of attempting suicide (Chu, et. al, 2010). Morrison & Downey (2000) reported that ethnic minorities are less likely to express suicidal ideation, which is referred to as hidden ideation. It is important to be

aware that ethnic minorities may not fully express ideation but might simply suffer in silence. It is vital to look for other signs of suicidal ideation, such as behavioral changes. In correctional settings, it might be difficult for people to speak up about suicidal ideation in the first place. Identifying as a minority might make it even more difficult for them to voice their concerns.

Chu, et al. (2010) further discussed *minority stress* which is the stressors cultural minorities experience because of their social identity or position. This stress can occur at two levels, proximal and distal. The distal level refers to negative events, and the proximal level refers to the internalization of negative events (Chu, et al., 2010). When a person assimilates to the dominant culture, they likely deal with challenges that come with balancing two identities. Greater assimilation has been shown to be a predictor of suicidal ideation (Chu, et al., 2010). Wadsworth & Kubrin (2007) found that second generation Latinos have an increased risk for suicidal behavior if they are living in an area without people of their same ethnicity. Additionally, discrimination, mistreatment, and harassment can easily occur, all of which have shown to have a relationship with increased suicidal behavior. This is important to consider in jail and prison inmates, as they may unlikely be with people of their similar race, ethnicity, or religion. Further, social disadvantages are common among ethnic minorities (e.g., income inequality, unemployment, and poverty), which are shown to correlate with suicide (Wadsworth & Kubrin, 2007).

Lastly, *social discord* is another important suicide risk factor among minority populations (Chu, et al., 2010). Examples of social discord as a lack of social support include family rejection or alienation. The idea that lack of social support could lead to suicidal behavior might seem obvious, but it is important to be aware of and learn about, particularly when it comes to minority populations. It is common for families to have conflict when a member ends up

incarcerated. If the incarcerated individual is placed far away from their family, it is likely they might not be receiving consistent visits or phone calls, making them feel more isolated, even more so if they are not with people of similar ethnicity.

### *Risk Assessment Training in Prisons*

Suicide risk assessment training for staff in correctional settings varies by location and type of facility. This training is crucial. If staff are given adequate training in assessing for suicide and understanding behavior, they are less likely to believe the inmates are simply being manipulative or vying for attention. People with serious mental illness or trauma experiences may display behaviors that seem out of their control, disruptive or aggressive, particularly to a security staff member with no mental health training (DeHart & Iachini, 2019). Trainings usually consist of identifying high-risk offenders, identifying signs and symptoms of mental illness, and handling communication of intent (Daniel, 2006). Other orientation trainings might include a brief segment on mental health issues, but there are few follow-ups, refreshers or in-depth trainings offered (DeHart & Iachini, 2019).

It is necessary for both correctional officers and non-clinical staff to have these trainings along with mental health staff. Education of these topics are needed to strengthen knowledge and build the skills of those staff already employed, along with training incoming employees. It is important that all staff recognize signs of depression and other suicidal risks, including cultural factors, which are largely ignored in trainings. In a large institution, it is unlikely that a mental health professional will be the first person to come to the aid of a suicidal inmate. The goal of training all staff is not that everyone can perform formal suicide assessments, but rather that they become more aware of the most common and obvious indicators of risk. There is a variety of professional disciplines that train staff, such as criminal justice, social work, and psychology.

However, there are few training programs that address corrections and mental health specifically (DeHart & Iachini, 2019).

### *Correctional Officers and Mental Health*

As previously discussed, correctional facilities are legally mandated to provide care to those incarcerated (Dvoskin & Spiers, 2004). Prisons operate much like any other community and have different groups of people trying to work together for a common goal. These groups include correctional officers, mental health staff, medical staff, and the inmates. There is a mutual dependence between staff and inmates, with the goal to keep everyone safe and secure. A central function and common goal of both mental health staff and security staff is to uphold the safety of the facility and those who live and work there.

One of the main forms of treatments for mentally ill inmates is basically talking and listening to them. Any staff member can be the one to do this, including correctional officers. While most mental health staff work a routine 40-hour work week, correctional officers are there 24 hours a day. There are also many more correctional officers working than mental health staff (Dvoskin & Spiers, 2004). Correctional officers are the employees who have the most contact with the inmates. Therefore, it is likely that many correctional officers are more likely to be responsible for responding to a mental health crisis than mental health staff are (Dvoskin & Spiers, 2004).

### *Cultural Training in Mental Health*

Health care workers are aware now, more than ever, of the importance of cultural competency when working with a racially diverse population (Benuto, Casas, & O'Donohue, 2018). In order to provide culturally competent care, it is necessary to have at least a basic knowledge of cultural beliefs, values and perspectives, and how those relate to providing proper

care (Bhui, Warfa, Edonya, McKenzie & Bhurgra, 2007). Carter & Qureschi (1995) discussed the variety of multicultural training programs that exist and focus on “increasing sensitivity and awareness, race-based training emphasizing intergroup conflicts and an inability to confront one’s own ‘isms.’” There is a call to increase and standardize trainings to agree on specific content and focus which are seen as imperative (Bhui et al., 2007).

There are different approaches when considering cultural competency in mental health practice. For example, there are numerous versions of Cognitive-Behavioral Therapy (CBT) that have been implemented for various minority groups (Griner & Smith, 2006). Cultural competency can also be looked at from an individual level; that is, practitioners focus on how different socio-cultural factors can affect each individual they work with clinically. This is seen as a way to avoid stereotyping certain ethnic and racial groups (Betancourt & Green, 2010).

While cultural competency is becoming increasingly important, there is an issue with standardizing trainings. There are differences in what people define as “cultural competency.” For example, it could be seen as simply gaining more knowledge of beliefs and practices of particular cultural groups. However, this approach does not include addressing how cultural beliefs and practices affect an individual’s mental or physical health. Most trainings are also not standardized, making it difficult to measure their effectiveness (Bhui, et al., 2007).

### *Culturally Infused Trauma Psychology Curriculum*

Trauma-informed care has the primary goals of accurately identifying trauma and related symptoms, minimizing retraumatization, and fundamentally to “do no harm” (Miller & Najavits, 2012). Importantly, prisons are a challenging setting for a person who has experienced trauma. Prisons are full of psychological triggers, including small living spaces, lack of privacy, loud noises, and large crowds. There are numerous resources readily available for clinicians.

However, there are a large number of professionals who have daily contact with incarcerated individuals who did not receive dedicated training on mental health or trauma (DeHart & Iachini, 2019).

If trauma-informed treatment principles are taught, all staff can help mental health professionals in minimizing triggers and stabilizing the inmates to the best of their ability (Miller & Najavits, 2004). One of the barriers that come with the prison environment is the underreporting of trauma symptoms. This is largely influenced by the general culture of mistrust that exists in prisons. This can also be caused by the idea of “ratting someone out” for acts done, which is off-limits both inside and outside of prison (Miller & Najavits, 2012). Further, those who have experienced sexual trauma may not disclose to correctional staff due to thinking of it as normal in that environment. Many inmates might experience symptoms of posttraumatic stress disorder, making it difficult for them to cope with living in a prison (Miller & Najavits, 2012). By understanding trauma-informed care and taking this approach with inmates, correctional staff may avoid retraumatization.

### *Training for Correctional Staff*

Miller & Najavits (2012) indicated three essential training elements for correctional staff on trauma informed care: 1) incorporating examples of how trauma informed care can make their lives easier (e.g., controlling costs, reducing restraints, behavior management, and safer facilities), 2) allowing role plays and group exercises regarding trauma, and 3) incorporating the voices of trauma survivors. By including these three elements, correctional officers receive training on trauma informed care when working with inmates.

Correctional staff are more likely to respect experience rather than research (Miller & Najavits, 2012). When creating a curriculum for correctional staff about mental health, it is

important to relate to them based on their experiences working with inmates with mental health concerns, explaining that this is to make their daily work easier, rather than telling them how to do their jobs. It is also imperative to reinforce staff intuition and compassion. An overwhelming majority of correctional security staff have years of experience in this field and have seen numerous inmates in a variety of crises. It is important for participants to understand that these trainings are not because there are issues with their job performance, but instead to further their knowledge and potentially make their jobs easier.

### *Barriers to Cultural Competency in Corrections Settings*

Bringing culture into mental health treatment involves reaching out in order to understand the worldviews of those being treated, including their values, experiences, and life circumstances. Doing so can be difficult for some to do. While cultural competence is seen as very important in general psychology, the same attention has not been given to correctional psychology. One reason for this is correctional facilities have difficulty providing basic mental health care to most inmates, given the ever-growing number of mentally ill offenders (Kapoor, Dike, Burns, Carvalho, & Griffith, 2013). Further, in general “prison culture” is seen as an “us vs. them” situation, the offenders versus the correctional staff. This makes it difficult to establish healthy trust among those who are incarcerated (Kapoor et al., 2013). This can then make it difficult for inmates to feel as though they can confide in correctional officers, particularly those of a different race or ethnicity. Correctional officers largely believe their job is not to work intimately with the inmates, other than for security reasons (Kapoor et al., 2013).

### **Summary and Recommendations**

Suicide is becoming more of an epidemic in all populations, but it is particularly salient in correctional facilities. The adjustment to being in a controlled environment, having to be



accounted for at all times, being away from your support system, and potentially being housed with people who you do not get along with, can bring out the worst in a person's mental health. Additionally, a majority of the prison population have extensive mental health needs prior to being incarcerated. Consistent mental health contact is difficult to come by in a correctional setting. Incarcerated individuals with a history of mental health needs and trauma are commonly unable to receive the consistent care they need, particularly in an environment as triggering as prison.

Correctional officers spend more time with incarcerated individuals than any other staff member in the facility. They are there through the night, on weekends, and on holidays, when most of the other staff are not readily available. While there is a distinct power differential between inmates and correctional staff, many inmates will turn to correctional staff for contact during a crisis. Correctional officers who are well-trained will be better able to pick up on behavioral changes and can intervene prior to a crisis. It is imperative that correctional staff receive training in mental health, including trauma informed approaches and suicide risk assessment.

Trainings for mental health professionals are beginning to include the concept of cultural competency, given the racially diverse populations most professionals are working closely with. Unfortunately, this has not been included in trainings geared towards correctional security staff. Considering the wide range of racially diverse individuals who are currently incarcerated, this is an important addition that needs to be considered in future trainings.

Future trainings for correctional officers need to be standardized across locations. The trainings vary significantly across facilities. Often, these trainings are short and not often repeated. This leaves correctional officers with the feeling that turning to psychology staff in

times of crisis is best practice. While it is imperative psychology staff have contact with a suicidal individual, correctional officers are often the first ones made aware of a potentially risky situation and provide their own interventions if mental health staff are not readily available.

Formal trainings should be taught by both psychology and higher status security staff. Officers have a tendency to trust status more than research, according to the literature. It would be most beneficial to have other security staff play an active role in the training to show its importance. Trainings should also include information on Joiner's myths about suicide. These myths are important ideas to discuss in order to increase understanding and empathy. For example, the myth that suicide is simply a cry for attention is important to talk about in trainings. This is an idea that is very prevalent in correctional facilities, where there is a large population of personality disordered and sometimes manipulative individuals.

Taking a trauma informed approach is imperative when establishing a training curriculum. Prison is a triggering environment for many, particularly those who have experienced a previous traumatic event. Taking a trauma informed approach when speaking with inmates can provide the inmate a safe place for them to be open and honest about their concerns, including potential suicidal behavior. Providing correctional staff training on trauma-informed care will allow all staff to be able to assist an inmate in crisis and provide quick care.

Additionally, future trainings should include theories of suicidal behavior, including the cultural model of suicide and the interpersonal theory of suicide. Understanding theory is imperative when conducting both formal and informal suicide risk assessments. Thwarted belongingness is a common concept in correctional settings. Many inmates might feel they do not belong in that environment, or even go so far as believing they no longer belong with their

family and support system. Finding meaning and purpose while incarcerated is difficult to do at times, making inmates potentially feel as though they do not belong anywhere.

Self perceived burdensomeness is another important concept to teach during trainings. Those who are incarcerated might feel as though they are a burden on their family and/or friends. Some inmates rely on their support system for money and other goods to be sent to them in order to survive their sentence. Additionally, if they are incarcerated far away, inmates might feel like a burden asking their family and/or friends to travel for a visit.

The Interpersonal Theory of Suicide discusses acquired capability for suicide. A large number of incarcerated people have a history of risky behavior, like substance use, self-harm, and impulsive actions. All of these can lower a person's fear of taking their own life. Add it to the two previous concepts discussed and an incarcerated individual becomes extremely high risk. By including this theory in trainings, participants can better understand these risk factors and be aware of warning signs.

The Cultural Model and Theory of Suicide should be included in suicide risk assessment trainings for correctional staff. This theory discusses the importance of understanding cultural sanctions, such as which life events may be considered shameful to different groups. Being incarcerated will likely be regarded as a shameful event, and can affect a person's mental wellbeing while being incarcerated. Additionally, being aware of the concept of idioms of distress, including hidden ideation, is key. Minority groups are less likely to display signs of mental illness or distress. It is important that staff is aware of other behavioral signs of suicidal ideation.

Given that correctional officers are those who spend the most time with the inmates and are often first to be made aware of a crisis, trainings for them are extremely important. Trainings

may be in lecture format, during which theory, research, and statistics are described to explain the rationale for the training. Additionally, vignettes should be utilized to allow open discussion amongst the members as to how they could handle each situation. Lastly, there would be time for questions and concerns from the participants. In order to measure the training's effectiveness, a short test would be given before and after completion of training.

Correctional facilities have been largely seen by the general population as places for simply containing and punishing those who have broken the law. Those who are incarcerated are largely ignored or forgotten by the general population. However, the unfortunate reality is these individuals are more likely to experience mental health crisis and suicidal behavior, compared to the general population. Psychology staff work tirelessly to provide adequate mental health care and rely upon other staff members to assist them. This is particularly salient in regard to correctional officers, the people who spend more time with inmates than any other staff member.

It is imperative correctional officers receive adequate training in crisis intervention and suicidal behavior, given the high-risk population they work with. Further, these individuals include a variety of races, ethnicities, religions, and sexual orientations, making the inclusion of culturally competent suicide risk assessment training all the more important. The purpose of the training is to make the jobs of staff members easier and work towards increasing empathy and understanding towards this often misunderstood population.

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