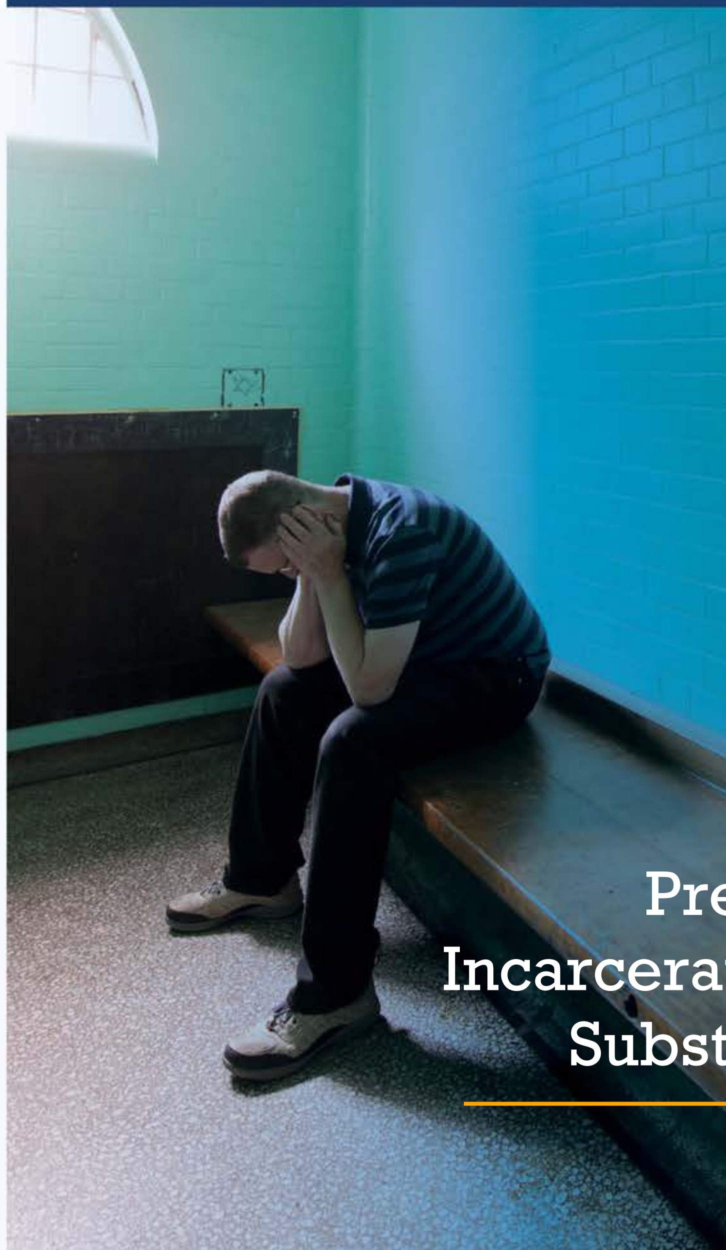
Bureau of Justice Assistance (BJA)
Residential Substance Abuse Treatment (RSAT) Program for State Prisoners
Training and Technical Assistance Resource



Preventing Suicides of Incarcerated Individuals with Substance Use Disorders

A Prison and Jail Policy Brief

BJA's RSAT PROGRAM | AHP Advocates for Human Potential, Inc. | BJA Bureau of Justice Assistance U.S. Department of Justice

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June 2024

This project was supported by grant No. 15PBJA-22-GK-01132-RSAT awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs which also includes the Bureau of Justice Statistics, the National institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the SMART Office, and the Office for Victims of Crime. Point of view or opinions in this document are those of the author and do not represent the official position of policies of the United States Department of Justice.

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Introduction

Prison and jail suicide deaths are increasing across the United States. So are the number of deaths attributed to drug and/or alcohol intoxication.[1] The two are inextricably related in both the nation's jails and prisons.

This document provides information on the link between substance use disorders (SUDs) and suicide and the increased risk of suicide during incarceration and offers strategies to reduce this risk during confinement.

I. General Link Between Substance Use Disorder and Suicide

Outside of prisons and jails, the link between SUD and alcohol use disorder (AUD) and suicides is widely recognized. A 2021 study review summarizes, for example, "Alcohol and opioid use disorders (AUD/OUD) significantly increased risk for suicidal ideation, attempts, and death, and are the two most frequently implicated substances in suicide risk." Pertaining specifically to alcohol, the researchers explain, "Among people with an underlying vulnerability to risk-taking and impulsive behaviors, chronic alcohol intoxication can increase maladaptive coping behaviors and hinder self-regulation, thereby increasing the risk of suicide." With respect to OUD, the researchers state that, "…chronic opioid use can result in neurobiological changes that lead to increases in negative affective states, jointly contributing to suicide risk and continued opioid use."[2]

A study of people misusing prescription drugs has documented, for example, after controlling for other conditions that "people with a prescription opioid use disorder (OUD) were … twice as likely to attempt suicide as individuals who did not misuse prescription opioids."[3] The same holds true for people with addictions to non-prescription opioids. An examination of people with OUD who overdosed found an "astounding" 58.5 percent of participants said that they had at least some desire to die before their most recent opioid overdose, and only a minority, 41.5 percent, said that they did not want to die.[4] Researchers explained, "This is quite remarkable when you remember that we had assumed all overdoses were accidental until recent work began to really look at the association between depression and overdose."[5]

Similarly, a 2023 study consisting of two randomized, controlled surveys of 244 persons who had initiated treatment in the past month using buprenorphine in one of five Federally Qualified Health Centers in Pennsylvania and New Jersey found 37.70 percent reported significant thoughts of suicide and 27.46 percent reported suicide attempts over their lifetime.[6]

Compounding the risk of suicide for individuals with SUD is the link between SUD and mental illness. Half of those who die by suicide are afflicted with major depression. The co-occurrence of a psychiatric diagnosis and substance misuse or the presence of more than one psychiatric diagnosis are major risk

factors for suicide.[7] Studies have found 60 to 90 percent of suicides are associated with depression, SUDs, and other forms of mental illness.[8]

However, persons, especially those with SUD who die by suicide, may not suffer a diagnosable depression to be at heightened risk for suicide. Researchers have surmised that people with SUDs may have declining “motivation to live,” manifested by a range of behaviors “from engagement in increasingly risky behaviors despite a lack of conscious suicidal intent to frank suicidal ideation and intent.”[9]

Recent studies specifically examined the role “hopelessness” plays in suicide. One concludes that hopelessness “may play a predictive role in suicidal ideation, independent of changes in depression severity.”[10] A meta-analysis of 166 longitudinal studies found that hopelessness was associated with an increased risk of suicide ideation by 2.2 times, attempted suicide by 2.0 times, and death by suicide by 2.0 times.[11]

Given this documented link between SUD and suicide in the general population, it should not be surprising or unexpected that it is even more profound in the nation’s jails and prisons where the concentration of people with SUDs and mental disorders is much higher than in the general population.

II. Specific Link Between SUD and Suicide in Prisons and Jails

SUD, Depression, Mental Illness and Hopelessness

The suicide risk for individuals with SUDs, with or without co-occurring mental illness is especially elevated in prisons and jails. While it is estimated that 11 percent of 18-25 year olds and 6 percent of those over 25 years old have a SUD in the general population,[12] 63 percent of people in jail and 58 percent in prison have a SUD.[13] And approximately three-quarters of people incarcerated in jails and prisons with mental health problems also have a co-occurring SUD.[14] Further, up to a third of people with depression also meet the criteria for SUD, a comorbidity specifically associated with an increased risk of suicide.[15]

However, just as in the general population, incarcerated individuals with SUD need not have a co-occurring mental illness to die by suicide. A review of the literature of correctional suicides reveals that correctional suicides are associated with high levels of hopelessness and depression. As a result, the review advised "the ultimate challenge for correctional suicide preventionists will be to assist at-risk and hopeless inmates to develop internal programs of purpose and hope, in often seemingly hopeless external life circumstances."[16]

As one writer summed up the impact of incarceration, "…the stress, loss of autonomy, removal from social and family networks, and unpredictable living conditions create a perfect storm for mental health crises."[17]

A study by the Pennsylvania Department of Corrections examined suicides in its prisons over two decades from 2007. It found that while less than a third of people who died by suicide had "depressive symptoms" or were experiencing "psychiatric turmoil," 70 percent had a history of SUD with 12 percent suffering from "hopelessness at time of suicide" and another 17 percent having received recent "bad news" immediately before the suicide. At the same time, 74 percent also had a "history of psychiatric treatment."

Withdrawal from Alcohol and Drugs

Sheriff: Subject Intentionally Jumped to Death "Suffering Effects" of Heroin Detoxification

The Orleans County Sheriff's investigation found the 46-year-old man who jumped to his death in 2022 was ""suffering the effects of detoxification from a heroin addiction." The family's wrongful death suit claimed medical staff refused to provide subject with "detoxification medication to assist with the descent from his drug-induced withdrawal.""[18]

Not only are incarcerated individuals with SUD at higher risk of suicide, but those entering jails and to a much lesser extent in prisons, are frequently also withdrawing from alcohol and/or licit or illicit drugs requiring clinical withdrawal management. Abrupt removal of alcohol or drugs from individuals who have SUDs or AUDs or who have an addiction to medications such as benzodiazepines dramatically heightens risk of suicide.[19] In an investigation of seven suicides of persons withdrawing from opiates in a Cumberland County, New Jersey jail, for example, the U.S. Department of Justice's (DOJ's) Civil Rights Division investigators concluded that untreated opioid withdrawal's serious medical consequences included risk of suicide, highlighting the fact that it is "particularly acute within the first days of incarceration."[20]

When a person takes a drug or becomes addicted to alcohol, there are many different neurochemical and biological responses. Addictive substances can rewire the brain's normal pathways. The brain and the body quickly become accustomed to having the drug or alcohol in the person's system. When a person stops taking the addictive substance or tries to cut back, the brain and the body respond with withdrawal symptoms. Suicide risk may rise with the severity of the withdrawal symptoms. Add an underlying or accompanying mental illness, and the suicide risk escalates.[21]

America's jails have become, *de facto*, the largest detoxification facilities in the country. It is estimated that in 2016, for example, more than 2.5 million people withdrew from opioids in jail or prison, far exceeding the estimated 300,000 who detoxified in residential rehabilitation centers and 65,000 in hospitals that same year.[22]

The risk of suicide by individuals withdrawing from alcohol and drugs in jails accounts for the different time frames suicides occur in jails and prisons. According to the Bureau of Justice Statistics, almost half of jail suicides (44%) occur within the first week of incarceration, while most prison suicides (75%) occur after the first year of incarceration.[23] For suicide and deaths linked to drugs or alcohol, the first few days in jail are the deadliest. Between 2000 and 2018, the number of people who died of intoxication while in jail increased by almost 400 percent, typically within just one day of admission.[24]

Undetected Suicide Risk in Jail Detoxification Unit

In January 2022, a man was found unresponsive in the detox unit of the Marion County, Indiana jail. Medical personnel pronounced him dead after being summoned. Suicide was reported as the cause of death. Booked the day before, the 45-year-old man was not under suicide watch because, according to the jail, he did not show any signs of suicidal ideation at or after booking. His death represented the second suspected suicide death in the jail's detox unit. The first occurred five months earlier. Jailers said the individual was not deemed at risk for suicide either because he too "did not show any signs of suicidal ideation at or after booking."[25]

Hopelessness Among Untreated Incarcerated Individuals and Availability of Contraband Drugs

The fact that most suicides in prisons occur after the first year is because fewer persons enter prison in need of withdrawal management except perhaps for those entering prisons directly off the streets for parole revocations. However, after a year's imprisonment, untreated individuals with SUD are at increased risk for suicide for several reasons. Their cravings for alcohol or drugs continue. They realize they will continue to be disabled by their disorders when they are eventually released. They have even less hope that their lives will improve upon release because they will have the additional barrier of having a criminal history. In addition, if they had self-medicated for mental challenges before imprisonment, after the prolonged abstinence in prison, those challenges may have painfully reasserted themselves.

Also, after a year's imprisonment, individuals may be in a better position to access contraband narcotics to end their pain. Contraband drugs often provide the means for jail and prison suicides, as was the case reported in the Montgomery, Alabama *Advertiser* in 2022.[26]

"Man Begged for Mental Health Care, Told Guards He Was Suicidal Before His Death"

The 30-year-old jailed individual informed officers that "If y'all aren't going to f*****g help me, I can get some fentanyl. I won't feel a f*****g thing." He carried through on his threat, dying of a fentanyl overdose a week later. The Advertiser explained, "Wade's experience in prison shows in detail what can happen when the horrors of prison are combined with an abundance of attainable illegal drugs and a failure to provide adequate mental health care." The article went on to describe the individual's struggle with drugs since age 16, his related arrests, former imprisonment, treatment failures in the community, and the probation revocation that landed him back in prison. According to his mother, Wade was "ashamed of himself," traumatized by a violent prison rape he witnessed, and scared of the debt he was amassing in prison buying contraband drugs."

Since 2018 through this individual's death in August 2022, more than 38% of Alabama's prisons deaths were reportedly caused by "overdoses or other drug-related deaths." [27]

Outside of corrections, researchers have found that suicides determined to be "accidental" or "indeterminate" are often, in fact, "intentional" – suicide. A Centers for Disease Control and Prevention Consultation Meeting in 2017 concluded that "determination of (manner of death) in deaths caused by drug intoxication is challenging, with marked variability across states….Research suggests that many suicides, defined typically as self-inflicted acts with the intent to die, may be hidden among accidental deaths.[28] A study of more than three million Veterans Affairs patients over a seven year period found, for example, that overdoses ruled to be "indeterminate" may be "misclassified suicide deaths….Additionally, overdose deaths not classified as suicides may include some cases due to suicidal-like thinking without overt suicidal intent."[29] Across the country, experts estimate that at least 30 percent of drug and/or alcohol overdose deaths declared to be "accidental" are, in fact, "intentional" (i.e., suicides).[30]

Given that correctional populations are at much higher risk for suicide than persons in the general community, it is reasonable to assume that a much higher percent of prison and jail overdose deaths classified as "accidental," are, in fact, "intentional." This is of essential importance because it means these overdose "accidental" deaths may be prevented, even if jails and prisons are unable to keep contraband drugs out of their facilities.

It also means that simply increasing monitoring to every 15 minutes, the typical response to prevent suicides, is insufficient. While increased monitoring will prevent typical suicides caused by hanging, increased monitoring will not easily reveal individuals attempting overdose suicides.

III. Preventing Suicides in Jails and Prisons

Assessments Must Go Beyond Mental Health Suicide Screening

Assessing incarcerated persons for mental health factors related to suicide risk only is not sufficient. As ample research reveals, many people who die by suicide in prisons and jails escape detection during the intake process because they have never experienced (or reported experiencing) a mental illness (or episode) prior to incarceration. Identification of these individuals proves to be especially difficult during intake, which makes it even more crucial not to underestimate the role of SUD in prison and jail suicides.[31] A systematic review of suicide risk instruments reveals most are supported by too few studies to allow for evaluation of accuracy. Among those that can be evaluated, none fulfills requirements for sufficient "diagnostic accuracy."[32] A suicide prevention guide by the National Commission on Correctional Health Care (NCCHC) and the American Foundation for Suicide Prevention (AFPS) specifically examined correctional suicide assessments and concluded "at present, there are no known suicide risk assessment instruments designed specifically for use in correctional settings."[33]

High Risk for Suicide Identified After Death

A 39-year-old individual died by suicide in the Alameda County, California jail in January 2023. The review of the death found that his intake process and prior custodial history did not indicate risk of suicide. His father said his son had no known mental health issues, however, he said, his son suffered from "severe substance abuse issues."[34]

Typical correctional risk assessments are made more problematic, according to the NCCHC and AFPS guide, for two "all too common" factors, the histories of trauma suffered, and the impulsive behaviors exhibited by a disproportionate number of incarcerated persons, often referred to as "criminal thinking." The former impedes honest self-reporting, and the latter results in "unpredictable and often dangerous behaviors, including suicidal actions." These factors may be especially common among persons with SUD, made worse by "criminal thinking." Criminal thinking is marked by, among other things, "cognitive indolence" (i.e., taking the path of least resistance) and discontinuity (i.e., sudden changes from order to chaos and vice versa)."[35] Given the availability of contraband drugs, even a momentary setback or transitory depression, may result in an impulsive, but deadly overdose that individuals who are more prone to consider longer term consequences of their behavior would be in a better position to resist.

For these reasons, suicide risk assessment instruments should be used to supplement, not replace, validated SUD and clinical assessments many jails and prisons use for enrollment in SUD treatment programming.

Reliance on Individual’s Denial of Suicidal Ideation Can Prove Fatal

During his intake assessment at the Clackamas County, Oregon jail, the 23-year-old man “denied that he had any suicide ideations” or was experiencing ongoing mental health issues that might influence his placement options within the jail. After his death by suicide a week after admission, the district attorney found that for months leading up to and including the day he was arrested, he made multiple suicidal statements to police officers, demonstrated intent to conduct self-harm, and demonstrated continued schizophrenic episodes and substance misuse.”[36]

Withdrawal Management

Clinical withdrawal management and SUD and AUD treatment that meet contemporary standards of care can reduce jail and prison suicides of individuals with these disorders.

The June 2023 guidelines released by the Bureau of Justice Assistance (BJA) and the National Institute of Corrections (NIC), *Guidelines for Managing Substance Withdrawal in Jails*, begins with the recommendation that all individuals at risk for withdrawal of alcohol or drugs should be assessed for SUD regardless of their expected length of stay. It adds that the SUD assessment should include risk for suicide and self-harm.

As it advises, **“Screening for suicide risk regularly throughout the withdrawal process is advised due to the rapidity at which suicidal ideation can evolve.”[37]** If screened positive for withdrawal, a clinical assessment should follow to determine the need for clinically managed withdrawal and action required “to avoid critical biomedical or psychiatric issues…(including) acute withdrawal syndromes, overdose, suicidality, and other acute psychiatric symptoms.”[38]

U.S. Department of Justice
Office of Justice Programs
Bureau of Justice Assistance

GUIDELINES FOR MANAGING SUBSTANCE WITHDRAWAL IN JAILS

A Tool for Local Government Officials, Jail Administrators, Correctional Officers, and Health Care Professionals

June 2023

BJA
Bureau of Justice Assistance
U.S. Department of Justice

NIC
National Institute of Corrections

The first consideration that the jail intake personnel must address is if the facility has the medical and mental health resources needed to safely manage the withdrawal or if the individual should be diverted to a hospital or a facility that offers a higher level of care. If the task of screening and assessing entering individuals is left to non-medical staff, arrangements should be made with telehealth providers knowledgeable in addiction medicine who can assist them in making these potential life and death judgements.

The BJA and NIC Guidelines provide information on diagnosing and monitoring withdrawal signs and symptoms as well as more specific guidance for alcohol, sedative, opioid, and stimulant assessment and withdrawal management.

Provision of Appropriate Medication

Easy Access to Contraband Drugs Facilitate Suicide of 18 Year-Old

As reported by KGUN in Tucson, it took one week in the Pima County, Arizona jail for a young man, 18, to overdose twice on fentanyl. The second overdose killed him. After the first overdose, he was treated in an area hospital, then returned to the jail and placed in the detox unit where he was able to acquire more fentanyl and died. [39] At the time, the jail did not provide MAT for persons with OUD.

There are Federal Drug Administration (FDA) approved medications that meet contemporary standards of care for withdrawal management. They include benzodiazepines for alcohol withdrawal and buprenorphine and methadone to alleviate cravings and prevent severe symptoms for opioid withdrawal and Lofexidine to address other related symptoms of opioid withdrawal. Gradually tapering persons off opioids and sedatives represents best practices although rapid tapering may be required if an individual's period of incarceration is circumscribed.

If the individual entering jail or prison is already prescribed either methadone or buprenorphine or various medications for psychiatric disorders, the individual should be continued on those medications preventing any risk of withdrawal related suicides. If the individual with OUD is already prescribed the antagonist medication naltrexone, and if the person is not under the influence of an opioid at admission, the person should also be continued on that medication. If an individual wants to be prescribed naltrexone, the individual must withdraw from opioids for at least a week to ten days before being provided that medication. If an individual with AUD is prescribed naltrexone, whether the individual has ingested alcohol or not, the individual can be provided the naltrexone immediately.

Although continuing prescribed medication and tapering persons gradually withdrawing from opioids and sedatives will mitigate against suicide, if the individual also has co-occurring mental health challenges, standard suicide prevention measures must also be taken. This may call for a change of policy if persons withdrawing from alcohol or drugs are isolated and placed in single cells to facilitate

monitoring by medical or security staff. As the NCCHC and AFPS advise, individuals at risk for suicide should not be placed in single cells. This includes persons also withdrawing from alcohol and drugs.

On-Going SUD Counseling and Treatment

Fortunately, the SUD counseling and support persons with OUD and AUD should receive while incarcerated also mitigate risk of suicide in two ways. First, correctional treatment programs, including medication-assisted treatment where appropriate, give individuals hope of recovery after release. Second, these programs lessen the demand for contraband drugs, helping to dry up supply and limit their availability for use in impulsive suicides.

In his seminal longitudinal study on recovery from AUD, George Vaillant found a major factor for recovery was overcoming feelings of "hopelessness." He surmised that recovery demands, in short, a new source of "self-esteem and hope."[40] Researchers studying suicide and overdose deaths across America conclude "Reducing the severity of opioid use disorder through medications will also improve mental health. Reducing barriers to use of these medications is essential to addressing both overdose and suicide""[41] As the U.S. Department of Justice's Civil Rights Division noted in its Cumberland County Jail investigation of withdrawal related jail suicides, "The consensus among the medical community is clear: MAT is the standard of care for treating [OUD] as it is far superior and more efficacious than other possible treatments. The National Institute on Drug Abuse, the Substance Abuse and Mental Health Service Administration, the Centers for Disease Control and Prevention, the American Medical Association, and the American Academy of Pediatrics all recommend that medical providers use MAT to treat individuals undergoing opiate withdrawal."[42]

The California Department of Corrections and Rehabilitation (CDCR) provides real-time evidence of the link between suicide prevention and SUD and AUD treatment. The Department introduced a new Integrated Substance Use Disorder Treatment Program (ISUDT) in January 2020. The program included five core elements: (1) SUD Screening and Assessment, (2) Medication-Assisted Treatment (MAT), (3) Cognitive Behavioral Interventions (CBI), (4) Supportive Housing, and (5) Enhanced Pre-Release Planning and Transition Services, aimed at strengthening care coordination upon release.[43] The program both continued agonist medications for persons entering jails and prisons with prescriptions and induced others with OUD on methadone or buprenorphine. CDCR medications for AUD are acamprosate and naltrexone, and its medications for OUD are naltrexone, buprenorphine, and methadone.

Shortly after it began, the program provided more than 22,600 people with these medications, constituting more than a quarter of the state's prison population. Prison overdose deaths were reduced by 58 percent and hospitalizations for overdoses by 48 percent. The overdose death rate plummeted from 51 per 100,000 in 2019 to 20 per 100,000 the following twelve months. Prison overdose deaths dropped from the third-leading cause of prison deaths to the eighth, its lowest ranking in nine years.[44]

California officials have not determined whether the prevented overdose deaths were because the treatment provided hope for persons at risk for suicide, or because the medications reduced either the

supply of or demand for contraband drugs, reducing the availability of contraband drugs used for planned or impulsive suicides. In either case, the link between SUD treatment and MAT and overdose deaths, whether by suicide or accidental, is clear.

Health Management Associates, which provides MAT technical assistance to California's jails, notes, "There is anecdotal evidence emerging from MAT implementation in jails and prisons to date that increased access to MAT reduces diversion incidents as availability of MAT increases due to inmates' ability to manage their cravings. Correctional facilities that have implemented MAT are also reporting a reduction in disciplinary infractions."[45]

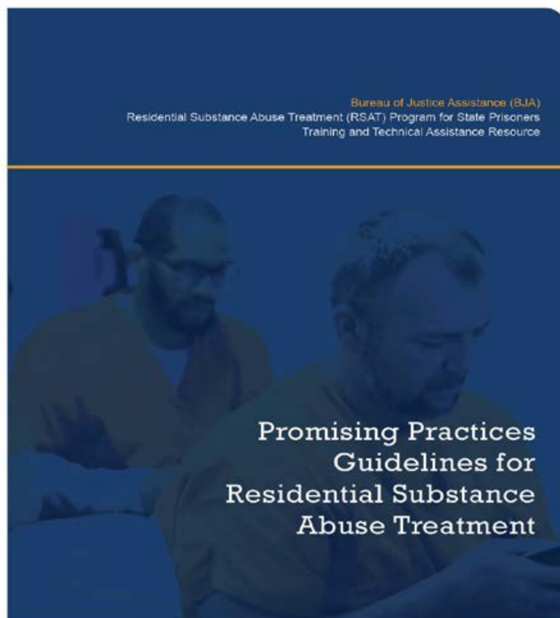
The Philadelphia Department of Prisons instituted a program to conduct clinical intake screening and assessments of all persons entering its jails within four hours. Those screened to have SUDs or are under the influence of drugs or alcohol are immediately referred to clinicians for withdrawal assessments. Where relevant, individuals are told about the availability of medication for OUD. If they opt for opioid medication, they are induced on buprenorphine as soon as withdrawal symptoms allow, generally the next day after admission. If they do not want agonist medications or want naltrexone, which requires detoxification, they are referred to withdrawal management to safely ease them off opioids. In addition, people entering jail on methadone or buprenorphine are continued on those medications. Every year, the Philadelphia jails release into the community more than 3,000 people taking buprenorphine and several hundred taking methadone. Dr. Dorian Jacobs, who runs the addiction medicine program for the city's jails, reports "the Suboxone program is instrumental in not only halting the opioid withdrawal process, but also in decreasing the risk of overdose both inside the jail and after incarceration."[46]

Data reveal that while the Philadelphia jails averaged 2.5 suicides a year between 2015 and 2020, other big city jails in Cuyahoga County, that includes Cleveland, and San Diego had more than double that number of jail suicides. The comparison is even more telling because the jail population in Philadelphia far exceeded that of Cuyahoga County and was roughly equivalent to that in the San Diego jails. During this period, neither of the other two counties offered MAT. A short video documenting the Philadelphia jails MAT program can be found at **https://www.rsat-tta.com/Training-Curricula/MAT-Resources---Assistance**.

IV. Use of Trained Peers for Scientific and Effective Prison and Jail SUD Treatment/Suicide Prevention

Prison and jail residential SUD treatment guidelines can be found in BJA's *Promising Practices Guidelines for Residential Substance Abuse Treatment*, revised in 2023 (**https://www.rsat-tta.com/Files/Manuals-Curricula/RSAT-PPG_February2023**). It provides a description of correctional residential SUD treatment's core requirements, including:

1. Intake, screening, and assessment.
2. Treatment components.
3. Program components.
4. Provision of medications and health care.
5. Continuing care and reintegration into the community.
6. Staffing and training.
7. Measuring results.[47]



Contained in the *Guidelines* are recommendations for the use of peers. The use of trained peers can promote treatment for both substance use and mental disorders, as well as suicide prevention. The *Guidelines* find that connections to safe and supportive peers, people in recovery from both substance use and mental health communities, and additional prosocial networks of support are important components of successful (correctional substance use disorder treatment) programs.

Specifically, it holds that "peers in addiction recovery can promote hope through positive self-disclosure, assuring others that recovery is possible." This also mitigates risk of suicide for individuals facing longer term imprisonment.

In 2022, the U.S. Department of Justice's Civil Rights Division reached a settlement with the Massachusetts Department of Correction. The Department had found, as summarized by the U.S. Attorney, "unconstitutional conditions and circumstances where incarcerated people in mental health crisis harmed themselves up to and

including suicide.” The settlement limited the isolation of individuals, and called for de-escalation rooms, out of cell activities and peer support programs.[48]

The effectiveness of peers in SUD treatment is not in dispute. As the Substance Abuse and Mental Health Services Administration (SAMHSA) concludes, “there is mounting evidence” that peers increase treatment success.[49] It cites, “(t)wo rigorous systematic reviews examined the body of published research on the effectiveness of peer delivered recovery supports published between 1995 and 2014. Both concluded that there is a positive impact on participants.”[50] SAMHSA adds that “peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process.”[51] This is particularly pertinent in correctional environments when treatment and medical staff may have only limited time onsite.

BJA’s *Peer Recovery Support Services in Correctional Settings* provide two great resources for the development and operation of correctional peer programs, which can be found at **https://www.cossup.org/Content/Documents/Publications/Altarum_PRSS_in_Correctional_Settings.pdf**.

V. Conclusion

Although suicide risk prevention must be embedded in SUD treatment programs, SUD withdrawal management and treatment are also essential components of jail and prison suicide prevention programming.

All prisons and jails should provide for SUD withdrawal management and SUD treatment that includes MAT to meet contemporary standards of care. Doing so will also reduce prison and jail suicides that additional mental health resources alone will not address.

As outlined, the following action steps should be taken.

1) All persons entering jail or prison should be immediately screened for SUD and state of intoxication.

2) Those screened positive for either should be considered at risk for suicide, even if standard suicide risk assessment instruments commonly used in prisons and jails do not so identify them. As potential suicide risks, they should then be treated as anyone else who is identified at risk for suicide. This includes increased monitoring, not placing individuals in a single cell, and other actions taken by standard correctional suicide prevention programs.

3) Those exhibiting symptoms of SUD withdrawal should be clinically assessed for withdrawal management and as appropriate referred for withdrawal management.

4) Those entering with prescriptions for FDA-approved medications to treat opioid or alcohol use disorders or enrolled in opioid treatment programs should be continued on these medications.

5) Others should be offered timely induction on FDA-approved medications as appropriate. As indicated in the BJA withdrawal guidelines, methadone may be provided immediately while buprenorphine can be provided after OUD withdrawal symptoms have abated after a day or so. Naltrexone cannot be provided until a week to ten days after OUD withdrawal.

6) All persons with SUD should be enrolled in SUD treatment that meet BJA RSAT promising practices guidelines.

7) Before release, SUD treatment or reentry staff should work with individuals to set up post-release access to medication and treatment and recovery support in the community.

Lastly, the National Commission on Correctional Health Care and the American Foundation for Suicide Prevention have created a resource on preventing suicide in correctional facilities, the *Suicide Prevention Resource Guide*. It can be found at **https://www.ncchc.org/wp-content/uploads/Suicide_Prevention_Resource_Guide.pdf**.

[1] According to the Bureau of Justice Statistics (BJS), combined deaths of people incarcerated in U.S. prisons and jails were 3,170 in 2001 and rose to 4,513, the highest number recorded, in 2018. Cancer (1,137) and heart disease (1,052) were the leading causes of death among this population in 2018. Both numbers had been fairly steady since 2013. By contrast, the number of deaths attributed to drug/alcohol intoxication and suicide rose dramatically in recent years. Only 50 deaths were attributed to drug/alcohol intoxication in 2014; this quintupled to 249 by 2018. Likewise, the 192 suicides in 2013 increased by 62 percent, to 311, in 2018. Just between 2017 and 2018, drug/alcohol deaths increased 23 percent and suicides increased 20 percent. The leading cause of death for people incarcerated in jails in 2018 was suicide (29.9%), followed by heart disease (25.9%) and drug/alcohol intoxication (15.9%). No other single cause accounted for more than 3 percent. The proportion of drug/alcohol intoxication deaths recently increased sharply, from 5.9 percent in 2012 to 15.9 percent in 2018. Carson, E. Ann (October 2021). Suicide in Local Jails and State and Federal Prisons, 2000-2019, Bureau of Justice Statistics, **https://bjs.ojp.gov/library/publications/suicide-local-jails-and-state-and-federal-prisons-2000-2019-statistical-tables**

[2] Rizk MM, Herzog S, Dugad S, Stanley B. Suicide Risk and Addiction: The Impact of Alcohol and Opioid Use Disorders. Curr Addict Rep. 2021;8(2):194-207. doi: 10.1007/s40429-021-00361-z. Epub 2021 Mar 14. PMID: 33747710; PMCID: PMC7955902

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