



Utility of the Suicide Intent Scale Within a Prison Setting

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Abstract

The Suicide Intent Scale measures the degree to which a person who has engaged in deliberate self-harm was intending to die. This scale comprises two sections: nine items that examine circumstances relating to the self-harm incident (e.g., whether precautions were taken against discovery) and six self-report items that examine introspective data (e.g., whether the person thought that his or her actions would result in death). In this paper I examine the Suicide Intent Scale's suitability for the prison setting. Minor modifications to, and clarifications of, the scoring criteria for several of the circumstance items are suggested in order to improve the utility of the scale for researchers and clinicians within Australian Prisons.

Keywords: Self-harm; Suicide; Suicide Intent; Prisoners

INTRODUCTION

Assessing the degree of suicidal intent is an important aspect of a thorough clinical assessment of a client who has engaged in deliberate self-harm (Hawton & Catalan, 1987). The degree of suicidal intent is an indicator of subsequent suicide risk particularly if the distress associated with the psychological and/or social problems that precipitated the incident has not yet been alleviated. One of the most widely used measures of suicidal intent is the Suicide Intent Scale (SIS; Beck, Schuyler, & Herman, 1974). While the SIS was designed for use in a wide range of clinical settings, the items might not be equally applicable to all settings in which self-harm occurs. Several of the items rest on an assumption that clients are able to control particular aspects of their environment and that arranging the environment in particular ways indicates a greater or lesser degree of suicidal intent. For example, isolating oneself prior to engaging in suicidal behaviour is seen to indicate a greater degree of suicidal intent than engaging in suicidal behaviour in the presence of others.

However, not all environments are malleable. Prisoners are unable to control many aspects of their environment. In this paper the SIS is critically examined in terms of its clinical and research utility in Australian prison settings.

THE SUICIDE INTENT SCALE

The SIS is administered in a semi-structured interview format to persons who have enacted deliberate self-harm. The scale comprises 15 items, each of which examines a specific indicator of suicidal intent. Items are equally weighted and scored 0, 1, or 2 according to specific criteria, with high scores indicating greater intent. The SIS has two sections. The first nine items examine circumstances relating to the self-harm incident (e.g., whether someone was present). The assessor scores these items on the basis of the patient's self-report, factual information regarding the incident, and information provided by other informants (e.g., the client's family). The second section (Items 10 to 15) comprises self-report data (e.g., whether the

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person thought that death was a likely outcome). Rather than administering these items as a self-completion questionnaire, the assessor asks open-ended questions and then applies the relevant scoring criteria to the client's responses.

Beck et al. (1974) reported high inter-rater reliability ($r = .95$) and internal consistency (Spearman-Brown coefficient of .82). Several studies provide evidence of construct validity; for reviews of this research see Eyman and Eyman (1992), Hawton and Catalan (1987), and Rothberg and Geer-Williams (1992). Most notably, SIS scores have shown significant associations with the medical seriousness of suicide attempts (Hamdi, Amin & Mattar, 1991; Pallis & Sainsbury, 1976), with a suicide risk scale comprising empirically derived demographic and clinical risk factors (Pallis & Sainsbury, 1976), and with subsequent suicide (Pierce, 1981, 1984). SIS scores were more strongly associated with hopelessness than with severity of depression (Beck et al., 1974) in line with other data that indicate that hopelessness predicts suicidal behaviour better than depression does. Similarly, Hamdi et al. found that high SIS scores were associated with feelings of hopelessness and isolation while low scores were associated with anger and frustration.

THE SUICIDE INTENT SCALE AND THE PRISON SETTING

The self-report items seek introspective data (expected outcome of the act, degree of planning, etc.) and there is no reason to believe that prisoners are less able than other client groups to provide such information. Item 9 also requires the assessee to report introspective data (manipulative versus escapist motives) and one could question why it was originally placed in the circumstance section. Indeed, Hawton and Catalan (1987) placed Item 9 in the self-report section. It is the remaining circumstance items that might not generalise to the prison setting and these are examined below.

Item 1: Degree of Isolation

This is one of the most problematic items for use in the prison setting because prisoners have such

limited control over their degree of isolation. For example, at night and during certain parts of the day prisoners are confined to their cells and it is not always their decision as to whether they are in single cells, double-up cells (two prisoners) or multiple-occupancy cells (three or more prisoners). While most suicides occur when the prisoner is alone, some suicides in custody occur in double-up or multiple-occupancy cells (Bogue & Power, 1995; Dear & Allan, 1998; Liebling, 1992; Towl & Crighton, 1998). Similarly, prisoners might engage in low-intent self-harm when isolated from others not because they engineered that isolation to avoid detection but simply because they happen to be secured in a single cell. Suicides and suicide attempts in the presence of another prisoner almost always occur while the other prisoner is asleep. Given this, the criterion for a score of 0 on Item 1 should be modified so that this score is only given if the other person who is present is awake (see Table 1). The criterion for a score of 1 refers to someone who is "nearby or in contact" while a score of 2 requires that there is "no one nearby or in contact". Another prisoner who is asleep in the cell is certainly "nearby or in contact" and therefore a self-harm incident that occurs while another prisoner is sleeping in the cell should always be given a score of 1. While this might underestimate the degree of intent on some occasions, other items in the scale (e. g., items 2 and 4) are likely to counteract any underestimation. Moreover, the clinician should always interpret item scores in the context of other information that is obtained throughout a comprehensive assessment. Most Western Australian prisons have an intercom system (known as the "cell-alarm") installed in every cell. If the self-harm incident occurred in one of these cells a score of 1 should be given (unless a score of 0 would apply) as there is always someone in contact. Consequently, and in keeping with the original rationale behind this item, a score of 2 should only be given for those incidents in which the prisoner deliberately isolated him or herself. Deliberate isolation would not include waiting until a cellmate falls asleep, for two reasons. First, the sleeping cellmate is nearby and in contact (as discussed above). Second, issues of timing are covered by Item 2. The modifications suggested in this paragraph are outlined in Table 1.

Table 1
Suggested Revisions to the Scoring Criteria for SIS Items 1 and 2.

| Original Scoring Criteria | Revised Scoring Criteria |
|--|---|
| Item 1: Degree of isolation. 0 = Somebody present 1 = Somebody nearby or in contact 2 = No one nearby or in contact | 0 = Somebody present and awake. 1 = Somebody nearby or in contact (e. g., another prisoner who is asleep, cell-alarm installed). 2 = No one nearby or in contact, but only score 2 if prisoner deliberately isolated him or herself. |
| Item 2: Timing of incident. 0 = timed so that intervention is probable 1 = timed so that intervention is not likely 2 = timed so that intervention is highly unlikely | 0 = timed so that intervention is probable or did not take timing into consideration. 1 = timed so that intervention is not likely (e. g., waiting for cellmate to fall asleep, waiting until officers have completed routine half-hourly checks). 2 = timed so that intervention is highly unlikely (e. g., waiting until locked in cell). |

Item 2: Timing of Incident

Given that it is possible for a prisoner to wait until circumstances are such that interruption is unlikely, few revisions to the original scoring criteria are required.

In order that a score of 2 is not applied to acts of self-harm that simply happen to occur when the prisoner is not likely to be interrupted, a score of 0 should be given if the prisoner reports that no consideration was given to the timing of the incident. Such information is only likely to emerge if appropriate questions are put to the prisoner. For example, open-ended questions along the lines of "How was it that you harmed yourself at that particular time?" would need to be followed by further questioning to verify that the timing was deliberate. The only other modification to the scoring criteria that I have suggested is to clarify the issue of waiting for a cellmate to fall asleep (see Table 1).

Items 3 to 8

These remaining items translate well into the prison setting and require no substantial modifications to Beck et al.'s (1974) scoring criteria (see Table 2), although more relevant examples of some criteria are required. For example, a score of 2 is given on Item 3 if the person has taken active precautions against intervention and the example is given of locking the door. Locking one's cell door is not always an action that a prisoner can take. More relevant examples of active precautions taken by prisoners would be hiding under bedclothes or in an area of the cell that is unsighted from the peephole

in the door. On Item 4, contacting another person would include contact via the cell-alarm if such devices were installed. Although prisoners have limited opportunities for making arrangements in anticipation of death the examples of definite arrangements that are provided within the original scoring criteria for Item 5 would apply to the prison setting. An act such as cancelling visits less clearly indicates an anticipation of death and therefore constitutes an ambiguous act and would receive a score of 1. Item 7 is straightforward, if a note was not found, then the assessor enquires as to whether or not the prisoner thought about writing a note or wrote a note that was destroyed. If a note was written and destroyed, or writing a note was contemplated, then the clinician should enquire as to what the prisoner had written or considered writing (this information doesn't affect the scoring but is useful clinically).

The original criteria for Item 6 contain no definitions of what constitutes each level of preparation. An example of no preparation would be a self-harm incident in which the prisoner used readily available items in an unaltered form. Minimal or moderate preparation would be when the prisoner deliberately obtained readily available means to self-harm, or manufactured means with minimal alteration to items (e. g., broke the plastic cover and extracted the blade from a safety razor). Extensive preparation would be when the prisoner used difficult to obtain items that were specifically procured for self-harming (e. g., saved and hid medication) or manufactured means with significant alteration to items (e. g., made a length of rope from a sheet and tested the viability of potential hanging points). As with Item 6,

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definitions for the different scoring levels on Item 8 need to be provided. An unequivocal communication (a score of 2) would be when the prisoner specifically stated an intention to suicide. A score of 0 is given if the prisoner did not

communicate intent to anyone not even to other prisoners who were sworn to secrecy. An example of an equivocal communication would be if the prisoner expressed distress and hinted at being unable to tolerate that distress.

Table 2
SIS Circumstance Items Not Requiring Modification

| Item | Original Scoring Criteria |
|---|---|
| 3. Precautions against discovery and/or intervention. | 0 = no precautions taken 1 = passive precautions, such as avoiding others but doing nothing to prevent their intervention (e. g., alone in unlocked room). 2 = active precautions (e. g., locked door). |
| 4. Acting to gain help during or after incident. | 0 = notified potential helper. 1 = contacted, but did not specifically notify potential helper regarding incident. 2 = did not contact or notify potential helper |
| 5. Final acts in anticipation of death. | 0 = none 1 = thought about making arrangements or made some arrangements 2 = made definite arrangements (e.g., made will, gave things away). |
| 6. Degree of planning. | 0 = no preparation. 1 = minimal or moderate preparation. 2 = extensive preparation. |
| 7. Suicide note. | 0 = absence of note. 1 = thought about writing note, or note written but destroyed. 2 = presence of note. |
| 8. Overt communication of intent prior to the incident. | 0 = none 1 = equivocal communication 2 = unequivocal communication |

USE OF THE MODIFIED SCALE

Despite initial concerns that the circumstance items might not translate easily into the prison setting, only a few items required clarification of the scoring criteria and most of these clarifications simply comprised the provision of examples that were relevant to the prison setting. Only Item 1 was seen to require a substantial reformulation of the scoring criteria. Given the minimal need for revision that was identified, the SIS appears to be an instrument that could easily be used in Australian prisons.

While clinicians and researchers should always be cautious about changing items on standardised measures, it is better to score an item in accordance with the rationale behind that item than to use a prescribed scoring method that one knows is inadequate or inappropriate for a particular case or setting. The suggested modifications to the scoring criteria of some of the circumstance items should improve, rather than compromise, the validity of the SIS for assessing prisoners who have self-harmed. The suggested modifications were based on a consideration of the Western Australian prison

setting and prisons in other parts of the world might require different modifications. Further research is needed to establish the inter-rater reliability and other psychometric properties of the modified SIS when it is used in prison settings.

Finally, it is important to remember that the use of any scale in a clinical assessment requires the exercise of clinical judgement rather than simply applying a mathematical formula. As Hawton and

Catalan (1987) noted, relying solely on SIS scores "would be only of limited value, but taken together with careful evaluation of the patient's problems and mental state, the Suicidal Intent Scale can be of great help to the therapist" (p.64).

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