RASSEGNA ITALIANA DI CRIMINOLOGIA ANNO XVIII N.1 2024
Società Italiana di Criminologia
Articoli generali

A tale of two worlds: life and death in prison. A comparison between Italy, and England and Wales

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OPEN ACCESS

Double blind peer review

How to cite this article: Zara, G. et al. (2024). A tale of two worlds: life and death in prison. A comparison between Italy, and England and Wales. *Rassegna Italiana di Criminologia*, XVIII, 1, 32-48. https://doi.org/10.7347/RIC-012024-p32

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Received: 13.02.2024
Accepted: 09.03.2024
Published: 31.03.2024

Pensa MultiMedia
ISSN 1121-1717 (print)
ISSN 2240-8053 (on line)
doi10.7347/RIC-012024-p32

Abstract

Suicide is a public health concern around the world. Undoubtably suicide is not a discrete event, and certainly it is not a pathology, and this is the only certainty that sustains the otherwise complicated spectrum of suicide. Suicide is essentially a psychological pain that becomes intolerable. The causes of suicide are not fully known but suicide behaviour is the complex outcome of a long-consuming suffering process.

The aim of this paper is to direct attention to suicide in the prison environment by looking at the suicide trends in Italy, and England and Wales, countries that differ in many ways for their responses to the problem but that they share the same responsibility and duty: humanising and making prison conditions liveable. The interest is to look at vulnerability and suicidality risk of inmates and to see whether prison conditions increase the risk of suicide or could, in some situations, even accelerate and encourage suicide. The practice of assessment of dynamic (also precipitating and acute) risk factors, and of the specific needs of the prison population, should become part of a preventive practice, dedicated not only to tackle suicide but more importantly improve the health conditions of people in prison.

Keywords: Suicide, prison, precipitating factors, risk assessment, prevention.

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A tale of two worlds: life and death in prison. A comparison between Italy, and England and Wales

Introduction

Suicide is a public health concern around the world (Favril, 2021): it is ranked as the 15th leading contributor to years of life lost (Taksler et al., 2017; Vos et al., 2020), and in 2019 it was the fourth leading cause of death among 15–29-year-olds globally (WHO, 2023). According to the WHO (2023), every year about 703.000 people take their own lives, and many more attempt suicides. The causes of suicide are not fully known but suicide behaviour is likely to be the complex outcome of a long-consuming suffering process. Psychological, relational, social and contextual factors, along with psychopathological conditions, have a critical role in influencing the person who intentionally decides to take their own life.

Suicide rates in prisons in developed countries are 3-8 times higher than in the community (Fazel et al., 2011). Specifically, epidemiological and clinical data show that incarcerated offenders are at an increased risk of contemplating, attempting, or dying by suicide compared to adults in the general population (Favril, 2021), and also when compared with people of similar age and sex who are living in the community (Zhong et al., 2021), representing a significant burden of morbidity and mortality in prisons worldwide.

The aim of this paper is to address the complex issue of suicide in prison by looking at the suicide trends in Italy, and England and Wales, countries that differ in many ways for their responses to the problem but share the same responsibility and duty: humanising and making prison conditions liveable. The interest is to look at the conditions that increase vulnerability risk in inmates and might even accelerate and encourage it. This paper starts with a brief description of the psychology of suicide and of its definition so as to analyse then the situation of suicide in prison.

The psychology of suicide

Suicide is essentially psychological pain, and according to Shneidman (1993, p. 145) suicide is caused by *psychache* (two syllables – sik-ak).

«*Psychache* refers to the hurt, anguish, soreness, aching, psychological pain in the psyche, the mind. It is intrinsically psychological – the pain of the excessively felt shame, or guilt, or humiliation, or loneliness, or fear, or angst, or dread of growing old, or of dying badly, or whatever. When it occurs, its reality is introspectively undeniable» (Shneidman 1993, p. 145).

Suicide always involves "an individual's tortured and tunneled logic in a state of inner-felt, intolerable emotion" (Leenaars, 2010, p. 10). This means that the individual suicide thresholds for enduring psychological pain vary (Shneidman, 1993).

Hilmann (1964/2020) draws attention to the importance of recognising the suicide threat as "a confusion of inner and outer" (p. 63). Indeed, each of us suffers when we confuse psychic reality with concrete events (especially when they are traumatic, ambiguous and negative), because by doing so, the person symbolises life and distorts reality. Therefore, the opposite also influences our well-being: "We suffer when we are able to experience psychic reality only by acting out fantasies and ideas" (Hillmann, 1964/2020, p. 63).

According to Shneidman (1993), suicide is not an adaptive act, but it is adjustive in the sense that it serves to reduce the tension of the pain related to the frustrated needs. Hence, while the *common purpose* of suicide is to seek a solution, the *common cognitive state* is ambivalence and the *common perceptual state* is constriction (Leenaars, 1999, p. 225; Leenaars, 2010, p. 9).

Definition of suicide manifestations

Undoubtably suicide is not a discrete event, and certainly it is neither pathology nor a disease per se, and this is the only certainty that sustains the otherwise complicated spectrum of suicide. Despite the extensive scientific literature, to define suicide is complex because it is still poorly understood, and the comprehension of suicide requires an integration of different scientific perspectives.

While extensive nomenclatures for suicide-related terminology have been proposed over time (Brenner et al., 2011), there is not a specific and widely adopted definition. Some authors (Turecki et al., 2016, 2019) have proposed a simplified classification that includes broad terms: suicide, suicide attempt, suicidal behaviour, suicidal ideation, and self-harm (see Table 1).

Suicide is characterised as a self-injurious behaviour that has a fatal outcome and is associated with at least some intention to die, which is the consequence of the act (Favril, 2021; Zara & Freilone, 2023).

Suicidal ideation is sustained by passive (only with the desire to die but without a plan) or active (with a plan) thoughts of suicide that are not accompanied by preparatory behaviour.

Term	Definition
Suicide	Intentionally ending one's own life.
Suicide attempt	Non-fatal self-harming behaviour or self-injurious non-fatal behaviour with presumed or actual intent to die.
Suicidal behaviour	Self-harming behaviour that can lead to ending one's own life, whether fatal (suicide) or not (suicide attempt). This term excludes suicidal ideation.
Suicidal ideation	Suicidal ideation is used interchangeably with suicidal thoughts and implies any thought (or wish) of ending one's own life, with (active) or without (passive) a clear plan for suicide.
Non suicidal self-injury	Self-injurious behaviour without any intent to die.
Self-harm	Self-injurious or non-fatal self-harming behaviour with or without intention to die. This term does not distinguish between a suicide attempt and non-suicidal self-injury (i.e. self-harming behaviours without any intent to die).
Suicide risk	It is a composite concept that includes both an individual risk to contemplate (suicidal ideation or thoughts) and attempt or die (suicidal behaviour) by suicide. The interplay between *predisposing* (i.e. diathesis and distal) and *precipitating* (e.g., proximal, triggering or stress) factors, along with some developmental factors and life events (e.g., social and environmental factors, and acute risk factors), contribute to suicide risk.

Source: Adapted from Favril, 2021; Turecki et al., 2019
Table 1 - Terms and definitions of the suicidal spectrum

Table 1 also includes a description of suicide risk (Favril, 2021) that is a composite concept that refers to an individual risk to contemplate (suicidal ideation or thoughts), attempt or die (suicidal behaviour) by suicide. The interplay between *predisposing* (i.e. diathesis and distal) and *precipitating* (e.g., proximal, triggering or stress) factors, along with some developmental factors and life events (e.g., social, environmental and acute factors), contribute to suicide risk.

Risk factors for suicide

Factors that have been associated with suicide over time can be grouped into the following categories: personality and individual differences, cognitive factors, social factors, and negative life events (O'Connor & Nock, 2014). These categories become particularly relevant when a person is involved in a criminal career and ends up in prison, where the sense of control over one's own life is completely dependent on the rhythm imposed by the system, and by the distance between the inside and the outside world (Crewe, 2021).

Among personality and individual characteristics, different traits have been associated with suicidal behaviour. For instance, both hopelessness (pessimism for the future) and perfectionism (belief that other people hold unrealistically high expectations of an individual) were found to be consistently associated with suicidal ideation and behaviour (Beevers & Miller, 2004; Brezo et al., 2006). Similarly, impulsivity, defined as novelty-seeking behaviour, or as short attention span, is considered a risk factor for suicide or self-harm, especially in young people (McGirr et al., 2008) and in individuals with personality disorders (Boisseau et al., 2013). Yet the combined effects of high neuroticism (people who are more sensitive to distress) and low extroversion (individuals who are socially isolated) can be a strong predictor of suicide (Fang et al., 2012). From a psychopathological perspective, the most widely studied risk factor for suicidal behaviour is the presence of a psychiatric disorder. Findings from post-mortem studies suggest that more than 90% of people who die by suicide have a psychiatric disorder before their death (Cavanagh et al., 2003). However, most people with a psychiatric disorder never experience suicidal thoughts or make suicide attempts (Bostwick & Pankratz, 2000).

Cognitive factors can also contribute to suicidal behaviour. Particularly cognitive rigidity, impaired decision making, rumination, and reduced coping strategies were found to be associated with suicidal thoughts and attempts (Miranda et al., 2012). Furthermore, the lack of social relationships and the subjective perception of a hindered belongingness have been proved to predispose individuals to the development of suicidal thoughts and behaviour (Hatcher & Stubbersfield, 2013). Similarly, personal perceptions that one is a burden to others has been found to be an independent predictor of suicide ideation in different populations (Carter et al., 2022).

Among social factors, family history of suicide increases suicide risk, suggesting at least a partial effect of intergenerational transmission (Qin et al., 2002). Lack of social support and social isolation have similarly been identified as key factors in suicidal behaviour (Haw & Hawton, 2011). Negative life events, especially childhood adversities, traumatic experiences during adulthood, physical illness, and other interpersonal stressors (including family problems, legal difficulties, and loss of income) can increase the risk of suicidal behaviour (Bruffaerts et al., 2010). Evidence shows that the risk of suicidal behaviour is significantly high in people who are socially disadvantaged (e.g., low income and education, unemployment) (Hawton et al., 2009, 2012; O'Connor & Nock, 2014).

Although the suicidal ideation takes place within the individual's head, most suicidal tensions are between two realities (the person and the outside world) (Shneidman, 1985): the precipitating factors that likely mediate between the individual psychology and the person's adjusting mechanisms to a life in prison add up to a multitude of factors that make an individual's life

unbearable. In other words, death by suicide itself is an extremely dyadic event (Leenaars, 1999, pp. 183-184).

Determining an individual risk of suicide is particularly challenging *per se*, so there is a need to address the state of emergency that many prisons in Western countries are facing, including Italy, and England and Wales.

Research evidence on suicide in prison

According to Favril's (2021) systematic review, the available evidence suggests that prison-specific stressors (*the deprivation of the environment*) may exacerbate suicide risk in an already vulnerable population (*the importation factor*) that has complex health and social care needs. As suicide risk is determined by a complex web of factors, the focus should always be on the interaction between the individual (importation) and their prison environment (deprivation).

By updating a previous systematic review (Fazel et al., 2017), Zhong and colleagues (2021) explored the impact of criminological, clinical and institutional factors upon suicide. Seventy-seven eligible studies were identified (of which 43 were new studies not identified in the 2017 review) from 27 countries[1] that included 35,351 suicide cases in prison. The variable of "not being a citizen of the country of incarceration" was inversely linked to suicide risk, and there was no clear association with age. Moreover, no clear association was found between suicide and having no formal education beyond age 16. Only two studies (Opitz-Welke et al., 2016; Rivlin et al., 2012) examined separately the risk of suicide in male and female inmates, and showed similar associations between some non-modifiable factors across sexes. The strongest clinical factors associated with suicide were suicidal ideation during the current period in prison, a history of attempted suicide, having a history of self-harm, and current psychiatric diagnosis (e.g., depression diagnosis), and alcohol misuse.

Findings from a previous meta-analysis of Fazel et al. (2016) are in line with these results, suggesting that the risk of suicide in recently discharged forensic psychiatric patients was particularly high, with 6 studies showing a crude death rate (CDR) of 325 per 100,000 person-years (95% CI 235-415). It seems clear that offenders with a history of mental illness have a higher likelihood of suicide than controls without mental illness (Fazel & Seewald, 2012). Berman and Canning (2021) examined proximal risk for suicide in correctional facilities: being a newly admitted prisoner is one of the strongest risk factors for suicidal behaviour in prison (Zhong et al., 2021), along with current suicidal ideation, a history of suicide attempts, and a diagnosis of a current mental disorder.

1 Austria, Australia, Belgium, Canada, Denmark, England and Wales, France, Germany, Iceland, Italy, [the] Netherlands, New Zealand, Norway, Scotland, Spain, Switzerland, USA, and from 10 countries in South America

For example, Berman (2018) found that the majority of patients who died by suicide experienced current anxiety/agitation, sleep disturbance, and social isolation and withdrawal within days of death, despite denying current suicidal ideation (SI) at the last interview. Researchers (Galynker et al., 2017), in proposing diagnostic criteria for a suicide crisis syndrome (SCS), identified persistent and desperate feelings of "frantic hopelessness", entrapment (an urgency to escape an unbearable life situation when such escape is perceived and felt as impossible), affective disturbance, and hyperarousal, all to be possible signs of near-term risk. The variable of *overarousal* (e.g., agitation, irritability, insomnia, or nightmares) seems to be in line with what is defined as "acute suicidal affective disturbance" (ASAD) (Rogers et al., 2019). These observed symptoms and behaviours, especially in combination with concurrent and acute factors specific to the correctional setting, such as transfers, impending court appearances, disciplinary actions, recent "bad news" arriving indirectly to the inmate (e.g., death of a family member, *fait accompli* of divorce from partner, etc.) might well describe the specific factors that affect the suicide risk among inmates.

The impact of the constraints of incarceration on perceived pathways leading to hope appeared to reduce the potential of hope as a protective factor when external controlling factors were taken into account (Pratt & Foster, 2020).

In Zhong et al. (2021) meta-analysis, institutional factors associated with an increased risk of suicide included occupation of a single cell and having no social visits. Regarding these factors there was substantial heterogeneity between studies. Poor physical health was not significantly associated with suicide, although this could be due to the small sample available to assess this factor. Criminological factors included remand status, serving a life sentence, and being convicted of a violent offence. Specifically, an index sexual offence and homicide are associated with increased risk. Conversely, conviction for a drug offence showed an inverse association with suicide. Being sentenced was associated with a reduced suicide risk when compared with detainee or remand status, which is characterised by uncertainty about their future and ambiguity about their present. It is often the "being in between" condition that provokes psychological uneasiness in a person.

The long-term impact of imprisonment upon mental health

The detrimental impact that a criminal career has upon the quality of life (Shepherd et al., 2009) is more evident when offenders are attempting to follow a pathway towards criminal desistance (e.g., detaching themselves from a life of crime) and re-entry into society) after prison. Two systematic reviews and meta-analyses are worth mentioning.

According to Skinner and Farrington (2020), what is

less known is the risk of suicide for community (non-institutional) offenders without psychiatric histories. Their work is the first to systematically and meta-analytically analyse the risk of suicide in offenders who were not, or who were no longer incarcerated, and who did not have a recorded history of psychiatric disturbance. Skinner's and Farrington's (2020) meta-analysis shows that, compared with the general population, community offenders usually have a significantly elevated likelihood of suicide at any age. This finding was confirmed for ex-prisoner samples who, in comparison with the general population, have high odds of suicide as expected, but their risk for suicide was significantly less than offenders who have not been incarcerated, when compared with the general population. As offender populations are drawn from socio-economically deprived backgrounds, with reduced access to health care and health seeking behaviour when living in the community, community offenders and people released from prison may be at heightened risk of death by suicide.

Zlodre and Fazel (2012) systematically reviewed studies reporting on mortality following release from prison. They identified 18 cohorts with information on more than 400,000 released prisoners resulting in 26,163 deaths of which 8% of these deaths were attributed to suicide. Offenders living in the community represent a vulnerable group that needs targeted intervention to reduce suicide rates across the lifespan. The antisocial lifestyle that offenders lead outside a secure environment poses a significant health risk and the prevention of this criminal lifestyle should be seen as a future public health challenge (West & Farrington, 1977). Certainly, these findings do not intend to suggest that offenders' length of stay in prison should be prolonged so as to offer a more secure environment for those at high risk of suicide, but they should be taken as a warning. It is the joint responsibility of prison, probation, health and social services to work more collaboratively in the provision of services for this high-risk group (Skinner & Farrington, 2020).

The importance of recognition and treatment of mental health problems among prisoners is underscored by research, and the strong associations reported should be considered in health-care service development and prison policy. Mental health services do not only need to be universally available to people in prison, but also adequately resourced and linked to effective interventions to address the higher prevalence of mental health diagnoses among prisoners in comparison with community-residing people.

Italy and its suicide rates in prison

Suicide in Italian prisons in the last 30 years exhibited a zig-zag trend, as shown in Figure 1, and what is evident is that there has not been a significant decrease in the number of inmates who succeed in their suicidal intent and behaviour. The «list of shame», attributable to the Italian penitentiary system, is made up of 1739 inmates who died by suicide since 1992.

In 2022, 85 suicides (of whom 80 were males and 5 women; 57.6% Italian *versus* 42.4% foreigners; among all 20 were homeless people) were counted during the year: 8 in January, with 5 in the first 14 days[2]. In 2023, 68 were the cases of suicides counted in Italian prisons. Unfortunately, by the end of January 2024 deaths by suicide in prison totalled 13 (one of them died by self-starving to death). In addition, there were several cases of self-harm, attempted suicide and assaults on staff and

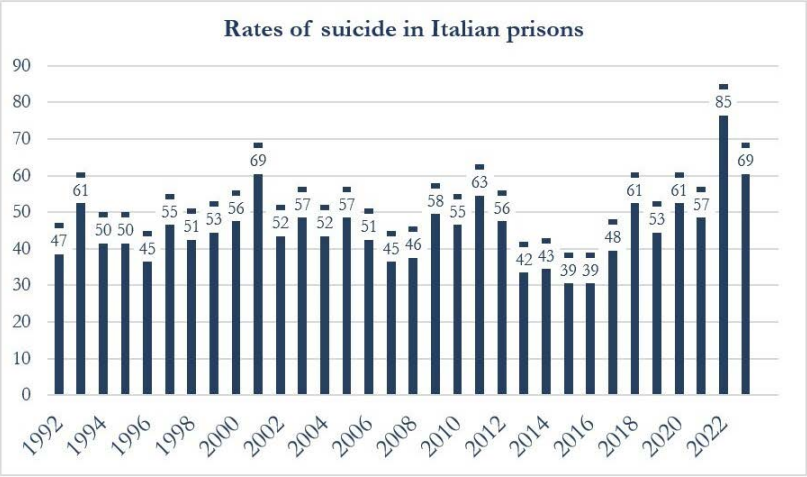

Figure 1 – Historical trend of deaths by suicide in Italian prisons
Source: Adapted from the Report of the National Guarantor of Persons Deprived of Liberty (2023) and Ristretti Orizzonti[3]

2 Garante Nazionale dei diritti delle persone private della libertà (2023). *Per un'analisi dei suicidi negli Istituti penitenziari* [*An analysis of suicide in prison*]. Studio a cura dell'Unità Privazione della libertà in ambito penale [The study was carried out by the Unity of Privation of Liberty in the penal context]: Emanuele Cappelli, Giovanni Suriano, Davide Lucia, Tiziana Fortuna, and with the collaboration of Nadia Cersosimo. Rome. The updated report is available at: https://www.garantenazionaleprivatiliberta.it/gnpl/pages/it/homepage/dettaglio_contenuto/?contentId=CNG14581&modelId=10019

3 For further information see: http://www.ristretti.it/areestudio/disagio/ricerca/

other inmates.

In line with the research findings mentioned above (Favril, 2021; Zhong et al., 2021), the legal position of those inmates who took their own lives offers important food for thought. In 2022, of the 85 persons who died by suicide in Italy, 39 were definitively convicted and 5 were in a "mixed position" which means that they were already convicted for previous crimes while still awaiting judgement for new crimes committed. The others were 7 inmates who made an appeal (appellants) and 2 inmates who had started an application against whom a criminal sentence of second instance was passed and were, then, awaiting trial at the Higher Court. This means that most of them (n = 44) were in a definitive position in prison: 38 had residual sentences of up to 3 years, while 5 of them had completed their time within 2023. Only a small proportion of them (n = 4) had a residual conviction of more than 3 years, and only 1 had a residual conviction of more than 10 years. It is also relevant to mention that approximately 60% of them (n = 50) committed suicide in the first six months of detention.

Another aspect to consider is in which prison wards (high security *versus* medium security) suicide is more likely to occur. For instance, the 85 cases of deaths by suicide in Italian prisons in 2022 (see Report of The National Guarantor of Persons Deprived of Liberty) occurred in medium security wards (n = 72 suicides; 84.7%). This aspect deserves attention because it seems to frame prison suicides within a unifying situation in which intolerable life conditions constitute the «normality» behind the prison regime.

Conditions of vulnerability in Italian prison

The conditions of vulnerability that were behind all these deaths by suicide cannot be ignored. Vulnerability is associated with the disrespect of certain rights (Adorno, 2016): the right to life, to dignity, to privacy, to family life, to health care, to education, and so on (see *The United Nations Declaration on Human Rights* - UNDHR, 2009). Although people enter prison with a range of preexisting vulnerabilities, as Heaslip and colleagues (2023) suggest, "the prison environment may make these intolerable or create new ones (environmental and human connectiveness dimensions of vulnerability)" (p. 123). If the environment of the prison is this, then it occurs to us that a prison that suffers is a prison that makes people suffer (Buffa, 2011, 2013).

Notwithstanding vulnerability is a broad concept and that detention is a condition of vulnerability *per se*, with «vulnerability» is meant that condition in which the person's wellbeing is at an heightened risk because of uncertainty, discrimination, loss of human connection, isolation, environmental instability, poor health, limited health care facilities, stigmatisation, fear of harm, conflicts. If these vulnerabilities are not addressed, instead of acting as a facilitator of rehabilitation (Chen & Shapiro, 2007; Heaslip et al., 2023), prison may in fact lead to an increase in antisocial attitudes and violent behaviour, not only towards others but also towards oneself (i.e. self-harm and suicide) (Zara & Freilone, 2023), but also of an enhanced sense of insecurity and distrust (Chisari, 2023).

Another condition of vulnerability is overcrowding which, paradoxically, exacerbates the sense of loss and isolation that the person feels when lacking privacy and an intimate space with oneself. In Italy the prison system suffers from an overcrowding of 127.54%, made up of 60,328 inmates, 13,000 more than the 47,300 places available.

The critical point in the density of the inmate population is exacerbated by the way in which the new medium-security detention regulations are implemented, whereby if people are not engaged in social, education, recreational, and treatment activities they remain locked in their cells. The risk of violation of rights and dignity of the people in prison is high and the need for urgent measures is paramount, for which the European Court of Human Rights has indicated the strong presumption of inhuman treatment, in violation of Article 3 of the Convention.

It is relevant to mention that findings on the link between suicide risk and prison overcrowding are inconsistent due to several influencing factors, including effects on staff-prisoner interactions (Zhong et al., 2021) and protective effects from double occupancy of single cells (van Ginneken et al., 2017). Countries with low incarceration rates are likely to have a higher proportion of people in prison for serious violent offences, with a potentially elevated suicide risk, compared with countries with high incarceration rates (which include prisoners convicted of non-violent offences, with lower risk for suicide) (Fazel et al., 2017).

According to Gianfrotta (2023), inmates appear to commit suicide in prisons not because they cannot cope with the narrowness of the spaces or the limitations that the detention regime entails on their social life, but for how unstable, unhealthy and psychological insecure life in prison is, especially for the most vulnerable ones. If this were the case, there would have been far more suicides among high-security inmates than the 2 that occurred last year in Italy.

Certainly, more studies are necessary not only to understand how to make prison conditions an «opportunity for life» but especially how to concretely implement conditions that promote an improvement in human wellbeing, and for adequate individualised treatment (Romano et al., 2023).

England and Wale and their suicide rates in prison

The prison population in England and Wales averages around 85,000 individuals incarcerated at any one time. England and Wales have the highest incarceration rate in Western Europe, with rates per capita averaging 159 per 100,000 of the population (Sturge, 2023). This is a

notable difference when compared with Italian incineration rates of 102 per capita (just under 60,000 prison population at the end of 2023).

The suicide rate of male prisoners in England and Wales was found to be 5 times higher than that of the general population between 1973 and 2003 (Fazel et al., 2005). The Ministry of Justice and National Offender Management Service[4] shares statistics on prisoners experience publicly. The most recent statistics[5] published on the 25th of January 2024 show that 93 "self-inflicted" deaths were recorded in 2023, and the majority of these were a result of hanging. This suicide method has been identified as common in the mid to late 2000s as well (Humber et al., 2013).

There are however some difficulties in establishing trends over time because of terminology used and how deaths are categorised. Statistics for prison suicide in England and Wales included drug related deaths before 2008; it was not possible to ascertain whether deaths defined as "self-inflicted" were suicide or accidental drug overdose. From 2008, statistics distinguished between drug-related and suicide, therefore, Figure 2 includes statistics from 2008 to current (unfortunately until only 2019), to represent rates of deaths in prison confirmed as suicide[6].

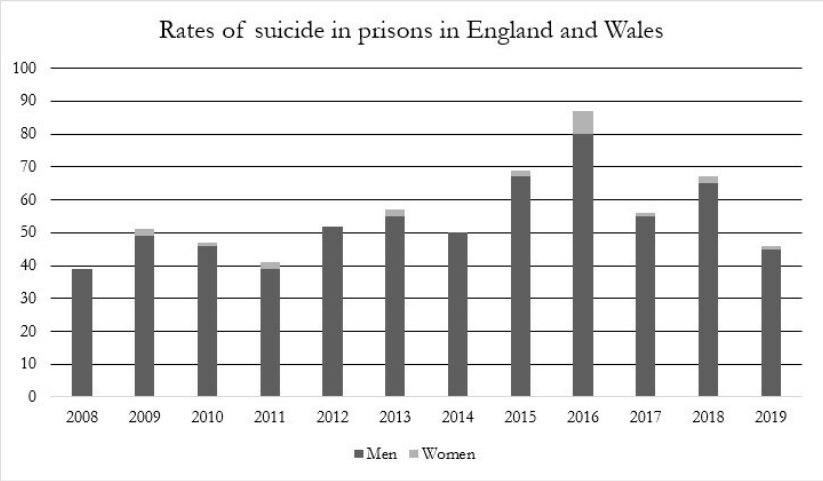

Figure 2 – Historical trend of deaths by suicide in England's and Wales' prisons
Source: Drug-related deaths and suicide in prison custody. *Office for National Statistics*. (ons.gov.uk)

Inmates seemed to be at especially high risk when they are on remand or when they have just entered a new custody situation[7]. This is in line with what happens in Italy, and with Coid et al.'s (2002) previous research. Self-harm in custody was also commonplace, and in the year preceding September of 2023, over 12 000 prisoners, for a total exceeding 65 000 events, were reported to have self-harmed.

Research evidence on mental health conditions in British prisons

Members of The Prison Research Centre at the Institute of Criminology at University of Cambridge have carried out a multiple decade long research programme into prisons, the prison experience (including some early and ground-breaking work on suicide), and prison conditions in the UK (Liebling, 1992; Liebling & Arnold, 2004; Liebling et al., 2019).

40 years ago, Coid (1984) conducted a review on papers to establish estimates of mental health problems in prisons. Out of the 11 studies that met the inclusion criteria for his review, four or five of these were carried out in the UK. The UK studies included spanned a period of 40 years (from 1950 to 1980), and the sample sizes ranged from 72 to 1800 prisoners. The findings varied depending on the study in question, but intellectual disabilities were estimated as high in the earlier studies and except for personality disorders (which had a high prevalence), most mental health problems showed a prevalence of less than 15 % across studies (see also Coid, 1984, Table 1, p. 80 for more detail on the included studies and their results).

4 See https://www.gov.uk/government/collections/safety-in-custody-statistics

5 See https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-september-2023/safety-in-custody-statistics-england-and-wales-deaths-in-prison-custody-to-december-2023-assaults-and-self-harm-to-september-2023#fn:3

6 See https://www.gov.uk/government/collections/safety-in-custody-statistics

7 See Drug-related deaths and suicide in prison custody - Office for National Statistics (ons.gov.uk)

In 2002, Coid and colleagues (2002) reported their findings from a comprehensive prison survey with a sample of over 3 000 prisoners (with response rates of over 75 % for both stages of the survey) in England and Wales. Mental health problems were common. For example, the prevalence of psychotic symptoms ranged 7-14 %, for "depressive episode" (Coid et al., 2002, p. 247) it ranged from 8 % to 21 %.

What these studies reported is that mental health problems are common amongst prisoners in England and Wales and have been for quite some time. Several prisoners do also report suicidal ideation within the prison context (Coid et al., 2002; Tyler et al., 2019).

Relatedly, and not discussed above, is the high prevalence of personality disorders (Coid, 1984; Coid et al., 2002; 2009; Tyler et al., 2019). In the recent study by Tyler et al. (2019), more than half of the inmates were found to have a personality disorder. There also appears to be comorbidity between personality disorders in prisoners and in secure hospitals in England (Coid, 2003). Of specific relevance to the current context is that borderline personality disorder (BPD) is quite common (e.g., Coid et al., 2002; 2009; Tyler at al., 2019). One of the criteria for this disorder is suicidal ideation and self-harm (American Psychiatric Association, 2013), and it has been found to increase the likelihood of self-harming behaviour in prisons (Knight et al., 2017).

Understanding prison self-harm and suicide in adult prisoners in England and Wales

Humber et al. (2013) carried out a unique case-control study on 220, predominantly male, suicides that had taken place in prisons in England and Wales. Each of these suicides were carefully matched for comparison purposes. The authors took great care to ensure that the matching took potential confounding variables into consideration and were able to access comprehensive information on both potential importation and deprivation factors. The results of the initial analyses showed that a wide range of factors related to both past mental health problems and the prison context were related to suicide. Some of the notable significant factors were past violent behaviour and offending, being on remand, being allocated in a single cell, and past and present mental health problems (Humber et al., 2013). Of interest is the finding of past violent behaviour because an identified challenge when trying to understand suicide in prison is the issue of *dual harm* (Slade et al., 2020, p. 182), which is the coexistence of a history of violence and self-harming behaviour within the same person. The strongest independent predictor however in Humber et al. (2013) was previously having engaged in self-harming behaviour.

The presence of self-harm in prisons in the UK has received some academic interest in past decades (Maden et al., 2000), but more recently Hawton et al. (2014) conducted a comprehensive study on self-harm in prisons in England and Wales. As shown by the more recent "Safety in Custody" statistics, self-harm was a common occurrence amongst prisoners in the mid-to late 2000s (Hawton, 2014). Hawton et al. (2014) investigated gender specific relationships between self-harm and suicide. For males, there were a set of factors that were associated with increasing risk for suicide amongst prisoners who self-harmed. The highest significant adjusted odds ratio for age was found for the age bracket of 40-49 years old. More severe self-harm was also significantly associated with suicide. For females, the factors that increased the likelihood for suicide amongst those who self-harmed were slightly different. A life sentence increased the likelihood with a significant adjusted odds ratio of over 10. A higher prevalence rate of past self-harm was also established as a risk factor.

Management of self-harm and suicide ideation in prisons in England and Wales

In 2005, the case management process for the identification, care, and support of prisoners in England and Wales who identify as at risk of self-harming and suicidal behaviour was updated from the Assessment, Care in Custody, and Teamwork (ACCT) process (Pike & George, 2019). This strategy, implemented by the National Offender Management Service, aims to reduce distress and improve the quality of life for prisoners (Walker et al., 2015) and therefore reduce rates of self-harm and suicide. ACCT management was developed to include risk and needs assessment, care plans and action points, and multi-disciplinary case reviews (Howard & Pope, 2019). Upon risk being identified by anyone working within the prison setting, an ACCT document is opened in the form of a bright orange folder which includes numerous sections to address relevant needs and reduce the vulnerability level. This folder remains active for as long as the individual is deemed to still demonstrate risk of self-harm or suicide and follows the prisoner through the prison. All staff have access to prisoner ACCT folders and are expected to update them accordingly.

In practice, those supported by the ACCT care plan encounter higher levels of observation, and additional support services such as healthcare attention, or intervention in the form of individual or group support, and heightened levels of observation. Although ACCT is considered a step in the right direction for reducing self-harm and suicide in prisons, it has yet to be demonstrated as effective in reducing suicide and self-harm rates in English and Welsh prisons. Additionally, male prisoners interviewed by Howard and Pope (2019) did not always find the ACCT process useful, with some individuals being concerned over the lack of confidentiality, issues with "over-observation" being intrusive and feeling like additional punishment, and reports of inconsistencies and confusion in the way the system was used. Recommendations for improvement are still in progress, and a new version of the plan is due for rollout in the near future.

Assessing the risk and the interplay between the needs of inmates and the prison environment

For Shneidman (1985, 1993), everything (research and training activities, suicide definition, operationalisation of suicide, measurements) is propaedeutic to the clinical enterprise of prevention. The proof of the suicidological pudding is in the "ventions" as in prevention, intervention, and postvention. In other words, all clinical and scientific efforts should be more evidence-based and effective (Leenaars, 2010, pp. 12–13).

The alarm of suicide in prison, as described in countries like Italy, and England and Wales, deserves serious institutional attention, scientific knowledge, professional intervention, and social support so as to reduce the gap between the two worlds: prison and society.

Many myths and misconceptions afflict the topic of suicide, the perception of risk level, the factors behind it, and the possibility of making preventive intervention effective.

Table 2 describes some of them and confronts them with scientific evidence.

Myths and Misconceptions	Facts based on scientific evidence
0# Suicide is pathology and suicidal people are mentally disturbed	0# Suicide is not a disease and is not pathology. Death by suicide is never about one single thing. Suicidal people are not mentally ill. Mental illness could be a risk factor. (see McKeon, 2009).
1# People who make suicidal statements or threaten to kill themselves usually do not do it.	1# Suicide is mostly achieved by people who have previously made either direct or indirect statements about their intentions. In prison, inmates more likely exhibit indirect warnings of their intentions given the climate of distrust. When needs and risk of inmates are not correctly identified or reported the risk for suicide attempts and behaviour is high. (see Berman & Canning, 2021; Folk et al., 2018; Hayes, 2011; Crosby et al., 2011).
2# Suicides usually occur suddenly and impulsively.	2# Most suicidal inmates, like most suicidal people in the general population, have a documented medical condition and a history of prior suicide attempts; in most cases they have an identified suicide thought-out plan. However, the more the context is deprived (as prisons are), the stronger the need to plan the suicide carefully and in detail. Some studies show that those inmates who died by suicide were less impulsive than those who attempted but did not die by suicide. The act itself can emerge impulsively, but the trail of suicidal thoughts is an underlying pattern in search of a trigger. (see Daniel & Fleming, 2005; Folk et al., 2018).
3# Failures in attempting to commit suicide will discourage other attempts.	3# Suicidal inmates who fail in the suicidal plan are at a higher risk for trying again to take their own lives. Intervention is paramount to dismantle their suicidal ideations and plans. (see Zara & Freilone, 2023).
4# Suicide in prison cannot be ever prevented.	4# Suicide is preventable even in prison, but is unpredictable in prison like in any other context. Awareness of the mental health professionals can make a difference, in so far as it can promote ability to intervene which could prevent the suicidal attempt from becoming a death by suicide. (see Boren et al., 2018; Folk et al., 2018).
5# Most suicidal people want to die.	5# Suicidal behaviour is an attempt to escape psychological pain, not necessarily to die *per se*. Psychological pain is not a pathology. It can become pathological when it is «orphaned» of understanding and meaning. (see Shneidman, 1985, 1993).
6# Risk assessment is probabilistic: it is a one-off procedure and is not informative in suicide cases.	6# Risk assessment is a scientific practice which consists in a temporal monitoring of the risk. The need for an ongoing suicide risk assessment throughout the period of incarceration would be crucial to promote intervention. For suicide risk, the assessment of risk factors and of their aggravation requires continuous observation of the case. This is essential also for building up professional awareness of the suicide risk that each inmate poses to themselves. Research shows that professional awareness acts as a part of the concept of external or institutional responsivity. External responsivity is essential in the correctional system, and it requires that mental health professionals recognise and actively document suicide-related historical, diagnostic, and treatment factors, and update the assessment by also looking at concurrent and proximal risk factors. These latter factors may not be reported or not present at the time of intake into the correctional system but might significantly emerge later on, during the conviction time. (see Folk et al., 2018; Zara & Freilone, 2023).

Table 2 – Dismantling myths and misconceptions about suicide in prison

While suicide in prison can be unpredictable this does not mean that it is not preventable (see point 4# of Table 2). For instance, in 2022 in Italy, 80% (*n* = 68) of those inmates who died by suicide had experienced critical events while in detention, and of them 33% (*n* = 28) had previously made at least one suicide attempt (and in 7 cases even more than one attempt) (see point 3# of Table 2).

These data suggest that an enhanced condition of vulnerability featured in their life while in prison, as shown in England's and Wales' prisons (see points 1#, 2# and 5# of Table 2). Thus, assessing the risk is paramount but it cannot be limited to the one moment at-intake of the person into prison (see point 6# of Table 2). It requires an ongoing process of observation and evaluation of the individual needs and conditions, and how they change while in prison. This requires professional sensitivity and attention to respond individually to those critical situations that can always emerge. Critical events could be indeed an expression of the cumulation of risk (historical and concurrent risk) (see later for details), with the acute risk (i.e. an unpredictable event) that can act as a trigger for suicidal behaviour.

Studies that compared the risk factors behind attempted suicides (i.e. cases of survivals) and successful suicides (i.e. cases of deaths) are quite informative as to how psychological pain could be either exacerbated in a system that focuses mainly on control or that can be addressed if professional attention is given both in time and in a responsive way (see Table 2 for details). Psychological pain is not a pathology. It can become pathological when it is «orphaned» of understanding and meaning (see points 0#, 1# and 5 # of Table 2).

In a recent analysis of a large multi-site sample, Boren and colleagues (2018) examined factors that differentiate between inmates who attempted (*n* = 735) and died by (*n* = 190) suicide. Findings show that compared to those who attempted suicide, those who died by suicide tended to be older, male, more educated, and married or separated/divorced, in pre-trial (*versus* post-sentence), arrested for a violent crime, incarcerated in jail (*versus* long-term prison), housed in an inpatient mental health unit or protective custody (*versus* general population), living in a single cell, not on suicide precautions, and not previously under close observation. Those who died by suicide were also more likely to act during overnight hours and die by hanging/self-strangulation. No differences were observed for race (White *versus* Black), length of time incarcerated, and month and day of the week when the suicidal incident occurred.

In another study carried out by Folks and colleagues (2018), a large sample of 925 inmates, divided between those who attempted suicide and survived (*n* = 735; 79.5%) and those who died by suicide (*n* = 190; 20.5%), between 2007 and 2015, were examined. Results show some counterintuitive findings that deserve further consideration. Inmates were disproportionately more likely to attempt than die by suicide if they were known to have a documented history of substance use problems, impulsivity, suicide/self-injurious behaviour, trauma, and lack of participation in psychological treatment (historical factors). Moreover, inmates were disproportionately more likely to attempt than die by suicide if they were noted by staff to have exhibited agitation, hopelessness, psychological turmoil, alienation, depressive symptoms, psychotic symptoms, an identified suicide plan, or a sudden change in mental status (concurrent factors). Individuals who died by suicide had significantly fewer documented concurrent risk factors than those who attempted suicide. This might also depend on the fact that behaviour of an inmates speaks louder than their words, as Berman and Canning (2021) suggest by quoting Hayes (2011) and Crosby et al. (2011).

It is then crucial for professionals in correctional settings to be able to understand what those inmate behaviours and symptomatic expressions are, which serve to signal heightened near-term or acute risk for suicidal death that can be stopped before the escalation into suicide.

Relying on a one-time assessment of risk at the time of intake seems to offer only a partial picture of the persons' needs and risk. It is more likely that dynamic risk factors (contextual, proximal, concurrent, acute risk factors) are not present at the time of incarceration or are not reported. It is also likely that the risk level changes in time. This is why an initial screen is a necessary but not a sufficient condition to ensure a management of risk (see Table 2).

In the study by Folk and colleagues (2018) what emerges as particularly relevant is the awareness of the correctional mental health staff about the inmates' suicide risk. When correctional mental health staff were aware of inmates' current and historical psychological state and social context, deaths by suicide were less likely to occur. This might be because professional awareness leads mental health staff to further intervene, for example through assessing risk and monitoring on the mental health caseload or facilitating psychological support or prescribing psychotropic medication. Mental health intervention, in turn, seems to be a protective measure against deaths by suicide.

Although mental health staff's awareness does not prevent suicide attempts per se, it appears that those most at risk of dying by suicide are individuals for whom mental health staff do not know about crucial risk-relevant information (e.g., suicide plan). Hence, assessing suicide risk requires not only professional sensitivity and attention, but also promptness in being able to intervene when specific needs are affecting the wellbeing of the inmates.

For instance, Daigle (2004) used the Minnesota Multiphasic Personality Inventory (MMPI) to examine personality differences among U.S. male federal inmates who died by suicide (*n* = 47), who attempted but did not die (*n* = 43), and non-suicidal controls (*n* = 123). Inmates who attempted suicide were higher on MMPI scales

assessing paranoia schizophrenia, psychasthenia (i.e., anxiety, phobias, obsessions, compulsions), and social introversion compared to those who died by suicide (and non-suicidal inmates). No differences were found on the MMPI hypochondriasis, depression, hysteria, psychopathic deviance, masculinity–femininity, and hypomania scales. Those inmates who exhibited more "pathological" symptoms became a priority for mental health intervention, and one may argue that they eventually had non-fatal self-destructive behaviours (namely, suicide attempts, self-mutilation, and parasuicidal acts) especially because of the prompt professional attentions they attracted and received.

Assessing suicidality and practice implications

In Italy, as in England and Wales, it has become an urgent priority to accurately assess suicidal risk, given the problematic conditions that characterise their correctional system as described before. The rest of this article will briefly describe some of the screening tools and instruments that are now available to assess suicide risk in prison.

Clinical risk assessment of suicidality refers to basic questions on how to guide treatment decisions and organise the results, starting from assessing the risk and needs at intake. Actuarial risk assessment looks at historical data and static variables while often overlooking current and acute factors. Suicidality is not static, and its dynamic nature requires not only a sensitive professional competence but the institutional interest to address it.

The screening of suicidal inmates at intake is a delicate procedure (Daigle et al., 2006), and one of the most important measures for preventing suicide. While screening suicidal risk at intake cannot be considered a one-off and conclusive procedure, it is the necessary condition to understand who the people coming into prison are: it should then be followed by an ongoing observation and monitoring of the person, of their needs and changes in their level of risk and vulnerability. Despite the recognition of its role, many studies have shown that inmates who died by suicide were not screened at intake (Gould et al., 2018; Hayes, 1989).

The increasing levels of suicide, attempted suicide and self-harm behaviour in prison would certainly benefit from instruments that can identify, with high margins of accuracy, individuals who may be at risk of self-harm and/or suicidal behaviour (Perry & Horton 2020).

The relevance of past suicidal history was recognised in a study by Pelizza et al. (2023), conducted in Parma Penitentiary Institute, in which there was found a 12% prevalence of both past suicide attempts and other prior self-harm behaviours, and that 3% of the men had suicidal ideation at the time of first assessment. These figures are higher than those reported in newly admitted inmates at the New York State prison (3.7% prevalence rate of prior suicide attempts) (Way et al., 2008; Pelizza et al., 2023).

The progressive incarceration rate increase in Italy, and England and Wales, and the related higher rates of inmates with mental disorders (especially depression) suggest two points that here can only be mentioned though not fully discussed. First, incarceration should become a measure of punishment only when any other alternative measures are not functional and applicable to the offender. Second, the high prevalence of mental health problems of offenders in prison indicate that these offenders should not be sent to prison in the first place, and that their mental problems should be addressed specifically and primarily before anything else.

Table 3 summarises some of the instruments and scales that can be used within the correctional systems, despite only few of them having been used in the United Kingdom and Italy. The table is an update of the systematic review of Gould and colleagues (2018): it does not intend to be an exhaustive summary, nor a complete description of the screening instruments available. The sense of the table is to pinpoint the attention on how suicidality is assessed as a dimension that touches upon different aspects of the person's life, of which their current situation must become primarily relevant.

For instance, START (Short-Term Assessment of Risk and Treatability) (Webster et al., 2004; Zara & Freilone, 2023) looks at the risk of *dual harm* (violence and self-harm) and assesses short-term risk (see Table 3 for its description). Hence, even though it was not conceived to assess suicide risk *per se*, it requires to make an assessment under conditions of uncertainty, often of emergency, and requires constant monitoring and reassessment (see 6# point of Table 2): it must be completed regularly and whenever an appreciable change in risk(s) is expected.

Authors	Instruments to assess suicidality	Country	Structure of the instruments	Specificity in assessing suicide risk in prison
Arboleda-Florez & Holley (1988)	Suicide Checklist	Canada	20 items that include: ■ Symptoms of depressions (11 items) ■ Past History (9 items)	√
Blaauw et al. (2001) Dahle et al. (2005)	Dutch Suicide Screening Tool	Netherlands	8 items. Examples of specific items: ■ Previous suicide ■ Suicidal utterances	√
	Dutch Suicide Screening Tool (optimized)	Berlin		
Cull & Gill (1998) Naud & Daigle (2010)	Suicide Probability Scale (SPS)	Canada	36 items organised in 4 subscales: ■ Hopelessness ■ Suicide Ideation ■ Negative Self-Evaluation ■ Hostility	√
Daigle et al. (2006) Frottier et al. (2009)	Suicide Risk Assessment Scale (SRAS) Viennese for Suicidality in Correctional Institutions (VISCI)	Canada Austria	9 items organised in parameters and named with alphabetic letters from A to Q. Examples of specific items: ■ A (custodial status) ■ Q (attempted suicide) ■ R (suicide threat) ■ V (suicide ideation)	√
Mills & Kroner (2005)	Depression, Hopelessness and Suicide Screening Form (DHS)	Canada	39 items: ■ Depression: 17 items ■ Hopelessness: 10 items ■ Critical risk checklist for suicide: 12 items	*X* More empirical work is needed on DHS in prison.
Nicholls et al. (2005) Ciappi (2011)	Jail Screening Assessment Tool (JSAT)	Canada Italy	sections are explored: ■ Demographic information ■ Legal situation ■ Violence issues ■ Social background ■ Substance use ■ Mental health treatment ■ Suicide and self-harm issues ■ Mental health status (integrated with the Brief Psychiatric Rating Scale - BPRS-E) (Lukoff et al., 1986)	√
Perry & Olason (2009) Perry & Horton (2020)	Self-harm concerns about offenders in prison environment tool (SCOPE)	United Kingdom	Originally structured in 28 items and then revised into 19 items organised in two scales: ■ O = Optimism ■ P = Protective self-worth	√
	SCOPE-2			
Webster et al. (2004) Zara & Freilone (2023)	Short-Term Assessment of Risk and Treatability (START)	Canada Italy	20 items organised to facilitate 1-month risk assessment decision-making in seven domains: ■ Risk of externalised violence towards others ■ Risk of self-harm ■ Risk of suicide ■ Risk of unauthorised removal (absenteeism) ■ Risk of substance abuse ■ Risk of self-neglect or self-abandonment ■ Risk of victimisation	*X* More empirical work is needed on START in prison.

Wichmann et al. (2000)	Suicide Potential Scale (or Suicide Risk Assessment Scale)	Canada	9 items focused on the needs of the offender: ■ Being suicidal (opinion of the referring agency) ■ Previous suicide attempt ■ Undergone recent psychological/psychiatric intervention ■ Recent loss of a relative/spouse ■ Experiencing major problems (i.e. legal) ■ Under influence of alcohol/drugs ■ Signs of depression ■ Suicidal ideation ■ Suicide plan	√
Zapf (2006) Szadejko & Ciappi (2011)	Suicide Assessment Manual for Inmates (SAMI)	Canada Italy	20 literature-supported risk factors. Examples of specific items: ■ Feeling of desperation and excessive sense of guilt ■ Depressive symptoms ■ Stress and coping ■ Suicide attempts ■ Suicide attempts within institutions ■ Experiences of suicide in the family ■ Suicide ideation ■ Suicide intent ■ Suicide plan	√ More research is necessary because SAMI development yielded poor factor structure including failure of several items to load.

Table 3 – Instruments to assess suicidality
Source: Adapted from Gould et al., 2018, p. 350

According to what has emerged from scientific research and clinical evidence, a progressive (stepwise or stepped care) approach, in which open-ended questions are followed by close-ended questions, may help the suicidal inmate to disclose (1) precipitant factors and triggers to suicidality; (2) current psychiatric symptoms; (3) level of hopelessness; (4) specific suicide-related details (e.g., nature and intensity of ideation). The scope is to help professionals build a climate of trust and connection with inmates who are experiencing suicidality, create peer-supporting opportunities, and implement differentiated and integrated crisis responses (for further information see the Collaborative Assessment and Management of Suicide - CAMS; Jobes, 2012).

A research group at the University of Oxford[8] is working on the development of a new structured risk assessment approach for people in prison who are at risk of self-harm and suicide. The RAPSS (*Risk Assessment for Prisoners at risk of Self-harm and Suicide*) approach, once validated, will be integrated into current practice in England and Wales, whereby people in custody who self-harm or express suicidal ideation and thoughts are placed on a suicide risk management plan called ACCT (Assessment, Care in Custody, and Teamwork; see above for details).

Developing an integrated approach that helps professionals understand modifiable risk factors and make informed decisions about when to open, close or reopen an ACCT, is also of paramount importance. If a risk assessment model can accurately assess and stratify (into well-defined risk levels) a person's risk of future self-harm, limited resources could be primarily directed to those most likely to need them. It can also enable the identification of needs that could be the focus of follow-up interventions.

Limitations

This work is not without limitations. For example, the analysis of suicide risk in prisons did not differentiate by gender or age, although a differentiated assessment is important when considering the needs of women or young adults in prisons. The concept of imminent or proximate risk is crucial for identifying reliable predictors of short-term suicide risk in prisons, and there is a need for further research on this topic, as well as research to test the accuracy and reliability of screening procedures.

Given the complexity of the issue, it would have been presumptuous on our part to analyse every aspect of suicidality risk in prisons in Italy, and in England and Wales.

Further research is certainly needed and is a necessary next step.

Conclusion

Suicide behind bars reminds us of the case when «mors omnia solvit» (death dissolves everything) is not true! Any

death by suicide leaves a trail of responsibility, regret, suffering and cumulative risk. While the fatal self-harming act cannot be predicted, suicide can be prevented, and suicidal risk can be assessed. More quality evidence-based interventions, based on quality scientific research, are required on how to tackle conditions of vulnerability in prison; to ameliorate the quality of life during imprisonment; to reduce suicidal thoughts and behaviours among people in contact with the criminal justice system; to recognise that mental health problems require specific and differential interventions; to promote a climate of more trust and security within prison; to train mental health professionals and penitentiary professionals to be prepared to work in a team to address suicidality in prison.

There is, certainly, a difference between people who are already suffering from mental problems and having suicidal thoughts prior to enter prison, and those who suffer from mental problems while in prison. It is a very fine line, but the system should not neglect to take into consideration this difference, and to put into motion any form of mental and psychological health care of inmates, and of prevention to stop inmates from harming themselves.

The practice of assessment of dynamic (also precipitating and acute) risk factors, and of the specific needs of the prison population, should become part of a preventive practice, dedicated not only to tackle suicide but more importantly improve the health conditions of people in prison.

Conflict of interest

The authors declare that they have no conflict of interest.

References

American Psychiatric Association (2013). *The diagnostic and statistical manual of mental disorders fifth edition. DSM-5*. American Psychiatric Association.

Andorno, R. (2016). Is vulnerability the foundation of human rights. In A. Masferer & E. G. Sanchez (Eds.). *Human rights of the vulnerable in the age of rights: Interdisciplinary approaches* (pp. 257–272). Springer.

Arboleda-Florez, J., & Holley, H. L. (1988). Development of a suicide screening instrument for use in a remand centre setting. *Canadian Journal of Psychiatry*, *33*(7), 595–598. https://doi.org/10.1177/070674378803300704

Beevers, C. G. & Miller, I. W. (2004). Perfectionism, cognitive bias, and hopelessness as prospective predictors of suicidal ideation. *Suicide & life-threatening behavior*, *34*(2), 126–137. https://doi.org/10.1521/suli.34.2.126.32791

Berman, A. L. (2018). Risk factors proximate to suicide and suicide risk assessment in the context of denied suicide ideation. *Suicide & Life-Threatening Behavior*, *48*(3), 340–352. https://doi.org/10.1111/sltb.12351

Berman, A. L. & Canning, R. D. (2021). Proximal risk for suicide in correctional settings: A call for priority research. *Psychological Services*, 19 (3), 407–412. https://doi.org/-10.1037/ser0000516

Blaauw, E., Kerkhof, A. J., Winkel, F., & Sheridan, L. (2001). Identifying suicide risk in penal institutions in the Netherlands. *The British Journal of Forensic Practice*, *3*(4), 22–28. https://doi.org/10.1108/ 14636646200100024

Boisseau, C. L., Yen, S., Markowitz, J. C., Grilo, C. M., Sanislow, C. A., Shea, M. T., Zanarini, M. C., Skodol, A. E., Gunderson, J. G., Morey, L. C., & McGlashan, T. H. (2013). Individuals with single versus multiple suicide attempts over 10years of prospective follow-up. *Comprehensive psychiatry*, *54*(3), 238–242. https://doi.org/10.1016/j.comppsych.2012.07.062

Boren, E. A., Folk, J. B., Loya, J. M., Tangney, J. P., Barboza, S. E., & Wilson J. S. (2018). The suicidal inmate: A comparison of inmates who attempt versus complete suicide. *Suicide and Life Threatening Behavior*, *48*, 570–579.doi: 10.1111/sltb.12374

Bostwick, J. M., & Pankratz, V. S. (2000). Affective disorders and suicide risk: a reexamination. *The American journal of psychiatry*, *157*(12), 1925–1932. https://doi.org/10.1176/-appi.ajp.157.12.1925

Brenner, L. A., Breshears, R. E., Betthauser, L. M., Bellon, K. K., Holman, E., Harwood, J. E., Giner, L., Guija, J. A., Root, C. W., & Baca-Garcia, E. (2016). Nomenclature and definition of suicidal behavior. In P. Courtet (Ed.). *Understanding suicide: From diagnosis to personalized treatment* (pp. 3–17). Springer International Publishing/Springer Nature. https://doi.org/10.1007/978-3-319-26282-6_1

Brezo, J., Paris, J., & Turecki, G. (2006). Personality traits as correlates of suicidal ideation, suicide attempts, and suicide completions: a systematic review. *Acta psychiatrica Scandinavica*, *113*(3), 180–206. https://doi.org/-10.1111/j.1600-0447.2005.00702.x

Buffa, P. (2011). La profezia penitenziaria: se il carcere diventa un laboratorio sociale [*Penitentriay prophecy: if prison became a social laboratory*]. *Rassegna Italiana di Criminologia* [*Italian Journal of Criminology*], *3*, 49–64.

Buffa, P. (2013). *Prigioni. Amministrare la sofferenza*. Torino: Gruppo Abele.

Carter, A., Butler, A., Willoughby, M., Janca, E., Kinner, S. A., Southalan, L., Fazel, S., & Borschmann, R. (2022). Interventions to reduce suicidal thoughts and behaviours among people in contact with the criminal justice system: A global systematic review. *eClinicalMedicine*, *44*, 101266. https://doi.org/10.1016/j.eclinm.2021.101266

Cavanagh, J. T., Carson, A. J., Sharpe, M., & Lawrie, S. M. (2003). Psychological autopsy studies of suicide: a systematic review. *Psychological medicine*, *33*(3), 395–405. https://doi.org/10.1017/s0033291702006943

Chen, M. K., & Shapiro, J. (2007). Do harsher prison conditions reduce recidivism? A discontinuity-based approach. *American Law and Economics Review*, *9*, 1–29. https://doi.org/10.1093/aler/ahm006

Chisari, C. (2023). Transitioning from dynamic security in italian prisons: assessing the influence of perceived insecurity on prison management. *Rassegna Italiana di Criminologia* [*Italian Journal of Criminology*], *XVII, 3*, 240–251. https://doi.org/10.7347/RIC-032023-p240

Ciappi, S. (2011). *JSAT, Jail Screening Assessment Tool: Uno strumento di screening psicologico in ambito forense e penitenziario*. Florence: Giunti OS.

Coid, J. (1984). How many psychiatric patients in prison? *British Journal of Psychiatry, 145*, 78-86.

Coid, J. (2003). The co-morbidity of personality disorders and lifetime clinical syndromes in dangerous offenders. *The*

Journal of Forensic Psychiatry & Psychology, 14(2), 341-366.
Coid, J., Bebbingon, P., Jenkins, R., Brugha, T., Lewis, G., Farrell, M., Singleton, N. (2002). The national survey of psychiatric morbidity among prisoners and the future of prison healthcare. *Medicine, Science and the Law, 42*(3), 245-250. https://doi.org/10.1177/002580240204200309
Coid, J., Moran, P., Bebbington, P., Brugha, T., Jenkins, R., Farrell, M., Singleton, N., & Ullrich, S. (2009). The co-morbidity of personality disorder and clinical syndromes in prisoners. *Criminal Behavior and Mental Health, 19*, 321-333.
Crewe B. (2021). The depth of imprisonment. *Punishment & Society*, *23*(3), 335–354. https://doi.org/10.1177/1-462474520952153
Crosby, A. E., Ortega, L., & Melanson, C. (2011). *Self-directed violence surveillance: Uniform definitions and recommended data elements* (version 1.0). Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.
Cull, J. G. & Gill, W. S. (1988). *Suicide Probability Scale (SPS): Manual*. Western Psychological Services.
Dahle, K-P., Lohner, J. C., & Norbert, K. (2005). Suicide prevention in penal institutions: Validation and optimization of a screening tool for early identification of high-risk inmates in pretrial detention. *International Journal of Forensic Mental Health 4*(1), 53–62. https://doi.org/-10.1080/14999013.2005. 10471212
Daigle, M. (2004). MMPI inmate profiles: suicide completers, suicide attempters, and non-suicidal controls. *Behavioral Sciences and the Law*, *22*, 833–842. https://doi.org/-10.1002/bsl.618
Daigle, M. S., Labelle, R., & Côté, G. (2006). Further evidence of the validity of the suicide risk assessment scale for prisoners. *International Journal of Law and Psychiatry*, *29*(5), 343–354. https://doi.org/10.1016/j.ijlp.2006.01.004
Daniel, A. E. & Fleming J. (2005). Serious suicide attempts in a state correctional system and strategies to prevent suicide. *The Journal of Psychiatry & Law*, *33*, 227–247.
Fang, L., Heisel, M. J., Duberstein, P. R., & Zhang, J. (2012). Combined effects of neuroticism and extraversion: findings from a matched case control study of suicide in rural China. *The Journal of nervous and mental disease*, *200*(7), 598–602. https://doi.org/10.1097/NMD.0b013e31825bfb53
Favril, L. (2021). Epidemiology, risk factors, and prevention of suicidal thoughts and behaviour in prisons: A literature review. *Psychologica Belgica, 61*, 341–355. https://doi.org/-10.5334/ pb.1072
Fazel, S., Benning, R., & Danesh, J. (2005). Suicides in male prisoners in England and Wales, 1978–2003. *Lancet*, *366*(9493), 1301–1302. https://doi.org/10.1016/S0140-6736(05)67325-4
Fazel, S., Cartwright, J., Norman-Nott, A., & Hawton, K. (2008). Suicide in prisoners: A systematic review of risk factors. *Journal of Clinical Psychiatry*, *69*, 1721–1731.
Fazel, S., Fimi ska, Z., Cocks, C., & Coid, J. (2016). Patient outcomes following discharge from secure psychiatric hospitals: Systematic review and meta-analysis. *British Journal of Psychiatry*, *208*(1), 17–25. https://doi.org/-10.1192/bjp.bp.114.149997.
Fazel, S., Grann, M., Kling, B., & Hawton, K. (2011). Prison suicides in 12 countries: An ecological study of 861 suicides during 2003-2007. *Social Psychiatry and Psychiatric Epidemiology*, *46*, 191–195. https://doi.org/10.1007/-s00127-010-0184-4
Fazel, S. & Seewald, K. (2012). Severe mental illness in 33,588 prisoners worldwide: systematic review and metaregression analysis. *British Journal of Psychiatry*, *200*, 364–373. https://doi.org/10.1192/bjp.bp.111.096370
Folk, J. B., Loya, J. M., Alexoudis, E. A., Tangney, J. P., Wilson, J. S., & Barboza, S. E. (2018). Differences between inmates who attempt suicide and who die by suicide: Staff-identified psychological and treatment-related risk factors. *Psychological Services*, *15*, 349–356. https://doi.org/10.1037/ser0000228
Frottier, P., Koenig, F., Seyringer, M., Matschnig, T., & Fruehwald, S. (2009). The distillation of "VISCI": Towards a better identification of suici-dal inmates. *Suicide and Life-Threatening Behavior*, *39*(4), 376–385. https://doi.org/10.1521/suli.2009.39.4.376
Galynker, I., Yaseen, Z. S., Cohen, A., Benhamou, O., Hawes, M., & Briggs, J. (2017). Prediction of suicidal behavior in high risk psychiatric patients using an assessment of acute suicidal state: The suicide crisis inventory. *Depression and Anxiety*, *34*(2), 147–158. https://doi.org/10.1002/da.22559
Garante Nazionale dei diritti delle persone private della libertà [National Guarantor of the Rights of Persons Deprived of their Liberty] (2023). *Per un'analisi dei suicidi negli lstituti penitenziari* [*An analysis of suicide in prison*]. Rome.
Gianfrotta, F. (2023). L'annus horribilis dei suicidi in carcere: o si cambia o si muore [The annus horribilis of prison suicides: either change or die]. *Questione Giustizia* [Question of Justice] Online Journal, June 2023. Available at: https://www.questionegiustizia.it/articolo/suicidi-carcere
Gould, C., McGeorge, T., & Slade, K. (2018). Suicide screening tools for use in incarcerated offenders: A systematic review. *Archives of Suicide Research*, *22*(3), 345–364. https://doi.org/10.1080/13811118.2017.1334611
Hatcher, S., & Stubbersfield, O. (2013). Sense of belonging and suicide: a systematic review. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, *58*(7), 432–436. https://doi.org/10.1177/070674371305800709
Haw, C., & Hawton, K. (2011). Living alone and deliberate self-harm: a case-control study of characteristics and risk factors. *Social psychiatry and psychiatric epidemiology*, *46*(11), 1115–1125. https://doi.org/10.1007/s00127-010-0278-z
Hawton, K., Linsell, L., Adeniji, T., Sariaslan, A., & Fazel, S. (2014). Self-harm in prisons in England and Wales: and epidemiological study of prevalence, risk factors, clustering, and subsequent suicide. *Lancet, 383*(9923), 1147-1154.
Hawton, K., & van Heeringen, K. (2009). Suicide. *Lancet (London, England)*, *373*(9672), 1372–1381. https://doi.org/10.1016/S0140-6736(09)60372-X
Hawton, K., Saunders, K. E., & O'Connor, R. C. (2012). Self-harm and suicide in adolescents. *Lancet (London, England)*, *379*(9834), 2373–2382. https://doi.org/10.1016/S0140-6736(12)60322-5
Hayes, L. M. (1989). National study of jail suicides: Seven years later. *Psychiatric Quarterly*, *60*(1), 7–29. https://doi.org/-10.1007/BF01064362
Hayes, L. M. (2011). *Guiding principles to suicide prevention in correctional facilities*. National Center on Institutions and alternatives. http:// www.ncianet.org/suicide-prevention/-publications/
Heaslip, V., Dugdale, C., Parker, J., Johnsen, B., & Hean, S. (2023). Experiences of vulnerability in adult male prisoners: An integrative review. *The Prison Journal*, *103*(1) 122–153. https://doi.org/10.1177/00328855221139868
Hilmann, J. (1964/2020) (3rd revised ed.). *Suicide and the soul*. Connecticut, USA: Spring Publications, Thompson.
Howard, F. F. & Pope, L. (2019). Learning to cope: an exploratory qualitative study of the experience of men who

have desisted from self-harm in prison. Ministry of Justice Analytical Series: HMPPS. [online] available at: Learning to cope: an exploratory qualitative study of the experience of men who have desisted from self-harm in prison - GOV.UK (www.gov.uk) (accessed on: 18/04/23).

Humber, N., Webb, R., Piper, M., Appleby, L., & Shaw, J. (2013). A national case-control study of risk factors among prisoners in England and Wales. *Social Psychiatry and Psychiatric Epidemiology, 48*, 1177-1185.

Jobes, D. A. (2012). The Collaborative Assessment and Management of Suicidality (CAMS): An evolving evidence-based clinical approach to suicidal risk. *Suicide and Life-Threatening Behavior*, *42*, 640–653. https://doi.org/10.1111/j.1943-278X.2012.00119.x

Knight, B., Coid, J., & Ullrich, S. (2017). Non-suicidal self-injury in UK prisons. *International Journal of Forensic Mental Health, 16*(2), 172-182. https://doi.org/-10.1080/14999013.2017.1287139

Leenaars, A. (1999) (Ed.). *Lives and deaths: Selections from the works of Edwin S. Shneidman.* Philadelphia: Brunner/Mazel.

Leenaars, A. (2010). Review Edwin S. Shneidman on Suicide. *Suicidology Online*, *1*, 5–18.

Liebling, A. (1992). *Suicides in prison*. Abingdon, UK: Routledge. https://doi.org/10.4324/9780203218365

Liebling, A. & Arnold, H. (2004). *Prisons and their moral performance: A study of values, quality, and prison life. Clarendon studies in criminology.* Oxford University Press. https://doi.org/10.1093/oso/9780199271221.001.0001

Liebling, A., Laws, B., Lieber, E., Auty, K., Schmidt, B. E., Crewe, B., Gardom, J., Kant, D., & Morey, M. (2019). Are hope and possibility achievable in prison? *The Howard Journal of Criminal Justice, 58*(1), 104-126. https://doi.org/10.1111/hojo.12303

Lukoff, D., Nuechterlein, K. H., & Ventura, J. (1986). Brief Psychiatric Rating Scale (Expanded - 1986). *Schizophrenia Bulletin*, *12*, 594–602.

McGirr, A., Renaud, J., Bureau, A., Seguin, M., Lesage, A., & Turecki, G. (2008). Impulsive-aggressive behaviours and completed suicide across the life cycle: a predisposition for younger age of suicide. *Psychological medicine*, *38*(3), 407–417. https://doi.org/10.1017/S0033291707001419

McKeon, R. (2009). *Suicidal behavior. Evidence-based Practice*. USA: Hogrefe Publishing.

Mills, J. F. & Kroner, D. G. (2010). *Concurrent validity and normative data of the depression hopelessness and suicide screening form with women offenders.* Correctional Service of Canada.

Nicholls, T. L., Roesch, R., Olley, M. C., Ogloff, J. R. P., & Hemphill, J. F. (2005). *Jail Screening Assessment Tool (JSAT): Guidelines for mental health screening in jails*. Burnaby, BC: Simon Fraser University, Mental Health, Law, and Policy Institute.

O'Connor, R. C. & Nock, M. K. (2014). The psychology of suicidal behaviour. *The lancet. Psychiatry*, *1*(1), 73–85. https://doi.org/10.1016/S2215-0366(14)70222-6

Opitz-Welke, A., Bennefeldt-Kersten, K., Konrad, N., & Welke, J. (2016). Prison suicide in female detainees in Germany 2000–2013. *Journal of Forensic and Legal Medicine*, *44*, 68–71. https://doi.org/10.1016/j.jflm.2016.08.016

Pelizza, L., Rossi, E., Zambelli, U., Violante, E., Scarci, M., Mammone, E., Adriani, A., Pupo, S., Paulillo, G., & Pellegrini, P. (2023). Psychological screening service for men newly admitted to an Italian prison: Preliminary clinical outcome analysis after 1 year of clinical activity. *Criminal Behaviour & Mental Health*, *33*(5), 342–353. https://doi.org/10.1002/cbm.2310

Perry, A. E. & Horton, M. (2020). Assessing vulnerability to risk of suicide and self-harm in prisoners: a Rasch analysis of the suicide concerns for offenders in the prison environment (SCOPE-2). *BMC Psychiatry*, *20*, 164, 1-11. https://doi.org/10.1186/s12888-020-02569-1

Perry, A. E. & Olason, D. (2009). A new psychometric instrument assessing vulnerability to risk of suicide and self-harm behaviour in offenders: suicide concerns for offenders in prison environment (SCOPE). *International Journal of Offender Therapy and Comparative Criminology*, *53*(4), 385–400. https://doi.org/10.1177/0306624X08319418.

Pike, S. & George, R. (2019). *The Assessment, Care in Custody, and Teamwork, Process in Prison: findings from qualitative research.* Ministry of Justice.

Pratt, P. & Foster, E. (2020). Feeling hopeful: can hope and social support protect prisoners from suicide ideation? *The Journal of Forensic Psychiatry & Psychology*, *31*(2), 311-330, DOI: 10.1080/14789949.2020.1732445

Qin, P., Agerbo, E., & Mortensen, P. B. (2002). Suicide risk in relation to family history of completed suicide and psychiatric disorders: a nested case-control study based on longitudinal registers. *Lancet (London, England)*, *360*(9340), 1126–1130. https://doi.org/10.1016/S0140-6736(02)-11197-4

Rivlin, A., Fazel, S., Marzano, L., & Hawton, K. (2012). Studying survivors of near-lethal suicide attempts as a proxy for completed suicide in prisons. *Forensic Science International*, *220*, 19–26. https://doi.org/10.1016/-j.forsciint.2012.01.022

Rogers, M. L., Chu, C., & Joiner, T. (2019). The necessity, validity, and clinical utility of a new diagnostic entity: Acute suicidal affective disturbance. *Journal of Clinical Psychology*, *75*, 999–1010. https://doi.org/10 .1002/jclp.22743

Romano, C. A., De Fazio, L., & Grattagliano, I. (2023). Quale futuro per il trattamento criminologico? [Which future for criminological treatment?]. *Rassegna Italiana di Criminologia* [Italian *Journal of Criminology*], *XVII*, *2*, 83–85

Shepherd, J. P., Shepherd, I., Newcombe, R. G., & Farrington, D. P. (2009). Impact of antisocial lifestyle on health: Chronic disability and death by middle age. *Journal of Public Health*, *31*, 506–511. https://doi.org/10.1093/pubmed/fdp054

Shneidman, E. (1985). *Definition of suicide*. (pp. 202–213.) New York: John Wiley & Sons.

Shneidman, E. S. (1993). *Commentary: Suicide as Psychache. The Journal of Nervous and Mental Disease, 18*, 145–147. https://doi.org/10.1097/00005053-199303000-00001

Silverman, M. M., Huggins, J., & Nagamoto, H. T. (2011). Implementation of a suicide nomenclature within two VA healthcare settings. *Journal of clinical psychology in medical settings*, *18*, 116–128. https://doi.org/10.1007/s10880-011-9240-9

Skinner, G. C. M., & Farrington, D. P. (2020). A systematic review and meta-analysis of offending versus suicide in community (non-psychiatric and non-prison) samples. *Aggression and Violent Behavior*, *52, 101421.* https://doi.-org/10.1016/j.avb.2020.101421

Slade, K., Forrester, A., Baguley, T. (2020). Coexisting violence and self-harm: Dual harm in an early-stage male prison population. *Legal and Criminological Psychology, 25*, 182-198.

Sturge, G. (2023). *UK prison population statistics*. House of Commons Library.

Szadejkom, K & Ciappi, S. (2011). *La validazione del rischio di*

suicidio in ambito forense e penitenziario. [*Italian validation of Suicide Assessment Manual for Inmates - SAMI*]. Florence: Giunti OS.

Taksler, G. B. & Rothberg, M. B. (2017). Assessing years of life lost versus number of deaths in the United States, 1995–2015. *American Journal of Public Health*, *107*, 1653–1659. https://doi.org/10.2105/ajph.2017.303986

Turecki, G. & Brent, D. A. (2016). Suicide and suicidal behaviour. *Lancet (London, England)*, *387*(10024), 1227–1239. https://doi.org/10.1016/S0140-6736(15)00234-2

Turecki, G., Brent, D. A., Gunnell, D., O'Connor, R. C., Oquendo, M. A., Pirkis, J., & Stanley, B. H. (2019). Suicide and suicide risk. *Nature reviews. Disease primers*, *5*, 74. https://doi.org/10.1038/s41572-019-0121-0

Tyler, N., Miles, H. L., Karadag, B., & Rogers, G. (2019). An updated picture of the mental health needs of male and female prisoners in the UK: prevalence, comorbidity, and gender differences. *Social Psychiatry and Psychiatric Epidemiology, 54*, 1143-1152. https://doi.org/10.1007/-s00127-019-01690-1

United Nations Human Rights (UNHR) (2009). *Basic principles for treatment of prisoners*. Available at: https://www.un.org/ruleoflaw/blog/document/basic-principles-for-the-treatment-of-prisoners/

van Ginneken, E. F. J. C, Sutherland, A., & Molleman, T. (2017). An ecological analysis of prison overcrowding and suicide rates in England and Wales, 2000–2014. *International Journal of Law and Psychiatry*, *50*, 76–82.

Vos, T., Lim, S. S., Abbafati, C., Abbas, K. M., Abbasi, M., Abbasifard, M., … Abdelalim, A. (2020). Global burden of 369 diseases and injuries in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *The Lancet*, *396*(10258), 1204–1222. https://doi.org/10.1016/s0140-6736(20)30925-9

Walker, T., Shaw, J., Hamilton, L., Turpin, C., Reid, C. and Abel, K. (2016). Supporting imprisoned women who self-harm: exploring prison staff strategies. *Journal of Criminal Psychology*, *6*(4), 173-186. http://dx.doi.org/10.1108/JCP-02-2016-0007

Way, B. B., Sawyer, D. A., Lilly, S. N., Moffitt, C., & Stapholz, B. J. (2008). Characteristics of inmates who received a diagnosis of serious mental illness upon entry to New York State prison. *Psychiatric Services*, *59*(11), 1335–1337. https://doi.org/10.1176/ps.2008.59.11.1335

West, D. J. & Farrington, D. P. (1977). *The delinquent way of life*. London: Heinemann.

Wichmann, C., Serin, R., & Motiuk, L. (2000). *Predicting suicide attempts among male offenders in federal penitentiaries*. Correctional Services Canada.

World Health Organization (2023). *Suicide*. Retrieved from: https://www.who.int/news-room/fact-sheets/detail/suicide

Zapf, A. (2006). *SAMI (Suicide Assessment Manual for Inmates*). Burnaby, BC: Mental Health, Law, and Policy Institute.

Zara, G. & Freilone F. (2023). *Valutazione del rischio a breve termine e della trattabilità* (START) [*Short Term Assessment of Risk and Treatability (START)*. Italian Version: C. D. Webster, M.-L. Martin, J. Brink, T. L. Nicholls & S. L. Desmarais, 2009). Firenze. Hogrefe (2023).

Zhong, S., Senior, M., Yu, R., Perry, A., Hawton, K., Shaw, J., & Fazel, S. (2021). Risk factors for suicide in prisons: a systematic review and meta-analysis. *The Lancet Public Health, 6*(*3*), e164–e174. https://doi.org/10.1016/s2468-2667(20)30233-4

Zlodre, J. & Fazel, S. (2012). All-cause and external mortality in released prisoners: systematic review and meta-analysis. *American Journal of Public Health*, *02*, e67–75. https://doi.org/10.2105/AJPH.2012.300764

Endnotes

[7] See https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-september-2023/safety-in-custody-statistics-england-and-wales-deaths-in-prison-custody-to-december-2023-assaults-and-self-harm-to-september-2023#fn:3

[8] For more details on RAPSS (*Risk Assessment for Prisoners at risk of Self-harm and Suicide*) see https://-www.psych.ox.ac.uk/research/forensic-psychiatry/rapss