Correctional Suicide Prevention Framework

Working to prevent prisoner and offender suicides in Victorian correctional settings

Justice Health

State Government Victoria
Department of Justice & Regulation

Authorised and published by the Department of Justice and Regulation
121 Exhibition Street, Melbourne
July 2015
ISBN 978-0-9943638-0-0 (PDF copy)

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Justice Health
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Tel 03 9947 1614
Also published on www.corrections.vic.gov.au

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Foreword

The death by suicide of a prisoner or offender is a tragic loss of life.

Over the 30 year period from 1983–2013, 76 prisoners have died by apparent or actual suicide in Victorian private and public prisons. Although an analysis of suicide rates indicates a statistically downward trend over this period, the department acknowledges the significance of all deaths in custody.

Suicide has far reaching impacts on prisoner and offender families and supports, their friends and other prisoners. It also affects those professionals who were working with the person prior to their death, including custodial and community corrections staff and health service providers.

The Department of Justice & Regulation has a statutory duty of care to ensure the safe and humane containment of prisoners and a graduated duty of care responsibility to offenders dependent on the nature of supervision required.

At the heart of this duty of care is a strong commitment to reducing and preventing suicide by prisoners and offenders. Corrections Victoria and Justice Health have invested significantly to be more responsive to suicide and its prevention.

Preventing and managing suicide is the duty of all who work with prisoners in custody, those transitioning into the community on release from prison and offenders under Community Correctional Services supervision.

The management of the risk of suicide is outlined in Commissioner's Requirements, Deputy Commissioner's Instructions, Local Operating Procedures and Justice Health Standards. These documents focus mostly on procedural requirements and are supported by suicide prevention training for correctional staff.

This *Correctional Suicide Prevention Framework* complements these documents and provides a single overarching whole-of-system prevention framework to complement existing standards and procedures, serves as a key reference guide for all relevant documentation and creates transparency in the key theoretical underpinnings and principles to guide the strategic nature of this work.

The framework outlines the interplay between environment, procedures, training and culture and the system's approach to ensuring a comprehensive approach to the prevention and management of suicide risk.

We acknowledge and thank those stakeholders in the justice and health sectors for their contributions to the development of this important framework.

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1 Executive summary

Suicide in Victorian public and private prisons is a significant health concern with research showing that Victorian prisoners suicide at a greater rate than people in the general population.

During the 30-year period to 2013, suicide was the leading cause of Victorian prisoner death in 11 of the years and second cause for all other years (excluding those years where no suicide occurred).

A positive development has been the noticeable reduction in the number of prison suicides per decade over the same 30 year period. In comparison to the 38 suicides for the ten year period from 1983–1993, the number of suicides decreased to 25 during the next ten year period (1993–2003) and further reduced to 13 during the subsequent ten year period (2003–2013).

Given the seriousness of this issue, the department has developed this framework to provide a single overarching whole-of-system approach for the prevention of suicide which complements the existing departmental standards and procedural documents used to guide activities on a daily basis.

This framework serves as a key reference guide for all relevant documentation and creates transparency in the key theoretical underpinnings and principles to guide the strategic nature of this work.

This framework recognises the significant but graduated duty of care and responsibility to prisoners and offenders placed on the State, with the State having greater obligations to protect people they hold in custody and a lesser requirement to intervene when offenders are under community supervision and free to access publicly available services.

The framework outlines the interplay between environment, procedures, training and culture and the system's approach to ensuring a comprehensive approach to the prevention and management of suicide risk.

Contained within this framework is a detailed summary of key risk factors, precipitation events that may increase risk and warning signs that a prisoner or offender may be having serious thoughts about taking their life. Awareness of the presence of factors that may increase the likelihood of a prisoner or offender taking their own life, the extent to which they may be vulnerable or resilient to those risk factors and how these factors may be changed to lower the risk of suicidal behaviour is a key element of suicide prevention.

This framework is based on a review of the prevalence of suicide and the range of prevention activities, occurring in both the broader community and correctional settings, in Australia and internationally. It situates prevention activities delivered to prisoners and offenders commensurate with identified community standards.

A set of foundational principles have also been included to inform and guide prevention activities in correctional settings.

This framework identifies a set of guiding principles to inform its prevention activities. These include:

- The intention of suicide prevention must be to do no harm
- A prevention approach must be taken to the likelihood of suicide in correctional settings
- Suicide prevention in correctional settings is a shared responsibility
- All staff must create a positive, responsive and supportive environment for addressing suicide prevention in correctional settings.
- Correctional prevention activities must:
  - include compassion and understanding
  - include the least restrictive and intrusive responses
  - be commensurate with community standards
  - include multi-target interventions
  - be therapeutic and not punitive
  - include professional treatment for crisis and recovery

- address social and cultural needs
- be timed to maximise outcomes
- reach those most at need
- be sustainable
- be evidence-based and outcome focussed
- be sensitive to risk factors
- include multi-disciplinary approaches
- meet management, security and therapeutic priorities.

This framework also outlines key objectives to be achieved across six operational domains in both custodial and Community Correctional Service environments. It specifies target groups and related actions. The domains and objectives include:

Domain 1: Universal strategy

Objective: To reduce access to the means of suicide, provide prisoner and offender education about suicide prevention and create a more supportive correctional environment.

Domain 2: Symptom identification

Objective: To know and be alert to signs of high or imminent risk, adverse circumstances and potential tipping points, and provide support and care when vulnerability and exposure to risk are high.

Domain 3: Treatment and support

Objective: To provide integrated, professional care to manage suicidal behaviours when specialised care is needed, comprehensively treat and manage any underlying conditions, and improve wellbeing and assist recovery.

Domain 4: Ongoing care and support

Objective: To involve health professionals, friends and family to support released prisoners and discharged offenders to adapt, cope, and to build strength and resilience within an environment of self-help.

Domain 5: Suicide incident management

Objective: To practically manage suicides and attempted suicides, as well as review practices to improve capability, responsiveness and identify potential operational enhancements.

Domain 6: Suicide incident impact minimisation

Objective: To build strength, resilience, adaptation and coping skills through support to affected staff, prisoners and their support people affected by suicidal behaviour.

To underpin suicide prevention activities across each of the six domains, this framework identifies four key supporting activities. These include:

- Workforce development
- Documentation and communication
- Monitoring and reporting
- Research.

A significant program of activities is already in place that aligns with the framework objectives and demonstrates the Victorian Government's commitment to preventing suicides in Victorian correctional settings.

The development of this framework identified the need for improved therapeutic responses to managing suicide risk in Victorian prisons. Subsequently, the department will undertake further consultations and research to examine non-segregation approaches and enhanced case management practices.

2 Background and context: understanding suicidal behaviour

2.1 Defining suicidal behaviour

Suicidal behaviour is best understood as a continuum of behaviour including a prisoner or offender:

- Thinking about suicide (suicidal ideation)
- Threatening suicide (suicidal threat)
- Self-inflicting an injury accompanied by an intention to die as a result of the action taken (suicidal act)(Queensland Health 2008, p. 10)
- Dying as a result of an injury inflicted with an intention to die as a result of the action taken, as determined by a coroner considering evidence (suicide) (Australian Government Department of Health and Ageing 2008, p. 10).

This approach is based on an understanding of suicidal behaviour as a continuum from ideation through to gesture, to threat through to action, and from action to death. While prisoners or offenders may start on this continuum, though at different points, not all who do so will progress through to suicide.

Suicide within a prison context is best understood from a 'stress-vulnerability model' where a prisoner becomes ill-equipped to handle certain stressful factors of confinement, reaching an emotional breaking point resulting in suicidal behaviour. This may arise as the result of personal vulnerabilities, the prison environment itself and a range of factors that lead to prisoner distress (Bonner 1995, p. 5).

Australian literature suggests that "the combination of interactions between random events, psychological vulnerability and the quality of the prison environment influence the frequency, nature, and severity of the stressors that the prisoner faces, and the intensity of his or her distress when faced with those stressful events" (Dear 2008, p. 478).

The profound changes to the lives of men and women entering prison can have major implications for their psychological wellbeing, placing them at an elevated risk of suicide.

As well as recognising the potential stressors of imprisonment, it is important to acknowledge that people entering prison experience higher levels of psychological distress compared with the general population (Australian Institute of Health and Welfare (AIHW) 2012, p. 42). The AIHW reports that a gender analysis shows that women entering prison are generally more distressed than men.

Suicide within a prison context is best understood from a 'stress-vulnerability model', where a prisoner becomes ill-equipped to handle certain stressful factors of confinement, reaching an emotional breaking point resulting in suicidal behaviour. This may arise as the result of personal vulnerabilities, the prison environment itself and a range of random factors that lead to prisoner distress.

Dr Ronald Bonner
Allenwood Federal Correctional Complex Pennsylvania

Prisoners released from prison, either on parole or released unconditionally, may continue to face a number of the same individual and social risk factors they experienced as prisoners (such as depression, hopelessness, lack of social support, poor coping skills and social isolation).

While institutional risk factors will decline, newly released prisoners face a number of new stresses in transitioning from prison to the community. Problems may include housing and employment needs, family and social support, and criminal justice supervision. A British study (Social Exclusion Task Force 2002, p. 7) found that one third of prisoners lose their house while in prison, two thirds lose their job and more than two fifths lose contact with their family.

From the perspective of applying this 'stress-vulnerability model' across correctional settings, suicide prevention necessitates a combination of activities to address individual, social and institutional stress factors. An effective suicide prevention approach requires the mindset that preventing suicide "needs to be seen as the duty of all who live and work in prisons" (Carroll 2011, p. 12).

As noted by the United States Surgeon General in the United States National Strategy for Suicide Prevention:

> "Because inmates can be at risk for suicide at any point during confinement, the biggest challenge for those who work in the justice system is to view the issues as requiring a continuum of comprehensive suicide prevention services aimed at the collaborative identification, continued assessment, and safe management of individuals at risk for suicidal behaviours" (United States Department of Health and Human Services 2012, p. 107).

2.2 Self-harm

The term 'self-harm' is often used interchangeably with that of 'attempted suicide'. However, there is a considerable body of Australian and international research literature which suggests that they are quite different phenomena (McArthur, Camilleri and Webb 1999, p. 2).

An act of self-harm is not necessarily a suicide attempt, but some forms of self-harm may include suicidal behaviour. Rather than an attempt by a prisoner or offender to intentionally end their life, self-harm is most often used as a strategy to actually cope with life and deal with negative emotions such as anger, frustration, depression, anxiety or fear, hopelessness and loss.

Self-harm is a significant health problem within correctional settings and due to its own complex psychodynamics, requires its own unique strategy to minimise its frequency and impact. As such, self-harm is not a focus of this framework, other than its recognition as a major risk factor for suicidal behaviour.

Prevalence of suicidal behaviour

Community

Suicide is a significant national health concern. Suicide rates in Australia have varied significantly over the past five decades, peaking in 1963 (17.5 deaths per 100,000 people), declining to 11.3 per 100,000 in 1984, and climbing back to 14.6 per 100,000 in 1997 (Mindframe 2014).

Mindframe reports that in 2012 an average of 6.9 people (11.2 per 100,000) took their own life in Australia each day, totalling 2,535 suicide deaths. This resulted in suicide being recognised by the Australian Government (response ability 2013, p. 1) as the leading cause of death for all Australians between 15 and 34 years of age.

Australian Government data (response ability 2013, p. 6) for the period between 2007–11 indicates that Victoria had the second lowest suicide rate (9.6 per 100,000) of all Australian states and territories. This compares with the Northern Territory which had the highest rate (19.3 per 100,000) and New South Wales the lowest rate (8.6 per 100,000).

Prisons

While suicide rates in the general public are of concern, research has shown that prisoners suicide at a greater rate than people in the general population and that suicide was one of the leading causes of deaths in custody.

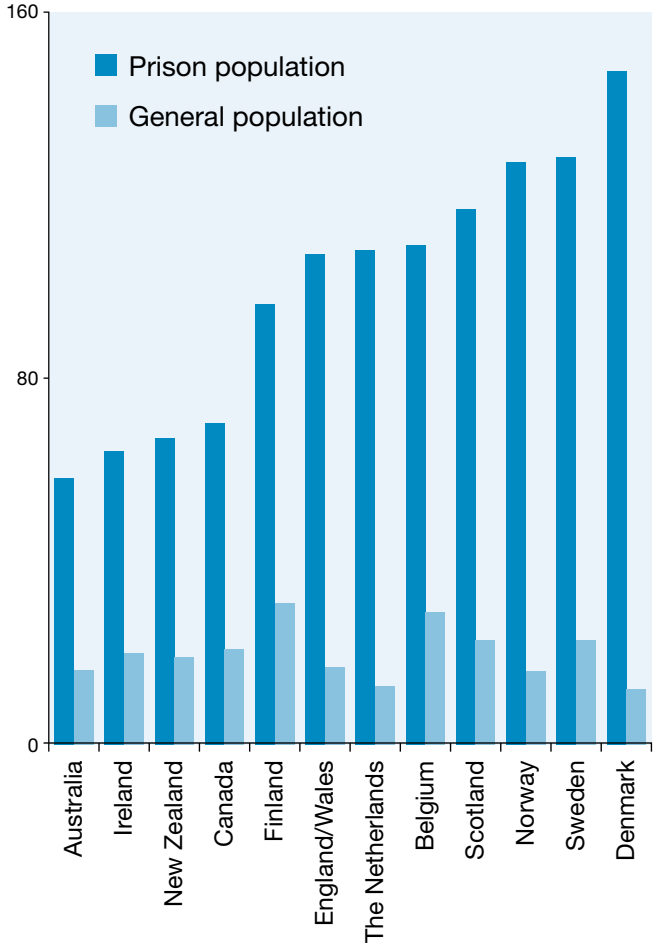
A study of male prison suicides during 2003–07 (Larney et al. 2012, p. 41) showed Australia had the lowest rate of the 12 countries considered (including Australia, Belgium, Canada, Denmark, England/Wales, Finland, Ireland, New Zealand, Norway, Scotland, Sweden and The Netherlands). The Australian rate was 58 suicides per 100,000 prisoners in comparison to the majority of countries whose rates exceeded 100 deaths per 100,000 (see Graph 1).

In Victorian prisons** over the past 30 years there have been 76 deaths from actual or apparent suicide[1]. This compares to 555 suicides in prisons across Australia during the same period (excluding 2011–13 where data is not available) (AIC 2013) (see Graph 2).

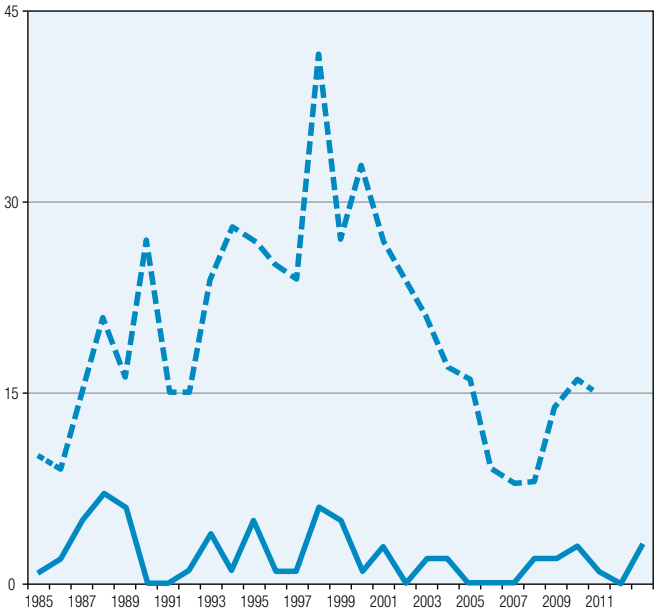
1 The formal determination of suicide as the cause of death can only be made by the Coroner. Often, this determination does not occur until several years after a prisoner's death. For the purpose of this Framework, Coroner determined and apparent suicides in prisons are both counted as suicides.

** Reference to Victorian prisons includes both private and public prisons unless otherwise stated.

Graph 1: 2003–07 Suicide Rate per 100,000 Prisoners



Graph 2: Victorian and National Prisoner Suicides 1984–2013



During this period, suicide was the leading cause of Victorian prisoner death in 11 of the years and second cause for all other years (excluding those years where no suicide occurred).

The Australian Bureau of Statistics (ABS) (2012a, p. 2) reports that the standardised suicide rate in Victoria decreased from 10.8 per 100,000 during 2001–05 to 9.8 per 100,000 during 2006–10. In comparison over the past five years, the average rate of suicide in Victorian prisons was significantly higher at 36.4 per 100,000, though still below the Australian national prison average of 58 per 100,000.

However, research indicates that this figure can be misleading. Even if there is one prisoner suicide in a year during which 6,000 prisoners were admitted to prison, the suicide rate would be 16.7 which is greater than the average community rate of 9.6 per 100,000 for 2008–13. Given the low base rate of prison suicide, only in years where the number of suicides in prison is zero would the rate for prisons fall below the community rate. Nonetheless, research indicates that the crude relative risk of suicide in Victorian prisons, averaged over the most recent five year period 2008–13, is approximately 3.8 times the community rate.

The number of prisoner suicides also needs to be considered in the context of the number of prisoners identified as being at risk, or at potential risk, of suicide. A data snapshot as of 15 November 2014 indicates within a Victorian prison population of 6,436, 16 were identified as being at current risk of suicide, 42 were assessed as at potential risk of suicide and 3,520 prisoners were identified as having a history of suicidal behaviour.

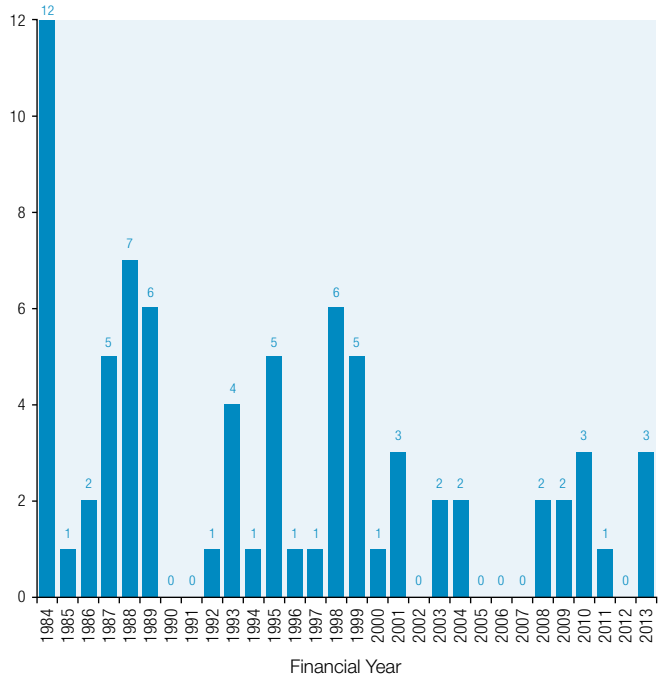
A positive development in Victoria has been the noticeable reduction in the number of prison suicides per decade over the past 30 years. In comparison to the 38 suicides for the ten year period from 1983–1993, the number of suicides decreased to 25 during the next ten year period (1993–2003) and further reduced to 13 during the subsequent ten year period (2003–2013) (see Graph 3).

Post- custody suicides

As well as risks associated with imprisonment, the first few weeks immediately following release from prison is a time of high risk of suicide with this group at greater risk than the general population.

A snapshot study of the Coroners Court Victorian Suicide Register for 2009 (the only year for which data is currently available) indicated that in that year there were two suicides by prisoners within 12 months of their release (occurring at four and six months post release respectively).

Graph 3: Victorian Prisoner Suicides 1984–2013



The study indicated that there were three prisoners released on parole who suicided during that same period.

Though no analytical data is readily available for Victoria, a 2007 New South Wales study (Jones et al. 2013, p. 25) found that released prisoners were almost five times more likely to die by suicide than the general population.

From a gender perspective, the NSW study (Kariminia et al. 2013, p. 389) found that women did not share an increased risk of suicide in the initial two week period of release, which it attributed to women generally having stronger family ties and supports than men.

Suicides under Community Correctional Supervision

The snapshot study of the Coroners Court Victorian Suicide Register for 2009 indicated that in that year there were 14 suicides by offenders on Community Based Orders and three by offenders on Intensive Correction Orders.

2.3 Patterns of custodial suicides

An understanding of the patterns that may exist for custodial suicides can play a key role in informing suicide prevention activities and identifying particular cohorts at greater risk within the broader prison population.

The following custodial suicide patterns were identified for Victorian prisons during the 29-year period from 1980–81 to 2008–09:

- **Gender:** The vast majority of suicides in prisons were by male prisoners (90.7 per cent)
- **Age:** Prisoners who died by suicide were statistically significantly younger (median male age of 31.7 and female age of 28.5) than those prisoners who died from other causes (median 43.5 years)
- **Sentence:** Un-sentenced prisoners accounted for 41.9 per cent of all suicides
- **Imprisonment offence:** A higher proportion of prisoners suiciding were serving sentences for violent offences (for example, murder, assault and robbery) than prisoners who died from other causes
- **Method of suicide:** Hanging was the most prevalent method for death by suicide (100 per cent among women and 82.3 per cent among men)
- **Time in prison:** Information was available for 81.3 per cent (61) of the 75 prisoners, with around one third having been in prison for less than 30 days and around two thirds for less than five months. For prisoners under 30 years of age, 55 per cent suicided within 60 days compared with 32 per cent who were over 30 years of age
- **Country of birth:** Of the 58 prisoners who died by suicide where there was information on the country of birth, 19 per cent (11) were born overseas
- **Koori prisoners:** There was one Koori prisoner suicide comprising 0.75 per cent of the number of prison suicides during the reporting period. The ABS reports (2012b) that, as at 30 June 2011, Aboriginal and Torres Strait people made up 0.86 per cent of the Victorian population and were imprisoned at a rate of over 11 times that for non-Aboriginal or Torres Strait Islander people.

This Framework does not address prevention strategies specific for Victorian Koori prisoners or offenders. It notes the role played by the existing *Victorian Aboriginal Suicide Prevention and Response Action Plan 2010–2015* as a key strategy to prevent and reduce the incidence and impact of Koori suicide and self-harm. Justice Health and Corrections Victoria have also worked with the Victorian Koori community to develop an *Aboriginal Social and Emotional Wellbeing Plan* which was released in March 2015.

- **Prisoner population:** Of particular interest was the counter-intuitive conclusion that fewer suicides occurred as the prisoner population increased. This finding is consistent with the conclusions of the Victorian Correctional Services Task Force (1998, p. 31) that "…in those years where there have been significant increases in the average daily prisoner population there have been decreases in both the actual number of suicides and the rate of suicides per 1,000 prisoners".

Unfortunately, the available literature provides no further information as to what particular factors may have supported this trend (for example, doubling up of prisoners in cells or increased restrictiveness in suicide prevention measures during this time).

Corrections Victoria noted in a 2010 literature review (p. 16) that suicides most often occurred between 7.00pm and 7.00am when prisoners occupy a cell alone and when prison staffing levels reduce.

While the identification of demographic profiles of prisoners can assist prison staff to be aware of some of the most common characteristics of prisoners who have suicided and to supplement warning signs of potential suicidal behaviour, research by the National Institute of Corrections (Hayes 2010, p. 4) concludes that they cannot be used to predict the risk of suicide and prison staff should not ignore prisoners who do not fit these criteria.

2.4 Understanding the 'suicidal process'

Complementing an understanding of particular at-risk cohorts in developing strategies to prevent suicidal behaviour, is the appreciation of the suicidal process, that is, how suicidal ideas or thoughts of harm begin, are converted into plans and eventually into actions.

While no data is available for the Victorian correctional context, a United Kingdom research project (Rivlin et al. 2011, p. 307) interviewed 60 male prisoners from 19 prisons who had engaged in near lethal suicidal behaviour about their suicidal process. Research findings included:

- **Reasons:** For most prisoners there was no single reason for their suicide attempt, often indicating multiple reasons
- **Time lapse between idea and action:** 20 per cent of prisoners said that they had contemplated the action for three hours or less, 40 per cent for more than three hours, and 40 per cent of prisoners reported that they acted impulsively and did not think about the act for longer than a few minutes
- **Precautions against discovery:** A third of prisoners said that they took precautions to prevent discovery
- **Communication of intent:** A third of prisoners had explicitly told someone of their suicide wish
- **Timing:** Most prisoners did not think about the timing of their action (21 per cent) or had no specific reason for the timing that they chose (43 per cent)
- **Prevention:** Half of the prisoners believed that their act could have been prevented, with 45 per cent thinking that nothing could have been done to stop their action.

2.5 Risk factors and their interplay

There are a number of factors that may increase the likelihood of a prisoner or offender taking their own life. Some of these factors will be specific to the prison context while others may also relate to the general population.

These risk factors are classified by the national suicide prevention framework, 'Living is For Everyone (LIFE): A Framework for Prevention of Suicide and Self-harm in Australia' (LIFE Framework) (Australian Government Department of Health and Ageing 2008, p. 11) as either things that:

- Act as acute stressors that can be changed or may change over time (for example, a prisoner's or offender's sense of guilt or failure). These stressors may be either environment-related or

be brought into this context as a characteristic of the prisoner or offender. These are often referred to as 'dynamic', 'modifiable' or 'situational' risk factors

- Cannot be changed but may serve as underlying long-term vulnerabilities (for example, a prisoner or offender's age or gender). These are often referred to as 'static', 'non-modifiable' or 'predispositional' risk factors.

The LIFE Framework (p. 14) indicates that suicide prevention requires the consideration of:

- The presence of risk factors
- The extent to which a prisoner or offender may be vulnerable or resilient to those risk factors
- How those risk factors may be changed to lower the risk of suicidal behaviour.

A reasonable conclusion from the literature overall is that optimal detection, assessment and management of psychotic disorder is certainly a necessary component of any suicide prevention strategy within prisons, but that an exclusive focus on psychiatric illness alone, particularly if 'psychiatric illness' is interpreted in the rather narrow sense that currently prevails in Australia public mental health discourse, is not adequate.

Forensicare, 2011.

The LIFE Framework (p. 11) details that the risk that a person may engage in suicidal behaviour can vary over time in light of the interplay between risk factors that may occur:

- Well before the person engaged in suicidal behaviour (for example, a person's genetic make-up). These are often referred to as 'distal' risk factors
- Closer to the time of the person engaging in suicidal behaviour and serve as actual triggers or tipping points (for example, a negative life experience). These are often referred to as 'proximal' risk factors.

However, the presence of risk factors may identify many 'false positives' and does not inevitably lead to a prisoner or offender engaging in suicidal behaviour. The LIFE Framework (p. 11) explains that risk factors best contribute to the determination of populations that might be at risk, rather than identifying individuals who may be at risk of suicide.

Not all prisoners in a particular risk group will share all of the characteristics and risks of that cohort. Conversely, it cannot be assumed that a prisoner or offender at low risk is at no risk or that a person with one risk factor is less likely to engage in suicidal behaviour than a prisoner or offender with several risk factors (Australian Government Department of Health and Ageing 2008, p. 11).

It is important to note that, while mental illness can be seen as a significant risk factor, it is not the sole cause for suicidal behaviour.

For example, of the 13 prisoners assessed as being at current risk of suicide or self-harm during a data snapshot taken on 19 November 2013, four were identified as having either a serious psychiatric condition requiring intensive and/or immediate care or a significant ongoing psychiatric condition requiring psychiatric treatment. Six of the prisoners were assessed as having a stable psychiatric condition and three were not identified as having any psychiatric condition.

As noted by Forensicare, "A reasonable conclusion from the literature overall is that optimal detection, assessment and management of psychotic disorder is certainly a necessary component of any suicide prevention strategy within prisons, but that an exclusive focus on psychiatric illness alone, particularly if 'psychiatric illness' is interpreted in the rather narrow sense that currently prevails in Australia public mental health discourse, is not adequate" (Carroll 2011, p. 21).

Gender, too, is an important factor to be considered. Women prisoners experience incarceration differently to men, with particular risk factors relating to issues of family stress and their outside relationships. This may include separation from dependent children, their children going into care or the women's imprisonment ending their ability to care for older family members.

While an examination of risk factors places emphasis on an individual's problems or vulnerabilities, it is also important to acknowledge the impact of custodial practices and approaches and the way in which custodians exercise their duty of care (West Australian Department of Justice Suicide Prevention Task Force 2002, p. 40).

The literature (Hayes 2005, p. 5) warns that negative attitudes (for example, "If someone really wants to kill themselves there's generally nothing you can do about it") can often hinder purposeful suicide prevention activities. As one United States prison administrator reflected:

> "When you begin to use excuses to justify a bad outcome, whether it be low staffing levels, inadequate funding, physical plan concerns, etc., issues we struggle with every day, you lack the philosophy that even one death is not acceptable. If you are going to tolerate a few deaths in your jail system, then you've already lost the battle" (Hayes 2005, p. 5).

A list of possible risk factors is included in Appendix 1.

2.6 Things to be aware of – tipping points

The LIFE Framework (p. 14) identifies that some precipitating events or circumstances which may increase a prisoner or offender's risk of engaging in suicidal behaviour, particularly when linked with risk factors and low levels of resilience. These are sometimes referred to as tipping points.

Tipping points may include events such as relationship instability, approaching court dates or increased legal frustration. Through the identification of potential tipping points staff can be alerted and responsive to circumstances where the risk of suicide may become elevated.

A list of possible tipping points is included in Appendix 1.

2.7 Things to look for – warning signs

There can be warning signs which indicate that a prisoner or offender is at increased risk or having serious thoughts about taking their own life. The signs may include:

- Changes in the way that they are relating to people (for example, withdrawal or isolation)
- Changes in their emotional state (for example, feelings of hopelessness and helplessness)
- Changes in their behaviours (for example, saying goodbye to people or finalising arrangements)
- Sudden improvements in demeanour (for example, unrealistic talk about getting out of prison).

Warning signs may be a cry for help (Australian Government Department of Health and Ageing 2008, p. 22) and can provide an opportunity for family members and supports, other prisoners and correctional and health service provider staff to intervene.

However, the LIFE Framework (p. 22) notes that in many circumstances there may be no obvious warning signs whereby even the most skilled professionals may not notice them.

A list of possible warning signs is included in Appendix 1.

2.8 Things that reduce risk – protective factors

Those factors that may decrease the likelihood of suicidal behaviour and improve a prisoner's ability to cope with stressful circumstances are known as *protective factors*.

The LIFE Framework (p. 11) notes that protective factors and risk factors are often at opposite ends of the same continuum. It cites as an example social isolation (risk factor) and social connectedness (protective factor) which are both extremes of social support. Like risk factors, protective factors may be seen as dynamic and modifiable or static and non-modifiable.

Protective factors have only recently become a concern for suicide prevention, with attention being given to not only assessing what heightens a person's risk but also what makes them strong and resilient and able to cope with stressful life situations (Australian Government Department of Health and Ageing 2008, p. 15).

A list of possible risk factors is included in Appendix 1.

2.9 Building resilience is key

Many prisoners or offenders exposed to stressful events will be able to handle these challenging situations, albeit with some degree of difficulty, without considering suicidal behaviour. For others these experiences may lead to a sense of hopelessness and suicidal ideation.

The building of individual resilience – the capacity to adapt and respond positively to stressful situations – is one of the key suicide prevention priorities in building the capacity of people to deal with life events (Australian Government Department of Health and Ageing 2008, p. 22).

In a correctional setting, the strengthening of a prisoner's or offender's resilience, and the development of their coping strategies, is supported through access to targeted therapeutic and personal development programs.

3 Operational and policy context

The Department Justice & Regulation has a statutory duty of care to ensure the safe and humane containment of prisoners and a graduated duty of care responsibility to offenders, dependent on the nature of supervision required. The department has a strong commitment to reducing and preventing suicide by prisoners and offenders. Corrections Victoria and Justice Health have invested significantly to reduce and be more responsive to suicide and its prevention.

The department's responses to suicide prevention are framed by a range of legislative, operational and policy contexts.

3.1 International instruments

Australia has a range of international obligations linked to human rights and criminal justice, as outlined in instruments developed by the United Nations. International instruments which relate to prisoner and offender suicide prevention include:

- Standard Minimum Rules for the Treatment of Prisoners (1957)
- Basic Principles for the Treatment of Prisoners (1990)
- Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Care (1991).

3.2 Victorian legislation and regulations

The *Corrections Act 1986* and the Corrections Regulations 1998 provide the legislative basis for the delivery of adult correctional services in Victoria.

Correctional services are also assessed for compatibility with the provisions of the Victorian *Charter of Human Rights and Responsibilities Act 2006* to ensure they give proper consideration to, and act in a way that is compatible with, human rights.

3.3 Policy

The *Correctional Suicide Prevention Framework* sits alongside a number of other frameworks and standards relating to the provision of health care within Victorian prisons. These include the:

- Justice Health Quality Framework 2011
- Justice Health Health Service Standards
- Justice Health Complaints Handling Framework
- Justice Health Communicable Diseases Framework
- Justice Health Aboriginal and Torres Strait Islander Health Standards.

Of particular relevance is the Quality Framework which drives consistently safe, quality and evidence-based care. This framework incorporates the principles of care delivery, standards to which care must be delivered, and the structures, systems and measures by which the quality of care is monitored and improved.

3.4 Standards

Standards exist at a national and state level to guide the operation of correctional services. These include:

- Standard Guidelines for Corrections in Australia
- Correctional Management Standards for Men's Prisons in Victoria
- Standards for the Management of Women Prisoners in Victoria
- Correctional Management Standards for Community Correctional Services
- Correctional Management Standards for Women Serving Community Correctional Orders.

3.5 Correctional requirements

Commissioner's Requirements, Deputy Commissioner's Instructions and Local Operating Procedures are issued to provide direction and ensure consistency of correctional practice across the prison and community correctional system.

Commissioner's Requirements (CRs) apply to all prisons, both public and private, and provide the minimum procedural standard. They are issued when specificity is required to ensure consistency in correctional practice across the prisons system.

Deputy Commissioner's Requirements (DCIs) provide public prisons with specific state wide instructions which put into operation the standards and CRs.

Local Operating Procedures (LOPs) apply only to one particular prison location and outline how the DCIs are to be implemented at the location.

A listing of key correctional requirements linked or closely relating to suicide prevention is included as Appendix 1.

3.6 Duty of care

One of the key foundation principles underpinning the LIFE Framework is that suicide prevention is a shared responsibility across the broader community, families and friends, professional groups, and non-government and government agencies.

However, with respect to the correctional environment, there is a significant but graduated duty of care and responsibility to prisoners and offenders placed on the State, with the State having greater obligations to protect people they hold in custody and a lesser requirement to intervene when offenders are under community supervision and free to access publicly available services.

Supervised high-risk offenders receive high levels of supervision and intervention and this increases the Community Correctional Services (CCS) duty of care and escalates the response to the offender and the community. Whereas, the expectation to intervene is much lower for offenders subject to unsupervised orders because, practically, it is difficult to be aware of their changes in circumstances due to limited contact with the offender.

However, in relation to prisoners, it is the State that is held to account for a suicide in custody by monitoring and investigative bodies such as the State Coroner, Victorian Ombudsman or the Victorian Auditor General.

In order to minimise the risk of a suicide in custody, for example, when a prisoner is assessed as being at immediate or significant risk of suicide or self-harm, the State acts assertively to protect the prisoner by putting in place a range of restrictive interventions that do not require the prisoner's consent. These interventions significantly restrict prisoner access to any means of suicide as well as the practical opportunity to suicide, allowing for the monitoring of prisoner wellbeing.

The Victorian measures are strong interventions but have proven successful in the short-term in saving prisoner lives. None of the 13 prisoners who suicided in the past decade did so in the context of these interventions.

In practice, State interventions for a prisoner assessed as at immediate risk of suicide (S1) may include accommodating them alone in a segregated observation cell designed to reduce potential hanging points, placing them in fire retardant clothing that cannot be used as ligature (for example, a canvas 'anti-suicide' smock). The prisoner may be issued with fire retardant canvas bedding that also can't be torn to be used as ligature, and then observed at a minimum every 15 minutes by a correctional officer. At the same time, a Risk Management Plan is developed and the prisoner is clinically reviewed by a mental health professional daily as well as formally assessed daily by the Risk Review Team (see page 24–29 for more details).

If a prisoner is assessed as at significant risk of suicide (S2), prison authorities may respond in a similar way, but with some less stringent restrictions given the lower risk, such as being placed in a single non-observation cell and with 30 minute observations.

The Victorian measures are strong interventions but have proven successful in the short-term in saving prisoner lives. None of the 13 prisoners who suicided in the past decade did so in the context of these practices.

The principles and practice of this Victorian correctional approach are in alignment with the contemporary international best practice prison standards developed by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (Council of Europe 2013, p. 30).

A critical issue subsequently arising for the correctional system is the identification of the limit that should apply to State intervention to prevent suicides in prisons, that addresses community equivalence of care and the notions of supported decision making by patients, recognising their capacity to make decisions affecting their lives and therefore requiring discussion with them about subsequent interventions.

An independent review of suspected suicides in Victoria's prisons in 2013 found that the system in place in Victorian prisons is sound and reflects best practice in preventing suicide in prisons. The review noted that the low rate of suicides and degree of care and attention paid to reducing suicide risk attested to the overall success of the current system.

However, while successful in the short-term, research has indicated the potential of both the segregation strategy (Hayes 2010, pp. 7 and 20; Western Australian Department of Justice Suicide Prevention Task Force 2002, p. 41) and the observation regime (Her Majesty's Government Department of Health 2012, p. 31; Carroll 2011, p. 21; Hayes 2010, p. 7) to have an anti-therapeutic impact at a time of major personal crisis and stress for the prisoner. Such restrictive interventions do not necessarily reduce the longer-term risk of suicidal behaviour.

The highly interventionist strategy appears to be in conflict with the principle that the intention of suicide prevention responses must be to do no harm and that their benefits should outweigh any potential adverse impacts.

A critical issue subsequently arising for the correctional system is the identification of the limit that should apply to State intervention to prevent suicides in prisons, that addresses community equivalence of care and the notions of supported decision making by patients, recognising their capacity to make decisions affecting their lives and therefore requiring discussion with them about subsequent activities.

In order to address this very complex issue, the department will undertake further consultations and research to identify improved therapeutic responses to managing suicide risk in Victorian prisons. This will include consideration of non-segregation approaches and enhanced case management models incorporating relational security dimensions (Department of Health Secure Services Policy Team 2010): that is, the translation of staff knowledge and understanding of a prisoner into appropriate placements, responses and care.

It is envisaged that the work will contribute to the resolution of the inherent 'therapeutic tension' that can exist between balancing, on the one hand, the State's duty of care and the meeting of prison security, operational and management requirements and, on the other, the maximising of therapeutic outcomes for prisoners and respecting their right to exercise responsibility for their own safety.

4 What we are working to achieve

The *Correctional Suicide Prevention Framework* is built on the key elements of the foundational LIFE Framework for suicide prevention, tailoring it based on the findings of research identifying successful evidence-based correctional-specific approaches.

4.1 Foundation principles

The *Correctional Suicide Prevention Framework* has identified a set of guiding principles to inform prevention activities. These include those from the LIFE Framework plus additional principles relevant to the correctional setting:

- **The intention of suicide prevention must be to do no harm.**
  The intention of suicide prevention must be to do no harm. Activities that aim to protect against suicide need to consider the weighing up of a range of complex issues which may have competing outcomes. Suicide prevention responses must ensure that their benefits outweigh any potential adverse impacts on the prisoner
- **A prevention approach must be taken to address the likelihood of suicide in correctional settings.**
  A prevention approach must be taken to address the likelihood of suicide in correctional settings, within the limitations of recognising the basic rights and dignity of prisoners and the good order, safety and security in prisons
- **Suicide prevention in correctional settings is a shared responsibility**
  Suicide prevention is a shared responsibility across the broader community, prisoners, families and friends, health service providers, correctional staff and government agencies and departments (Australian Government Department of Health and Ageing 2008, p. 12)
- **Staff must create a positive, responsive and supportive environment for addressing suicide prevention in correctional settings**
  Prison staff are responsible for the creation of a positive, responsive and supportive environment in which prisoners feel that staff will be concerned for their welfare and dignity (Carfi Consulting 2011, p. 2)
- **Correctional prevention activities must include compassion and understanding**
  Prisoners need compassion and understanding when experiencing psychological or physical distress (Government of South Australia 2012, p. 18)
- **Correctional prevention activities must use the least restrictive and intrusive responses**
  Responses to prisoners and offenders should involve the least restrictive and intrusive conditions possible, without compromising their health and wellbeing (Corrective Services Queensland 2012, p. 3).
- **Correctional prevention activities must be commensurate with community standards**
  Suicide prevention activities should be delivered to prisoners commensurate with access and quality equivalent to community standards (Carroll 2011, p. 12)
- **Correctional prevention activities must include multi-target interventions**
  Activities should be designed and implemented to target and involve the whole prison population, specific groups who are known to be at risk of suicide and individual prisoners and offenders at risk of suicide (Australian Government Department of Health and Ageing 2008, p. 12)
- **Correctional prevention activities must be therapeutic and not punitive**
  Suicide prevention activities should be promoted as having a therapeutic and not punitive intention (Corrective Services Queensland 2012, p. 3)

- **Correctional prevention activities must include professional treatment for crisis and recovery**
  Activities need to include access to clinical or professional treatment for prisoners in crisis and support for those who are recovering (Australian Government Department of Health and Ageing 2008, p. 12)
- **Correctional prevention activities must address social and cultural needs**
  Activities must be appropriate to the social and cultural needs of prisoners and offenders (Australian Government Department of Health and Ageing 2008, p. 12)
- **Correctional prevention activities must be timed to maximise outcomes**
  Information, service and support need to be provided at the right time, when it can best be received, understood and applied (Australian Government Department of Health and Ageing 2008, p. 12)
- **Correctional prevention activities must reach those most at need**
  Activities need to be located at places and in environments where target groups feel comfortable and where the activities will reach and be accessible to those who most need them (Australian Government Department of Health and Ageing 2008, p. 12)
- **Correctional prevention activities must be sustainable**
  Local suicide prevention activities must be sustainable to ensure continuity and consistency of service (Australian Government Department of Health and Ageing 2008, p. 12)
- **Correctional prevention activities must be evidence-based and outcome focussed**
  Suicide prevention activities should either be, or aim to become, evidence-based, outcome focused and independently evaluated (Australian Government Department of Health and Ageing 2008, p. 12)
- **Correctional prevention activities must be sensitive to risk factors**
  Activities need to be sensitive to the broader factors that may influence suicide risk – the many social, environmental, cultural and economic factors that contribute to quality of life and the opportunities life offers – and how these vary across different cultures, interest groups, individuals, families and communities (Australian Government Department of Health and Ageing 2008, p. 22)
- **Correctional prevention activities must include multi-disciplinary approaches**
  Services for prisoners and offenders who are recognised as suicidal should reflect a multi-disciplinary approach and aim to provide a safe, secure and caring environment (Australian Government Department of Health and Ageing 2008, p. 12)
- **Correctional prevention activities must meet management, security and therapeutic priorities**
  Policies and procedures for responding to suicidal behaviour must be responsive to correctional management and security priorities while also providing for tailored individual approaches best suited to prisoner and offender therapeutic outcomes.

4.2 Assessment of risk

Corrections Victoria operates a four-tier assessment regime for risk of suicidal behaviour.

The level of correctional management support is defined in the Corrections Victoria Risk Level Framework (see summary in Appendix 4). The risk rating system is comprised of six primary elements:

- Placement/accommodation
- Observation level
- Custodial officer interaction with the prisoner
- Risk Management Plan
- Risk Review Team review
- Clinical review by a psychiatric professional.

Broadly, the suicide assessment regime includes:

Rating S1 - Currently at risk

Assessment: Prisoner or offender is assessed as at *immediate* risk of suicide or self-harm

Requirement: Intensive management and support

This means the prisoner or offender is in immediate danger of self-harming or attempting suicide, including:

- Those who have an acute psychiatric illness where there is a high risk of self-harming behaviour
- Prisoners who are assessed as having the potential to cause self-harm or attempt suicide if they are not supervised, for example, in their cell after lock-down or during out-of-cell hours.

Rating S2 - Currently at risk

Assessment: Prisoner or offender is assessed as at significant risk of suicide or self-harm

Requirement: Intermediate management and support

This means the prisoner or offender is:

- At significant (but not immediate) and/or chronic risk of suicide or self-harm; and/or
- No longer high risk but still requires intermediate management and support; and/or
- A person who was previously considered to be at lesser risk of suicide or self-harm (see below) whose risk has escalated.

Rating S3 - Not currently at risk

Assessment: Prisoner or offender is assessed as at potential risk of suicide or self-harm.

Requirement: Follow-up management and support.

This means that the prisoner or offender is:

- Identified as having a number of risk factors where, without intervention, there is the potential for escalation of his/her risk, but who is not at high/moderate risk of suicide or self-harm; and/or
- In need of some intervention to ensure his or her risk level does not escalate; and/or
- No longer moderate risk but still requires follow-up management and support; and/or
- A person who has previously been categorised as having no current risk but a history of self-harm behaviour (see below) and whose risk has escalated.

Rating S4 - Not currently at risk

Assessment: Previous history of self-harm behaviour

These prisoners are those considered not to be currently at risk, but given their history of suicide attempts or self-harming behaviour, the potential for suicide may escalate.

Prisoners who receive an S4 rating during their reception process at the Melbourne Assessment Prison, and who are experiencing their first time in custody, are provided with a welfare review within 48 hours.

Prevalence

A data snapshot as of 15 November 2014 indicates that of a Victoria prison population of 6,436, 16 (0.3 per cent) were allocated an S risk rating and were at current risk of suicide and 3,562 (55.4 per cent) were allocated an S risk rating but were not at current risk of suicide. The breakdown of ratings included:

Currently at risk

- Four prisoners were assessed as at immediate risk of suicide and rated as S1 (0.1 per cent)
- Twelve prisoners were assessed as at significant risk of suicide and rated as S2 (0.2 per cent).

Not currently at risk

- 42 prisoners were assessed as at potential risk of suicide and rated as S3 (0.70 per cent)
- 3,520 prisoners were assessed as having a history of suicidal behaviour and rated as S4 (54.7 per cent).

4.3 Domains of care and support

The department has identified six domains of care and support with related goals and strategies to prevent suicide in a correctional setting. These include three from the LIFE Framework with an additional three developed specifically for the correctional context.

The domains are consistent with the key components of suicide prevention identified by the Department of Mental Health and Substance Abuse of the World Health Organisation (WHO).

A summary of the domains, objectives, target groups and activities is contained in Appendix 1 with a schematic representation included as Figure 1 below.

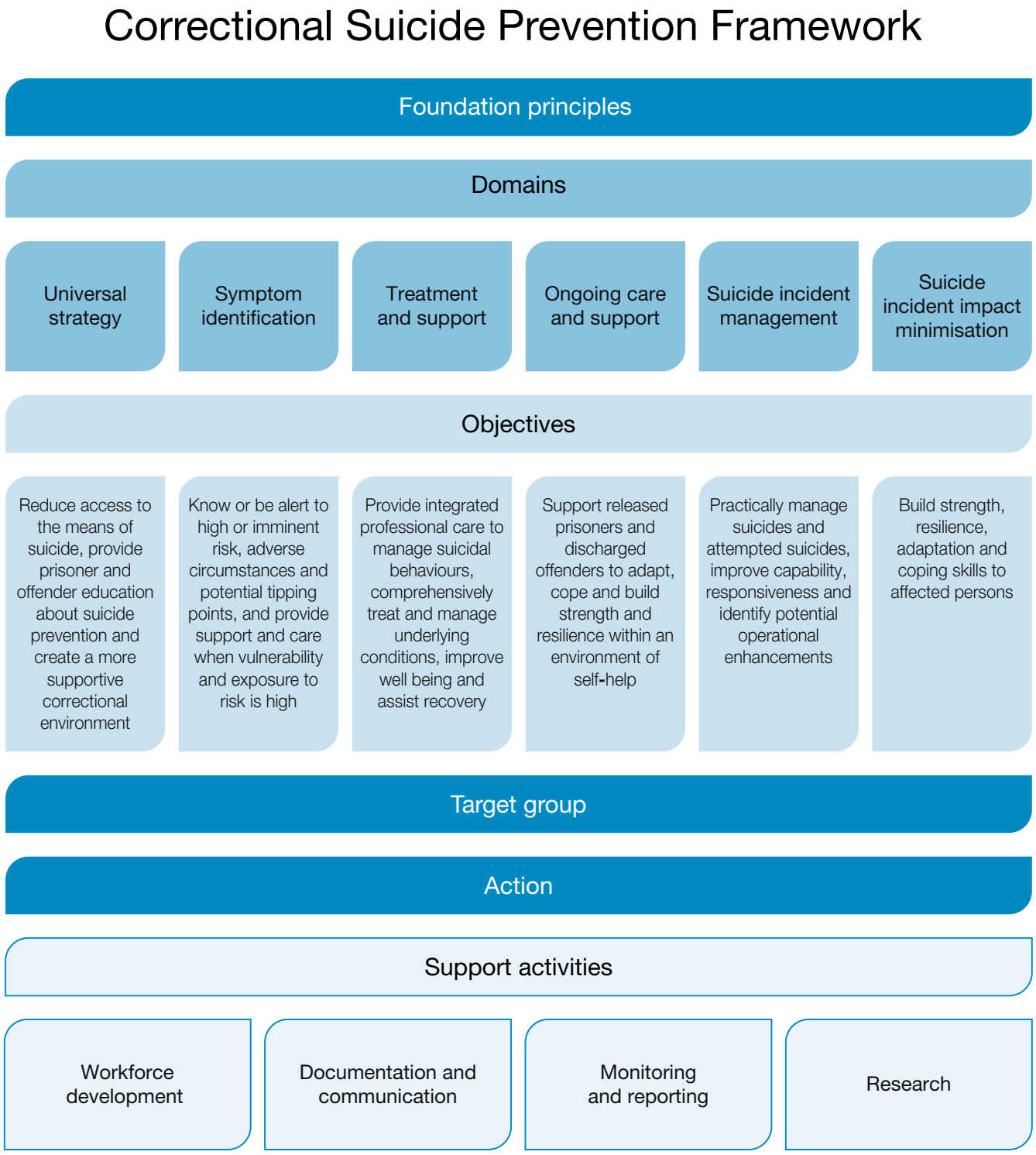


Figure 1: Schematic representation of the Correctional Suicide Prevention Framework.

In particular, the quality of the social climate of prisons is critical in minimizing suicidal behaviours.

World Health Organisation

The WHO guidelines (WHO 2007) emphasise the importance of maintaining a healthy prison environment:

> 'Attention needs to be paid to the general prison environment (levels of activity, safety, culture and staff-prisoner relationships). In particular, the quality of the social climate of prisons is critical in minimizing suicidal behaviours. While prisons can never be stress free environments, prison administrators must enact effective strategies for minimizing bullying and other violence in their institutions, and for maximizing supportive relationships among prisoners and staff. The quality of staff-prisoner relationships is critical in reducing prisoners' stress levels and maximizing the likelihood that prisoners will trust staff sufficiently to disclose to them when their coping resources are becoming overwhelmed, feelings of hopelessness, and suicidal ideation.'

4.3.1 Domain 1: Universal Strategy

Objective: To reduce access to the means of suicide, provide prisoner and offender education about suicide prevention and create a more supportive correctional environment.

Suicide prevention strategies include:

Prisons

Supportive correctional environment

Corrections Victoria prison standards provide for a prisoner management system that treats prisoners in a humane and just manner in an environment that aims to protect the physical and emotional wellbeing of individuals.

Prisoner management plans are designed to ensure that prisoners have access to a range of services, programs and activities appropriate to their needs, including assistance in resolving personal difficulties and crises.

During their time in custody, prisoners are encouraged to take responsibility for the constructive use of their time in custody, maintain their mental and physical health and to develop positive social habits.

Corrections Victoria provides meaningful and productive work for all sentenced prisoners and a range of vocational training and education programs to address prisoner disadvantage and support their successful social and economic participation upon release into the community.

Prisoners have access to a visit program that assists them to maintain positive and supportive relationships with their family and friends.

Koori prisoners and prisoners from culturally and linguistically diverse backgrounds are managed in a manner that is sensitive to their cultural needs.

Prisoners with a disability are accommodated in a safe, secure environment which provides them with assistance to adjust to the prison environment and with programs which address their needs.

Cells without hanging points

Corrections Victoria has introduced the Building Design Review Project (BDRP) to eliminate and/or reduce potential hanging points in prison cells.

Prisoners considered at current immediate or significant risk of engaging in suicidal behaviour (S1 and S2 rated) are required to be housed in BDRP compliant cells. In general, a prisoner with a potential but not current risk does not require placement in a BDRP compliant cell. However, given both the higher number of unnatural deaths and accommodation of a higher number of prisoners at risk of engaging in suicidal behaviour, redevelopment has occurred at the Melbourne Assessment Prison which enables all prisoners assessed as at potential risk and above (S1, S2 and S3 rated) to be accommodated in cells that comply with the BDRP guidelines (a mandatory requirement).

At all other secure prisons, consideration is given to accommodating a prisoner with an S3 rating in a BDRP compliant cell when possible, taking into account other risk management and protective factors, such as placing the prisoner in a supportive unit environment. All maximum and medium-security prisons have at least one accommodation unit which has BDRP compliant cells and into which prisoners who are seen to have an escalating risk can be placed if required.

As of 2 November 2014, in considering all ongoing placement options for prisoner accommodation in correctional settings, approximately 76.1 per cent of prison beds were either BDRP compliant or accommodation that is not required to meet BDRP guidelines (for example, low-security shared cottage accommodation). This excludes temporary placement options such as observation cells, medical units or wards, and short-term management cells.

Information to prisoners

As part of the induction process, suicide prevention information is provided to each prisoner at their initial reception into the prison system. The information includes:

- Suicide in prison and supports available
- How to refer other prisoners if concerned for a peer.

Information to families/supports

Information is made available to the families and support persons of prisoners at the time of the prisoner's reception that explains how to report safety and welfare concerns.

CCS

Supportive correctional environment

CCS ensures that offenders are provided with a safe and supportive environment when attending programs and appointments and that they have access to interventions that are tailored, taking into account their specific learning styles and needs related to age, ethnicity, gender or disability.

CCS provides offenders with information to ensure that they are aware of their rights and what is expected of them and motivates offenders to engage in and continue with programs and services designed to address their offending behaviour and assist their integration into the community.

Offenders are provided with opportunities which enhance their social, functional and job-related skills by being referred and supported to undertake a range of community-based education/vocational services to address their personal development needs.

CCS assists offenders released from prison to make a successful transition back into the community.

Koori offenders and offenders from culturally and linguistically diverse backgrounds are managed in a manner that is appropriate and sensitive to their cultural needs.

4.3.2 Domain 2: Symptom identification

Objective: To know, and be alert to, signs of high or imminent risk, adverse circumstances and potential tipping points, and provide support and care when vulnerability and exposure to risk are high.

Suicide prevention strategies include:

Prisons

Risk assessment

A mental health and broader risk assessment, including a suicide risk assessment, is undertaken at the reception process by a mental health professional within 24 hours of reception. The aims of the assessment include the identification and addressing of risk issues in the critical first few days of each prisoner's term of imprisonment. An automatic referral process also exists to identify the types of prisoner known to be at heightened risk of suicide immediately after entering the prison system.

After transferring to another prison, all prisoners are medically screened - including having their risk of suicide and self-harm status assessed – by medical practitioners or nursing staff as soon as possible on arrival and within 24 hours.

All prisoners after returning from court, (including Family Court or Tele-Court and where the prisoner has appeared as a witness), have their risk status further assessed by custodial staff within 2 hours of being received at the prison. If required, a referral is made to a mental health professional.

Staff who become aware of a prisoner's distress following a telephone conversation or information received via the mail, in the first instance intervene and enquire into the prisoner's welfare. If they remain concerned as to the prisoner's welfare they immediately communicate this information to the Officer In Charge (OIC) of the prison unit and record the incident in the prisoner's file, including any action taken. The unit OIC briefs staff on the incident and directs appropriate monitoring. If the prisoner's behaviour or mental state deteriorates to the point

of being considered at risk of suicide by a trained staff member, then a referral for an assessment by a mental health professional is made by the staff member.

Similarly, where it is believed on the basis of observations by a trained staff member, the prisoner's self-disclosure or from reports of others (including another prisoner, any staff member, a professional from an outside agency, friend or a member of the prisoner's family) that the prisoner may be at risk of self-harm or suicide, a referral for an assessment by a mental health professional is also made by the staff member.

Where a relative, friend, other prisoner or any other person reports concern regarding a prisoner's risk of suicide, that person is advised of the steps that will be taken to address their concerns. The person is also advised that due to privacy legislation, the outcome of the investigations into the prisoner's welfare will not be able to be relayed to them without the prisoner's consent. Where consent is granted, staff will endeavour to provide the information to the reporting person. If the person who reports concerns about a prisoner wishes to remain anonymous, their identity is not revealed to the prisoner.

In undertaking the mental health assessments, the following domains are considered by the mental health professionals:

- Appearance, attitude, behaviour and social interaction
- Motor activity
- Mood
- Affect
- Self concept
- Speech
- Thought processes
- Thought content
- Intellectual functioning
- Judgment and impulse control
- Insight.

The department has developed a comprehensive risk assessment classification system to identify those prisoners who may be at risk of suicide or self-harm. The assessment tool has a four-tier classification of risk. Two of these relate to the identification of current risk. These are:

- S1 rating when a prisoner is in immediate danger of self-harming or attempting suicide and requires intensive management and support (this includes a prisoner who may have an acute psychiatric illness where there is a high risk of self-harming behaviour).
- S2 rating when a prisoner is at significant risk of suicide or self-harm and requires intermediate management and support.

The third tier, S3, relates to a prisoner who is not at current risk but is at potential risk of suicide or self-harm and requires follow-up management and support.

The fourth tier, S4, relates to a prisoner who is not at current risk but, given their history of suicide attempts or self-harming behaviour, the potential for self-harm may escalate.

At the same time of a risk assessment being undertaken, prisoners are also assessed to identify if they have a psychiatric disorder. Given that the presence of a mental illness is a known risk factor for prisoners engaging in suicidal behaviour, the psychiatric assessment and subsequent treatment programs are an important element of suicide prevention.

CCS

Application of the Suicide and Self-harm Screening Checklist:

- At induction
- At court in the case of offenders having a supervision order and exhibiting suicidal or self-harm behaviour.

4.3.3 Domain 3: Treatment and support

Objective: To provide integrated, professional care to manage suicidal behaviours when specialised care is needed, comprehensively treat and manage any underlying conditions, and improve wellbeing and assist recovery.

Suicide prevention strategies include:

Prisons

Mental health care

Given that the presence of a mental illness is a known risk factor for prisoners engaging in suicidal behaviour, the provision of health care is an important element of suicide prevention.

Treatment and support is provided with an emphasis on early intervention and positive outcomes for prisoners. Health service providers give consideration to minimising the isolation of the prisoners and maximising their interaction with others, while maintaining the safety of all persons. Protocols are in place for the use of seclusion for managing prisoners exhibiting challenging behaviour.

Prescription of medications known to have potential for dependency or abuse is avoided wherever possible and only prescribed when clinically indicated. The safe use and potential side effects are considered and monitored when prescribing psychotropic drugs.

- **Primary mental health care**
  The primary mental health care model for prisons reflects that of the community health system. The model incorporates a multidisciplinary health team:
  - » Providing mental state assessments
  - » Providing a current treatment, care and management plan, developed in consultation with, and regularly reviewed, with the prisoner
  - » Providing treatment including a range of relevant therapies and interventions
  - » Conducting regular reviews
  - » If necessary, transferring the prisoner to specialist inpatient units or a secure hospital setting
  - » Aiming to minimise the prisoner's psychiatric disability, prevent relapse and enhance their social rehabilitation.

  Mental health service staff communicate with custodial staff about the management needs of prisoners with a mental illness, and when required, provide mentoring and education assistance for custodial staff and health staff across the Victorian prison system to facilitate positive outcomes for prisoners.

  Prisoners who demonstrate mental illness during their period in custody are triaged and assessed by a mental health professional and referred in a timely manner to a psychiatrist if necessary.

  Mental health assessments and diagnoses made are evidence-based and use recognised outcome measurement tools, as well as internationally accepted disease classification systems, in accordance with the *National Standards for Mental Health Services* (2010).

  Specialist assessments, such as neurological assessments, are conducted according to individual clinical need.

  The health service provider has a documented system for prioritising referrals according to risk, urgency, distress, dysfunction and disability. Protocols are in place for coordination and follow-up of care following referral.

- **Ambulatory mental health care**
  Consultant psychologists, psychiatrists, psychiatric registrars and nurse practitioners are available to provide treatment and diagnostic services for prisoners whose treatment requires more complex and specialised skills and facilities than primary healthcare services offer.

  The Mobile Forensic Mental Health Unit is based at the Metropolitan Remand Centre providing comprehensive diagnostic evaluations, targeted psychological intervention, mental health management for those prisoners on remand with severe impaired mental functioning. It also provides in-reach services to the Melbourne Assessment Prison, a transition outreach service to support prisoners transitioning out of the Metropolitan Remand Centre and information and support to correctional staff around prisoner mental health issues.

- **Residential mental health treatment**
  Prisoners with acute mental illness assessed as requiring the most complex and specialist type of clinical care, requiring sophisticated forms of treatment and diagnostic services, are admitted as inpatients at the prisons' acute mental health wards (16-bed Acute Assessment Unit for men at the Melbourne Assessment Prison and 20-bed Marrmak

Unit for women at the Dame Phyllis Frost Centre). The St Paul's 30-bed psychosocial rehabilitation unit for men at Port Phillip Prison operates as a multidisciplinary model to rehabilitate prisoners with chronic, but stable, mental health conditions.

- **Involuntary mental health treatment** Those prisoners assessed as requiring involuntary acute mental health treatment are admitted to the 116-bed secure Thomas Embling Hospital which operates acute, continuing and transitional care programs.

Referring prisoners for assessment of risk of suicide

A formal referral (both verbal and written) is made:

- Immediately after concerns of risk are identified at reception or transfer to any prison
- If the risk is identified at any other time during the prisoner's period of imprisonment.

The referral process ensures that appropriate information is transferred between prison staff and mental health professionals in a timely manner, and assists the mental health professionals in completing the risk assessment within the required timeframe.

Monitoring assessment timeliness

The operation of a Risk Assessment Referral List enables the monitoring of the timeliness of health assessments of all prisoners identified as at risk of engaging in suicidal behaviour and referred for assessment. This form records a list of all prisoners referred, regardless of the outcome of the assessment.

Coordination of prisoner management

The Risk Review Team (RRT), a multi-disciplinary team consisting of relevant professional staff, coordinates the management of prisoners assessed as at risk of engaging in suicidal behaviour. The RRT may be referred to by different names at different locations (for example, High Risk Assessment Team), but develops a risk management plan for prisoners, reviews this plan and status of risk at regular intervals, and makes changes to the plan where required.

The RRT ordinarily comprises:

- A case coordinator (who may be one of the following persons) to coordinate and implement the risk management plan
- An Operations Manager or other nominee of the General Manager
- A mental health professional, for example, psychiatric nurse or general nurse if no psychiatric nurse is available
- Other staff (for example, unit or programs staff) who have had or will have significant contact with the prisoner
- A clinician where there are major behavioural issues and/or where the prisoner is a client of Offender Behaviour Programs
- A clinician from the Major Offenders Unit (MOU), where the prisoner is engaged in MOU intervention
- The Indigenous Services Officer/Aboriginal Wellbeing Officer for Koori prisoners, or other appropriate cultural informant for prisoners from culturally and linguistically diverse backgrounds, or appropriate specialist for prisoners with intellectual disabilities or acquired brain injuries whenever possible will attend RRT meetings.

Where a prisoner's risk status is to be reduced, the RRT must at least consist of an Operations Manager and appropriately trained mental health services staff member, in order to make that assessment.

The RRT appoints an appropriate case coordinator to monitor the implementation of the Risk Management Plan.

Prisoner risk management

All prisoners at risk of suicide undergo an initial assessment by a mental health professional within two hours of identification of risk indicating behaviour.

In undertaking the mental health assessments, the following domains are considered by the mental health professionals:

- Appearance, attitude, behaviour and social interaction
- Motor activity
- Mood
- Affect
- Self concept

- Speech
- Thought processes
- Thought content
- Intellectual functioning
- Judgment and impulse control
- Insight.

An Interim Risk Management Plan is developed following this assessment, which goes to the RRT for endorsement at which time a modified Risk Management Plan is completed. The Risk Management Plan will identify the:

- Level of risk
- Accommodation placement
- Level of observation, and where appropriate differentiated observation specifications for:
  - Day or night
  - Cell or out of cell hours
  - Different daily activities in which the prisoner may be involved
- Type and level of support to be provided (counselling, correctional officer, family, peer support, chaplaincy, culturally appropriate support)
- Treatment plan
- Daily activity
- Significant issues (for example, court dates and visits)
- Search regime
- Type and level of interaction to be promoted (prisoner/peer, volunteers, visitors).

The prisoner's Risk Management Plan will also specify a level of correctional officer interaction with the prisoner that is over and above the observation regime. This is to reinforce the need for correctional staff to provide supportive supervision in addition to formal observation requirements.

An At Risk Register is maintained to keep a record of all prisoners at a location who are deemed to be at risk of engaging in suicidal behaviour after a health assessment. The Prison General Manager is responsible for ensuring that the register can be accessed at all times by both Corrections Victoria and mental health professionals.

Safe placement of prisoners

As a general principle, a prisoner is placed in the least restrictive accommodation that maximises the prisoner's safety. Appropriate accommodation is ordinarily consistent with the Corrections Victoria Risk Level Framework which prescribes:

- Prisoners assessed as at immediate risk are housed in either:
  - 'Muirhead' or observation cell for male or female prisoners
  - Acute Assessment Unit (AAU), Melbourne Assessment Prison for male prisoners
  - A1, A2, Murray Unit, Marrmak or medical centre (Dame Phyllis Frost Centre) for female prisoners
  - Secure psychiatric facility for male or female prisoners, where the prisoner meets the criteria for transfer.
- Prisoners assessed as at significant risk are placed according to prisoner's needs, which may include a 'Muirhead' or observation cell, single cell or shared cell in exceptional circumstances.
- Prisoners assessed as at potential risk are placed according to prisoner's needs, which may include single or shared cell, with prisoners at the Melbourne Assessment Prison assessed at this level of risk accommodated in a BDRP compliant cell.

  Consideration is given to accommodating prisoners, assessed as at potential risk, in a BDRP compliant cell at all other secure locations, taking into account other at risk management and protective factors, such as placing the prisoner in a supportive unit environment.
- Prisoners identified as having a previous history of suicidal behaviour are placed according to prisoner's needs in a single or shared cell.

Information sharing

Corrections Victoria maximises the safety of prisoners through effective communication and information sharing (and documentation) between all parties who have a role to play in the management of prisoners.

Justice Health has provided written guidance which supports appropriate sharing of information

between corrections, health, mental health and alcohol and other drug services to ensure the safety, welfare and wellbeing of prisoners.

The Justice Health guidelines indicate that health service providers may disclose information collected during reception medical assessments and routine health consultations without prisoner consent to correctional staff:

- If the disclosure is reasonably necessary for the performance of the health service provider's official duties of providing health-related services to a prisoner, or
- To lessen or prevent a serious and immediate risk of harm to the prisoner, other prisoners or to correctional staff, or
- To inform appropriate placement and management to ensure the safety and welfare of the prisoner.

Where a relative, other prisoner or any other person reports concerns regarding a prisoner's risk of suicide, that person is advised of the steps that will be taken to address their concerns (in conformance with privacy legislation).

Minimising opportunities to suicide

All prisoners are placed on the least restrictive and intrusive searching plan to maximise the prisoner's safety. The aim of a searching plan is to minimise the opportunity for the prisoner to access items or means to self-harm. A searching plan will include requirements for cell, strip and property searches and will be determined individually for prisoners giving consideration to:

- The type of accommodation
- The daily activity schedule
- Contact with other prisoners or visitors
- The prisoner's mental state and the potential impact of intrusive strip searches on their level of distress, balanced with the need to preserve the prisoner's safety.

Transport

Prior to a prisoner assessed as being at current risk of suicide being transferred between units, between two prisons or between prisons and court, the following requirements must be met:

- Prison transport staff are informed of the prisoner's risk status
- The RRT provides a recommendation as to whether or not the prisoner is to be segregated during transportation
- Female prisoners assessed as at risk of suicide are not transported with male prisoners
- The Individual Management Plan (IMP) files and health files accompany the prisoner
- For unit and prison transfers, a verbal briefing of the OIC of the receiving unit is provided by the OIC of the transferring unit as to the issues surrounding the intervention, strategies adopted and ongoing management of the prisoner. The OIC of the receiving unit allocates the prisoner the most appropriate officer and ensures that all staff are briefed as to the issues before the prisoner's arrival
- Where practical and the option exists, a prison vehicle which is safer is used (for example, in terms of hanging points and CCTV coverage). Where escort vehicles are used, intervention knives for the emergency cutting of hanging ligatures are carried by staff when doors are opened for the removal of prisoners.

Acute intervention

In rare cases of acute suicidal behaviour where a prisoner is actively attempting suicide and will not cease the behaviour, a body belt may be used temporarily to restrain the prisoner. Strict requirements are in place to guide the application of the restraint to cause minimum discomfort and to be as least restrictive as is possible under the circumstances while ensuring the immediate welfare of the prisoner.

Monitoring behaviours

In undertaking observations of prisoners, prison staff take reasonable steps to ascertain that a prisoner is unharmed, while taking into consideration the potential for exacerbating the prisoner's distress by intrusive actions. Prisoners deemed to be at risk of engaging in suicidal behaviour are placed under regular direct physical observation. Prisoners deemed to be at immediate risk are observed at 15-minute intervals and those at significant risk at 30-minute intervals (more or less frequently on the advice of the RRT or health services). Prisoners

assessed as at potential risk are observed hourly or as determined in their Risk Management Plan or by the Unit Manager. Differentiated observation regimes may be in place for:

- Observations during the day and overnight
- During in cell and out of cell periods
- Different out of cell activities.

In addition to the observation regime, Custodial Officers are required to interact with the prisoner involving a meaningful discussion in an appropriate environment with the prisoner regarding their current concerns and situation, with a brief file note made regarding the discussion.

Peer support

Where appropriate, a peer support can be used to associate with a prisoner who is under strict observation in order to reduce the social isolation of placement in an observational cell.

Re-assessment

The Risk Review Team oversees a review of the Risk Management Plan for each prisoner on a daily basis for a prisoner at immediate or significant risk, or at a minimum of every three days for a prisoner assessed as at potential risk of suicide.

Monitoring recovery

The Risk Review Team oversees the implementation of the Risk Management Plan for each prisoner and is the body that determines when a prisoner is no longer considered at risk of suicide.

CCS

Referral

Screening assessment, induction and observations are reported at supervision and reporting meetings. If an offender is identified as at risk of suicide following the application of the screening checklist, a referral is made to a General Practitioner, private practitioner under the rebateable Medicare Benefits Schedule items, headspace (for young people aged under 25 years), a Community Health Service counsellor or a Mental Health Community Support Service. In a smaller percentage of more serious cases, referrals will be made to an Area Mental Health Service (AMHS).

Involvement of an AMHS may be required for problems that:

- Cause moderate to severe distress and impairment
- Are associated with a greater risk of enduring disability
- Are associated with a moderate to high risk of harm
- May involve the presence of a co-morbidity
- Require specialist psychiatric treatments or psychosocial interventions.

Case managers sometimes need to access AMHS when they perceive the need for assessment and treatment to be urgent. Depending on the presentation there are several options for action:

- The case manager assists to de-escalate the level of distress by identifying previous circumstances and by problem solving with the person. This is followed by a management plan that may include contact with the AMHS if he/she is unable to manage their distress
- Referral to a General Practitioner
- Contact AMHS telephone triage. AMHS triage will determine the most appropriate mental health response for the CCS client. This may include calling 000, directing the person to attend an emergency department immediately, or arranging a face-to-face assessment by a community mental health team. Triage may also refer the CCS client to other services, including primary care, headspace (for clients aged less than 25 years), PDRSS or other support services.
- Contact police if:
  - The CCS client is threatening violence and there is a genuine and immediate risk of self-harm or harm to other people
  - The CCS client is armed with any weapon
  - A police presence is reasonably necessary for personal safety.

Crisis intervention may be required when CCS clients attend or contact CCS locations whilst appearing to be in mental health ‘crisis’, or distress, or when expressing suicidal tendencies. In these situations, AMHS triage is called.

Triage services conduct a preliminary assessment and determine the most appropriate response. This may include calling 000, directing the person

to attend an emergency department immediately, or arranging an urgent face-to-face assessment by a community mental health team. It is important to note that mental health services are not an emergency service and, unlike ambulances, may not always be able to provide an immediate response.

Mental health

It is recognised that CCS case managers develop a sound understanding of their clients through the offender management process and are generally well placed to make judgements about their potential need for mental health care. Given that the presence of a mental illness is a known risk factor for offenders engaging in suicidal behaviour, the provision of health care is an important element of suicide prevention.

The following indicators assist CCS case managers determine whether a person appears to have a serious mental illness and whether an AMHS assessment should be considered. They serve as a guide rather than as factors confirming the presence of a serious mental illness or disorder.

Specific symptoms and signs vary depending on the mental disorder and the person's age. Psychiatric assessment is required to confirm the diagnosis of mental disorder and determine the level of impairment and treatment needs.

In addition to suicidal thoughts or acts of self-harm, the following are potential indicators of mental illness:

- Bizarre or unusual thinking
- Hallucinations
- Significant changes of mood, such as pronounced depression, pronounced anxiety or pronounced elevation in mood
- Restless, agitated and disorganised behaviour, or marked decrease in activity
- Significant impairment of social, educational and/or occupational functioning
- Significant impairment in self-care
- Destructive or high-risk behaviour
- Significant memory impairment
- Confusion and disorientation.

Monitoring behaviours

Certain events, such as an offender resurfacing following the issuing of a warrant as a result of their breach of an order may still require the intervention of the case manager when the offender makes a request. Similarly, an offender who is in breach of an order may return to request assistance. If the offender presents at a Community Correctional Service location displaying risk of engaging in suicidal behaviour, standard referral processes are applied.

Liaison

Liaison and consultation with the treating professional may result in the establishment of a communication plan which would determine the appropriate level of case management and initiation of joint case management. The 'Risk Alert or Recommended Action' can only be downgraded in consultation with the health professional.

4.3.4 Domain 4: Ongoing care and support

Objective: To involve health professionals, friends and family to support released prisoners and discharged offenders to adapt, cope, and to build strength and resilience within an environment of self-help.

Suicide prevention strategies include:

Prisons

Transition and reintegration programs

Prisoners are provided with an integrated approach to transitional planning and support that commences on entry to prison and continues throughout their correction episode to post-release.

The transition service supports prisoners in their preparation for release and seeks to link them to critical services such as mental health care, housing and employment services when they return to the community. There is also a focus on alcohol and other drug services, living skills and family and community connectedness.

The reintegration pathway operates at four key stages:

Entry Stage: The reintegration pathway commences at reception to support each prisoner's transition and minimise the social and economic impact of imprisonment.

Sentence Stage: Prisoners may participate in Offending Behaviour Programs, education, training and industry, among other programs during the sentence phase. Issues identified on entry to prison continue to be addressed preparing the prisoner for release.

Pre-Release Stage: The Pre-Release stage provides a range of transitional support services and referrals that aim to address individually identified needs prior to release. The Pre Release Stage incorporates three tiers of service combining group based and one-on-one service support proportionate to the complexity of transitional needs.

Post-release stage: The aim of the post release stage is to provide an effective reintegration program to eligible prisoners' exiting custody that will address their individual and complex transitional needs. This is achieved through a responsive, tailored and flexible support approach to facilitate community reintegration and reduce re-offending.

Release on parole

The conditional release of a prisoner from custody by placing them on parole provides for the prisoner to serve the unexpired portion of their prison sentence in the community. This is subject to the supervision, support and ongoing rehabilitation that parole provides.

Standard conditions as well as an intensive parole period ensure that prisoners receive the management and supervision required to support them immediately after release – the period of highest risk and vulnerability. In addition to standard and intensive parole conditions, the Adult Parole Board may impose other conditions to meet the individual needs and risk of the parolee, such as requirements to attend personal development programs or participation in ongoing rehabilitation.

Prison Discharge Plan

A prisoner who may be at risk of suicide and have a significant mental illness has a detailed discharge plan prepared for them prior to their release, along with details of referrals to an appropriate community health service provider. The plan details the health needs of the prisoner, a summary of the health care provided while in prison, a summary of current medications, referral letters to community health service providers, details of any appointments made for external care and any other information relevant to the prisoner's mental health care.

Prisoners requiring medication upon release are provided with written details of the names, dose, administration schedule and possible significant side effects of their medications, and up to five days' supply of medications to allow continuity of treatment until they can consult a medical practitioner.

Eligible prisoners prescribed pharmacotherapy treatments are referred to community pharmacies to receive four weeks subsidy of their community pharmacy fees upon release.

Prisoners are provided with easily understood information on the range of relevant services and supports available in the community and are consulted about their preferred ongoing healthcare provider to improve continuity of care.

CCS

In managing discharges and terminations for those offenders who are considered to be at risk of suicide or are known to have a prevalence of suicide risk factors, Case Managers ensure that appropriate community service and support networks have been established and communicated to the offender, prior to their last appointment.

4.3.5 Domain 5: Suicide incident management

Objective: To practically manage suicides and attempted suicides, as well as review practices to improve capability, responsiveness and identify potential operational enhancements.

Suicide prevention strategies include:

Prisons

Incident response

- Detailed correctional responses to prisoner suicides and attempted suicides are contained within Commissioner's Requirements and Deputy Commissioner's Instructions.

Learning from incidents

- **Corrections Victoria Internal Management Review**
  An Internal Management Review is conducted and a report developed that provides greater detail about the incident or subject and may identify process and systemic improvements. This is prepared for a specific internal audience. An Internal Management Review may make recommendations and an Action Plan will then be developed in response to the recommendations.
- **Corrections Victoria Formal Debrief**
  A formal debrief is conducted by Corrections Victoria to identify insights and lessons arising from suicides. The debrief can be delivered in different ways but will generally examine the incident and related policies, procedures and practice, with a view to identifying ways in which such incidents could be avoided or better managed in future.
- **Justice Health Death Review**
  Justice Health conducts a review into a suicide in custody to establish the nature and effectiveness of the health service provision and the health care afforded the prisoner prior to death. The review identifies any systemic and emerging issues and makes recommendations for service delivery improvement.
- **Office of Correctional Services Review - Death Review**
  The Office of Correctional Services Review (OCSR) conducts a review into a suicide in custody to establish the circumstances surrounding the incident that resulted in the prisoner's death, the nature and effectiveness of the prisoners custodial management and the custodial care afforded to the prisoner prior to death. It also determines the nature and effectiveness of the emergency response to the death, including the adequacy of procedures in place to guide such a response and the level of compliance with those established procedures and whether systemic improvements can be made.

  The OCSR also conducts a review into a death, including by suicide, of a prisoner while on parole and of an offender within three months of unconditional release from prison.
- **Coronial Inquest and Review**
  The Coroner investigates the death of every prisoner to determine the identity of the deceased, how the death occurred and the cause of death and may make recommendations to prevent future deaths.

CCS

Detailed responses to incidents where an offender has attempted suicide resulting in hospitalisation and/or police involvement during any stage of an order are contained within Deputy Commissioner's Instructions.

4.3.6 Domain 6 : Suicide incident impact minimisation

Objective: To build strength, resilience, adaptation and coping skills through support to affected staff, prisoners and their support people affected by suicidal behaviour.

Suicide prevention strategies include:

Prisons

Support to prison staff

Corrections Victoria prison staff affected by the suicidal behaviour of a prisoner will have access to the department's Employee Assistance Program, specialist Trauma Debriefing, in addition to support provided by prison management and colleagues. Private prisons have their own separate support arrangements for their staff.

Support to prisoners

Critical Incident Support is provided to ensure that any prisoner who may be unduly affected by a critical incident is provided an opportunity to discuss their feelings, be given assistance to understand how they are feeling and be linked to further support if necessary.

Information to families and support persons

While no specific guidelines exist regarding the support provided to families of prisoners who suicide, it is open to prisons to refer families to various supporting agencies or counsellors.

CCS

Support to CCS Staff

CCS staff affected by the suicidal behaviour of an offender will also have access to the department's Employee Assistance Program, in addition to support from CCS management and colleagues.

Information to families and support persons

While no specific guidelines exist regarding the support provided to families of offenders who suicide, it is open to CCS to refer families to various supporting agencies or counsellors.

5 Supporting our work

There are four key support activities that impact across each of the six domains and that serve to underpin the *Correctional Suicide Prevention Framework* and its strategies.

5.1 Workforce development

All Corrections Victoria employees (prison officers and community correctional officers) are required to be appropriately trained in all aspects of safety, critical incident management and prisoner and offender management procedures relevant to their role. This includes the identification of prisoners and offenders at risk of engaging in suicidal behaviour.

The aim of this training is to provide participants with the ability to translate theory about suicide prevention into practice. Forensicare (Carroll 2011, p. 13) have noted that "the most significant component of any suicide prevention policy is arguably the proficiency of the staff working in the facility".

The most significant component of any suicide prevention policy is arguably the proficiency of the staff working in the facility.

Forensicare, 2011.

An intensive suicide prevention training package, including an introduction to suicide and the identifying and managing of suicidal behaviour, is provided for new custodial staff, CCS officers and Field Officers, as well as annual refresher courses. The provision of this training is contracted by Justice Health to Forensicare.

5.2 Documentation and communication

The implementation of the *Correctional Suicide Prevention Framework* will only be successful if effective methods of communication are in place that traverse the breadth of the domains of care in environments of multiple service providers and varying reporting obligations.

Comprehensive documentation of all suicide prevention activities is also critical to any effective suicide prevention program (Hayes 1995, p. 50) with prisons and CCS having detailed standards and procedures in place for prisoner and offender file and record management.

5.3 Monitoring and reporting

Accountability is a crucial element in the implementation of all frameworks. It is important that the ongoing progress towards reducing prisoner engagement in suicidal behaviour by all stakeholders is monitored by the department and that this information can be used to inform future initiatives and continue to reduce the rates of suicides in Victorian prisons.

5.4 Research

There has been a growing emphasis, both within Australia and internationally, on the need for suicide prevention interventions to be evidence-based. However, research into the overall effectiveness of the many facets of the *Correctional Suicide Prevention Framework* may be problematic for a number of logistical and resource reasons. One reason is because the number of suicides is very small and does not provide a sufficient sample size against which to measure effectiveness of individual interventions.

However, there are a range of opportunities that exist for 'consumer'-based research into ways in which specific *Correctional Suicide Prevention Framework* activities can be strengthened and made more effective. For example, this could include discussing with prisoners and their families/supports about what information is most helpful and how it can be provided to them in the most effective way.

Appendix 1

Summary of risk factors, tipping points, warning signs and protective factors for prisoner and offender suicide

Risk factors

General Risk Factors

- Male gender
- Trans and gender diverse
- Age (young or elderly prisoners)
- History of alcohol and/or illicit drug use
- Past psychiatric history (including substance abuse disorders, affective disorders and schizophrenia)
- Recent contact with psychiatric services or discharge from psychiatric in-patient facility
- History of impulsive behaviour, including violence to others or self
- History of previous suicide acts, especially within the context of institutionalisation
- History of traumatic incidents (such as victim of abuse)
- In custody for the first time, and those with four or more arrests appear to be at elevated risk after several weeks or months in prisons
- Childhood adversity
- Loss or absence of one or both parents for more than 12 months before the age of 15
- Low socioeconomic status
- Family history of mental illness
- Family history of suicide
- Learning disability
- Poor coping skills
- Inability to communicate due to language barriers
- Unmarried, separated or widowed

Prison Specific Risk Factors

- Offences of violence against another person, especially against family members or partners, arson and sex offences
- Distrust of the authoritarian environment
- Perceived dehumanising aspects of imprisonment
- Short period spent in a particular custodial facility (independent of time spent in custody)
- Sentence length (life-sentence may demonstrate greater risk than long-term sentence)
- Indeterminacy of expected time to serve
- Nature of the offence and position within prison social hierarchy
- Boredom and lack of meaningful occupation.

Risk factors on immediate entry of prison system

- Identified history of mental illness or psychiatric hospitalisation
- Demonstrated history of suicidal behaviour, identified by an intention to suicide/self-harm in the past 2 years and or a previous computerised record flag for suicide/self-harm
- Expressed suicidal ideation or exhibited acute distress
- Charged with a serious offence (e.g. murder) which is likely to attract a very long sentence if convicted
- Aged 18 years or younger
- First time in prison
- Aboriginal or Torres Strait Islander

- Cognitive impairment including intellectually disabled and acquired brain injury
- Charged under the Family Law Act or for breaching an Intervention Order
- Charged with offences that are bizarre/sexual in nature or have attracted a significant amount of media attention
- Disclosed a history of physical, sexual or emotional abuse
- Remanded in custody pending a psychiatric report
- Suffering a life-threatening illness
- Appeared distressed or was imprisoned contrary to expectation or received a significantly longer sentence than expected.

Recently released prisoner risk factors

- History of alcohol misuse
- History of self-harm
- Having a psychiatric diagnosis, particularly those which may have difficulty obtaining medications from community providers after the prison provided medications have run out
- Hopelessness
- Significant loss
- Social isolation
- Lack of support
- Poor coping skills
- Unemployment
- Homelessness.

Sources:

Australian Government Department of Health and Ageing, 2008, Living is For Everyone (LIFE): A Framework for the Prevention of Suicide and Self-harm in Australia, Canberra.

Australian Institute of Health and Welfare (AIHW), 2012, The Health of Australian Prisoners 2012, AIHW, Canberra.

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New Zealand Department of Corrections, 2013, Department of Corrections Suicide Prevention Framework, Department of Corrections, New Zealand.

Tipping Points

- Life sentence/parole board hearing refusal/further charges laid
- Loss or disruption to outside relationships
- Conflicts, bullying and victimisation within the prison
- Increased legal frustration
- Approaching court date
- Death in the family
- Inability to attend mourning rituals
- Segregation into single observational cells
- Disciplinary infractions
- Undesired unit placement or work assignment
- Transfer to a prison from another prison, court or medical facility
- Security classification increased
- Significant detrimental life event
- Subjection to sexual coercion in prison
- Losing contact with one's children (particularly separation from dependent children, or children going into care, for women prisoners)
- Physical illness, especially chronic conditions and/or those associated with pain and functional impairment
- Inability to continue to care for older family members
- Experience of humiliation or rejection
- Spouse or partner with terminal illness
- Isolation from family and significant others
- Perceived lack of control over the future
- Loss of social support
- Lack of purposeful activity
- Recently divorced or relationship instability
- Anniversaries and key dates
- Intoxication or the symptoms of withdrawal of drugs
- Infectious influence of suicidal acts of other prisoners
- Deterioration of prison conditions (e.g. lock downs).

Sources:

Australian Government Department of Health and Ageing, 2008, Living is For Everyone (LIFE): A Framework for the Prevention of Suicide and Self-harm in Australia, Canberra.

Carroll, A., 2011, Internal Review of Suicide Risk Assessment and Management Practices at Forensicare, Melbourne Assessment Prison. Forensicare, Melbourne.

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Western Australian Department of Justice Suicide Prevention Task Force, 2002, Suicide in Prison, Department of Justice, Perth.

Warning signs

Changes in relating to people

- Withdrawal and isolation, lack of interest in relationships.

Changes in behaviour

- Crying
- Finalising arrangements
- Giving away belongings, surrendering other things that were previously held dear
- Talking or writing about death, dying or taking their life
- Trying to obtain a single cell
- Hoarding of medication
- Saying goodbye to people
- Rehearsal behaviours observed
- Expression of suicidal ideation or threat of self-harm
- Fear engendered by unfamiliarity and uncertainty
- Excessive guilt.

Sudden improvement in demeanour

- Unrealistic talk about getting out of prison (apparent optimism may mean that the prisoner has resolved upon suicide as course of action)
- Being unusually happy following depression.

Changes in emotional state

- Depression, including disturbed sleep, fatigue, loss of interest, sad mood, appetite disturbance
- Feelings of hopelessness and helplessness
- Intense negative emotions (usually extreme sadness but sometimes anger, frustration or seeking revenge)
- Preoccupation with the past and poor grasp of the present
- Mood swings
- Expressing no reason for living or no sense of purpose in life
- States of heightened impulsivity
- Dichotomous thinking
- Low self esteem
- Acute psychosis
- Acute anxiety state
- Severe guilt or shame of offence
- Shame of incarceration
- Feelings of being trapped in an indifferent or hostile world
- Physical and emotional breakdown
- Using expressions of rage, anger.

Sources:

Australian Government Department of Health and Ageing, 2008, Living is For Everyone (LIFE): A Framework for the Prevention of Suicide and Self-harm in Australia, Canberra.

Carroll, A., 2011, Internal Review of Suicide Risk Assessment and Management Practices at Forensicare, Melbourne Assessment Prison. Forensicare, Melbourne.

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Corrections Victoria, 2013, Corrections Victoria - Public Prisons, Deputy Commissioners' Instruction 1.02 At Risk Procedures, Department of Justice, Melbourne.

Protective Factors

- Female gender
- Supportive and caring parents or family
- Family harmony
- Safe and secure living environment
- No alcohol or illicit drug problems
- No family history of mental illness
- No family history of suicide
- Mental health and wellbeing
- Good physical health
- Good communication skills
- Good coping skills
- Positive outlook and attitude to life
- Positive sense of self
- Sense of meaning and purpose in life
- Absence of guilt and shame
- Sense of social connection
- Supportive social relationships
- Physical and emotional security
- Little exposure to environmental stressor.

Sources:

Australian Government Department of Health and Ageing, 2008, Living is For Everyone (LIFE): A Framework for the Prevention of Suicide and Self-harm in Australia, Canberra.

National Institute of Corrections, 1995, An Overview and Guide to Prevention, Department of Justice, Washington, D.C.

Appendix 2

Key Corrections Victoria and Justice Health requirements

Corrections Victoria Commissioner's Requirements

- Commissioner's Requirement: Security; Management of Prisoners At Risk of Suicide or Self-Harm: E*Justice Risks and Recommended Actions. 24 December 2009.
- Commissioner's Requirement: Management of At Risk Prisoners. December 2013.
- Commissioner's Requirement: Deaths in Prisons: Reporting and Review of Prisoner Deaths. June 2013.
- Commissioner's Requirement: Access to Plastic Bags, Plastic Wrap, Shavers and Toothbrushes. June 2012.

Corrections Victoria Deputy Commissioner's Instructions

- Deputy Commissioner's Instruction 1.17: Separation regimes. 2 October 2012.
- Deputy Commissioner's Instruction 2.05: Orientation. 17 December 2012.
- Deputy Commissioner's Instruction 2.02: Prisoner placement and reviews. 1 February 2013.
- Deputy Commissioner's Instruction 3.14: Preparation for release. 19 September 2013.
- Deputy Commissioner's Instruction 9.1: (Corporate): Staff selection, training and development. 15 September 2011.
- Deputy Commissioner's Instruction 4.15: Offending behaviour programs – critical incident support for prisoners. 31 August 2011.
- Deputy Commissioner's Instruction 3.17: Peer listener support for prisoners. 14 June 2013.
- Deputy Commissioner's Instruction 1.11: Reception, care and control of prisoners. 12 March 2013.
- Deputy Commissioner's Instruction 2.02: Prisoner placement and reviews. 1 February 2013.
- Deputy Commissioner's Instruction No. 1.20: Deaths in prisons. 3 June 2013.
- Deputy Commissioner's Instruction 5.13: Community Correctional Services, Risk Identification and Management. 27 March 2013.
- Deputy Commissioner's Instruction 1.02: Public Prisons, At Risk Procedures. 29 November 2013.
- Deputy Commissioner's Instruction 1.24: Public Prisons, Surveillance, CCTV Taping Protocols and Retention Periods. 24 April 2013.
- Deputy Commissioner's Instruction 3.17: Public Prisons, Peer Listener Support for Prisoners. 14 June 2013.
- Deputy Commissioner's Instruction 2.07: Aboriginal and Torres Strait Islander Prisoners. 17 December 2012.
- Deputy Commissioner's Instruction 2.09: Prisoners from Culturally and Linguistically Diverse backgrounds. 20 June 2012.

Community Correctional Services

- Protocol between Mental Health, Drugs and Regions, Division and Community Correctional Services, November 2012.

Justice Health Requirements

- Justice Health Quality Framework 2011.
- Justice Health, Health Service Standards.

Appendix 3

Correctional Suicide Prevention Framework summary

DOMAIN	OBJECTIVE	TARGET GROUPS	ACTIONS
Universal strategy	Reduce access to the means of suicide, provide prisoner and offender education about suicide prevention and create a more supportive correctional environment	Prison population	• BDRP compliant cells • Provision of information at induction on suicide in prison and supports available • Provision of information on how to refer other prisoners if concerned for a peer
		Families and support persons of prisoners	• Information available on reporting safety or welfare concerns
		Prison population and all CCS offenders	• Creating a more supportive correctional environment
Symptom identification	Know or be alert to high or imminent risk, adverse circumstances and potential tipping points, and provide support and care when vulnerability and exposure to risk is high	Whole prison population	• Assessment within 24 hours of initial reception • Observations throughout period in custody by custodial staff, other prisoners and external professionals
		Prisoners transferred from another prison	• Assessment within 24 hours of transfer
		Prisoners returned from court	• Assessment within 2 hours of return from court
		CCS offenders with supervision condition	• Assessment at court
		All CCS offenders	• Assessment at induction

Appendix 3 (cont.)

DOMAIN	OBJECTIVE	TARGET GROUPS	ACTIONS
Treatment and support	Provide integrated professional care to manage suicidal behaviours, comprehensively treat and manage underlying conditions, improve wellbeing and assist recovery	Prison population	• Referral process • Assessment
		Prisoners assessed as at immediate, significant or potential risk of suicide	• Mental health services • Risk Assessment Referral List and At Risk Register • Risk Management Plan • Coordination of prisoner management • Safe placement • Information sharing • Minimising opportunities to suicide via prisoner and cells searches • Transport • Acute intervention • Monitoring behaviours • Offending Behaviour Programs addressing adjustment to prison • Peer support • Re-assessment • Monitoring recovery
		All CCS offenders	• Observation at supervision/reporting • Referral process
		CCS offenders referred to appropriate services	• Professional liaison and establishment of communication plan
		Breached CCS offenders	• Monitor behaviours • Referral process

DOMAIN	OBJECTIVE	TARGET GROUPS	ACTIONS
Ongoing care and support	Support released prisoners and discharged offenders to adapt, cope and build strength and resilience within environment of self-help	Prisoners due to be released	• Pre-release programs and information on heightened risk
		Prisoners released on parole	• Management and supervision (possible rehabilitative requirements)
		Families and supports of prisoners due to be released	• Information to families and supports on heightened risks
		CCS offenders	• Establishment of support networks
Suicide incident management	Practically manage suicides and attempted suicides, improve capability, responsiveness and identify potential operational enhancements	Prison staff	• Incident response • Internal Management Review • Formal debrief
		Office of Correctional Services Review	• Correctional Management Review
		Justice Health	• Health Management Review
		Coroners Court	• Coronial inquest and review
		CCS offenders	• Incident response
Suicide incident impact minimisation	Build strength, resilience, adaptation and coping skills to affected persons	Prison staff	• Trauma Debriefing, Employee Assistance Program, prison management and collegial support available to staff to assist in responding to grief and loss
		Prisoners unduly affected by suicidal behaviour of another prisoner	• Critical Incident Support given to assist in responding to grief and loss and their own elevated risk of suicide
		Families and support persons of prisoners who have taken their life	• Possible referral given to assist in responding to grief and loss
		CCS staff	• Employee Assistance Program, prison management and collegial support available to staff to assist in responding to grief and loss
		Families and supports of CCS offenders	• Possible referral given to assist in responding to grief and loss

Appendix 4

Summary of Correctional Risk Level Framework

LEVEL/ TERMINOLOGY	IMMEDIATE RISK Intensive Management & Support S1	SIGNIFICANT RISK Intermediate Management & Support S2	POTENTIAL RISK Follow-up Management & Support S3	PREVIOUS HISTORY of Self-harm Behaviour S4
Criteria	The prisoner is in immediate danger of self-harming or attempting suicide, including those who: • Are assessed as having the potential to cause self-harm or attempt suicide if they are not supervised, for example, in their cell after lock-down or during out-of-cell hours, and/or • Have an acute psychiatric illness where there is a high risk of self-harming behaviour	• Significant (but not immediate) and/ or chronic risk of suicide or self-harm, and/or • No longer high risk but still requires intermediate management and support, or • Previously considered lesser risk of suicide or self-harm, whose risk has escalated	• Identified as having a number of risk factors where, without intervention, there is the potential for escalation of his/ her risk, but who is not at a high/ moderate risk of suicide or self-harm, and/or • In need of some intervention to ensure his/her risk level does not escalate • No longer moderate risk, but still requires follow-up management and support • Previously been categorised as S4 and whose risk has escalated	Not currently 'at risk' but given history of suicide attempts or self-harm behaviour, the potential for self-harm may escalate

LEVEL/ TERMINOLOGY	IMMEDIATE RISK Intensive Management & Support S1	SIGNIFICANT RISK Intermediate Management & Support S2	POTENTIAL RISK Follow-up Management & Support S3	PREVIOUS HISTORY of Self-harm Behaviour S4
Placement/ Accommodation	Placement according to prisoner's need: • 'Muirhead' or observation cell for male or female prisoners, or • AAU (MAP) for male prisoners, or • A1, A2, Marrmak or medical centre (DPFC) for female prisoners, or • Secure psychiatric facility for male or female prisoners, where the prisoner meets the criteria for transfer	Placement according to prisoner's needs. • May be 'Muirhead' or observation cell, or • Single cell, or • Shared cell in exceptional circumstances BDRP compliant cell	Placement according to prisoner's needs: • Single cell, or • Shared cell BDRP compliant cell preferred Note: S3 prisoners at the MAP will be accommodated in a BDRP compliant cell. For S3 rated prisoners at all other secure locations, consideration is to be given to accommodating an S3 rated prisoner in a BDRP compliant cell, taking into account other at risk management and protective factors, such as placing the prisoner in a supportive unit environment	Placement according to prisoner's needs: • single cell, or • shared cell[8].
Observation Level[1]	Interval of every 15 minutes[2]	Interval of every 30 minutes[2]	Hourly or as specified in the Risk Management Plan	None
Custodial Officer Interaction with Prisoner[3]	Regular interaction with prisoner as per Risk Management Plan	Regular interaction with prisoner as per Risk Management Plan	Regular interaction with prisoner as per Risk Management Plan	As appropriate
Risk Management Plan	Yes	Yes	Yes	No. Monitored by unit staff or Psychological Services as appropriate

LEVEL/ TERMINOLOGY	IMMEDIATE RISK Intensive Management & Support S1	SIGNIFICANT RISK Intermediate Management & Support S2	POTENTIAL RISK Follow-up Management & Support S3	PREVIOUS HISTORY of Self-harm Behaviour S4
Review by Risk Review Team (RRT) **(Minimum Standard)**	Daily	Daily	Minimum of every 3 days, or more frequently as determined by RRT. If RRT consider prisoner no longer to be 'at risk', RRT to make a post-intervention management plan (e.g. referral to Psychological Services)	No. Monitored by unit staff or Psychological Services as appropriate
Review by Risk Review Team (RRT) **(Desirable)**	Daily	Daily	As determined by RRT	No. Monitored by unit staff or Psychological Services as appropriate
Clinical Review by Psychiatric Professional	Daily	Twice weekly, or as determined by clinical judgment	As determined by the RRT	No. Monitored by unit staff or Psychological Services as appropriate

1 Observation level refers to direct observation of the prisoner. Observation via CCTV may be used to supplement, but not replace, direct observation.

2 More or less frequently on the advice of the RRT or Health Service.

3 Custodial officer interaction refers to a meaningful discussion in an appropriate environment with the prisoner regarding their current concerns and situation, with a brief file note regarding the discussion. This is in addition to the observation regime.

Appendix 5

Framework development

The project to develop this Framework was led by Justice Health, in collaboration with Corrections Victoria, prison health service providers and the Department of Health and Human Services. Project governance arrangements were established at two levels: a Steering Committee and Reference Group.

Steering Committee

The Steering Committee membership including:

- Julia Griffith, Deputy Secretary, Corrections, Department of Justice & Regulation (Convenor)
- Dr Douglas Bell, Assistant Clinical Director, Prison Operations, Forensicare
- Dr Mark Oakley Browne, Chief Psychiatrist, Department of Health and Human Services
- Jan Shuard, Commissioner, Corrections Victoria, Department of Justice & Regulation
- John Hoogeveen, General Manager, Correct Care Australasia
- Larissa Strong, Director, Justice Health, Department of Justice & Regulation
- Paul Smith, Deputy Secretary, Mental Health, Wellbeing, Social Capital and Ageing, Department of Health and Human Services
- Rod Wise, Deputy Commissioner, Operations, Corrections Victoria, Department of Justice & Regulation
- Mick Boyle, Strategic Adviser, Justice Health, Department of Justice & Regulation (Secretariat).

Project Reference Group

The project Reference Group membership including:

- Mick Boyle, Strategic Adviser, Justice Health, Department of Justice & Regulation (Convenor)
- Aleksandra Belofastov, Senior Psychologist, Marrmak (Forensicare)
- Brett Ryan, General Manager, Melbourne Assessment Prison, Corrections Victoria, Department of Justice & Regulation
- Emma Law, General Manager, System Performance, Corrections Victoria, Department of Justice & Regulation
- Karen Payne, Health Services Manager, Correct Care Australasia
- Sanjeev Choudhary, Clinical Standards and Review Officer, Justice Health, Department of Justice & Regulation
- Sofeya Chakik, Acting Senior Project Officer, Operations Division, Corrections Victoria, Department of Justice & Regulation
- Fiona Rippin, Senior Policy Officer, Prevention, Policy and Research, Department of Health and Human Services.

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Published by Department of Justice & Regulation,
Victoria, Australia

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Department of Justice

Authorised by the Department of Justice & Regulation,
121 Exhibition St, Melbourne

July 2015

State Government Victoria

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