Suicide and self harm – Prison services

Brian Tyrrell

National average

- In 2019, there were 3,318 deaths by suicide.
- This equates to an average of 9.1 deaths by suicide in Australia each day.
- There were 2,502 male deaths.
- There were 816 female deaths

Risk factors in custody

- Incarcerated individuals have a higher rate of suicide than their counterparts in the general community.
- Rates typically **three to five times** those of the general community.
- Offenders enter the prison system with more risk factors for suicide than those released to the general community can remain at elevated risk of suicide following their release – CCS officers

General risk factors

Aboriginal, No access to family, relationship problems, Online and Face to face bullying, Family history of suicide, hx of self harm. Hx of MI, Hx of AOD use

Risk Factors Prison Specific

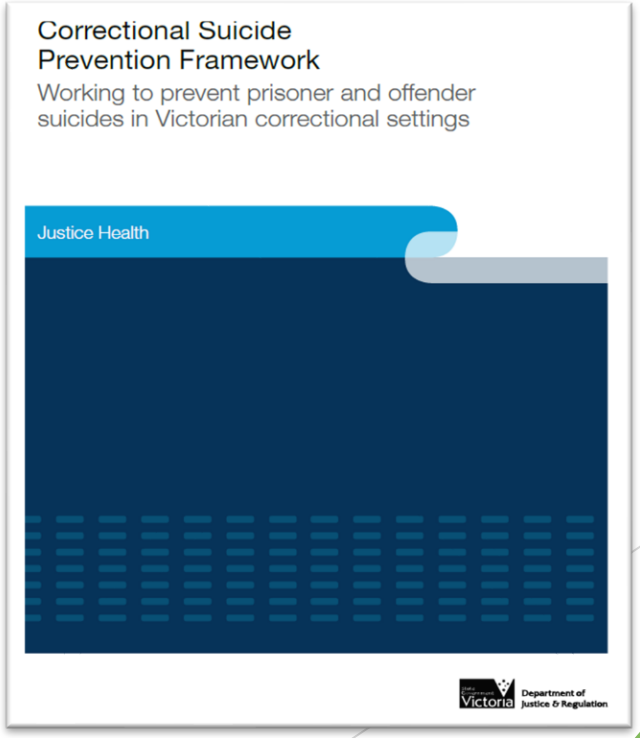
Remand, 1st time, single cell placement., loss of privileges. Violent offences, poor physical health , mental illness. AOD abuse.

Rates of Suicide and self harm – Time in motion snapshot

- **Total No. of prisoners in Vic: 7925**
- No of S rated prisoners 4359 (55%)
  - S1- Immediate Risk 5
  - S2 - Significant Risk 11
  - S3 - Potential Risk 64
  - S4 - Previous Risk 4279
- Source – E-justice 2021

Suicide prevention framework

- 1984 – 64 deaths <3000 prisoners
- 2018 – 9 deaths < 8000 prisoners
- Corrections Victoria's commitment to reducing suicides has been effective.
- Correctional suicide prevention activities must:
  - Do no harm
  - Be therapeutic and not punitive
  - Staff must create *positive environments*
  - Include compassion and understanding
  - Use the least restrictive and intrusive responses
  - Include professional treatment for crisis and recovery
  - Meet management, security and therapeutic priorities



Suicide prevention framework

- Officer awareness training - All delivered by Forensicare at prisons – Formal and informal.
- Engagement styles. Use of terminology. Identification of early warning signs
- BDRP complaint cells – living arrangements – No hanging points.
- Banning plastic bags
- Developing robust process around identification and management of at risk patients
- Reducing restrictive intervention and improving psychosocial interventions

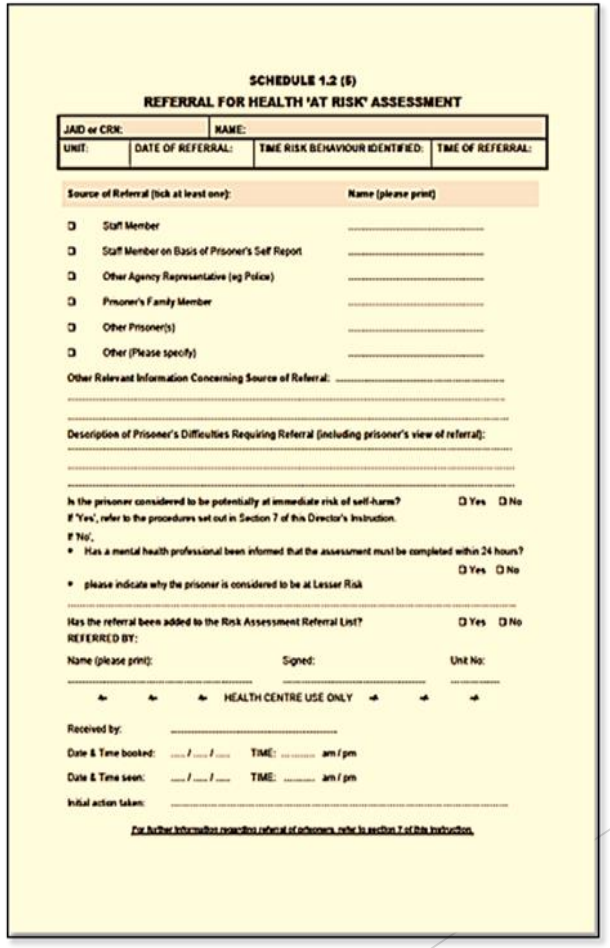
At Risk Procedures
Risk Level Framework

Level/ Terminology	Immediate Risk S1	Significant Risk S2	Potential Risk S3	Previous History S4
Criteria	High or chronic risk of suicide or self Harm behaviour if not supervised Requires Intensive management and support	At significant risk of suicide or self harm Requires intermediate management and support	Has identified risk factors & requires follow-up management & support Is not of high or /moderate risk of SASH	Not currently 'at risk' but has past history of suicide attempts or self-harm behaviour,
Placement	Muirhead or Observation cell, or, IPU or medical centre (DPFC)	Muirhead or Observation cell, or, Single cell, or Shared cell in special cases BDRP compliant cell	Single cell, or Shared cell BDRP compliant cell preferred	Single cell, or Shared cell
Observation Level	Intervals at most 15 mins	Intervals at most 30 mins	Intervals at most 60 mins	None
Risk Management Plan	yes	Yes	yes	No
Review by Risk Review Team (RRT)	Daily	Daily	Minimum of every 3 days	No
Clinical Review By Psychiatric Nurse	Daily	Twice weekly	As determined by RRT/HRAT	No

DCI 1.02: At Risk Process

- Officers and other stakeholder identify at risk behaviors
- Written referral (yellow form) and phone call to ‘at Risk’ team.
- At-risk review by a nurse - 2 hrs.
- The mental health professional is responsible for informing officers of the nature of the risks and developing an Interim Risk Management Plan

- Daily HRAT/RRT meeting
  - Discuss, plan and co-ordinate the management and care of at risk patients
  - Develop, review and update the at risk management plan
  - Update all the documentation related to the at risk process.



SCHEDULE 1.2 (5)

REFERRAL FOR HEALTH 'AT RISK' ASSESSMENT

JAID or CRN:	NAME:		
UNIT:	DATE OF REFERRAL:	TIME RISK BEHAVIOUR IDENTIFIED:	TIME OF REFERRAL:

Source of Referral (tick at least one): **Name (please print)**

- ☐ Staff Member
- ☐ Staff Member on Basis of Prisoner's Self Report
- ☐ Other Agency Representative (eg Police)
- ☐ Prisoner's Family Member
- ☐ Other Prisoner(s)
- ☐ Other (Please specify)

Other Relevant Information Concerning Source of Referral: .....

.....

.....

Description of Prisoner's Difficulties Requiring Referral (including prisoner's view of referral):

.....

.....

.....

Is the prisoner considered to be potentially at immediate risk of self-harm? ☐ Yes ☐ No

If 'Yes', refer to the procedures set out in Section 7 of this Director's Instruction.

If 'No',

- Has a mental health professional been informed that the assessment must be completed within 24 hours? ☐ Yes ☐ No
- please indicate why the prisoner is considered to be at Lesser Risk

.....

Has the referral been added to the Risk Assessment Referral List? ☐ Yes ☐ No

REFERRED BY:

Name (please print): ..... Signed: ..... Unit No: .....

HEALTH CENTRE USE ONLY

Received by: .....

Date & Time booked: ..../..../.... TIME: ..... am / pm

Date & Time seen: ..../..../.... TIME: ..... am / pm

Initial action taken: .....

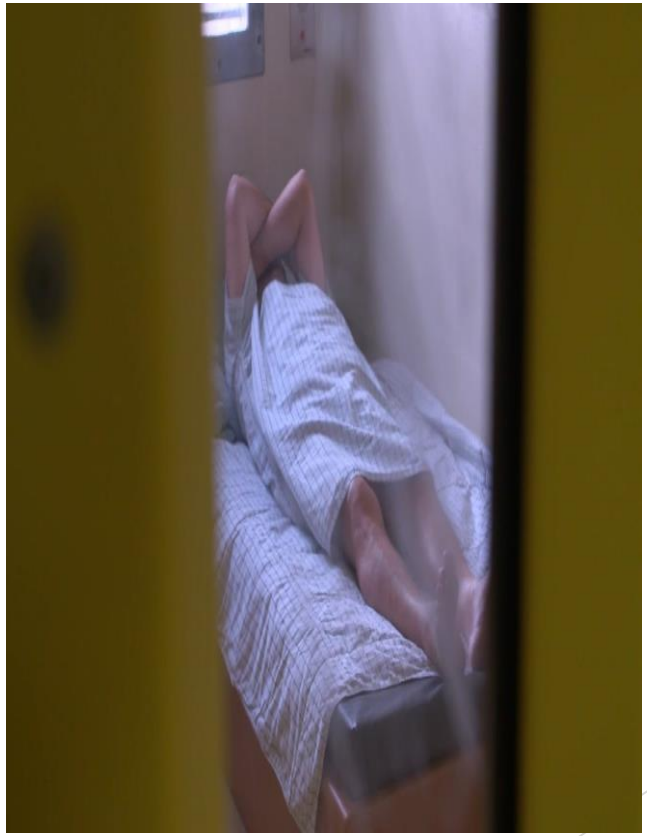
For further information regarding referral of prisoners, refer to section 7 of this Instruction.

Wet cells/Muirhead/observation cells/safe cells – S1/S2 patients

- The segregation strategy and the observation regime **do not reduce** the **longer-term risk** of suicidal behavior.
- These strategies are in conflict with the principle, “do no harm", as they **may increase distress** for prisoners in crisis.

- Safe cells should be used for the **least amount of time required**.

Safe cells continued….



PHD Research results – Literature review

- Observation cell placement to separate and isolate acutely suicidal patient is noted to be more practical and readily available
- Occupation of a single cell (OR 6·8, 95% CI 2·3–19·8) and having no social visits (OR 1·9, 1·5–2·4) were associated with an increased risk of suicide
- Complete isolation and depriving patients of their clothing further impair their self-esteem, human dignity and their ability to cope with the extreme social and psychological environment of the prison system.
- Majority of patients (almost 80%)did not favor the current primary intervention: the observation cell. Safety cells were one of the least favored treatment options for suicidal ideation
- The inclusion of family and friends in the treatment of suicidal ideation were the most desired options.

Therapeutic approach rather than confinement

Vast improvements in clinical services on the ground –

- Increased allied health/psychologists/RPN/neuropsychologists on the floor across most sites but in particular metro area melbourne.
- Units and programs developed to specific management challenging behaviours – Morroka program, MFMHS, Marlborough unit.
- Allied health employed directly by the prison operators to provide distress and support to patients at risk
- External service providers working within the prisoner – Regen, Carniche, CASA, Salvation army, Jesuit services, ACSO, Melbourne mission, NDIS support co-ordinators on site visits, AMHS site visits
- Aboriginal health, LGBT awareness

- More work to do – A HDU style rather than confinement?

Suicide and self harm

- Thank You
- Questions?