

RISK FACTORS AND CIRCUMSTANCES SURROUNDING SUICIDES IN CORRECTIONAL CENTRES IN GAUTENG, SOUTH AFRICA¹

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ABSTRACT

Suicides occur in correctional centres even though the behaviour of offenders is supposed to be closely monitored and regulated. The present study set out to identify and describe the risk factors and circumstances surrounding suicides in selected correctional centres in Gauteng (Johannesburg, Zonderwater, Boksburg and Kgosi Mampuru II). Qualitative methods, in particular semi-structured interview and focus group strategies, were followed to obtain data from two psychologists, two social workers, nine case management officers and twelve offenders. In addition, the case files of eight offenders who committed suicide in a correctional centre were scrutinised for information regarding their backgrounds, mental health, contact with their families, sentences and parole applications. The study identified an array of risk factors associated with suicide in correctional centres that can be categorised in terms of individual, interpersonal and structural contributors. Important risk factors include contact with families, mental health, type of cell accommodated in, access to prescription medication and overcrowding. The general strain and escape theories are used to explain the phenomenon of suicide in correctional centres.

Keywords: *unnatural death; suicide; correctional centre; offender; cry-for-help; overcrowding.*

INTRODUCTION

Suicide is a global phenomenon with variations across countries and cultures. Worldwide, more than 800 000 people die annually due to suicide that, in 2012, was the leading cause of death among 15-29 year olds. The suicide rate in South Africa is less than five per 100 000 of the general population compared to countries such as Russia, India and Zimbabwe where the suicide rate is more than 15 per 100 000 inhabitants (World Health Organization, 2015). Suicide in South Africa, which amounts to roughly 8 000 deaths annually, accounts for 10% of all unnatural deaths in adults and 9.5% of unnatural deaths in youths. An estimated 23 suicides and 230 attempted suicides take place daily and nearly two-thirds of victims are between 20 and 39 years of age (South African Depression and Anxiety Group, 2014; South African Federation for Mental Health, 2014). Suicide also occurs in institutionalised settings such as correctional centres where the behaviour and actions of offenders are supposed to be closely monitored and regulated. Being behind bars in South Africa is five times more life-threatening than it was in the late 1990s because the mortality rate has increased substantially. Two in five (40%) unnatural deaths in correctional centres result from suicide (Skweyiya, 2015:86).

The annual reports of the Judicial Inspectorate of Correctional Services (JICS) stipulate the number of suicides in correctional centres and a brief description of the deceased offender and how the suicide was committed. In 2011, the Directorate: Risk Profile

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Management of the Department of Correctional Services¹ identified the need for more information about the phenomenon of unnatural deaths in correctional centres. An electronic search using Sabinet for articles about suicides in South African correctional centres yielded no results. Articles, which focus on offenders, varied in focus, ranging from constitutional matters and prison administration to matters of health care and access to treatment. In general, most of the sources available on suicide in correctional settings appear dated. The information hiatus was, therefore, clear and the theme considered important to investigate.

Unnatural deaths in correctional centres take different forms, namely suicide, homicide, assault and road traffic accidents involving offenders being transported to and from court or from one correctional centre to another (Van Zyl, 2009:24). However, the boundaries of the present study are limited to unnatural deaths as a result of suicide in correctional centres. The aim of the study was, therefore, to identify and describe the risk factors associated with and circumstances surrounding suicides in selected correctional centres in Gauteng (Johannesburg, Zonderwater (near Cullinan), Boksburg and Kgosi Mampuru II (in Pretoria) – all in the Gauteng Province).

DEFINITIONS

It is important to take note of the following concepts that feature prominently throughout the article.

Correctional centre

A correctional centre is an institution under state jurisdiction for confinement and custodial authority of people who are awaiting trial or have been found guilty of an offence (Roual, 2012:3). A correctional centre refers to any place established under the Correctional Services Act (25 of 2008) where persons are sent for the purpose of imprisonment or detention. In this article, a correctional centre refers to a place where offenders are incarcerated following sentencing by a court (in other words, the study excludes remand detainees).

Offender

The term offender refers to a convicted person who is detained in custody for a criminal offence or who is being transferred in custody or is enroute from one correctional centre to another (White Paper on Corrections in South Africa, 2005:20). Offenders are removed from society because they may pose a threat to the safety and security of the general public (Davis, 2007:206). In the present article an offender refers to a person incarcerated in a correctional centre after having been found guilty of an offence.

Suicide

Suicide is when a person consciously inflicts harm upon him/herself with the intention to die (Barlow & Durant, 2009:249). It is the human act of intentional, self-inflicted death, in other words, death caused by self-directed injurious behaviour with the intent to die (Ireland & Rush, 2011:435). In this article suicide refers to an offender's intentional act of ending his/her own life.

Unnatural death

Unnatural deaths occur in violation of the natural law; it is abnormal because it is not in accordance with or determined by nature (Caplan, 2008:72). In the context of the present article, unnatural death specifically refers to suicide, which is the most common manner of unnatural deaths in correctional centres worldwide (Shaw, Baker, Hunt, Moloney & Appleby, 2004:267).

THE EXTENT OF SUICIDE IN CORRECTIONAL CENTRES

Suicide rates in correctional settings are higher compared to the general population (Sattar, 2001:v). Mortality rates in correctional centres between 2000 and 2007 in the United States of America (USA) show that suicide was the leading cause of unnatural deaths with 42 suicides per 100 000 offenders (Noonan, 2010:1-2). Among adult males incarcerated between 1984 and 2000 in Switzerland, a total of 174 unnatural deaths took place of which 76 were caused by substance overdose, 75 by suicide, 14 from road traffic accidents and 9 were due to homicide (Sattar & Killias, 2005:323). In Kingston, Canada, a total of 308 offenders died in custody between 1990 and 1999. Most of the deceased male offenders died as a result of suicide (90) followed by homicide (64). There was a much higher incidence of death by poisoning and suicide in correctional centres when figures were compared to the general population of Canada (Wobeser, Datema, Bechard & Ford, 2002:1111).

In South Africa, 1 048 deaths were recorded in correctional centres between April 2008 to March 2009, of which 66 were unnatural and mainly due to assaults and suicide (Muntingh, 2008:4-6). Between April 2009 and March 2010, 992 deaths took place, of which 55 deaths resulted from unnatural causes. Of the 55 cases, 55% were due to suicide, 34% resulting from murder and 11% were due to other causes (Van Zyl, 2010:29). Between April 2010 and March 2011, natural deaths totalled 900 and unnatural deaths amounted to 48 cases (Van Zyl, 2011:2).

RISK FACTORS ASSOCIATED WITH SUICIDE IN CORRECTIONAL CENTRES

In the present study, risk factors refer to those characteristics and vulnerabilities that could result in offenders committing suicide while they are in prison. The risk factors are broadly structured in terms of individual, interpersonal and structural classifications to guide the organisation of suicide risk factors. The authors acknowledge that the risk factors discussed below are not comprehensive and cover only the most important factors associated with suicides in correctional centres. In addition, the risk factors are briefly presented in order to allow ample space for local voices and experiences to feature in the results section.

Individual factors

Age

Younger offenders appear more at risk of committing suicide while they are imprisoned. An analysis of 464 cases of suicides in prisons in the USA by Thigpen, Beauclari, Hutchinson and Zandi (2010:13) revealed that 58% of the deceased were younger than 37 years of age. Depression about their future and embarrassment and remorse about their criminal acts could drive younger offenders to commit suicide (Liebling in Sattar, 2001:3).

Mental health

People with mental health illnesses present higher rates of suicide. The mental health of offenders is worse than that of the general population (Sattar, 2001:11). More than a third (38%) of offenders who committed suicide in prisons in the USA was identified to have had a history of mental illness at the time of intake, the greater part of whom suffered from depression or psychosis. One in five offenders (20%) who committed suicide was receiving psychotropic medication (mostly for depression) at the time of the suicide. In almost half (47%) of cases the deceased offenders were assessed by a mental health professional within three days prior to the suicide (Thigpen et al., 2010:17-18, 30). On 8 July 2014, an offender committed suicide in the Johannesburg Correctional Centre (Medium C) by taking an overdose of his prescription medication. The offender has been diagnosed with depression and had two previous suicide attempts (Skweyiya, 2015:67).

Alcohol and drug abuse

A history of alcohol and drug abuse is common among offenders. A survey done in 2004 by the Department of Justice (USA) showed that 70% of offenders in state prisons and 64% in local prisons regularly used drugs prior to incarceration (Mumola & Karberg, 2007:47). Nearly half (47%) of offenders who committed suicide in prisons in the USA had a history of substance abuse. One in five offenders (19.6%) was intoxicated at the time of suicide (Thigpen et al., 2010:15, 23).

Self-harm and attempted suicide

Prison officials sometimes identify self-harm or suicide attempts as a cry for help or attention-seeking behaviour (Pannell, Howells & Day, 2003:104-106). Offenders with a history of self-harming behaviour can later succeed in committing suicide. Research indicates that half of offenders who committed suicide had a history of self-harm and attempted suicide (Moscicki, 2001:316). In the USA, a third of offenders (34%) who committed suicide reported previous suicide attempts at the time of intake (Thigpen et al., 2010:19). Clearly, strategies are needed to intervene following a suicide attempt. For example, an offender in Johannesburg Correctional Centre was placed under suicide watch after he attempted suicide in a segregation cell. He received psychiatric treatment and fellow inmates were requested to monitor him (Tshabalala, 2014:46).

Type of offence committed

Evidence from the USA shows that offenders with particular profiles are more likely to commit suicide. The suicide rate of violent offenders was nearly triple that of non-violent offenders. Offenders incarcerated for kidnapping had the highest suicide rate, followed by offenders incarcerated for rape or homicide. Offenders sentenced to imprisonment for drug-related crime had the lowest suicide rate (Mumola, 2005:5).

Detention stage and length of prison sentence

One of the most vulnerable groups in correctional centres is inmates in the first month of their sentence, especially first-time offenders (Liebling & Maruna, 2005:212). The remand stage² in particular increases an offender's risk of committing suicide (Fazel, Cartwright, Norman-Nott & Hawton, 2008: 3). In local³ USA prisons, almost a quarter of all suicides occurred either on the date of admission (14%) or the following day (9%) (Mumola, 2005:9). Nearly two thirds (65%) of suicides in local prisons occurred within the first 30 days of incarceration, but only 7% of suicides in state prisons took place during the same timeframe (Mumola, 2005:4-5). Offenders who serve longer sentences are more at risk of committing suicide. In addition, offenders who are incarcerated for life present higher levels of suicide compared to those serving short-term sentences (Crighton & Towl in Sattar, 2001:10).

Interpersonal risk factors

Marital status and family contact

Offenders who commit suicide tend to be single (Sattar, 2001:8; Thigpen et al., 2010:14). Offenders who have very little contact with their families are at higher risk of committing suicide due to experiences of isolation. At the same time, contact with family members could fuel feelings of longing and depression. In USA prisons, roughly two-thirds (67%) of offenders who committed suicide and received a telephone call and/or visit died within 24 hours after the call and/or visit (Thigpen et al., 2010:31). On 24 August 2012, in Boksburg Correctional Centre, at 01:25 an offender was found hanging in the shower with a belt tied to the bars in front of the bathroom window. DCS had provided the offender with social work assistance after he had complained of a lack of communication with his family. He had been encouraged to communicate with his family in writing (Tshabalala, 2014:62).

Offenders who are parents

Offenders who have children are less likely to commit suicide. Not having children has been found a stronger predictor of suicide compared to marital status (Towl & Hudson in Sattar, 2001:3). The majority of incarcerated women have children (Wolf, Silva, Knight & Javdani, 2007:189). Concern about the wellbeing of their children could increase feelings of fear, anxiety, loneliness, anger and guilt (McGee, Joseph, Allicott, Gayle, Barber & Smith, 2007:509). Local research, however, demonstrated that incarcerated female offenders with children do not necessarily present high levels of depression, anxiety and stress (cf. Steyn & Hall, 2015:82), thus they may well present lower risks of committing suicide.

Structural risk factors

Prison infrastructure, lock-up times and materials

Offenders who are incarcerated in single cells are more likely to commit suicide compared to those who are accommodated in communal cells where inmates observe each other's behaviour (Thigpen et al., 2010:26; Van Zyl, 2010:30). Most suicides occur between evening lock-ups and morning unlocks in correctional centres as proper vigilance is often lacking between these times. Window bars in prison cells are sometimes used to commit suicide by hanging, while make-shift ropes are braided from blankets and sheets to hold the body weight in cases of hanging or self-strangulation (Shaw et al., 2004:267; Thigpen et al., 2010:24). On 28 December 2012, at Modderbee Correctional Centre, during unlocking, everything appeared in order. After submitting the total number offenders in the cell, all the units were ordered to recount as the numbers did not balance. During recounting officials found an offender in a single cell hanging from two steel beds that had been raised against the wall. The deceased's single cell had two beds instead of one and the beds were not bolted to the ground (Tshabalala, 2014:64).

Type of correctional centre

Correctional centres differ in terms of the number of offenders and human resources. It has been argued that offenders, especially first-time offenders, who are taken up in large correctional centres may experience higher levels of trauma and stress compared to those accommodated in smaller correctional centres (Towl & Crighton in Sattar, 2001:8). Similar arguments can be made regarding how correctional centres are managed; offenders may experience lower levels of stress in centres that are properly managed (Shabangu, 2006:13).

Overcrowding in correctional centres

Several correctional centres are dangerously overcrowded while others are well below maximum capacity. South Africa's correctional centres have accommodation for 117 814 offenders, although the latest figures indicate that 160 508 sentenced and remand offenders are accommodated in correctional centres (resulting in an overcrowding rate of 136%) (Department of Correctional Services, 2015). Offenders in critically overcrowded centres have less than 1.2 m² in which they sleep and spend the greater part of the day. Offenders have to manage with limited living space, unhygienic circumstances, spread of disease and insufficient healthcare, all of which can lead to tension and violence (Bridges, 2009:1). Overcrowding hampers adequate supervision of daily correctional centre life, while severely overcrowded facilities have less supervision as correctional officials are asked to monitor two to three times the number of offenders they can adequately control (Muntingh, 2009:5). Roughly two-thirds (68%) of offenders who committed suicide in South African prisons in 2013/2014 did so while they were left unattended/unsupervised in a single cell or shower area (Tshabalala, 2014:60).

THEORETICAL UNDERSTANDING OF SUICIDES IN CORRECTIONAL CENTRES

Strain Theory

Strain theories of crime and criminality originate from the work of Emile Durkheim on suicide in the late nineteenth century. Durkheim proposed that some suicides occur due to states of normlessness and rapid socio-economic change in societies. Assumptions about anomie and social strain as drivers of criminal behaviour were further developed by Merton and Cloward and Ohlin, while Agnew introduced the general strain theory which proposes that the subjective interpretation of the sources of strain influence the (criminal) responses to such strains (Langton & Piquero, 2007:2). Agnew identified three types of strain-inducing stimuli that could lead to criminality, namely the failure to achieve one's positively valued goals, the threat of or removal of positively valued stimuli and the threat of or the presence of negatively valued stimuli (Brown, Esbenson & Geis, 2010:294).

Blevins, Listwan, Cullen and Jonson (2010:148) applied the general strain theory to correctional settings. The authors explain that violence and other forms of problem behaviour in correctional centres are subjected to three models, namely the deprivation model, the importation model and the coping model. These three models were intergraded within the general strain theory. The theory enriches the deprivation model by revealing three broad categories of strain, namely stressful life events, chronic stressors and life hassles (Blevins et al., 2010:159). However, not all offenders will react to these strains with misconduct; rather, reactions to the strains of the environment depend on an individual's attributes and personal values (Blevins et al., 2010:159). Therefore, general strain theory encompasses the importation model in hypothesising that values and associations will structure the response of offenders to strains of the correctional centres (Blevins et al., 2010:150). General strain theory further incorporates the coping model in its emphasis on how a lack of social support can be seen as a strain for offenders (Blevins et al., 2010:151).

Escape Theory

The escape theory of suicide posits that suicidal behaviour may result from a failure to meet unrealistically high self-expectations. The theory predicts that suicidal behaviour is associated with emotional traits of sadness, anxiety, guilt and self-consciousness (Seidnitz, Conwell, Duberstein, Cox & Denning, 2001:124). Baumeister developed six main steps that explain suicide as an attempt to escape. The first step involves the individual's belief that existing circumstances fall short of standards. These views can be perceived as imposed by other people who are significant or can be self-imposed. The belief is caused either by worrying life events, by unrealistically high expectations or both (Dean & Range, 1999:561). In the second step of the escape theory of suicide, as a product of being unable to satisfy unrealistically high expectations, the individual makes negative self-attributions. The individual then blames the disappointing outcomes on him/herself, which creates negative implications about the self, such as low self-esteem (O'Conno, 2003:298).

In the third step of the escape theory of suicide, the individual develops a high state of self-awareness as a result of falling short of standards and attributing blame to the self. This is a negative self-awareness that creates the feeling of incompetence (Dean & Range, 1999:562). The fourth step, negative affect, such as anxiety and depression, arises because of high self-awareness that focuses on negative events blamed on the self. Depression is generally considered when studying predictions of suicide (O'Conno, 2003:298). The fifth step of the escape theory includes cognitive deconstruction, a subjective shift in the individual to less meaningful, less integrative thought and awareness. Hopelessness represents the components of such cognitive thought. Finally, the sixth step of the escape theory entails four consequences of cognitive deconstruction: disinhibition, passivity, absence of emotions and irrational cognition that can be linked to suicide (Dean & Range, 1999:564).

RESEARCH METHODS

A qualitative research approach was deemed necessary to investigate the phenomenon of suicides in correctional centres, especially in the absence of South African evidence on the matter (apart from the minimal data provided by the JICS Annual Reports). The purpose of the study was, therefore, explorative to identify and describe the risk factors and circumstances surrounding suicides committed by offenders (Hall, 2008:53). Qualitative and explorative studies are generally associated with non-probability sampling procedures. The JICS Annual Reports of 2010 to 2014 were scrutinised for incidences of suicides in correctional centres in Gauteng and the Zonderwater, Johannesburg, Boksburg and Kgosi Mampuru II correctional centres were identified as centres with such occurrences. At these correctional centres, professional service providers and correctional staff were deemed important sources of information, which resulted in two psychologists, two social workers and nine case management officers (CMOs) being identified through purposive sampling methods. The views of offenders had to be obtained and two focus group discussions were conducted with offenders at the Kgosi Mampuru II Correctional Centre. This facility was purposively selected due to one of the present authors engaging in developmental work at the facility and access to focus group participants could easily be arranged. Twelve offenders participated in the first focus group while seven of them participated in the second focus group. The personal interviews and focus group discussions were guided by semi-structured schedules to allow for follow-up questions on the matter of suicides in correctional centres. The interviews and focus groups were voice-recorded and transcribed verbatim. In addition to the personal interviews and focus groups, eight case files of offenders who died as a result of suicide in prison were scrutinised for background information such as biographic profiles, mental health and treatment, contact with family, general behaviour, parole applications and outcomes, and participation in rehabilitation programmes.

Data analysis amounted to content analysis where emerging themes and patterns from the various sources of information were identified and categorised. Data triangulation allowed confirming or highlighting incongruence within and across the different sources of information (Merriam, 2009:248-249), thereby also enhancing the trustworthiness of the study. The data is presented in text, where direct quotations serve to substantiate the observations made from the primary data. Moreover, and in line with qualitative research reporting, effort has been made to provide the reader with as much “insider perspective” as possible by presenting the data in the words of the research participants. The sources of information are also indicated. The standard ethical considerations applicable to research in the social sciences were adhered to throughout the study, in particular informed consent, voluntary participation, confidentiality and no harm to research participants. The study was approved by the Research Ethics Committee (Faculty of Humanities) and the Research and Ethics Committee of the Department of Justice and Correctional Services.

EMPIRICAL RESULTS

Background information

The research participants with professional qualifications (the two psychologists and two social workers) were all White females. Of the nine CMOs interviewed, all were male of whom six were Black and three were White. The participants in the focus groups consisted of male offenders with the first group comprising nine Black offenders, two Coloured offenders and one White offender. The second focus group consisted of one Coloured and six Black offenders. Of the eight case files scrutinised, all were male of whom six were Black and two were White. Some of the case files were incomplete, disorganised or damaged, with information not consistently clear on matters related to mental health, employment, contact with family and parole applications. Five deceased offenders were

imprisoned in maximum and three in medium security facilities. Two case files indicated that the offenders had medical problems. Only one case file indicated that the offender had no medical problem.

The manner of the deceased offenders' suicide amounted to five hangings and three cases of drug overdose. The research participants explained that there are different methods of committing suicide. CMO 2 noted: *"In the bathroom, using linens, bandages or sheets. They hang themselves or drink pills ... The problem is with pills. When they overdose, they are committed to hospital but come alright again. That is why they rather hang themselves"*. CMO 4 stated that: *"They use shoe laces, they can use belts, sheets, blankets to cut in pieces. Some use shirts for hanging"* while CMO 8 stated that: *"... people are hanging themselves and cutting themselves. Because hanging material is everywhere, you can use almost anything to hang yourself"*.

RISK FACTORS OF SUICIDE IN CORRECTIONAL CENTRES

The risk factors associated with suicide in corrections, as generated through the interviews, focus groups and analysis of the case files, are presented in terms of individual, interpersonal and structural variables.

Individual risk factors

Offender characteristics

The data notes a number of personal characteristics that serve as indicators for suicide, including inadequate communication skills that lead to the *"inability to deal with problems and stress"* (Psychologist 2). Weak internal control, low frustration tolerance and impulsivity can fuel suicidal thoughts: *"... it is his immediate reaction, when something goes wrong, they will commit suicide"* (Social Worker 2). CMO 8 commented that family problems could contribute to suicide ideation: *"... the father or the mother was absent in his childhood. You have to watch him carefully"*.

A lack of direction and withdrawn behaviour has potential to stimulate suicidal thoughts: *"... a do not care attitude"* (Offender 4). Offender 3 stated that: *"In my experience, most of the suicides happen from the first-time offenders because they do not want to accept their sentence"*. CMO 6 noted that: *"It is generally known that offenders guilty of rape and crimes against children are often treated harshly by their fellow offenders, a factor which could also increase suicide ideation"*.

Mental health and mental health services

Questions about mental health and suicide generated much comment. Social Worker 2 stated that: *"People with psychiatric or mental issues such as depression, anxiety and substance abuse are more at risk to commit suicide ... Mood disorders, psychiatric problems such as depression which goes hand in hand with suicide and isolation"*. In the context of depression, Offender 8 commented that: *"Now things are bad in my life, so I just give up, I do not try anymore ... it is the guy who throws in the towel, who does not want to get involved in stuff that means hard work"*.

Four case files included information about the mental health of deceased offenders that warrant extensive quotation:

"The offender was a mental health concern. The court recommended psychological treatment. The offender was suicidal and he also threatened to commit suicide. He heard voices at a later stage of imprisonment. He had nightmares and flashbacks related to his victims. He also had an aggression problem" (Case file 2).

“The offender was on psychiatric treatment. He explained how he felt anxious and fearful in his therapy session. He also mentioned that he had panic attacks in his single cell alone at night. He drank a lot of medication such as pills for his depressive state. He also had insomnia and a lot of nightmares. He said that the gangs harassed him. He said that he was very frustrated, especially for the situation he is in and that dagga relaxed him” (Case file 3).

“The offender was a mental health patient. He had insomnia, social withdrawal, irritability, poor impulse control, anger outbursts, suspiciousness and fighting with another offender. He was also afraid to sleep and struggled emotionally to cope. He could not sleep when other offenders were sleeping. He was prescribed psychiatric drugs but he had a history of drug abuse” (Case file 4).

“The offender was a known psychiatric patient. He struggled with sleep because he had insomnia and nightmares. He was on medication for sleep” (Case file 5).

Psychologist 1 provided the following information about a suicide case:

“He was going through a phase of depression, and after that it went better. When we think he is through the depression phase, he is actually the most at risk because he has the energy to commit suicide. A person who is suicidal is going through curves. He went through curves the whole four/five years I worked with him. It did not go very well with him, and I think it was a matter of time because he did not really see a future because of his sentence. Of course, other personal factors also played a role... The person was also on psychiatric drugs for a long period... he was suicidal before imprisonment... He did not have any more reserved energy to the noise, the locks, to be incarcerated, the stressors... He had no more energy to deal with everyday challenges”.

Correctional centres provide treatment for offenders: *“... especially with mentally ill offenders, we have a psychologist who comes in at least twice a month” (CMO 5).* Psychologist 2 explained that:

“... prisoners are referred or they will come on their own ... I make my services available to them but it is their choice to use our services. If I know about someone that is in need of my services I will go to him, I am not going to wait for him to develop a problem ... We are aware of a lot of offenders in the sections that are not identified/referred ... The psychiatrist comes once a week. The services are not on a permanent basis available”.

Social Worker 2 indicated that: *“There are offenders that must be removed from the prison environment and be located at a psychiatric institute”.* CMO 8 stated that: *“We are dealing with offenders. How are we going to treat offenders with mental problems? If he is not alright, he can commit suicide. They just dump them [mental health patients] here”.* CMO 6 identified a specific challenge the mental health system is faced with: *“Your primary health care currently says the hospital personnel can give a week’s or month’s medication, prescribed by the doctor to an offender, because he has to manage himself”.* Social Worker 1 elaborated that:

“... prisoners will get high-schedule medication, and a month’s medication will be given to them. Between 30 and 60 pills are made available to them. If you look at suicides, it is often due to an overdose of medication. I feel that the prison should be treated as a psychiatric institution, where the prisoners are on pill parades to get his daily medication. At this stage Primary Health Care is the

reason for the current distribution of medications. This is the most popular method to commit suicide”.

Regarding the availability of treatment, Offender 9 stated that:

“I saw a doctor and he prescribed me some pills. After two to three weeks, I went back to the hospital to get my medication. They said the pills did not arrive yet. In the fourth week I came back and they told me they gave my pills to someone else but it is okay, they will give me someone else’s pills”.

CMO 6 indicated that offenders with mental health problems are not a concern because *“... the programmes they attend are taking care of them”*. However, Offender 4 felt that the correctional centre does not have trained staff to deal with mentally ill offenders: *“... because they would ask inmates to look after the mentally ill. The people who look after that guy, they have their own problems. If they find a mentally ill person doing something wrong they would kick him and abuse him”*. Offender 6 continued that no mental health care was provided to this offender: *“... they beat him up and took him to the single cells”*.

Self-harming behaviour of offenders

Psychologist 1 stated that the self-harming behaviour of an offender can be seen as a cry for help:

“I think they sometimes use their methods to manipulate the system, for example, to go on a food strike. The one offender sewed up his mouth because he did not want to talk anymore. They do not necessarily want to end their life, but to gain something, which usually works”.

CMO 9 stated that: *“If the prisoners are crying for help, you can give more attention to them. They are like kids because they need a lot of attention”*. CMO 5 confirmed that these tactics have occurred in the past: *“... offenders who are cutting themselves, but it is just a superficial cut. It is actually saying something ... he is rebelling or he is against somebody abusing him and he is actually saying he has a problem”*.

Social Worker 2 noted that the offenders who present cry-for-help behaviour are immediately referred to them: *“We support them then they are in therapy. 90% of the cases are a cry for help ... the intentions are not always to kill themselves but to manipulate”*. Social Worker 2 further stated that: *“Unfortunately when some offenders are placed in isolation, they try to commit suicide. They know they will be taken out of the isolation if they have suicidal tendencies”*. Offender 11 explained that he also used this tactic: *“In 2013 I tried to cut myself to bring something under the authorities and area commissioner’s attention, about something that happened ... it was a cry for help and until today nobody took notice”*.

Time served and duration of sentences

Responses from correctional officials varied as to when suicides occur during the period of incarceration. CMO 8 stated that: *“In the beginning of a sentence ... They cannot take the prison environment. Some do not know there is parole”*. However, Social Worker 1 stated that: *“Mainly in the middle of the sentence. In the beginning they are still in shock and trying other alternatives to come out. In the middle of the sentence you have nothing to do and to fight for”*. Psychologist 1 noted that:

“The hardest time of a prisoner is in his last phase of sentencing. The risk is greater because it is a stage where nothing is happening. Especially when they have received feedback that their parole application was unsuccessful. The appeal also takes a long time, actually a few years and all their energy is focused”.

As to the duration of sentence and suicide, Social Worker 2 noted that: *"You will get someone who is a suicide risk on the outside ... where the period of his sentence was the last nail in the coffin, in order to trigger that behaviour"*. However, Social Worker 1 indicated that: *"... they will also tell you the life sentence is like a death sentence. For the lifers, it is a lot of uncertainty that goes with it and that may be a risk"*. CMO 6 explained that: *"... if you look at the short-termers, he has a focus and goal. But long-termers, everything is dark and you have no goal"*.

The case files of offenders who committed suicide indicated that the duration of their sentences ranged from four years (n=1), ten years (n=1) and 15 years (n=3) to 20 years or more (n=3).

Adjustment to prison life

The environment of some correctional centres was described as hostile and even dangerous: *"... unknown environment and staying with hardened criminals"* (CMO 1), *"... everyone are criminals"* (Psychologist 1) and *"Because here we live with strangers ... we do not live in a safe environment"* (Offender 1). CMO 2 reflected on some of the crimes committed by incarcerated offenders: *"... lots of sodomy. There is a lot of stabbings and smugglings that convert to violence. They smuggle dagga, mandrax, cell phones, money, because money is not allowed in prisons. In prison we have males who act as prostitutes"*.

Offender 4 explained that it is difficult to adjust to life in prison because of the unpredictable nature of the correctional centre: *"You cannot say what you are going to do tomorrow. The officials can come in anytime and search you"*. Offender 5 pointed out that even prison schedules are at times unpredictable: *"Sometimes there is no food and you cannot complain. They will not even listen to you, so then you have to wait until late before you can eat"*. Offender 7 felt that getting used to life in correctional centres depends upon the person, because *"... some people from outside live as animals and some people like people ... It only depends on how you live on the outside"*. Offender 8 stated that: *"... it was difficult for me because I was used to the things of the outside too much"*. Offender 9 noted that: *"... it is going to be difficult, especially if you do not have money in the prison ... You will get nothing if you do not have money"*.

Offender 9 stated that: *"Life in prison is difficult only when you think of the things on the outside"*. He added that it is problematic if you do not have money or visitors because: *"If you ask someone for cigarettes, milk and sugar, afterwards he is going to look for pay back. It is obvious what I mean with pay back – he wants to have sex with you"*. Offender 10 reportedly adjusted easier: *"... because I come with friends. We always said we were outlaws. So we take defeat of everything. But I think it is difficult for others"*.

Interpersonal risk factors

Psychologist 1 pointed out that *"most of them [the offenders] have contact with their family but there are others who are in isolation and have no contact"*. CMO 5 stated that family visits vary: *"It is 50/50. It is the families that comes in on a regular basis and puts more pressure on this person. We also found those who do not have visitors and the person gets depressed"*. CMO 6 suggested that there are relevant sources to assist offenders with their family ties: *"If he needs assistance from the correctional officials, there are relevant sources to go through such as social workers that he needs to contact, so that they can contact the family to make the family ties stronger"*.

Psychologist 1 noted that: *"Family problems from outside can sometimes be so dramatic that it can affect the offender to commit suicide ... especially when there are no visits or financial support from the family"*. Psychologist 2 added that: *"It is problematic, where they know there is no family waiting outside, where they have no option"*. CMO 7

agreed: "Maybe you feel like that you are dumped. You committed a crime so your relatives do not want to see you anymore". Offender 12 mentioned that: "If you do not have family support or lack of support you commit suicide because they feel they are useless and their families do not care for them". Further comments regarding family ties and suicidal behaviour are:

"Usually after the investigation the family would tell you that they indicated that they would commit suicide. In some cases you get those that do not have family or anyone relating to them. Normally when there are things that do not go well in the family and there is nowhere to go after release, they tend to commit suicide" (CMO 6).

"This plays a predominant role if the offender does not have contact with his family, especially if your cell mate has all those privileges and money ... the offenders feels frustrated and it can be seen as a risk factor" (CMO 8).

"One of the offenders did not want to cut his hair, shave or shower. The reason why he came to prison is that he was accused of raping his sister's child. So when he came here, the family did not want to have anything to do with him. His life went backwards, he went backwards. I do not know how he is now, but the last time I heard of him he took razors and cut himself. He was here last year, he burnt his cell. His whole body was burnt" (Offender 7).

CMO 8 emphasised procedures of dealing with family, especially if the offender is the breadwinner:

"If someone arrives today and we need to interview him, within six hours to see if there is family who is taking care of his kids. If he is the bread winner, we have to make contact with someone at home that will take care of the kids. After 24 hours they have to follow up and make an assessment".

Three of the eight case files of deceased offenders indicated their next of kin as their mother, while the rest indicated a sister, wife, grandmother and uncle. Very little information featured regarding the nature of relationships or the frequency of prison visits as can be discerned from the following statements in the case files: "The offender was not married. He had contact with his parents and siblings. He also had visits, telephone calls and letters from them" (Case file 3). "The offender was married. His wife had personal problems because she struggled financially" (Case file 4). "The offender's grandmother looked after him. He had one child and he had no father. The offender indicated he had problems getting visits from family/close friends" (Case file 8).

Structural risk factors

Single and communal cells

Offender 11 stated that it is easier for an offender to commit suicide in a single cell: "because you are alone for 23 hours". Psychologist 1 indicated that: "If an offender wants to commit suicide, he will manipulate the system so that he could be sent to a single cell". In some correctional centres, single cells "are more frequently monitored" (CMO 6). However, CMO 8 stated that: "... if you look at the Act, it says an offender in single cells must be monitored every 4 hours and it is not the case". Offender 9 provided more information about a suicide in a single cell: "... a guy in prison was sexually abused. The officials took him to the single cells instead of the person abusing him. He hanged himself because he was ashamed".

Psychologist 2 indicated that offenders with mental health problems or a history of mental health challenges must be placed in a communal cell since: "there is a policy that says that psychiatric patients cannot live alone in a single cell. A person who experiences

depression may not live in a single cell". Of the eight case files, two offenders who were incarcerated in single cells were mental health patients. The one mental health patient was transferred to a single cell on application. The reason for his application was: *"I am in fear for my own life"*. The other deceased offender with mental-health problems was incarcerated in a single cell as punishment because he was in possession of the hospital key.

Time of day of suicide

The data suggests that most of the offenders choose to commit suicide at night. CMO 6 explained that: *"Suicides happen mostly during the night, because in the day they are open"*. CMO 5 noted that: *"The reason for this is because they do not want to be saved"*.

Overcrowding as a risk factor in correctional centres

All the participants agreed that the correctional centres they were working at are overcrowded. CMO 7 stated that: *"All of them are overcrowded, especially those that are awaiting trial"*. CMO 5 felt that the issue of overcrowding has a serious effect on human resources: *"We cannot satisfy everybody. There could be somebody passing through the cracks"*. Overcrowding is a risk factor for stability in correctional centres because: *"... there are not enough staff ... and not enough developmental programmes for the offender"* (Social Worker 2). Offender 9 commented that: *"We sleep in toilets, on top of each other"* to which Offender 5 added: *"In a single bed, three guys will sleep there"*. Psychologist 1 explains that:

"Originally, there were a certain total in a cell and a single cell was only for one person. Overcrowding is starting to become a problem. Now there are more than 34 people in a communal cell that there are not supposed to be. In some prisons, there are even two to three in a single cell. Space becomes less".

Overcrowding affects offenders in different ways: *"If you wake up late you will not get the hot water ... you must wake up early, at 04:00"* (Offender 8). Offender 5 pointed out that there is not always enough food: *"... they will tell you the food is finished ... You must wait so that they boil eggs for you or they will give you four slices of bread"*. Offender 10 mentioned that: *"Overcrowding is also affecting my health, if you go to the hospital there is no pills ... you also cannot get any privacy"*. Offender 5 noted that:

"Another thing is smoking. For example there are 40 in a cell, 15 of them do not smoke, so the rest are smoking. For those people who do not smoke, it is a health risk. You will also see there is a TB test in prison every day because in prison there is the high rates of TB it is because of the blankets here".

Offender 8 explained how overcrowding also has an impact on their use of toilets: *"There is one toilet in a cell and then the cell is overcrowded. If you want to go to the toilet then somebody is already there ... The others even defecate in a plastic bag"*. Offender 5 added that: *"Even in the showers, there are three/four in a shower"*. Offender 3 stated that: *"Sometimes we are four that sleep in a single cell"*. The lack of space causes frustration, as Offender 5 remarked: *"You get angry and frustrated because you want to go to the bathroom, but the guy that is sleeping there does not want to move and that is when you end up fighting"*. Offender 5 provided another example: *"The one guy was doing life. He did not want anyone to sleep in his passage but they forced someone to sleep there. Then he boiled some water and threw it over that guy"*.

The providers of mental health services in the correctional centres acknowledged the link between the institutionalised environment and frustration. Psychologist 1 stated that:

"The people stay together, and you are with people the whole day that you do not want to associate with. This often causes impulsive outbursts. Their tolerance

levels are very low. The overcrowding definitely contributes to the frustration. The frustration levels contribute to the violence”.

Similarly, Psychologist 2 made reference to overcrowding, frustration and conflict:

“To be locked up with 40 prisoners for more than ten hours per day ... who are perhaps violent or aggressive and do not have any conflict management skills or communication skills. It is seen as stressors. There is a constant friction and frustration”.

Suicide and gangs in correctional centres

During one of the focus group discussions, Offender 1 stated that: *“When you are in you are in, you must die a gang member”* which is one of the well-known phrases used by gang members. CMO 5 noted that suicide can be an option to escape from a gang: *“Suicide is also a possibility, because people feel they have nowhere to run and only an escape or exit [is] to commit suicide”*. Social Worker 2 noted that: *“I think if a ‘wyfie’ in the 28s wants to drop his membership, where he is constantly misused and part of gang rapes, suicide can be an option”*. CMO 7 suggested that: *“In the Western Cape it is different. In the Western Cape they have so much intimidation, they took suicide as an option”*. Offender 5 explained in length:

“It all depends on the time. A few years ago the gang activities was like a lifestyle in prison to survive. The gang membership is actually a way for survival in prison. If you were not a gang member in prison, you would not have survived in prison. But now, today, you can get easy out of the numbers and out of the membership. In those days, you had to die or someone had to kill you to cancel the gang membership because they said once you are in it goes into your veins, thus when your blood is a 26, you are going to die a 26”.

The case files of deceased offenders indicated that three were affiliated with gangs (one having been a captain in the 28 gang), three did not belong to a gang and two files contained no information on gang affiliation.

DISCUSSION

Suicide is a global phenomenon and occurs in correctional settings where the behaviour of offenders is supposed to be supervised. As elsewhere in the world (Sattar & Kiliyas, 2005:323; Wobeser et al., 2002:1111), suicides in South African prisons mainly take the form of hanging and drug overdose. In terms of self-hanging, offenders make ropes from various materials to support their body weight such as sheets and blankets, with these suicides taking place in bathrooms, presumably from showerheads or the railings of shower curtains. With reference to unnatural deaths in prison by drug overdose, the literature and results are unclear as to whether these deaths are due to accidental drug overdose or overdose with the intent of committing suicide.

The primary health care system appears to facilitate suicide by drug overdose since medication is dispensed to patients for a week or even a month in advance. Persons with mental health problems are more prone to suicide (Thigpen et al., 2010:17) and, coupled with the negative attributes of life in prison creates conducive circumstances for suicide by drug overdose. Depression appears particularly prevalent among offenders (Thigpen et al., 2010:18), although other mental health conditions may well play a role in suicide (*“heard voices”, “had flashbacks”, “nightmares”, “anxious”, “panic attacks” and “insomnia”*). Managing and counselling offenders who receive mental health treatment may be constrained by shortages in professional staff (*“we have a psychologist who comes in at least twice a month”*) as well as the availability of treatment (*“they said the pills did not arrive yet”*). It is

of grave concerns that, at some correctional centres, offenders are expected “*to look after the mentally ill*”. Prison officials expressed similar concerns (“*they just dump them here*”) which raises questions about the pre- and post-sentencing assessment of offenders.

The above demonstrates the important role of mental health as a risk factor in offender suicides, and specifically so in three contexts: mental health status prior to imprisonment, the influence of the prison environment on mental health following incarceration, and the mental health services and treatment available to imprisoned offenders. In addition, poor communication and problem solving skills may fuel levels of frustration and intolerance, which could cause offenders to consider suicide as a way out of their current situation. The results further indicate that offenders guilty of certain offences, in particular sexual violence against children, are treated harshly by fellow-inmates which suggest close monitoring of potential victimisation and suicidal behaviour in this group of offenders. Self-harm as a risk factor for suicide proposes that such behaviour entails a cry for help, in other words a dire expression to communicate a matter of (personal) importance, although self-harm could result in unintended serious injuries. Limited contact with family members and significant others, including receiving financial support from them was put forward as a risk factor for depression and suicide. The results confirm the literature (Van Zyl, 2010:30) that suicides take place more often in single as opposed to communal cells and calls for closer consideration when an offender requests to be moved to a single cell.

The results provide no clear indication at what stage of imprisonment suicides are more likely to occur thus suggesting that suicide can take place at the beginning, middle or end phases of incarceration. Nevertheless, the data propose that offenders serving longer sentences are more at risk of committing suicide (“*short-termers ... a focus and goal*”). Short-term offenders (i.e. offenders serving a sentence of less than two years) may not experience the same feelings of decreased meaning, anxiety and depression about the future. Also, offenders serving short-term sentences are not exposed to the long-term impact of chronic stressors and hassles associated with life in prison, which suggest that the theoretical frameworks adopted by the present study may apply to a lesser extent to this profile of offenders. In addition, the time of qualifying and applying for parole, as well as the outcomes of parole decisions, appear important variables in suicidal behaviour.

The theoretical frameworks presented earlier advance understandings of the risk factors associated with suicide in prison. The escape theory proposes that suicide stems from, among others, sadness (“*Now things are bad in my life*”) and guilt (“*suicides happen from the first-time offenders because they do not want to accept their sentence*”). Such feelings tie in with the general strain theory’s notion of removal of positively valued stimuli (“*Life in prison is difficult only when you think of the things on the outside*”) and the presence of negative valued stimuli (“*staying with hardened criminals*”; “*we do not live in a safe environment*”). The deprivation model suggests that chronic stressors in the immediate environment (“*the noise, the locks, to be incarcerated, the stressors*”) and life hassles such as overcrowding (“*you want to go to the toilet then somebody is already there*”) could affect coping mechanisms (“*angry and frustrated ... you end up fighting*”). In addition, the individual’s belief that existing circumstances fall short of standards drives hopelessness (“*he did not really see a future*”) and depression (“*which goes hand in hand with suicide*”). Such beliefs can be self-imposed or enforced by others (“*the family did not want to have anything to do with him*”). One aspect of eventual cognitive deconstruction in the escape theory relates to subjective shifts in perceptions of meaning (“*so I just give up*”) which is potentially experienced more often by offenders serving longer-term sentences (“*long-termers, everything is dark and you have no goal*”).

The researchers present the following risk alert model, which could assist correctional staff in the early identification of suicide ideation and suicidal behaviour.

Table 1: Risk alert model for suicide in correctional centres

Risk factor	Descriptor (increasing risk)
Individual level	
Age	Younger age
Offender characteristics	Poor communication skills, weak internal control, low frustration and tolerance, impulsiveness
Mental health	Diagnosed with mental health condition and receiving treatment (prescription medication)
Substances	Alcohol and substance misuse prior to imprisonment
Self-harm	History of suicide attempts and attention-seeking behaviour
Type of offence	Having been convicted of violent offences, kidnapping and sexual transgressions
Detention stage	Initial/first intake and remand status
Duration of sentence	Offenders serving longer and life sentences
Number of sentences	First time offenders
Parole	Application procedures, turn-around time of decisions and rejected parole
Interpersonal level	
Social support	Poor relationships inside and outside correctional centre; absence of visits by family
Victimisation	Rape and sexual assault
Structural level	
Infrastructure	Single cells and structural features
Materials	Access to materials to commit suicide
Overcrowding	Lack of supervision and dealing with harsh living conditions and limited resources

The risk model presented above is based on the literature and qualitative results of the present local study. It represents, therefore, a crude and provisional attempt at condensing the identified risk factors with the view of portraying important indicators of potential suicidal behaviour of sentenced offenders. Refinement of the model is needed in order to identify which of these predictors are robust in the identification of likely suicide behaviour.

FUTURE RESEARCH

The present research findings furthered, from a qualitative stance, knowledge regarding suicides in correctional centres. Future research should encompass quantitative, random sampling strategies to strengthen the generalisation of results to other correctional centres. Potential differences between public and private prisons in South Africa further warrant investigation. Other themes for future research include the training of frontline correctional staff to identify and manage suicides in prison, correctional policy on suicide and mental health services and treatment in correctional centres.

RECOMMENDATIONS

The Department of Justice and Correctional Services should place more emphasis on following the correct procedures regarding the treatment of offenders with mental health problems. It is also recommended that the current practice of issuing offenders with a week or month’s prescription of psychiatric medication should be revisited and that pill parades be reinstated as overdose is one of the main methods of committing suicide in corrections.

Proper training is needed for officials regarding the recognition, assessment and management of offenders who pose a suicide risk – these vulnerable offenders include youth offenders, the mentally ill and those incarcerated for the first time. The infrastructure of some correctional centres should be revisited because it appears to facilitate suicide, for example suicide by hanging from showerheads and curtain railings. Furthermore offenders housed in single cells should be discouraged from covering the cell door window, by using sheets, as it prevents proper observation into the cell. Additional professional DJCS staff is needed, in particular psychologists, social workers, psychiatrists and medical professionals to provide greater access to health and mental health services. Programmes must be developed specifically to strengthen the mental health of offenders. Overcrowding can be addressed by using alternative sentencing in cases of first-time offenders who committed non-serious crimes.

ENDNOTES

1. Following the 2014 general elections, the Department of Correctional Services merged with the Department of Justice and Constitutional Development to form the Department of Justice and Correctional Services (DJCS).
2. Remand detainees await trial to determine whether they are guilty or not. More remand detainees commit suicide than sentenced offenders (Sattar, 2001:11), potentially due to the daunting prospects of trial and imprisonment.
3. In the USA, local prisons accommodate detainees while state prisons house convicted offenders (Department of Justice, 2005:5).

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