
9. HIGH RISK BEHAVIOURS IN PRISON: THE NEED FOR BEHAVIOURAL REHABILITATION

The present prison system is a university with a difference. It serves as a fertile ground to convert small time offenders and help them graduate to being a part of an organised crime syndicate. Merely rounding people up, without offering opportunities for change in attitude and behaviour is the biggest failure of custodial settings. In India, thousands of persons enter prison each year, and a substantial number are periodically released on bail. Any opportunity to offer a corrective experience is completely lost in the 'prison mentality', which looks at time in prison as 'punishment' and has the attitude that 'nothing works'. That is certainly not the case. Rehabilitation is arguably the best approach towards correction as most prisoners are released at some stage.

There is an urgent need to explore the reasons behind the offending behaviours that lead to people getting into prisons, so that the best remedy can be offered. For example, a person who commits crimes when drunk but not when sober is likely to be suffering from harmful use of alcohol. Treating the alcohol problem may diminish the chances of the offending behaviour. Similarly, a person may become violent because of his/her difficulty in controlling anger. Anger management techniques will help such an individual in the long run. A person who gets into frequent fights with the family may benefit from family therapy. Hence, there is a need to identify the characteristics which can predispose the prisoner to commit a crime or reoffend. This is also called identifying an individual at 'high-risk'.

High risk behaviour is any behaviour that places a person at increased probability of suffering from a particular condition compared to others in the normal population. In simple words, high-risk behaviours increase the possibility of negative consequences or outcome. This chapter focuses on the prisoners with high-risk behaviours, presents brief treatment strategies for managing each and concludes with a proposed set of recommended goals for creating a national strategy to develop behavioural rehabilitative and reformative programmes in correctional settings.

Prisoners with High-Risk Behaviours

Prisoners persistently engage in a range of behaviours such as violence towards others, suicide, suicidal attempt, deliberate self harm, substance use, unprotected sexual activity,

slavery and destruction of public property that increase their probability of being involved in serious physical diseases or mental disorders. Such behaviours result in frequent conflict with law, death, injuries to self or others.

Table 1. High-Risk Behaviours and their consequences

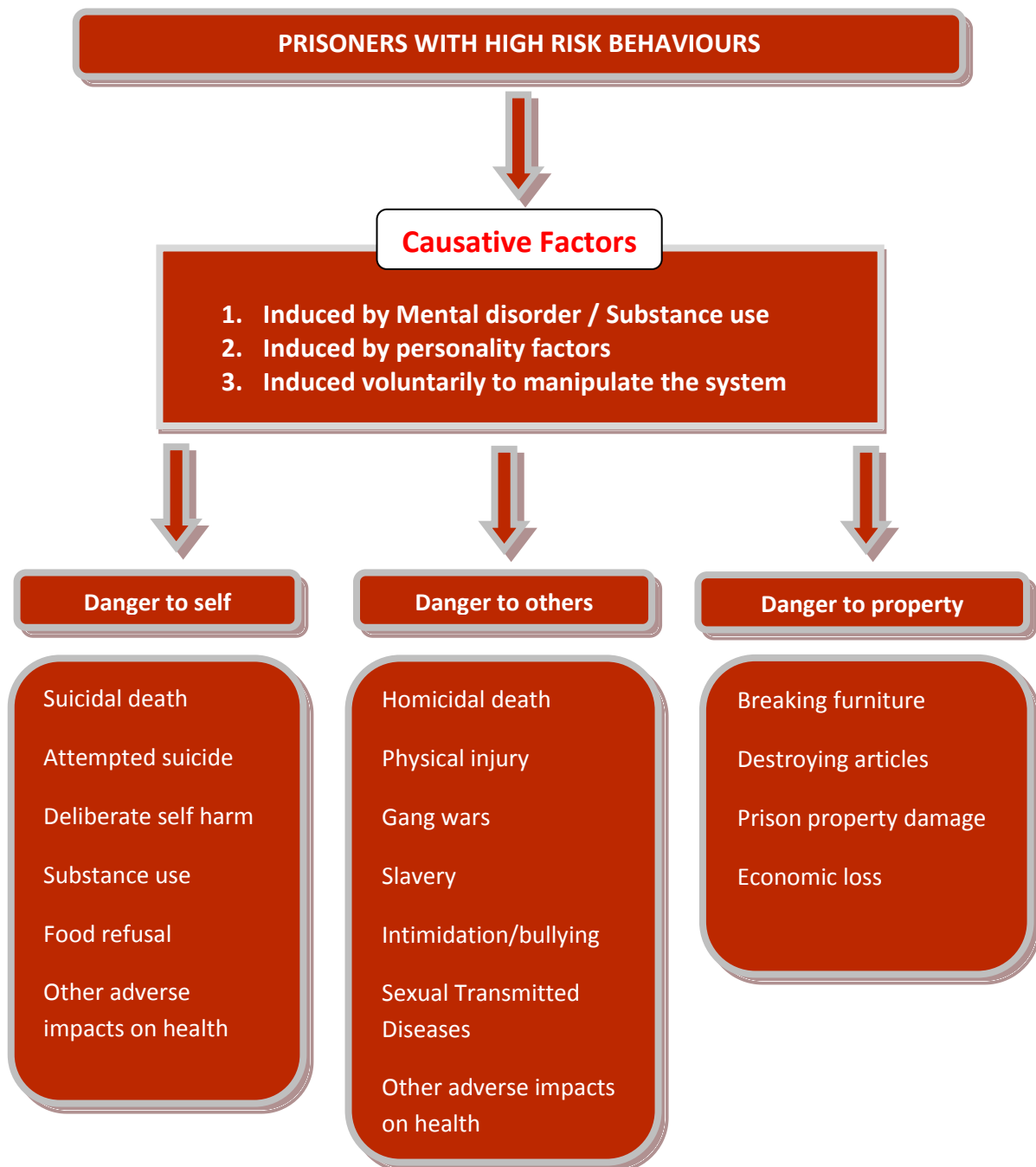
High-risk behaviours	Negative outcomes
<i>Unprotected sexual intercourse with multiple partners</i>	Sexually transmitted diseases, HIV, AIDS and Hepatitis
<i>Alcohol use</i>	Conflict with law, crime, physical cruelty, domestic violence, public nuisance, poor judgement, physical and mental illnesses
<i>Drug use</i>	Accidents, violence, conflict with law, physical and mental illnesses
<i>Cannabis use</i>	Acute intoxication, Psychosis
<i>Intravenous drug use</i>	HIV, Hepatitis, septicaemia
<i>High speed driving</i>	Accident, Death
<i>Smoking</i>	Cancer, Hypertension
<i>Tobacco chewing</i>	Oral cancers
<i>Sedentary life style</i>	Obesity, hypertension, diabetes and depression
<i>Deliberate self-harm</i>	Death, grievous injury, conflict with law
<i>Suicidal attempt</i>	Death, grievous injury, conflict with law

Given the poor quality of assessment and lack of remedial measures in prison, most prisoners with high-risk behaviours remain undetected and these problems remain unaddressed. For the purpose of managing prisoners with high-risk behaviours, it is useful to have a classification of these behaviours based on causative factors on the one hand and consequential dangers on the other.

It is essential to know the causes of high-risk behaviours, so that effective management can be planned. These high-risk behaviours have consequential danger and impact at various levels. Impact can occur at personal level, on others and property. Prison environments breed aggressive behaviours. Many prisoners get things done by expressing their dominance through aggression and violence. This acts as a model for other prisoners

to try and emulate. Hence, it becomes essential to modify their behaviour before they leave the prison. If not intervened, this may continue even in the community. Behaviour modification needs to be considered seriously in all the correctional centres.

Figure 1: Most commonly noted high-risk behaviours in prisons



High-risk behaviours can occur for a variety of reasons as shown below.

Figure 2: Causes of high-risk behaviours in prisons

Mental Disorders or Substance use

- Persons with mental illness have abnormal behaviour and violence resulting from the illness. Similarly, substance use (alcohol, cannabis, cocaine and other drugs) can cause abnormal behaviour because of intoxication or substance induced mental illness.

Personality Factors

- Sensation/novelty seeking, poor coping skills, ineffective communication, impulsivity, poor interpersonal skills, low frustration tolerance, seeking immediate gratification, release of emotional turmoil and exploitative behaviours

Malingering /Ulterior Motive

- Behaviour with ulterior motive to manipulate the system

Unfortunately, the current correctional system works under the punishment principle and not for reformation and rehabilitation.

DANGER TO SELF

Dangerousness to self behaviour in prisoners is detrimental both to the individual and the safety and morale of the prison environment. High mortality in prisoners has been attributed to various factors such as suicide, self injurious behaviour, substance use, TB, HIV and other health related conditions (Kjelsberg and Laake, 2010). Media highlights only the custodial deaths due to police excess but unfortunately forgets that more deaths occur because of health related reasons causes, which often go unnoticed. However,

currently, many countries have been calling for action to prevent such deaths and to educate staff in prevention, early recognition and management of such behaviours.

“Dangerous to self” behaviours are those behaviours which have a direct effect on both prisoners’ physical and mental health. These behaviours are shaped by a number of interacting factors such as mental disorders, personality factors, impulsivity, physical illness, personal motive, financial, family, social, cultural, situational, psychological, and biological factors. Dangerous to self behaviours can be classified into substance use (alcohol, nicotine, cannabis, cocaine, opioid and other substance use), self injurious behaviours and food refusal. Substance use related issues, because of their magnitude and ramifications are discussed in a separate chapter.

Food refusal

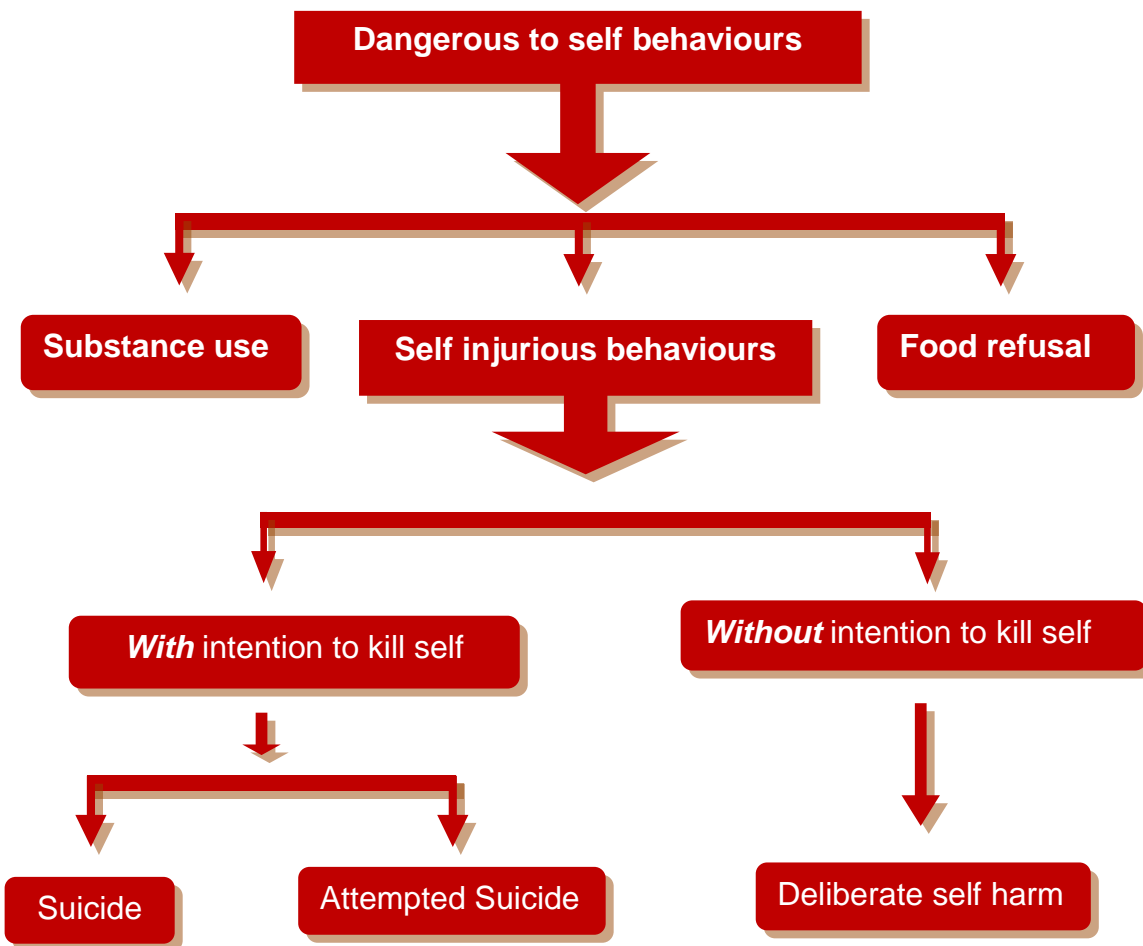
Food refusal can occur for different reasons. Prisoners, singly or in a group, can refuse food by agitating to fulfil their demands (for e.g., going on strike). The most common reason for this in prisons is poor quality of food. Another common reason for food refusal is ill- health (decreased appetite because of Cancers, AIDS, Tuberculosis, Depression, Psychosis and other illnesses). In the latter, the underlying cause needs to be treated. For all other reasons underlying this behaviour, the prison administration needs to form guidelines and standard operating procedures to deal with such situations without violating the rights of the prisoners.

Self injurious behaviour (SIB)

The most challenging and problematic behaviour in prisons is self injurious behaviour. Self-harm among prisoners is a common phenomenon (Knoll, 2010). A study on the prevalence of self-injurious behaviour (SIB) among Greek male prisoners revealed such behaviour among 35% (Sakelliadis et al., 2010). The most common underlying motives were to obtain emotional release (32%) and to release anger (21%). Psychiatric disorders, illicit substance use and aggression seem to be powerful predictors of SIB in prison population (Carli et al., 2010; Sakelliadis et al., 2010). Similarly, another study reported that 42% of prisoners had lifetime suicide ideation, 13% attempted suicide and 17% were self-mutilators (Carli et al., 2010).

Self-injurious behaviour among prisoners poses a great challenge to the correctional staff, mental health team, public health administrators and also to the judiciary. To address SIB, there are many barriers and obstacles to effective assessment and treatment (Fagan et al., 2010). Self-injurious behaviour resulting from suicidal and non-suicidal intent needs to be distinguished to plan for appropriate management.

Figure 3: Dangerous to self behaviours



Defining self injurious behaviours

Various definitions have been suggested for self injurious behaviour. There is no single standard acceptable definition and classification. Self injurious behaviour is a very complex behaviour with various factors contributing to it. It encompasses a range of phenomena from fatal to non-fatal behaviours. There are ongoing debates regarding what

constitutes self injurious behaviour. From the prison and correctional centre's perspective, self injurious behaviour needs to be understood differently than it is in the community. In a correctional setting, the behaviour needs to be de-codified from the management and rehabilitative perspective.

Prison staff and the medical team in charge must ask themselves the following questions, when they encounter SIB in a prisoner.

- a) What is the medical condition of the prisoner? (For emergency medical management)
- b) What is the intent of the SIB (Death or non-lethal)? (To de-codify the behaviour)

Motivation of the SIB provides clear indication of the prisoner's thoughts, emotions and behaviour. This also provides an immediate management plan and also future prevention strategies. The following classification and definitions can help in understanding and managing self injurious behaviour.

Defining self injurious behaviour

Suicide is the act of intentionally taking one's own life.

Attempted suicide is an unsuccessful attempt to kill oneself.

Suicidal ideations refers to thoughts of killing oneself, in varying degrees of intensity and elaboration

Deliberate self harm is a behaviour in which people inflict harm upon themselves, without intention to die and with non-fatal outcome.

Source: Chandrashekar et al., 2007; Shneidman, 1985

SIB with intention to kill oneself

Jails and prisons are responsible for protecting the health and safety of their inmate populations, and it is the responsibility of the state to protect the prisoners. If the state is not able to protect its own citizens under their custody, it raises serious questions about protective mechanisms in place outside the prison. The World Health Organization estimates that one suicide attempt occurs approximately every three seconds, and one completed suicide occurs approximately every minute. Every year more than one million people commit suicide throughout the world, accounting for 1 to 2 per cent of total global

mortality (World Health Organisation., 2000). Suicide is a serious health problem. Suicide and attempted suicide are symptoms of emotional distress. Suicidal behaviour is “a desperate cry for help” or a way of showing one’s anger and frustration. This can manifest as suicidal thoughts (suicidal ideations), and suicidal actions (suicidal attempters and completers). Data on suicides, attempted suicides and other self-harming behaviours that occurred from 1990 to 2002 was studied in Italian prisons. Over the study interval, completed suicide rates in Italian prisons were constantly about ten times higher than among the general population. Attempted suicides were about ten times higher than completed suicides. Female prisoners were significantly more likely to attempt suicide, whereas male prisoners were more likely to complete suicide (Preti & Cascio, 2006).

Higher rates of suicide in prison can be attributed to the following reasons.

These reasons operate in combination rather than in isolation.

- Jails and prisons are repositories for vulnerable groups that are traditionally among the highest risk for suicide, such as young males, the mentally ill, socially disenfranchised, socially isolated, substance abusers, or previous suicide attempters.
- The psychological impact of arrest and incarceration or the day-to-day stresses associated with prison life may exceed the coping skills of vulnerable individuals.
- There may be no formal policies and procedures to identify and manage suicidal inmates.
- Even if appropriate policies and procedures exist, overworked or untrained correctional personnel may miss the early warning signs of suicidality.
- Correctional settings may be isolated from community mental health programmes so they have poor or no access to mental health professionals or treatments.

Source: World Health Organization (2000). Preventing suicide; a resource for prison officers. Pub by; Mental and Behavioural Disorders, Department of Mental Health, World Health Organization, Geneva (WHO/MNH/MBD/00.5)

A study conducted on Australian adolescents on remand reported that 19% had made a suicide attempt during the previous 12 months compared to 4% in the community (Sawyer et al., 2010). Similar results have been replicated in adolescents on remand. It has been estimated that they is a four fold increased risk for adolescents in correctional settings than in the community (Suk et al., 2009). Studies have also documented that

recently released prisoners are at a markedly higher risk of suicide than the general population. Factors significantly associated with post-release suicide were a history of alcohol misuse or self-harm and having psychiatric disorder (Pratt et al., 2010)

RISK FACTORS FOR SUICIDE

Risk Factors: Evidence from prison population studies

1. Previous history of suicidal attempt
2. Mental illness like-depression, bipolar disorders and schizophrenia
3. Substance use such as alcohol, cannabis, cocaine, opioid and use of other drugs
4. Poor social integration (lack of confiding relationships/long standing relationship problems)
5. Recently sentenced/convicted/serving life sentence
6. Young or elderly male
7. Impulsive and aggressive personality traits

(Baillargeon et al., 2009; Camilleri & McArthur, 2008; Carli et al., 2010; DuRand et al., 1995; Fazel et al., 2005; Fazel et al., 2008; Knoll, 2010; Pratt et al., 2010)

Risk Factors: Evidence from general population studies

1. Family history of suicide
2. Family discord
3. Poor family support, broken family, physical abuse by parents, feeling neglected by parents and loss of loved ones
4. Hopelessness
5. Barriers to accessing mental health care
6. Ongoing and /or recent life events such as relationship problems, loss of romantic relationship, financial loss, job related and social issues
7. Chronic medical/surgical illness including HIV, AIDS and cancer
8. Loss of social status / reputation in the society.
9. Easy access to lethal methods to killing oneself
10. Unwilling to seek to help because of stigma attached to mental health consultation and substance use consultation
11. Evolving personality disorders
12. Cultural and religious beliefs

(Beautrais, 2000; Hirschfeld & Davidson, 1988; Mortensen et al., 2000; Phillips et al., 2002; Satcher, 1999; Vijayakumar & Rajkumar, 1999)

In many countries, there has been a call for action to prevent such deaths and to educate staff in the early recognition of suicide risk. The best practices for preventing suicides in jail and prison settings should include the following elements: training programmes, screening procedures, communication between staff, documentation, internal resources, and debriefing after a suicide (Pompili et al., 2009). There is also a need to improve the continuity of care for people who are released from prison (Pratt et al., 2010)

SIB without intention to kill oneself

Deliberate self-harm (DSH): This is behaviour in which persons hurt or harm themselves without the motive of suicide. Most commonly noted DSH in prisoners are:

- a) Superficial cuts (wrist slashing, trying to cut their own throat, abdomen, hands and legs) on the body parts using sharp objects
- b) Head banging
- c) Swallowing non-edible materials such as glass pieces, blade pieces and other material
- d) Scratching
- e) Opening old wounds

Findings suggest that self-injury occurs regularly and recurrently in a subset of inmates. The causes for DSH are mental illness, substance use, personality problems, manipulative behaviours and as a coping mechanism (DeHart et al., 2009). It has also been noted that many prisoners with anti-social personality, borderline personality, mental retardation and organic brain disorders indulge frequently in DSH behaviours (Sarchiapone et al., 2009). Many a times such behaviours occur under drug intoxication. Depression, frustration and an avenue to release their pent up emotions also play a crucial role (Jenkins et al., 2005). There are prisoners who indulge in DSH behaviours to seek attention from the prison staff, co-prisoners and family members. They also do it to manipulate the prison authorities for personal gains. Though deliberate self harm is not lethal, it is a strong predictor of repetition of DSH and completed suicide in near future (Fazel et al., 2008; Skegg, 2005). Hence, each DSH attempt needs to be taken seriously and evaluated.

DANGEROUS TO OTHERS AND PROPERTY

Dangerousness to others in prison setting results in harm to the co-prisoners and to the prison staff. Harming others may range from physical to verbal harm. It can be considered as a spectrum, with bullying on one extreme and homicide on the other. It also encompasses violence, attempts to dominate and to obtain sexual gratification. Behavioural scientists believe that aggression is present in each of us, and can be modified by experience in both positive and negative ways. They have defined aggression as behaviour aimed at causing harm or pain to others or self. Human aggression can be manifested towards self or others, can be direct or indirect, physical or emotional, active or passive, and verbal or non-verbal (Chandrashekar CR et al., 2007). It may even take the form of slavery such as forcing co-prisoners to perform activities that degrades them. Violence directed towards others can be in the form of physical injury/harm (hitting), psychological pain (insulting), destruction of property and bullying (shouting or spreading rumours). Violence and aggression raises concerns about its serious impact on the correctional system, safety of others, economic and public health issue. Violence in prison settings is endemic but at times it takes epidemic forms if proper mechanisms are not in place. Prevalence of aggression and violence towards others varies depending upon the type of violence measured.

Violence in prison is a known phenomenon all over the world, but how the prison authorities deal with such behaviour is debatable from various perspectives, including health and human rights. Responses can be self defence, physical restraint, physical torture, punishment, isolation in a dark room, withholding basic needs and at times chemical restraint. Correctional facilities have a responsibility to take "reasonable measures" to preserve and protect inmate safety (Wolff & Shi, 2009). The problem of aggression in correctional institutions should be recognised and effective preventive measures need to be put in place against violent behaviours (Merecz-Kot & Cebrynska, 2008)

Causes for violence

Many inter-related and complex factors have been attributed to violence and include illness, personality traits, and individual as well as environment factors. However, there may be instances of violence without any identifiable causes. This is commonly seen in persons with mental illness and substance induced intoxication. They may indulge in

violence without any provocation. Often, correctional setting administration denies any sexual encounters in prison. The unisex nature of the prison institution provides a potentially fertile ground for sexual aberrations. Various kinds of sexual activity have been documented such as masturbation, transsexualism, prostitution, sex between prisoners and prison staff, consensual homosexuality and non-consensual homosexuality (rape among prison inmates) (Awofeso & Naoum, 2002). Such behaviours are often associated with dangers to self and others.

Causes for violence in prison settings:

Illness factors:

- ✓ Mental illness
- ✓ Substance use such as cannabis, cocaine, opioid and other drug use

Individual factors:

- ✓ Personality factors such as impulsivity and low self esteem
- ✓ Poor coping skills
- ✓ Revenge
- ✓ To show dominance
- ✓ To revolt against authority
- ✓ Stress

Pleasure:

- ✓ Sexual gratification
- ✓ Gambling
- ✓ Entertainment (bullying)

Environment:

- ✓ A response to dissatisfaction with food, water, entertainment and other facilities
- ✓ Gang wars
- ✓ Rigid inhuman rules and torture
- ✓ Corruption

Considering the causes of violence, the question that rises in such situations is when to intervene? How to intervene? When to seek professional help? In order to answer these questions, other important dimensions to be considered with regard to aggressive behaviour are the antecedents, situations, frequency, duration, intensity of the aggression

and deviation from the cultural and social norms. All forms of violence may not require professional help. However, there are certain prisoners at risk who require professional help. Hence, it is essential to identify these high-risk prisoners and provide the necessary professional help.

People at risk of having frequent aggressive behaviour: Learning to identify and predict those at risk of developing aggression can prevent serious consequences. The following risk factors have been identified:

People at risk of having frequent aggressive behaviour

Individual factors:

- ✓ Mental illnesses like depression, anxiety disorders, epilepsy and psychosis
- ✓ Substance use such as cannabis, cocaine, opioid and other drug use
- ✓ Personality factors
- ✓ Poor coping skills
- ✓ Childhood trauma like sexual/physical abuse

Family factors:

- ✓ Family discord
- ✓ Violence within the family (role model)
- ✓ Substance use by the parents
- ✓ Poor family support

Social factors:

- ✓ Poor social support
- ✓ Exposure to violence
- ✓ Victimisation by peers (bullying)
- ✓ Life events and stress

The notion that ‘nothing works’ in offender rehabilitation has slowly faded and evidence based behavioural interventions are being introduced in the rehabilitation programme. In recent years, correctional administrations have increasingly identified prisoners with high-risk behaviours as a key target group for rehabilitation programmes and a number of such programmes have been developed.

MANAGEMENT OF PRISONERS WITH HIGH-RISK BEHAVIOUR

‘Dangerous to self’ - management in prisons

Any ‘dangerous to self behaviour’ such as suicide usually occurs as a process in which a chain of events leads to the final act and this process is usually triggered by a precipitant. A person may show various signals like neglecting personal care, becoming withdrawn, eating less, showing decreased interest in almost all activities, increasing use of mind altering substances. He or she may even verbalise ‘directly’ plans of harming self (by saying ‘life is not worth living’ ‘I wish I had not been born’ ‘I will kill myself’) or ‘indirectly’ (‘every thing will be all right within few days’ ‘saying good bye’ ‘meeting loved ones before the act’ ‘donating favourite articles/things to others’). Suicide is usually preceded by weeks/days of death wishes, suicidal ideas, depressed feelings, plans and subtle warnings. Thus, it is preventable by timely identification and response to such pre-act symptoms.

Assessment of high risk behaviours needs to be done from the first day of the imprisonment and then periodically depending upon the situation and environment. The influence of dynamic risk factors (for e.g., easy availability of substance use, mental illness, stress) highlights the importance of assessment at regular interval for the risk of imminent and repetitive violence. However, prison staff work under various constraints such as lack of trained human resources, inadequate funding and poor infrastructure. These factors also act as barriers in planning effective management. Low staff morale and burnout are the most important challenges. Acknowledging the prevailing situation, a simple assessment and management outline has been suggested here. It is essential to have a national and regional policy to prevent high-risk behaviours rather than blaming the correctional staff.

a) Need for Suicide Prevention Programmes in Correctional settings as a national policy

All correctional facilities, regardless of size, should have a reasonable and comprehensive suicide prevention policy that addresses the key components noted in the following sections. Of course, it is not the officers' but prison authorities' responsibility to approve and install such programmes (World Health Organization, 2007).

b) Training

The essential component to any suicide prevention programme is properly trained correctional staff, who form the backbone of any jail, prison, or juvenile facility. Very few suicides are actually prevented by mental health, health care or other professional staff because suicides are usually attempted in inmate housing units, and often during late evening hours or on weekends when they are generally outside the purview of programme staff. Correctional officers are often the only staff available 24 hours a day; thus, they form the front line of defence in preventing suicides (World Health Organization, 2007).

c) Intake Screening

Once correctional staff are trained and familiar with risk factors of suicide, the next step is to implement formal screening for suicidal risk among newly admitted inmates. Since suicides in jails may occur within the first hours of arrest and detention, screening for suicide must occur almost immediately upon entrance into the institution to be effective. To be most effective, every new inmate should be screened at intake and again if circumstances or conditions change. Screening for suicide needs to be a responsibility of correctional staff and they should be adequately trained and aided by a checklist for assessing suicidal risk (World Health Organization, 2007). In a correctional setting assessment, affirmative answers to one or more of the following items could be used to indicate an increased risk of suicide and a need for further intervention by the professionals.

d) Monitoring

Screening identifies the person at risk but does not prevent an attempt. For an effective prevention programme, monitoring plays a crucial role. Around the clock monitoring requires adequate communication between the staff around the shift. Communication needs to be open, clear and precise in nature. Proper documentation is of extreme importance. If required, help needs to be taken from other prison inmates to monitor for suicidal behaviour. Signs such as withdrawn behaviour, crying, food refusal, sad mood, expressing suicidal ideas and attempts, must be the indicators for immediate referral to mental health professional care.

e) Reducing the availability of means/modes of committing suicide

The prison environment needs to be safe. Access to hanging materials (ropes, wires) and self electrocution needs to be prevented. Keeping sharp instruments, potentially poisonous items and medications away from the person is very important. A person with a suicidal risk must never be left alone. Someone should stay with the person and keep a close vigil. A suicide monitoring environment would be a cell or dormitory that has eliminated or minimised hanging points and unsupervised access to lethal materials.

Check list for assessment of suicide by prison staff

1. The inmate is intoxicated and/or has a history of substance abuse.
2. The inmate expresses unusually high levels of shame, guilt, and worry over the arrest and incarceration.
3. The inmate expresses hopelessness or fear about the future, or shows signs of depression, such as crying, lack of emotions, lack of verbal expression.
4. The inmate admits to current thoughts about suicide
5. The inmate has previously received treatment for a mental health problem.
6. The inmate is currently suffering from a psychiatric condition or acting in an unusual or bizarre manner, such as difficulty to focus attention, talking to self, hearing voices.
7. The inmate has made one or more previous suicide attempts and/or admits that suicide is currently an acceptable option.
8. The inmate admits to current suicide planning
9. The inmate admits or appears to have few internal and/or external supportive resources.
10. The arresting/transporting officer believes that the inmate is at risk for suicide.
11. Facility records indicate that the inmate had a risk for suicide during a prior confinement.

Source: World Health Organization (2000). Preventing suicide; a resource for prison officers. Pub by; Mental and Behavioural Disorders, Department of Mental Health, World Health Organization, Geneva

f) Supportive role

The prison staff must try to help the at-risk person in all possible ways, within their limitations. Any unnecessary delay in the process of providing help must be avoided.

Concern and support for the prisoner's recovery is vital. The staff must acknowledge his/her limitations and try to assure the person of the best possible help. A person making a suicidal attempt must never be challenged.

g) Professional Help

Availability of mental health professional for further management adds value to the services. They can provide medications, electro-convulsive therapy, counselling and psychotherapy.

If Suicidal attempt occurs: Rapid response mechanisms

First aid needs to be administered and on a high priority, emergency hospital referral to save the person's life needs to be done. Training the staff in providing first aid is also the key to success of the suicide prevention programme. The higher authorities of the prison must be immediately alerted. There is an urgent need to formulate standard operating procedures to manage a suicidal attempt if it occurs. Around the clock availability of escorts to shift the person to higher centres needs to be formalised and should occur without any delay.

Malingering a suicidal attempt

At times suicidal attempt can be used with the motivation of gaining entry into hospital. Suicidal behaviour because of mental illness is usually labelled as "MAD" behaviour and with manipulative intent as "BAD" behaviour. *Such a classification adopted by health professionals and prison staff needs to be abandoned* because of following reasons:

- a) This dictates "MAD" requires treatment and "BAD" needs punishment.
 - b) It also assumes that suicidal behaviour is a static phenomenon, but in fact it is a dynamic phenomenon. Today's manipulative intent of suicide may be tomorrow's completed suicide.
 - c) Even though a suicidal attempt may have a manipulative intent, punishment and challenging may lead to the extreme step of completed suicide.
 - d) 30-40% of completed suicides have a past history of attempted suicide and self injurious behaviour.
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Hence, for all practical purposes, every prisoner with a suicidal risk needs to be evaluated and managed. If there are well documented, multiple, manipulative suicidal attempts in the past, then that case definitely needs professional help for his maladaptive and poor coping ability.

If completed suicide occurs: dealing with the grief process

Suicide committed by a prisoner can have severe psychological impact on the co-prisoners and the prison staff. It can even become a model for other prisoners as a method to tackle their own problems. Hence a protocol should be developed by the prison authorities for dealing with such situations. Authorities should get adequate factual information about the event. Then information should be given to the other inmates. To avoid rumours, all inmates should get the same information. It is important not to keep discussing the suicidal event with everyone. The suicidal act must not be glorified.

At times, completed suicide can provoke anger and violence inside the prison. Hence, prisoners must be allowed to discuss their thoughts and feelings. Severely affected co-prisoners (close friends) of the deceased should be allowed to ventilate and if required counselling services should be offered. This opportunity should be utilised later for discussing or brain storming sessions or seminars about suicide, help seeking behaviour, available services, problem solving techniques and depression.

Dangerous to others and/or property - assessment and management in prisons

The present relatively primitive level of management and treatment of violence risk needs to be replaced by evidence based management from the health and human rights perspective. Assessment plays a crucial role in predicting and preventing violence in custody. Violence is a dynamic phenomenon as already discussed. Hence, assessment needs to be done as and when required. Each assessment is relevant only for a limited time frame of days to weeks (Simon RI & Tardiff K, 2008). There are various forms of assessment including clinical and structured assessments of violence.

Assessment of 'dangerous to others and property' behaviour needs to encompass the following issues a) nature; what kinds of behaviour might occur? b) consequences; what may be consequences of the high-risk behaviour? c) frequency: how often might high-

risk behaviour occur? d) expecting; how soon might high-risk behaviour occur? and e) probability; what is the probability that high-risk behaviour might occur?

Factors that needs to be evaluated in the assessment risk of violence

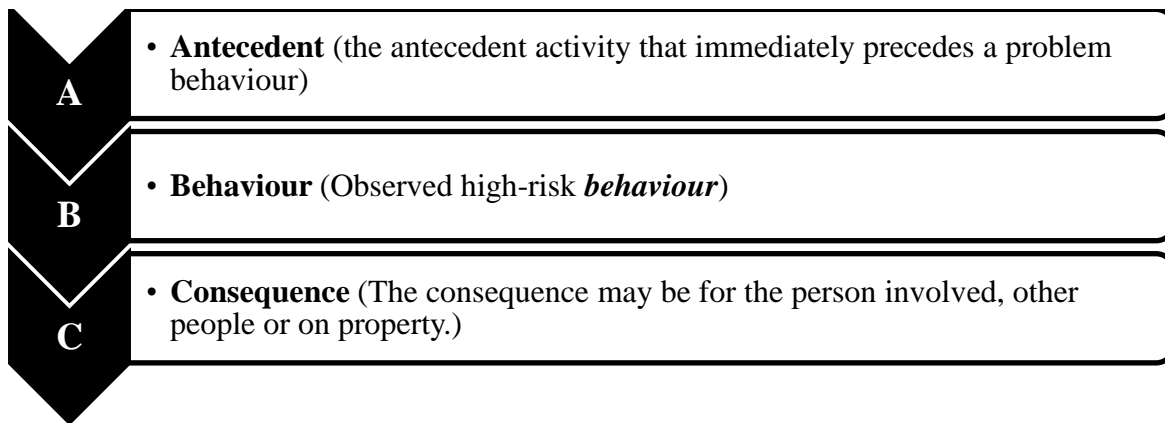
1. Nature and personality of the prisoner
2. Motivation for violence (Provoked/unprovoked)
3. Planning, means, severity, nature, place and details of violence
4. Past history of violence /Violent crime/ Domestic violence
5. Gang activities
6. Substance use such as alcohol and drugs
7. Presence of mental illness
8. Relationship instability and impulsivity
9. Ongoing stress

It is also essential to do the analysis of the behaviour in the (recent) past. This gives us a rough picture about the person's personality and gravity of the risk assessment involved. This assessment can be done by trained counsellors or a psychologist. Depending upon the assessment, risk quantification can be done on four point scale, each indicating the ascending hierarchy of the severity level. 0=no risk present, 1=mild risk, 2=moderate risk and 3=severe risk. Depending upon the available resources and results of the assessments, various actions can be initiated to curtail the current violence, to predict and prevent future violence. Action can be shifting the person to the hospital or to a high security area, requiring assessment from the psychiatrist and initiating the behavioural management rehabilitation.

'ABC' Analysis of the behaviour

An 'ABC' analysis of the behaviour helps to carry out a direct observation and to collect information about the events that are occurring within a prisoner's environment. "A" refers to the *antecedent*, "B" refers to observed *behaviour* and "C" refers to the *consequence*. Consequences may be positive, negative or sometimes a combination of both (O'Neill RE et al., 1997). It is also important to identify the settings, events that may be working to keep the behaviour going (what are the factors maintaining that behaviour). This analysis can be done on an ABC analysis chart as shown in the accompanying figure. Analysis is not one time but must be carried out over a period of days to weeks.

Figure 4: ABC analysis of behaviour



‘ABC’ analysis chart

Name (of the inmate)..... Date.....

Referral no.....

Sl No	Date and Time Activity	Antecedents	Behaviour	Consequences	Comments
1	16.12.2009 10.30 AM Bathing	Altercation with a co-prisoner over the availability of water in the toilet	Physical abuse of the co-prisoner	Co-prisoner sustained grievous injury to the right eye and lost his vision	Un-controlled explosive violence. Urine analysis positive for cannabis
2					
3					
4					

Observer signature

Name.....Date.....

‘ABC’ chart analysis helps not only in understanding the behaviour in a given situation but also the consistent pattern of behaviour and the situations in which it occurs. It also helps to make a proper plan of management. The plan of management needs to occur under the supervision of professionals including medical, prison staff and others

concerned. This decision needs to be a group decision rather than an individual one, for several reasons. In a given case, it may be decided to refer to a psychiatrist, or to a mandatory anger management programme or to a lifeskills programme. There are various behavioural rehabilitation programmes that can be initiated in correctional settings. However, there are only a few programmes which have been rigorously researched and found to be effective. This section has only provided a bird's eye view of those programmes.

Mental Health Services and De-addiction Programme

Availability of mental health services and de-addiction services in a correctional setting is the need of the hour (Chandler et al., 2009). There is no doubt about their need and effectiveness. These services start from educating about mental illness, supportive counselling, medications, de-addiction treatment, emergency services, HIV counselling, family counselling, stress management programmes, behaviour therapy and life skills training programmes (Edens et al., 1997). They also need to be involved in providing training to the correctional setting staff. The staff spends more time with prisoners, hence it makes sense to use their expertise to train them in counselling, behaviour therapy, family therapy and other therapeutic methods of dealing with prisoners (Edens et al., 1997). This also will help us to address the lack of trained manpower in rehabilitation settings.

There are many countries providing mental health and de-addiction services in correctional settings (Adams et al., 2009; Armitage et al., 2003; Blitz et al., 2006; Gorski et al., 2008; Kolind et al., 2010). A strong linkage between substance abuse and criminal activity among young offenders has triggered a new wave of rehabilitation by adding de-addiction services in prison settings (Dowden & Latimer, 2006; Steel et al., 2007). In many countries, considering the nature of risk involved, such as dangerousness to others from the use of drugs or alcohol, A Compulsory Drug Treatment Correctional Centre (CDTCC) has been established and this is also endorsed by the judiciary. A Compulsory Drug Treatment facility in the Correctional Centre of Australia was established in 2006 for repeat drug-related male offenders (Birgden A & Grant L, 2010). Though compulsory treatment goes against the individual rights, the high-risk behaviours of the offenders put others at risk. This necessitates appropriate action, best done in a rehabilitation and reformation framework. Innovative approaches of collaboration between correctional settings with medical colleges for providing mental health services have been successful

(Appelbaum et al., 2002). Studies have also documented that providing mental health care and de-addiction decreases recidivism, time spent incarcerated and successful community integration (Case et al., 2009; Lamberti et al., 2001)

Anger Management programme

Anger management is probably one of the most common forms of rehabilitation offered to prisoners with high-risk behaviours. For this reason, it is important to determine whether anger management works in reducing anger and anger-related problem behaviours. Five published meta-analytic studies with at least moderate effect sizes, have all suggested that anger management is effective, (Beck R & Fernandez E, 1998; Del Vecchio T & O'Leary K D, 2004; DiGiuseppe R & Tafrate R, 2003; Edmondson CB & Conger JC, 1996; Sukhodolsky et al., 2004). Hence, anger management needs to be offered to the high-risk prisoners.

Life skills training programme

Lifeskills are abilities for adaptive and positive behaviours that enable individuals to deal effectively with the demands and challenges of everyday life (World Health Organization., 1997). A list of 10 lifeskills, described as generic lifeskills for psychosocial competence, was identified by WHO as core lifeskills applicable across a wide range of contexts in daily life and risk situations.

Ten Life skills identified by WHO (World Health Organization., 1997)	
Problem solving	Decision making,
Empathy	Self-awareness
Inter-personal relationships	Communication skills
Critical thinking	Creative thinking
Coping with emotions	Coping with stress

They are depicted in The above box. These skills have been successfully implemented to curtail sexually transmitted diseases, to prevent mental illness, in the management of

substance use, in school mental health programme, in anger management and also in correctional settings (Edens et al., 1997; Marshall et al., 1989).

Cognitive behavioural therapy for sexual offenders

A meta-analysis of 69 studies comparing treated and untreated offenders on controlled outcome evaluations of sexual offenders reported that the majority of the studies confirmed the benefits of treatment. Treated offenders showed 37% less sexual recidivism than controls. Cognitive behavioural therapy approaches revealed the most robust effect (Lösel & Schmucker, 2005). Similar results have been replicated in another meta-analysis. This meta-analysis of 10 studies was conducted to know the effectiveness of treatments for male adolescent sexual offenders (N = 644). Results from the study reported that cognitive-behavioural therapy approaches were the most effective (Walker et al., 2004).

Another interesting treatment approach called ‘Multisystemic Therapy’ in young sexual offenders has been found to be effective in a well conducted trial (Borduin et al., 2009). ‘Multisystemic Therapy’ incorporates family therapy, cognitive behaviour therapy and individual therapy. Involving family members in the treatment process has yielded positive results. Therapeutic benefits of ‘Multisystemic therapy’ continued even after one year of undergoing treatment (Letourneau et al., 2009). Hence, any programme having cognitive behavioural therapy component needs to be advocated in sexual offenders.

Family therapy / Assistance programme

This programme provides assistance to the family members of the inmates. Immediately after arrest, inmates are worried about their family members. They want to know about their condition and safety. Families are also in a state of transition when their family member is arrested or receives a custodial sentence. Significant reactions include shame, guilt, physical and emotional distress, loss of social mobility and income stability, stigmatisation, stress and anxiety (Hardy & Snowden, 2010).

Family intervention programmes focus mainly on the following issues:

- a) To enhance communication between inmates and their families
 - b) Helping the family to cope with the incarceration of their dear one
 - c) Promoting family visits and parole
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- d) Addressing issues like domestic violence in the family context
 - e) Involving family members in treatment of the inmate such as de-addiction and aftercare (Gideon, 2007)
 - f) Family therapy or marital therapy (Henggeler et al., 1992)
 - g) Counselling in parenting (Thompson & Harm, 2000)
 - h) Providing educational support to the children of the inmates
 - i) Assisting in employment and rehabilitation and
 - j) Family re-integration (Gideon, 2007)

This programme helps the prisoners to relieve their anxiety and focus on rehabilitation. Family therapy can thus be used to engage prisoners into the rehabilitation programme. Adding family therapy into any rehabilitation programme gives a whole new meaning to the life and hope for the prisoner.

Other behavioural rehabilitation programmes

There are various other behavioural rehabilitation programmes that have been suggested but their efficacy has still not been backed by proper trials. These include: Mindfulness therapy (Bowen et al., 2006), Social skill training, Sex education programme as a part of HIV prevention programme, Stress management, Yoga, Relaxation, Meditation, and Spirituality

Educational programme

Supporting educational needs of the prisoners has been occurring since many decades. There seems to be a general acceptance by the public and policy makers that education has benefits in its own right. It is based on the understanding that an educated person has a higher probability of finding a job and less recidivism. However, this surmise has never been confirmed. Only recently, a review on correctional and vocational education (MacKenzie DL, 2008), has yielded positive results leading to the conclusion that educational programmes reduce the recidivism of offenders as well as increase employment. This review has also raised serious concern about the content of education programmes. They need to bring about a change in thinking and cognitions and not just in their ability to directly impact the offender's ability to get employment.

In conclusion, rehabilitation should be the guiding principle of all correctional institutions. It is time to acknowledge that punishment and deterrence based interventions are ineffective. Appropriate interventions should be instituted and improved by supporting systematic research to differentiate effective and ineffective correctional interventions. It is also important to eradicate the idea that “nothing works” to change offenders. Health care and rehabilitation need to be integrated, so that multimodal approaches of public health care such as early recognition and treatment of prisoners with high-risk behaviour (secondary prevention), behavioural rehabilitation (tertiary prevention) and prevention of re-offending behaviour (primary prevention) occur hand in hand.

Evidence-based treatment and rehabilitation services are an absolute need in any correctional centre. Treatment approaches should include behavioural interventions that are effective in changing an array of human behaviour. To achieve this herculean task, correctional and health staff need to establish credibility, develop competence, learn effective communication and collaborate effectively. This constitutes the bedrock of a successful programme in any correctional setting.

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