THE BURDEN OF SELF-HARM AND SUICIDE AMONG WOMEN PRISONERS: A CROSS-COUNTRY PERSPECTIVE

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ABSTRACT

This research serves as a poignant reminder of the distressing rates of self-harm and suicide among women who are incarcerated, and it draws insightful comparisons of these rates across diverse countries. Women in prison confront distinctive challenges, and their struggles with mental health frequently lead to behaviours that harm themselves, such as self-inflicted injuries and suicide attempts. This study meticulously examines data from various nations to cast a light on the frequency and gravity of these incidents within the female prison populace. It also probes the factors that contribute to such occurrences, encompassing issues like overcrowding, the inadequacy of mental health resources, and the enduring effects of past trauma.

Through meticulous cross-country analysis, this study exposes notable disparities in the occurrence of self-harm and suicide among women in detention, with certain nations witnessing disproportionately higher figures. It probes how cultural, societal, and structural discrepancies might influence these disparities and inquires whether specific policies or interventions play a role in ameliorating or exacerbating the situation. Moreover, the research expounds on the grievous personal and societal tolls resulting from self-harm and suicide among incarcerated women. Beyond the tragic loss of life, it delves into the emotional toll on families, the financial strain on healthcare systems, and the far-reaching consequences for society as a whole.

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The study explores successful strategies used in select countries to address self-harm and suicide among incarcerated women. By sharing effective early intervention, mental health support, and rehabilitation approaches, it seeks international collaboration to improve conditions. Urgent research, global cooperation, and compassionate policy reforms are emphasized to reduce self-harm and promote a more humane criminal justice system.

Keywords: *Equality, Female Prisoners, Self-Harm, Social Cost, Women Health.*

1. INTRODUCTION

The global definition of suicide is characterised by variations across countries. Certain nations categorise any self-inflicted death as suicide, irrespective of intent, while others mandate a clear intention. For instance, the US CDC (Centre for Disease Control and Prevention) defines suicide as "self-directed harmful behaviour with intent to die," whereas the UK's ONS (Office for National Statistics) encompasses deliberate self-harm and undetermined intent. While some advocate for distinguishing between suicide and accidents, prison suicide rates remain high regardless of intent. Suicide not only signifies a risk within mental health disorders but also qualifies as a disorder itself, termed suicidal behaviour disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). The DSM-V's criteria entail recent suicide attempts with a foreseeable outcome of death, excluding suicidal thoughts and preparations. Conversely, self-harm, as defined by Favazza, lacks suicidal intent and is regarded as a reaction to stress. The reasons for self-harm are varied, encompassing factors such as mental illness and desperation. Non-suicidal self-injury, a DSM-V disorder, necessitates purposeful harm with specific expectations. Despite established definitions, research articles diverge in interpreting suicide and self-harm. Some incorporate self-hangings into self-harm, while others perceive them as suicide attempts. Parallel disparities emerge in the classification of suicide methods based on intent.[1]

In a study involving 26,510 incarcerated individuals in England and Wales, researchers investigated 139,195 instances of self-inflicted harm and estimated that approximately 5–6% of male prisoners and 20–24% of female prisoners engaged in self-harm each year[2]. Moreover, the study revealed a significant link between self-harm and subsequent suicides during imprisonment, with rates of 450 deaths per 100,000 individuals with a history of self-harm compared to 98 deaths per 100,000[3]. Self-harming behaviour often displayed repetition, a comprehensive analysis of 90 studies conducted in Europe and the UK indicated that at least 15% of individuals who were hospitalised for self-inflicted harm within the community had multiple incidents of self-harm within a year of being discharged from the hospital[4].

[1] Seth J. Prins, *Prevalence of mental illnesses in U.S. state prisons: A systematic review. Psychiatric Services*, 65(7), PSYCHIATRIC SERV. 862, 865 (2014)
[2] Amanda Butler, Jesse T. Young, Stuart A. Kinner & Rohan Borschmann, *Self-harm and suicidal behaviour among incarcerated adults in the Australian Capital Territory,* 13 HEALTH & JUSTICE (2018)
[3] *Id.*
[4] David Owens, Judith Horrocks & Allan House, *Fatal and non-fatal repetition of self harm: Systematic review*, 181(3) BRITISH J. PSYCHIATRY, 193, 196 (2002)

Additionally, two-thirds of suicide cases were preceded by self-harm. In the prison environment, the likelihood of suicide was found to increase by 6–11 times among those with a history of self-harm compared to those without. Mental disorders were disproportionately prevalent among incarcerated adults and were robust predictors of both self-harm and suicide[5].

While instances of social exclusion, disadvantage, and trauma were prevalent adversities prior to imprisonment, there were also prison-related factors that could trigger or exacerbate mental illness and escalate the risk of suicide. These factors, often referred to as "pains of imprisonment"[6], encompassed prison violence, social isolation, job insecurity, a, lack of privacy, and enforced solitary confinement[7].

The higher probability of suicide among incarcerated individuals compared to those outside prison has ignited a scientific discussion about potential explanations. Theoretical accounts have largely fallen into two major categories, alternately focusing on the individual inmate and the prison milieu. One body of clinical and public health research accentuates the intricate health demands and pre-existing susceptibilities that prisoners bring into incarceration. These vulnerabilities are often contextualised within a backdrop of societal disadvantages, with their suicide risk remaining elevated before and after imprisonment. Conversely, another perspective, primarily emerging from sociology and criminology, emphasises the influence of the prison environment. This viewpoint highlights the inherent deficiencies and hardships of confinement that can contribute to suicidal tendencies. These two separate lines of literature attribute the reasons behind prison suicides either to the vulnerabilities individuals bring with them or to factors unique to the prison setting that result in deprivation[8].

2. VULNERABILITY OF INCARCERATED

[5] Seena Fazel & Katharina Seewald, *Severe mental illness in 33 588 prisoners worldwide: Systematic review and meta-regression analysis*, 200(5) BRITISH J. PSYCHIATRY 364, 370 (2012)
[6] Cherrie Armour, *Mental health in prison: A trauma perspective on importation and deprivation*, 5(2) INT'L J. CRIMINOLOGY & SOCIOLOGICAL THEORY 886, 891-892 (2012)
[7] JL Metzner, & Jamie Fellner, *Solitary confinement and mental illness in U.S. prisons: A challenge for medical ethics*, 38(1) J. AM. ACAD. OF PSYCHIATRY & L. (2010)
[8] Louis Favril, Freya Vander Laenen, Christophe Vandeviver & Kurt Audenaert, *Suicidal ideation while incarcerated: prevalence and correlates in a large sample of male prisoners in Flanders, Belgium*, 55 INT'L J. L. & PSYCHIATRY (2017)

Even before entering incarceration, prisoners form a vulnerable group with a heightened risk of suicide. Offenders typically come from backgrounds characterised by various indicators of socio-economic disadvantage, such as inadequate housing, low educational attainment, poverty, and experiences of abuse. These deeply entrenched inequalities that contribute to their involvement in the criminal justice system often coincide with factors influencing health[9]. Consequently, individuals passing through the prison system are marked by poor health conditions[10].' Many of them face intricate and co-occurring physical health issues, like infectious and chronic diseases. Additionally, meta-analyses have illuminated the disproportionately high occurrence of mental disorders among prisoners, encompassing depression, psychosis[11], posttraumatic stress disorder, substance use disorders, and personality disorders.

Collectively, prisons harbour a group of individuals characterised by pronounced vulnerability, grappling with complex health and social care needs. These markers of social disadvantage and health-related issues serve as well-established risk factors for suicidal tendencies. In the general population, ample evidence highlights robust connections between suicidal risk and factors such as socioeconomic disenfranchisement, early-life hardships, trauma, physical illnesses, substance abuse, mental health conditions, and personality traits like impulsivity and aggression. These vulnerability factors not only contribute to the likelihood of criminal justice involvement but, given their overrepresentation among prisoners, may also contribute to the disproportionate prevalence of suicidal thoughts and behaviours within custodial settings. And Table 1 demonstrates the suicidal ideation and attempt between males and females across different countries.

Table 1: Lifetime prevalence (%) of suicidal ideation and suicide attempt in prisoners by Sex[12]

	SUICIDAL IDEATION			***SUICIDE ATTEMPT***		
	MEN	**WOMEN**	**ALL**	**MEN**	**WOMEN**	**ALL**

[9] Prof Nathan Hughes, Prof Michael Ungar, Prof Abigail Fagan, Prof Joseph Murray, Olayinka Atilola & Kitty Nichols, *Health determinants of adolescent criminalisation*, 4(2) LANCET CHILD & ADOLESCENT HEALTH (2020)
[10] Seena Fazel & Jacques Baillargeon, *The health of prisoners*, 377(9769) LANCET (2011)
[11] Fazel & Seewald, *supra* note 5
[12] Louis Favril, Devon Indig, Craig Gear & Kay Wilhelm, *Mental disorders and risk of suicide attempt in prisoners*, 55(9) SOCIAL PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY (2020)

AUSTRALIA	**33**	**39**	**34**	**20**	**29**	**21**
BELGIUM	**43**	**58**	**44**	**20**	**37**	**22**
ENGLAND & WALES	**38**	**54**	**39**	**22**	**40**	**22**
NEW ZEALAND	**34**	**43**	**35**	**19**	**28**	**19**

3. RISK OF SUICIDE AMONG PRISONERS

Thus, the "importation model" posits that the susceptibility to suicide among inmates originates from the inequalities in both social conditions and health factors that they bring with them into the prison setting. This theory gains support from comprehensive analyses that encompass multiple studies[13] and systematic evaluations[14]. These collective findings consistently establish a connection between existing vulnerabilities before imprisonment and an increased likelihood of suicide within correctional facilities (Table 2)[15]. To illustrate, individuals with a previous history of self-inflicted harm are considerably more prone, by a factor of seven, to engaging in suicidal activities during their time in incarceration compared to those without such a background. Within the prison environment, mental disorders, particularly mood-related, anxiety-related, psychotic, and substance use disorders, significantly contribute to the risk of suicidal behaviour among detainees, and the presence of multiple disorders intensifies this risk. It's noteworthy that borderline personality disorder is closely linked to self-harm incidents in prison, while the criteria for diagnosing antisocial personality disorder overlap with the reasons for imprisonment. Furthermore, a substantial body of work confirms a heightened likelihood of suicide among individuals who have committed violent crimes (such as murder and manslaughter)[16], suggesting a convergence of predispositions for violent and suicidal behaviours in certain individuals, potentially influenced by neurological factors. Offenders with a history of violence might exhibit

[13] Johannes Lohner & Norbert Konrad, *Risk factors for self-injurious behaviour in custody: problems of definition and prediction*, 3(2) INT'L J. PRISONER HEALTH (2007)
[14] Louis Favril, Rongqin Yu, Keith Hawton & Seena Fazel, *Risk factors for self-harm in prison: a systematic review and meta-analysis*, 7(8) LANCET PSYCHIATRY (2020)
[15] *Id.*
[16] Anne Bukten & Marianne Riksheim Stavseth, *Suicide in prison and after release: a 17-year national cohort study*, 36(10) EURO. J. EPIDEMIOLOGY, 1075, 1079-1080 (2021)

pronounced levels of impulsiveness and aggression—traits that are acknowledged to amplify the risk of suicide, where the lack of proper behavioural control could serve as an underlying mechanism. [5]

Table 2: Summary of Models explaining risk of suicidal behaviours in prisoners.[17]

MODEL	PREMISE	SELECTED RISK FACTORS
Importation	Prisoners represent a non-random selection of vulnerable individuals who already are at high risk of suicide before imprisonment. The elevated risk of suicide in prisoners is a consequence of the social and health inequalities which they import into prison.	Socioeconomic disadvantage Trauma and childhood abuse Psychiatric (co) morbidity Drug and alcohol abuse Impulsivity and aggression History of self-harm
Deprivation	Prisoners are at increased risk of suicide by virtue of the highly demanding and restrictive environment they find themselves in. Deprivations and stressors inherent to the prison experience are what primarily account for the excess risk of suicide in prisoners.	Loss of freedom and autonomy Poor social support Lack of purposeful activity Solitary confinement Isolation and overcrowding Victimisation and bullying

Childhood maltreatment stands as a strong predictor of the potential for suicide among incarcerated individuals, underscoring a lasting vulnerability to suicide in those who have undergone traumatic experiences and abuse during their early years. These outcomes have been consistently duplicated in studies that examine risk elements for thoughts of suicide in extensive and varied groups of inmates. The escalated likelihood of suicide within two

[17] Fravil & Indig, *supra* note 5

specific groups, those serving sentences within the community[18] and those who have recently been released from incarceration, aligns with the principles of the importation model. This implies that an individual's susceptibility to suicide is not restricted solely within the boundaries of the prison environment, extending beyond those confines to encompass broader circumstances.

4. CULTURAL AND SOCIETAL STIGMA AMONG FEMALE PRISONERS

Women in correctional facilities contend with the weight of cultural and societal stigma, frequently resulting in their abandonment by their own families. This sense of abandonment is especially notable among those who do not receive visits from their relatives during their time in incarceration[19]. Unfortunately, these women can also find themselves subjected to harassment, not just from fellow inmates but, on occasion, even from prison personnel. The accumulation of these difficulties amplifies the urgency for initiatives aimed at tackling the distinctive hardships encountered by incarcerated women[20].

5. LACK OF HEALTH CARE

The stark contrast in depression and mental disorders between female and male inmates raises significant concerns, with women exhibiting higher rates. Female inmates also experience a higher suicide rate compared to their male counterparts. Notably, a 2010 study discovered that 36% of incarcerated girls resorted to self-harm during their confinement, underscoring the mental health challenges confronting them.

Tragically, a considerable number of incarcerated women who commit suicide have pre-existing medical conditions. The lack of proper primary care within correctional facilities potentially contributes to these suicides. Overlooking minor medical concerns, including chronic pain, could play a role[21]. The provision of appropriate medication while incarcerated might offer avenues for prevention and intervention. Establishing trust between staff and inmates could encourage the disclosure of suicidal thoughts or non-adherence to medication.

[18] Carlene King, Jane Senior, Roger T. Webb, Tim Millar, Mary Piper, Alison Pearsall, Naomi Humber, Louis Appleby & Jenny Shaw, *Suicide by people in a community justice pathway: population-based nested case-control study*, 207(2) BRITISH J. PSYCHIATRY 175, 176 (2015)
[19] Lorie S Goshin, *Stigma and US Nurses' Intentions to Provide the Standard of Maternal Care to Incarcerated Women*, 110 AM. J. PUB. HEALTH (2020)
[20] *Id.*
[21] AE Daniel, *Preventing suicide in prison: A collaborative responsibility of administrative, custodial, and clinical staff*, 34(2) J. AM. ACAD. OF PSYCHIATRY & L.165, 169-170 (2006)

Numerous factors contribute to the heightened occurrence of mental health challenges among female inmates. These encompass experiences of trauma and sexual violence before incarceration, which can amplify mental health issues. Emotional distress may also originate from circumstances like divorce or separation. Furthermore, a report on female prisons in Pakistan highlighted that 30% of inmates are either separated or divorced, which can also intensify emotional challenges[22].

Additionally, the scarcity of mental health services within correctional facilities compounds the complex challenges faced by female inmates. It is imperative to implement tangible measures that cater to the mental health needs of incarcerated women, ensuring they receive the necessary support and attention. Elevating mental health services within prisons, including therapeutic interventions, counselling, and facilitated access to psychiatric medications, is essential.

Incorporating trauma-informed care strategies stands out as a pivotal approach to addressing the underlying trauma experienced by numerous female inmates, thereby nurturing their psychological well-being. Moreover, proactive initiatives like prevention and intervention programmes can significantly contribute to the identification and management of mental health concerns before they escalate.

To support successful reintegration into society and decrease the risk of relapse or reoffending, comprehensive supportive re-entry programmes are indispensable. By conscientiously addressing the mental health needs of female inmates, substantial strides can be taken to improve their overall well-being and reduce the prevalence of conditions like depression, self-harm, and suicide within the correctional setting.

6. WOMEN PRISONERS IN INDIA (2021)

According to the prison statistics provided by the National Crime Records Bureau (NCRB), out of a total of 478,600 inmates, 19,913 were female prisoners.[23] Reflecting on the year 2016, more than 300,000 women were arrested for various offenses under the Indian Penal Code and other legal regulations. A notable proportion of these arrests were associated with

[22] Nur Oktavia Hidayati, Suryani Suryani, Laili Rahayuwati & Efri Widianti, *Women Behind Bars: A Scoping Review of Mental Health Needs in Prison*, 52(2) IRANIAN J. PUB. HEALTH (2023)
[23] *Prison Statistics India-2021 ¸executive summary*, NATIONAL CRIME RECORDS BUREAU (Dec. 10, 2023), https://ncrb.gov.in/sites/default/files/PSI-2021/Executive_ncrb_Summary-2021.pdf

acts like cruelty, involvement in riots, and violations of prohibition laws. This analysis reveals a noticeable increase in female involvement in criminal activities over the last decade. This upward trend is underscored by the consistent figures of incarcerated women, ranging from 300,000 to 360,000.[24]

7. THE INTERNATIONAL DECLARATIONS AND THEIR SIGNIFICANCE

The established standards for equitable treatment of incarcerated individuals, which are applicable to both genders, were established more than five decades ago. These rules are rooted in principles drawn from various United Nations conventions and declarations, thereby aligning with existing international legal frameworks.

The Doha Declaration, formulated in 2015 during the 13th UN Congress on Crime Prevention and Criminal Justice, holds particular significance. This declaration underscores the necessity of integrating crime prevention and criminal justice into the broader United Nations agenda. It recognises the interdependence and mutual reinforcement of sustainable development and the rule of law. [25]

The Doha Declaration reaffirms the dedication of UN member states to implement and enhance policies concerning prisoners. It focuses on various dimensions, including education, employment, medical care, rehabilitation, social reintegration, and the reduction of recidivism.

The Global Programme for the Implementation of the Doha Declaration, spearheaded by the United Nations Office on Drugs and Crime (UNODC)[26], aims to assist nations in achieving enduring and positive outcomes in areas such as crime prevention, criminal justice, anti-corruption efforts, and upholding the rule of law.

The four-year programme is structured around four interlinked components, one of which centres on "fostering the rehabilitation and social integration of prisoners to provide a second chance in life." To achieve this objective, UNODC has developed various resources, including a roadmap for establishing prison-based rehabilitation programmes, an updated

[24] *Id.*
[25] James T. Gathii, *The Legal Status of the Doha Declaration on TRIPS and Public Health Under the Vienna Convention of the Law of Treaties*, 15 HARVARD. J. L. TECH. (2002)
[26] *Doha Declaration Global Programme*, UNITED NATIONS (Dec. 11, 2023, 7:00 PM), https://www.unodc.org/unodc/doha-declaration/index.html

guide on preventing repeat offenses and reintegrating offenders, and a technical manual for creating nationally branded prison products[27].

Direct assistance from UNODC is currently extended to 11 countries, aiding them in adopting more rehabilitative approaches to prison management. This assistance involves technical support and practical aid in establishing prison-based rehabilitation programmes that emphasise education, vocational training, and employment opportunities for inmates.

In 1980, the 6th United Nations Congress on the Prevention of Crime and the Treatment of Offenders adopted a resolution specifically addressing the distinct needs of female prisoners. This commitment continued through the 7th, 8th, and 9th congresses, which put forth targeted recommendations for the treatment of women prisoners.

The 10th Congress marked the adoption of the Vienna Declaration on Crime and Justice. At this pivotal moment, member states pledged to rectify any imbalances stemming from gender-specific programmes and policies within UN crime prevention initiatives and national strategies. This included the formulation of actionable policies tailored to the unique requirements of female prisoners and offenders. The corresponding plan of action featured a dedicated section (Section XIII) outlining specific recommendations for subsequent steps.

Finally, the Bangkok Declaration on Synergies and Responses, endorsed by the 11th United Nations Congress on Crime Prevention and Criminal Justice in April 2005, delineated regulations applicable to both male and female prisoners. It also encompassed numerous provisions that particularly addressed the concerns of women and children within the criminal justice system.

Incarcerated women often face not only the punitive aspects of imprisonment but also the societal stigma and cultural barriers that lead to rejection by their families. Those prisoners who receive no visits from family members are susceptible to harassment from both fellow inmates and, at times, prison staff.

8. THE IMPORTANCE OF PRISON MANAGEMENT

The role of prison management in shaping the well-being and rehabilitation of incarcerated individuals, particularly female inmates, is of paramount importance.[28,] To effectively address

[27] *Id.*

the distinct challenges that women prisoners encounter, prison management can employ a series of strategies aimed at creating a safer and more supportive environment.[29]

To begin, providing specialised training for prison staff regarding gender-sensitive issues is an imperative step. This training can heighten staff awareness about the unique requirements of female inmates, helping to prevent instances of discrimination and foster a more empathetic approach to their care.

Secondly, establishing standardised procedures to address gender-specific violence is of utmost significance. Female prisoners often face vulnerabilities that demand attention. Clear protocols can ensure their protection and overall well-being.

Furthermore, ensuring accessible counselling services within the prison setting is vital for delivering crucial mental health support. This proactive measure can assist incarcerated women in managing prevalent challenges such as trauma and stress inherent to the correctional environment.

Beyond addressing immediate challenges within the prison walls, the correctional administration should focus on the post-release welfare of female inmates. Providing sustained mental health assistance and guidance upon release can facilitate their successful reintegration into society, thus diminishing the likelihood of recidivism.

By implementing these strategies, correctional facility management can foster an environment that upholds the dignity of incarcerated women, prioritises their mental and physical well-being, and contributes to their journey of rehabilitation. Ultimately, these efforts align with the overarching goal of establishing a just and effective correctional system.

9. STRATEGIES TO REDUCE THE STIGMA AMONG THE INCARCERATED WOMEN

In response to the intricate challenges faced by incarcerated women, both non-governmental organisations (NGOs) and prison management can collaboratively implement a comprehensive array of strategies. Effectively addressing stigma within correctional facilities

[28] Fazel & Seewald, *supra* note 5
[29] Sibulelo Qhogwana, *Negotiating the Maximum-Security Offender Identity: Experiences From Incarcerated Women*, 64 INT'L J. OFFENDER THERAPY & COMPARATIVE CRIMINOLOGY (2019)

entails proactive steps by NGOs, such as conducting surveys to collect first hand experiences, providing specialised training for prison staff, and establishing discreet channels through which incarcerated women can confidentially report instances of discrimination. Simultaneously, prison management can play a role by enhancing staff knowledge through gender-specific training and fostering an environment where women feel empowered and comfortable voicing their concerns.

Addressing the societal stigma that impacts the families of incarcerated women requires a thoughtful approach. This involves identifying cultural sensitivities, offering family counselling services, and extending support to both women and their families to adeptly navigate these challenges[30]. To tackle the pressing issues of violence, mental health, and suicide, a multipronged approach can be adopted[31]. This includes implementing education programmes for prison staff, establishing standardised protocols for addressing gender-specific violence, ensuring accessible counselling services within prisons, and formulating comprehensive policies aimed at preventing suicide[32]. Essential components also encompass confidential complaint systems, facilitating communication between inmates and their families, and robust measures to prevent self-harm.

These efforts should extend beyond the period of incarceration. By providing continued mental health support after release and specialised care for pregnant inmates, a comprehensive framework for support is created. Through the coordinated implementation of these strategies, both NGOs and prison management can collaboratively contribute to establishing an environment that is more equitable and supportive for incarcerated women. This approach not only promotes their well-being during incarceration but also enhances their prospects for successful reintegration into society.

10. CONCLUSION

Crafting a comprehensive strategy to address the intricate issue of self-harm and suicide among incarcerated women necessitates a well-informed approach based on research insights. The United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders, known as the Bangkok Rules, emphasise the importance of

[30] Goshin, *supra* note 19
[31] Juliana van Olphen, *Nowhere to go: how stigma limits the options of female drug users after release from jail*, 4(10) SUBSTANCE ABUSE TREATMENT, PREVENTION & POLICY (2009)
[32] Fazel & Seewald, *supra* note 5

implementing strategies to prevent suicide and self-harm. Current efforts have focused on tackling risk factors associated with prison suicides, including existing suicidal thoughts and prior instances of self-harm.

It's noteworthy that within jails, suicide stands as the primary cause of death, accounting for more than half of such fatalities. Psychological disorders like depression, stress, and aggression are prevalent within the female prison population. Despite constituting a relatively small portion of overall inmates, the number of female prisoners in India has experienced a notable increase[33]. These incarcerated women face distinct challenges, ranging from inadequate mental health services to confinement in facilities lacking proper amenities.

Effective strategies encompass several facets, such as reducing stigma, facilitating family reconnection, and tailoring rehabilitation programmes to meet the unique needs of women prisoners[34]. A crucial element involves the active involvement of both inmates and relevant stakeholders in the development of these initiatives. Implementing rehabilitation projects, updating resources, and providing technical guidance for producing prison goods locally can aid in successful reintegration and offer a fresh start.

In conclusion, a multifaceted approach that prioritises mental health, provides gender-sensitive services, and emphasises rehabilitation efforts is imperative to effectively combat self-harm and suicide among incarcerated women[35].

[33] Prison Statistics, *supra* note 23
[34] Hidayati & Suryani, *supra* note 22
[35] Annelise Mennicke, *Suicide Completion Among Incarcerated Women*, 27(1) J. CORR. HEALTH CARE (2021)