Cureus
Part of SPRINGER NATURE

Open Access Original Article

Mental-Health Facility Stays Among Suicide Decedents in U.S. Jails and Prisons: A Descriptive Analysis of Federal Data, 2010-2019

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Review began 10/21/2026
Review ended 10/25/2026
Published 10/29/2026

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DOI: 10.7759/cureus.118789

Abstract

Background: Published correctional mortality tables describe selected characteristics of suicide decedents, but aggregate data cannot estimate an individual's suicide risk or determine whether mental illness was undocumented. We describe the reported history of an overnight mental-health facility stay since admission among suicide decedents in local jails and state prisons.

Methods: We conducted a retrospective descriptive secondary analysis of federal statistical tables for 2010-2019. We summarized published Yes, No, and Unknown percentages overall and across two five-year periods, retaining the applicable suicide totals as denominators. Because category counts were not published, we estimated counts as each published denominator multiplied by its rounded percentage, rounded to the nearest whole number. These are approximate estimates, not source-reported counts. No individual-level records or inferential comparisons were used.

Results: Among local-jail suicide decedents (N=3,327), estimated counts were 462 (13.9%) with a reported stay, 2,389 (71.8%) with no reported stay, and 469 (14.1%) with unknown status. Among state-prison decedents (N=2,403), estimated counts were 363 (15.1%), 1,235 (51.4%), and 759 (31.6%), respectively. Published percentages sum to 99.8% for jails and 98.1% for state prisons, leaving arithmetic residuals of 0.2 and 1.9 percentage points. Rounding alone cannot explain these residuals; the source (Bureau of Justice Statistics) notes missing data but does not specify their exact composition. The percentages are the primary results; estimated counts cannot recover exact frequencies. From 2010-2014 to 2015-2019, the reported Yes percentage decreased by 0.7 percentage points in jails and 6.2 points in prisons; these are descriptive changes, not tested trends. Local-jail totals exclude deaths in six combined jail-and-prison systems included in state-prison totals.

Conclusion: These aggregate tables describe service history among suicide decedents only. They cannot establish an association with suicide, estimate suicide risk, or support causal or individual-level conclusions. Unknown status and differing jurisdictional coverage limit interpretation. Evaluating relationships among mental-health needs, documentation, services, and mortality requires appropriately governed individual-level data and valid comparison groups.

Categories: Forensic Medicine, Health Policy, Epidemiology/Public Health
Keywords: bureau of justice statistics, correctional facilities, correctional mortality, custodial deaths, jail suicide, mental health services, mortality, mortality surveillance, prison suicide, suicide

Introduction

Suicide in correctional settings is a public-health and institutional safety concern. This study examined whether suicide decedents had a recorded overnight stay in a mental-health facility after admission to a local jail or state prison. This administrative service-history item is distinct from psychiatric diagnosis, current symptoms, treatment need, and quality of care. National mortality tables can describe its recorded distribution, but cannot establish why a death occurred or estimate individual suicide risk [1-3].

Correctional populations have substantial mental-health needs, but estimates based on self-reported histories, symptom screening, and clinical diagnostic assessments measure different constructs [1,4-7]. Likewise, absence of an overnight facility stay does not establish absence of illness or treatment. Reviews of correctional screening and mortality surveillance reinforce the need to specify what an administrative measure captures before drawing clinical conclusions [8-11].

Prior studies describe clinical, social, and custodial factors associated with suicide and self-harm, and support comprehensive prevention approaches involving assessment, communication, access to care, and institutional safeguards [12-24]. These studies provide context; the present tables do not measure these pathways or evaluate prevention effectiveness. Local jails and state prisons also differ in their populations,

lengths of stay, and jurisdictional coverage, which limits direct setting comparisons [3,9].

The Bureau of Justice Statistics (BJS) Mortality in Correctional Institutions collection provides an official national source of reported deaths. Its published suicide tables cover 2000-2019, but data for the overnight mental-health facility stay item were first collected in 2010. The item records a stay since admission, without specifying its timing, reason, duration, quality, or relation to outpatient care. The public tables contain neither individual-level records nor a living comparison group for this item [3,9].

The original BJS report already publishes the response percentages. This secondary analysis therefore focuses on synthesis of their interpretability: it places the two settings and periods together, quantifies differences in Unknown status and arithmetic residuals, and shows how restricting the denominator to published Yes and No responses changes the descriptive comparison. This addresses a measurement question rather than introducing a new estimate of psychiatric morbidity or suicide risk [3].

Our primary objective was to describe the published Yes, No, and Unknown distributions among suicide decedents in local jails and state prisons during 2010-2019. Secondary objectives were to describe setting contrasts, changes between 2010-2014 and 2015-2019, and the Yes share conditional on a published Yes or No response. The analysis distinguishes source-reported percentages from derived estimates and makes missingness and coverage limitations explicit; it does not test causation, assess care adequacy, or estimate individual risk.

Materials And Methods

We conducted a retrospective descriptive secondary analysis of published aggregate data in the Bureau of Justice Statistics report, Suicide in Local Jails and State and Federal Prisons, 2000-2019 - Statistical Tables [3]. The primary descriptive measure was recorded overnight mental-health facility stay status after admission (Yes, No, or Unknown) among suicide decedents. This service-history measure is not a diagnosis, measure of current clinical need, or assessment of treatment adequacy. We included local jails and state prisons and excluded federal prisons.

Data were verified against Table 7 (printed page 16; local jails) and Table 15 (printed page 25; state prisons), specifically the rows labelled “Inmate had an overnight stay in a mental health facility after jail admission” and “Prisoner had an overnight stay in a mental health facility after prison admission.” Both tables state that the final all-years column for this item reflects 2010-2019 because collection began in 2010. We therefore used the 2010-2014 and 2015-2019 suicide totals for the relevant setting, rather than the full 2000-2019 or 2001-2019 total [3].

The applicable five-year totals were 1,613 and 1,714 for local jails and 1,046 and 1,357 for state prisons; their sums were 3,327 and 2,403 for 2010-2019. We transcribed the published Yes/No/Unknown percentages, respectively: local jails, 14.3/71.4/14.1 in 2010-2014, 13.6/72.2/14.1 in 2015-2019, and 13.9/71.8/14.1 overall; state prisons, 18.6/47.1/30.6, 12.4/54.6/32.4, and 15.1/51.4/31.6, respectively. BJS reports these percentages to one decimal place and does not publish exact category counts for this item [3].

Published percentages were the primary results. For approximate count equivalents only, we calculated n = round (N × percentage/100), rounding to the nearest whole person. These derived estimates are not source-reported counts and cannot reconstruct exact frequencies. We checked each percentage sum and calculated the arithmetic residual as 100 − (Yes + No + Unknown). Residuals were retained separately, without assigning them to Unknown or any other response. Rounding three percentages to one decimal place can account for at most 0.15 percentage points of departure from 100%. The larger observed departures therefore cannot be attributed to rounding alone. BJS notes rounding and missing data but identifies no additional response category or item-specific explanation of the residual in these tables [3].

We calculated setting contrasts as state-prison minus local-jail percentage points and period changes as 2015-2019 minus 2010-2014 percentage points. As a secondary denominator-restricted summary, we calculated the Yes share conditional on a published Yes or No response: 100 × Yes%/(Yes% + No%). This calculation used source percentages directly, rather than rounded estimated counts. We divided the state-prison conditional share by the local-jail conditional share to describe how denominator restriction changes the setting comparison. This ratio is neither a suicide risk ratio nor an adjusted effect estimate. Unknown responses and residual percentages were excluded without imputation; selection bias is possible if their distribution differs systematically from that of reported responses.

All calculations were descriptive. We did not conduct hypothesis tests, calculate confidence intervals or p-values, fit regression models, or estimate risk. A one-sample proportion test would require a specified reference proportion; comparisons between settings would address a different inferential question and require justified count, sampling, and missing-data assumptions. We retained the descriptive scope because exact category counts are unavailable and coverage and recorded-status completeness differ. The absence of living comparison subjects or person-time separately prevents estimation of suicide risk. Two five-year summaries do not establish a temporal trend. Figures retain the published percentages and distinguish

arithmetic residuals from BJS response categories.

This study used publicly available aggregate statistics only; no individual-level records were accessed or linked.

Results

BJS reported 3,327 local-jail and 2,403 state-prison suicide deaths during 2010-2019, based on the published five-year totals [3]. The published Yes/No/Unknown percentages were 13.9/71.8/14.1 for local jails and 15.1/51.4/31.6 for state prisons (Figure *1*). Their approximate count equivalents were 462/2,389/469 and 363/1,235/759, respectively. These are derived estimates, not BJS-reported counts; the percentages remain the primary findings.



FIGURE 1: Recorded prior overnight mental-health facility stay among suicide decedents, 2010-2019

Source: Bureau of Justice Statistics (BJS), Table 7 (p. 16) and Table 15 (p. 25) [3].

Values are published rounded percentages for 2010-2019. Applicable totals are 3,327 local-jail and 2,403 state-prison suicide deaths. Approximate count equivalents, where shown, are calculated as round (N × percentage/100), not source-reported counts. Local-jail totals exclude deaths in the combined jail-and-prison systems of Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont; state-prison totals include them.

*Arithmetic residuals are 0.2 and 1.9 percentage points, respectively; both exceed the maximum 0.15-point departure attributable solely to rounding three percentages to one decimal place. BJS notes missing data but does not identify an additional response category or explain the residuals in detail. Residuals are not included in Unknown.

The three published categories sum to 99.8% for jails and 98.1% for state prisons, leaving arithmetic residuals of 0.2 and 1.9 percentage points. The corresponding rounded count estimates sum to 3,320 and 2,357, leaving differences of 7 and 46 from the totals. Across the two five-year periods, percentage residuals were 0.2 and 0.1 points for jails and 3.7 and 0.6 points for state prisons. Except for the 0.1-point jail residual in 2015-2019, these exceed the maximum 0.15-point departure attributable solely to rounding three percentages to one decimal place. BJS notes missing data as well as rounding, but these tables do not establish the exact composition of the residuals. Residuals were not recoded as Unknown or interpreted as a newly identified category [3].

The state-prison Yes percentage was 1.2 percentage points higher than the local-jail percentage, while its Unknown percentage was 17.5 points higher. These are differences in recorded responses among decedents, not differences in mental-health need, care quality, or suicide risk. Interpretation is limited by the larger Unknown share in state prisons and the different jurisdictional coverage of the two settings [3].

Between 2010-2014 and 2015-2019, the published Yes percentage decreased by 0.7 percentage points in local jails and 6.2 points in state prisons. Unknown status remained 14.1% in jails and increased from 30.6% to 32.4% in state prisons. Figure *2* provides the full period-specific distributions. These are descriptive changes between two aggregated periods, not tested temporal trends.

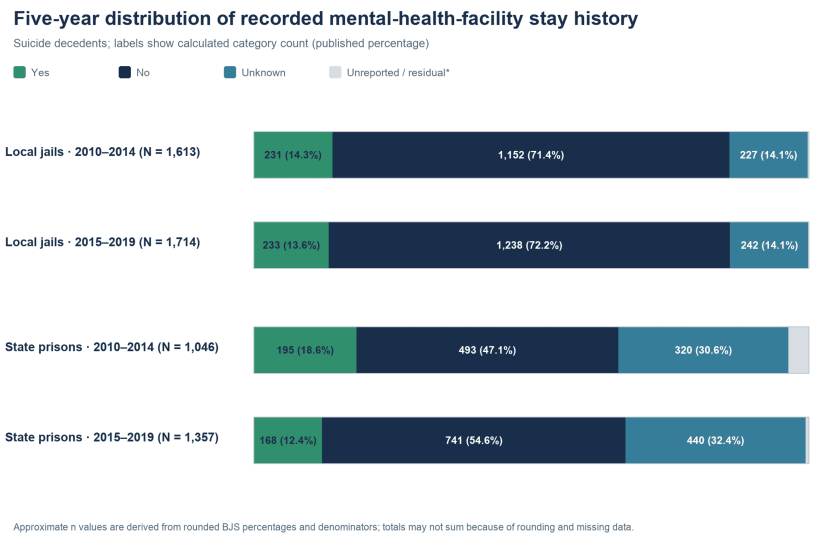


FIGURE 2: Five-year change in recorded mental-health facility stay history

Source: Bureau of Justice Statistics (BJS), Table 7 (p. 16) and Table 15 (p. 25) [3].

The figure shows BJS-reported rounded percentages and approximate category counts calculated by multiplying each published percentage by its period denominator and rounding to the nearest whole number: local jails, 2010-2014, Yes 231 (14.3%), No 1,152 (71.4%), Unknown 227 (14.1%), N=1,613; 2015-2019, Yes 233 (13.6%), No 1,238 (72.2%), Unknown 242 (14.1%), N=1,714. State prisons, 2010-2014, Yes 195 (18.6%), No 493 (47.1%), Unknown 320 (30.6%), N=1,046; 2015-2019, Yes 168 (12.4%), No 741 (54.6%), Unknown 440 (32.4%), N=1,357. Counts are calculated estimates, not BJS-reported counts. Changes are descriptive, not inferential.

*Arithmetic residuals to 100% are 0.2 and 0.1 percentage points for jails and 3.7 and 0.6 points for state prisons, respectively. Except for 0.1 points, these exceed the maximum 0.15-point departure due solely to rounding. BJS notes missing data but does not separately identify the residuals; they are not added to Unknown.

When restricted to the published Yes and No percentages, the conditional Yes share was 13.9/(13.9 + 71.8) = 16.2% for local jails and 15.1/(15.1 + 51.4) = 22.7% for state prisons. The difference was 6.5 percentage points, and the state-prison-to-local-jail ratio of conditional shares was 1.40. This secondary calculation illustrates sensitivity to denominator restriction; it does not correct missingness or estimate suicide risk. Unknown responses and residuals were excluded, and systematic missingness could bias the comparison. No inferential tests were performed.

Discussion

Interpretation of findings

This descriptive analysis found that a recorded stay of at least one night in a mental-health facility since admission was listed for 13.9% of local-jail and 15.1% of state-prison suicide decedents in the BJS tables for 2010-2019 [3]. The recorded Yes percentages differed by 1.2 percentage points; this descriptive contrast does not establish equivalence or a statistically supported difference. The source publishes rounded percentages rather than exact category counts. Unknown status was reported for 14.1% of local-jail and 31.6% of state-prison decedents, limiting interpretation of the Yes and No categories, especially for state prisons.

The measure is a specific within-custody service-history indicator. It is not a psychiatric diagnosis, complete treatment history, or measure of documentation quality. It may not capture outpatient care, symptoms, a diagnosis made before admission, or care delivered within a correctional facility. A recorded stay likewise does not establish that a diagnosis was recognized or that care was adequate. Aggregate tables cannot show why a response was unknown.

Comparisons also require attention to source coverage. BJS excludes deaths in combined jail-and-prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont from its local-jail totals, while including deaths in those systems in state-prison totals [3]. The two setting totals therefore do not represent identical jurisdictional coverage. This limits direct interpretation of the differences and should be considered alongside the larger unknown share in state-prison records.

Strengths and limitations

A key strength is the use of an official BJS report with setting-specific suicide totals and a defined service-history measure [3]. The focused synthesis adds explicit residual accounting and a comparison of full-distribution and denominator-restricted summaries to the original report. There are limitations to the data that limit interpretation of the results: the data are aggregate and include only people who died by suicide. They include neither survivors nor person-time, so they cannot estimate suicide risk, compare risk by service history, or support causal conclusions. Percentages are rounded, and exact category counts are unavailable. Rechecking Tables 7 and 15 confirmed that the overall published response percentages sum to 99.8% and 98.1%; the residuals exceed what rounding alone can explain. BJS notes missing data but does not identify the exact composition of these residuals. Derived counts are approximate equivalents, not recovered frequencies, so interpretation rests on the source percentages. Excluding Unknown responses and residuals changes the population described and may introduce selection bias; the conditional comparison does not resolve missingness. Two aggregated periods cannot establish a temporal trend. The six-jurisdiction coverage difference further limits cross-setting comparisons. Federal prisons were outside this analysis. Also, the item is reported for 2010-2019; these findings do not describe current conditions [3].

Implications and future research

These findings point to a surveillance and measurement limitation, not a demonstrated clinical mechanism. More complete reporting of unknown responses and publication of unrounded category counts would make future tables easier to interpret. To study whether diagnosis, documentation, or service access is associated with suicide, future research would need individual-level data that include people who survive, valid denominators or follow-up time, well-defined measures, and prespecified analyses. Such work would require authorized data access, privacy safeguards, and an appropriate ethics review. It should distinguish facility stays from diagnosis and correctional-health-record documentation, and assess data quality before inferential analysis.

Potential applications

At the system level, the difference in unknown-response percentages can motivate a focused review of how prior facility-stay histories are obtained, transferred, and coded in mortality reporting. A review could identify where records are unavailable and assess whether reporting guidance is applied consistently. This is a proposed application of the descriptive finding, not evidence that a jurisdiction has deficient care or reporting. Local teams should first confirm that definitions, populations, and coverage are comparable before using the figures to frame quality-improvement questions.

For researchers and policymakers, these tables can help specify stronger surveillance measures and future research questions. A multi-source study could assess the completeness and agreement of administrative history against appropriately governed clinical and custody records, then separately evaluate associations using a comparison population and valid time-at-risk denominators. Any record linkage would require data-use authorization, privacy protections, and suitable ethics review. The present aggregate analysis performs no such linkage, cannot rank facilities, and cannot infer an individual's clinical need.

A future feasibility study could evaluate technology-assisted, human-verified detection of clinically supported documentation gaps across authorized clinical records. A proposed workflow would reconcile relevant histories, flag possible discrepancies or omissions with traceable supporting evidence, and route them to clinicians for verification and appropriate follow-up. It should distinguish absent documentation from absent illness or care and should not infer diagnoses solely from missing information. Independent clinician adjudication should provide the reference standard, with evaluation of sensitivity, positive predictive value, false-positive burden, review time, and performance across demographic and institutional groups. Privacy protections, audit trails, and prospective assessment would be required before drawing conclusions about effects on documentation completeness, clinical follow-up, or patient outcomes. These capabilities remain proposed applications requiring separate validation; they were not tested in this aggregate analysis.

Conclusions

This descriptive analysis underscores the importance of clear measurement and transparent reporting when interpreting mental-health service histories in correctional mortality surveillance. A recorded overnight mental-health facility stay is a limited service-history indicator and should not be treated as a proxy for psychiatric diagnosis, treatment need, or care quality. Unknown responses, unexplained arithmetic residuals, and differences in jurisdictional coverage constrain comparisons. The findings support clearer reporting definitions, more complete ascertainment of service histories, and publication of unrounded category counts; they do not establish individual suicide risk or causal relationships.

Future research should use appropriately governed individual-level records, valid comparison populations, and clearly defined measures to examine relationships among mental-health needs, documentation, services, and outcomes. One potential application is technology-assisted, human-verified detection of clinically supported documentation gaps, with traceable supporting evidence and clinician review before

any documentation change or follow-up decision. Such workflows require independent clinical validation, privacy safeguards, and evaluation of accuracy, false-positive burden, reviewer workload, and subgroup performance.

Additional Information

Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the work.

Concept and design: Samy Allam, Anusuya Sen

Acquisition, analysis, or interpretation of data: Samy Allam, Anusuya Sen

Drafting of the manuscript: Samy Allam, Anusuya Sen

Critical review of the manuscript for important intellectual content: Samy Allam

Supervision: Samy Allam

Disclosures

Human subjects: Informed consent for treatment and open access publication was obtained or waived by all participants in this study. **Animal subjects:** All authors have confirmed that this study did not involve animal subjects or tissue. **Conflicts of interest:** In compliance with the ICMJE uniform disclosure form, all authors declare the following: **Payment/services info:** All authors have declared that no financial support was received from any organization for the submitted work. **Financial relationships:** All authors have declared that they have no financial relationships at present or within the previous three years with any organizations that might have an interest in the submitted work. **Other relationships:** All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

Acknowledgements

We thank the Bureau of Justice Statistics for making its aggregate correctional mortality tables publicly available. This analysis used published summary tables only; no individual-level dataset or analytic code was generated.

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