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Research Article

Mental Health Education for Correctional Staff and Officers to Impact Early Detection and Treatment of Suicide in At-Risk Incarcerated Individuals.

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Received Date: June 22, 2026; **Accepted Date:** July 16, 2026; **Published Date:** July 24, 2026

Citation: Nicole Cooke, Theresa Galakatos, Clark Porter, (2026), Mental Health Education for Correctional Staff and Officers to Impact Early Detection and Treatment of Suicide in At-Risk Incarcerated Individuals, *Clinical Medical Reviews and Reports,* 8(7); **DOI:10.31579/2690-8794/329**

Abstract

Background/Aim: Suicide and self-injury occur four times more within correctional facilities than in the general population. Mental health education for correctional staff and officers are rarely included at correctional facilities.

Materials and Methods: A mental health education intervention was provided to correctional staff and officers. A descriptive, retrospective, before and after analysis was conducted to compare suicidal ideation, suicide completion, attempts, and self-injuring behaviors among incarcerated individuals before and after the intervention.

Results: Lower-tailed two-proportion z-tests were conducted at an alpha level of .05 to compare pre- and post-intervention event rates. Following the intervention, self-injurious behavior decreased from 25 to 9 events ($p = .0028$) and suicidal ideation decreased from 33 to 17 events ($p = .0110$), representing statistically significant reductions. Suicide attempts decreased from 10 to 4 events ($p = .0538$), and suicide completions decreased from 1 to 0 events ($p = .1586$); however, these reductions were not statistically significant.

Conclusions: Mental health education for correctional staff and officers was associated with significant reductions in documented self-injurious behavior and suicidal ideation, supporting its use as one component of correctional suicide prevention.

Keywords: suicidal ideation; self-injuring behaviors; suicide attempt; severely mentally ill; vulnerable populations

Introduction

According to the Centers for Disease Control and Prevention (CDC), suicide accounted for 48,824 deaths in the United States in 2024; an estimated 14.3 million adults seriously considered suicide, 4.6 million planned a suicide attempt, and 2.2 million attempted suicides [1]. Suicide is a major public health concern in correctional settings. The Bureau of Justice Statistics (BJS) reported that suicide was the leading single cause of death in local jails in 2019, accounting for 355 deaths, or 30% of all jail deaths, with a rate of 49 deaths per 100,000 inmates [2]. In state and federal prisons, suicides accounted for 5%-8% of deaths from 2001 through 2019, reinforcing the need for suicide prevention strategies across correctional environments [2].

Correctional staff and officers play an important role in decreasing suicide risk yet often lack training in strategies and procedures that support timely interventions, resulting in delays in preventive care or care after an incident occurs [3-5]. Incarcerated individuals may experience alienation or isolation from family and community, loss of personal control, and disruption of familiar roles; daily interactions with correctional staff and officers can either intensify distress or support early identification and timely intervention. A critical step forward is for correctional staff and officers to receive mental health education and preventive strategies to recognize observable mental health warning signs and initiate referrals for mental health evaluation and treatment [6-8]. Although correctional

facilities have established procedures for mental health screening, referral, and treatment, gaps may occur when frontline staff do not consistently recognize early behavioral changes or know when and how to activate referral procedures.

Correctional facilities with early identification and suicide prevention procedures have shown a reduced risk in suicides [6].

The purpose of this project was to provide mental health education to correctional staff and officers at one Southern correctional facility and include early identification strategies and treatment procedures for at-risk incarcerated individuals exhibiting behavioral or psychological symptoms. Mental health services are most beneficial when they include the monitoring of medication adherence or medication changes, diagnosing and treating mental illness, and addressing substance use or withdrawal [6]. Incarcerated individuals may be reluctant to request psychological or behavioral health services; however, when correctional staff, officers, and nurses collaborate, the ongoing well-being of incarcerated individuals can be addressed proactively [4,9]. Interventions that promote early symptom detection, address suicide risk, and offer timely treatment help close the evidence-to-practice gap [3,10].

The aim of this project was to evaluate a 1- to 2-hour mental health education intervention for correctional staff and officers on the number of suicide attempts, suicidal ideation events, suicide completions, and self-injurious behaviors among incarcerated individuals. The intervention was delivered during mandatory staff training and included evidence-based content on early recognition of common mental health conditions, differentiation of substance use effects from symptoms of mental illness, de-escalation strategies for individuals at risk for suicide or self-injurious behavior, attention to basic human needs such as food, shelter, and activities of daily living items, and review of established procedures for initiating a mental health referral for an at-risk incarcerated individual.

Review of Literature

In a review of the current literature, four themes were discovered: severity of mental health in corrections, staff education, collaboration, and barriers. These themes are discussed in this section.

Severity of Mental Health in Corrections

Suicide and self-injury present an ongoing public health challenge for correctional facilities, placing incarcerated individuals at greater risk for suicide compared with the general population [7,11-13]. In international studies, Italian prisons reported that one in every ten incarcerated individuals engaged in self-injurious behavior [14]. In cases of serious mental illness (SMI), incarcerated individuals are at elevated risk for suicide [3]. Marzano et al. [7] identified potentially modifiable clinical, psychosocial, and environmental factors associated with near-lethal suicide attempts in prisons, including psychiatric morbidity, trauma, social isolation, bullying, and prison-related stressors. For incarcerated individuals who experience anxiety, depression, bipolar disorder, schizophrenia, substance use concerns, or personality disorders, early access to mental health services initiated by correctional staff and officers can mitigate poor outcomes.

Corrections Staff and Officer Education

In the correctional setting, security and safety are priorities and are further enhanced when correctional staff and officers use early symptom detection strategies and initiate referrals to mental health services for evaluation and treatment [4,6]. Darani et al. [4] found limited but positive evidence that mental health education programs for correctional officers can improve knowledge, skills, and attitudes, particularly when training is applicable to correctional work and incorporates experiential teaching methods. Further, correctional staff and officers' attitudes toward incarcerated individuals may improve, and improvements in safety risks, staff burnout, trauma-informed responses, and rehabilitative efforts may be realized [4,13]. Empathy strategies and interprofessional collaboration can significantly affect incarcerated individuals experiencing a mental health crisis and may reduce incidents of suicidality [15]. Yet, correctional staff and officers who intervene during a mental health crisis report limited mental health education, including limited preparation for how to cope with a witnessed suicide or how to help themselves or colleagues access mental health support [16]. Mental health training for correctional staff and officers has been reported as minimal, and annual professional competency training may lack sufficient substance when staff must rely primarily on personal judgment [14]. Correctional facilities can strengthen mental health education programs by including detection of early warning signs, de-escalation strategies, referral procedures, and expedited access to mental health services to prevent or stabilize mental health crises [4,11]. Education and skill enhancement that reinforce decreased risk in self-injurious behaviors also reinforce security and safety, which are shared responsibilities in public health and population management [12].

Collaboration

Correctional staff, officers, and nurses can help improve suicide awareness, safety, and access to mental health care through collaboration [4,6,15]. Collaborative efforts between the criminal justice system and the mental health system can significantly affect individuals with serious mental illness [17]. Quality interactions between correctional staff and incarcerated individuals are critical for behavior monitoring and activation of preventive strategies, including recognizing mental illness, implementing de-escalation strategies, and reducing the incidence of self-harm and suicide [7,10]. Collaboration improves communication, and communication from the top down can lead to a better balance between safety and early access to mental health care [18].

Barriers

Security within correctional facilities is maintained through rigorous monitoring, removal of threats, and providing a culture of safety; yet these principles may pose a barrier when beliefs about mental illness contribute to stigma and inaction [16]. Bias and stigma occur in correctional systems due to the negative narrative that follows incarceration [9]. This negative narrative significantly impacts the incarcerated individual's mental health [16]. Nonetheless, correctional staff or officers who do not understand their role during a mental health crisis or observing self-harm, lack education opportunities and access to resources and strategies for effective responses [16].

Further, workforce capacity in correctional facilities may lack infrastructure for mobilizing human resources for adequate staffing and timely interventions. Correctional facilities are often short-staffed and deploy security, mental health, and medical human resources sparingly, which can delay mental health identification, referral, and treatment. Marzano et al.

[7] emphasized that suicide prevention in prisons requires attention to modifiable clinical, psychosocial, and environmental factors, not solely individual risk. It is imperative that these challenges be addressed

through strategic mobilization of resources, data surveillance and reporting policies, and mental health training that guides prevention efforts.

Concepts and Definitions

Defining concepts helps clarify and differentiate the significance of each term.

Correctional officer: a person responsible for the custody, safety, security, and supervision of inmates in a correctional facility [19].

Self-injuring behaviors: the deliberate injury to one's own body done without the aid of the other person; injuries severe enough to cause tissue damage/scarring [20].

Severely mentally ill: a mental, behavioral, or emotional disorder resulting in serious functional impairment, that interferes or limits one or more major life activities [21].

Suicide attempt: self-harm with intent to end their own life, not resulting in death [22].

Suicidal ideation: suicidal thoughts or ideas ranging from contemplations to reoccupation with death and suicide [23].

Vulnerable populations: individuals at greater risk of poor physical and social health status due to disparities in physical, economic, and social health status and who are less able to anticipate, cope, resist, or recover [24].

Materials and Methods

A descriptive, retrospective, before-and-after analysis was conducted to measure differences in suicidal ideation, suicide completions, suicide attempts, and self-injurious behaviors among incarcerated individuals following a mental health education intervention for correctional staff and officers. The intervention was delivered by the principal investigator (PI), Nicole Cooke, to correctional staff and officers during mandatory training and focused on improving early detection, management, referral, and prevention procedures for incarcerated individuals at risk for suicide-related behaviors. The intervention content included recognition of common mental health symptoms, differentiation of substance-related behaviors from symptoms of mental illness, de-escalation strategies, attention to unmet basic needs, and steps for initiating mental health referral according to facility procedures. At the project site, routine correctional health procedures included mental health screening and referral processes for incarcerated individuals who demonstrated psychological distress, suicidal ideation, self-injurious behavior, substance-related concerns, or other behavioral changes requiring clinical evaluation. The PI's role as a nurse within the correctional facility provided direct practice insight into the importance of strengthening staff recognition of mental health warning signs and timely activation of referral procedures. The goal of the education intervention was not to replace evaluation by mental health specialists, but to improve frontline staff awareness, communication, and referral practices so that at-risk individuals could be identified earlier and connected to appropriate mental health assessment, treatment, crisis intervention, or follow-up care. Although incarceration does not uniformly worsen mental health symptoms for all individuals, correctional environments may exacerbate preexisting mental health disorders and intensify psychological distress among vulnerable incarcerated individuals [25].

Data for suicide-related outcomes were obtained from routinely collected correctional health and safety records, including monthly chart audits, incident reports, and electronic medical record (EMR) reports generated by the Department of Corrections. These data are collected by the correctional system for institutional monitoring, quality assurance, mortality review, suicide prevention, and required reporting of in-custody deaths. For this project, existing aggregate data were used retrospectively to evaluate whether documented suicide-related outcomes changed after the mental health education intervention for correctional staff and officers. To protect privacy, only aggregate, de-identified data were provided to the PI by the administrators responsible for maintaining these statistics. None of the 18 HIPAA identifiers were collected; only the minimum necessary aggregate data required to meet the project aims were obtained.

Inclusion criteria consisted of aggregate, de-identified event data for documented suicide attempts, suicide completions, suicidal ideation events, and self-injurious behaviors among incarcerated individuals housed at a participating Level 6 correctional facility in the Southern region during the designated pre-intervention and post-intervention periods. Aggregate statistics were provided for three housing or care areas: closed management dorms, open population, and inpatient. Exclusion criteria included duplicate records, events occurring outside the project periods or outside the participating facility, records with insufficient information to classify the event, and incidents that could not be reliably assigned to the appropriate comparison period. Suicide-related outcomes were classified using the facility's established incident-reporting and mental health documentation procedures and were consistent with commonly recognized definitions of suicide attempts, suicidal ideation, and suicide-related behaviors [1,20,22,23].

Institutional Review Board and project-site approvals were obtained before data collection. Pre-intervention data were collected from August 1, 2023, through September 30, 2023. Mental health education was provided to correctional staff and officers on October 1, 2023. Post-intervention data were collected through December 31, 2023. A total of 300 correctional staff and officers received the education intervention. The project site housed 1,042 male incarcerated individuals.

Results

Data were collected and analyzed before and after the mental health education intervention. All data collected were secured under a triple lock, stored in a locked file, on a password-protected computer, in a locked private office. Lower-tailed two-proportion z-tests were conducted at an alpha level of .05 to compare pre- and post-intervention event rates for suicide attempts, suicide completions, suicidal ideation, and self-injurious behaviors (SIB). The lower-tailed approach was selected because the project aimed to determine whether post-intervention event proportions were lower than pre-intervention proportions.

Key findings showed improvements following the mental health education. More specifically, suicide attempts decreased from 10 pre-intervention events to 4 post-intervention events (not statistically significant, $p = .0538$); suicide completions decreased from 1 event to 0 events (not statistically significant, $p = .1586$); SIB decreased from 25 to 9 events (statistically significant $p = .0028$): and suicidal ideation decreased from 33 to 17 events (statistically significant $p = .0110$). There were no statistically significant changes in suicide attempts or completions and there were statistically significant changes seen in self-injury and suicidal ideation. Self-injurious behavior and suicidal ideation

showed statistically significant reductions after the intervention, whereas suicide attempts and suicide completions did not reach statistical significance (see Table 1).

Outcome	Post events, n	Pre events, n	Difference in proportions	Z statistic	p value	95% confidence interval	Statistical decision	Post hoc power
Suicide attempts	4	10	-0.0058	-1.6090	0.0538	-0.0128 to 0.0013	Do not reject null hypothesis	0.4857
Suicide completions	0	1	-0.0010	-1.0002	0.1586	-0.0028 to 0.0009	Do not reject null hypothesis	0.2595
Self-injurious behavior	9	25	-0.0154	-2.7666	0.0028	-0.0262 to -0.0045	Reject null hypothesis	0.8695
Suicidal ideation	17	33	-0.0154	-2.2904	0.0110	-0.0285 to -0.0022	Reject null hypothesis	0.7410

Note. All analyses used a lower-tail test with an alpha level of 0.05 and equal group sample sizes of 1,042. Negative differences indicate lower post-intervention event proportions compared with pre-intervention event proportions. Self-injurious behavior and suicidal ideation showed statistically significant reductions after the intervention, whereas suicide attempts and suicide completions did not reach statistical significance.

Table 1: Summary of Pre- and Post- Intervention Outcomes.

Discussion

This project evaluated whether a mental health education intervention for correctional staff and officers was associated with changes in suicide-related outcomes among incarcerated individuals. The project was informed by the PI's direct clinical experience within the correctional facility, where the need for improved mental health recognition, timely referral, and suicide prevention procedures was identified through practice. The PI delivered the education intervention and collected the project data, strengthening the practice-based relevance of the findings. The second author, Theresa Galakatos, contributed to the scholarly development of the manuscript through writing support, editing, interpretation of the literature, and assistance with data analysis.

Following the intervention, self-injurious behavior and suicidal ideation decreased significantly; however, reductions in suicide attempts and suicide completions did not reach statistical significance. These findings are consistent with prior literature indicating that correctional staff play an important role in recognizing psychological distress, identifying self-directed violence risk, and facilitating timely referral to mental health services [6,11,16]. The observed reduction in self-injurious behavior and suicidal ideation is consistent with Darani et al. [4], who found that correctional officer mental health education programs can improve knowledge, skills, and attitudes, although gains may decline after training.

The present project extends this literature by examining documented suicide-related outcomes among incarcerated individuals rather than focusing only on staff knowledge, confidence, or attitudes. This is an important contribution because correctional officers are often the first to observe behavioral changes, psychological distress, or escalating suicide risk. By linking staff education to documented institutional outcomes, the project adds practice-based evidence supporting correctional staff education as one component of suicide prevention in correctional environments.

However, correctional staff education should not be viewed as a stand-alone intervention.

Suicide prevention in correctional settings requires a broader system of ongoing mental health evaluation, repeated assessment, referral, treatment access, safety monitoring, and multidisciplinary collaboration. Mental health assessment may be especially important at intake, during housing transitions, after disciplinary events, following medication changes, after family or legal stressors, and whenever staff observe changes in mood, behavior, withdrawal, agitation, hopelessness, or self-harm risk. Individuals who demonstrate symptoms of mental illness, suicidal ideation, self-injurious behavior, substance withdrawal, anger dysregulation, grief, or significant psychological distress may require regular follow-up by mental health professionals, including psychiatric providers, nurses, counselors, and other members of the correctional health team.

These findings align with Marzano et al. [7], who identified modifiable clinical, psychosocial, and environmental factors associated with near-lethal suicide attempts in prisons and recommended improved detection, management, and prevention of suicide risk. The nonsignificant findings for suicide attempts and suicide completions should be interpreted with caution. Suicide attempts and completions were infrequent events during the project timeline, limiting the ability to detect statistically significant differences. Research has shown that suicide risk in correctional settings is complex and influenced by multiple individual, environmental, institutional, and treatment-related factors; therefore, education alone may not be sufficient to influence rare outcomes within a short timeframe [6,7,18]. Findings suggest that education interventions may contribute to earlier identification of distress and may have a more immediate effect on outcomes that are more frequently documented, including suicidal ideation and self-injurious behavior.

In addition to mental health referral and clinical treatment, correctional systems may benefit from structured interventions that support coping, emotional regulation, anger management, grief processing, communication, and prosocial behavior. Educational materials, therapeutic groups, peer support, family contact when appropriate, and evidence-informed programming may help address psychological distress and reduce behavioral escalation. These approaches are consistent with the need to move beyond crisis response toward prevention, early intervention, and continuous mental health support within correctional environments.

Recent public reporting has also highlighted ongoing concerns regarding mental health care access and crisis response within Missouri correctional settings, illustrating the continued gap between mental health needs and available correctional resources [26]. Although media reports are not

equivalent to empirical evidence, they provide timely context for the public health urgency of this work. The present findings should therefore be viewed within a broader correctional health landscape in which staff education, early symptom recognition, timely referral, and coordinated mental health response remain essential components of suicide prevention.

Limitations

There were several limitations when interpreting the findings. First, a retrospective, single-site, before-and-after design without a comparison group cannot establish that changes were caused solely by the mental health education intervention. Other influences, including changes in staffing, institutional procedures, availability of mental health services, housing practices, seasonal variation, population turnover, or concurrent suicide prevention efforts, may have affected the outcomes. Second, the project was conducted at one correctional facility in the Southern region of the United States; therefore, findings may not be generalizable to correctional settings with different security levels, staffing models, resources, policies, facility cultures, or incarcerated populations. Third, a single mental health education session may not produce sustained knowledge retention, consistent use of de-escalation strategies, or lasting changes in suicide prevention practices. Without measuring staff knowledge, attitudes, confidence, training attendance, intervention fidelity, or changes in staff behavior after the education session, it is not possible to determine whether learning translated into practice. Fourth, outcomes were obtained from aggregate EMR and incident-report data, which may have introduced measurement or ascertainment bias from variability in documentation practices, staff recognition of symptoms, classification of events, and reporting thresholds. Potential changes in the incarcerated population between the pre- and post-intervention periods, including admissions, transfers, releases, housing assignments, and variation in individual time at risk, were not measured or controlled for in the analysis. Fifth, the pre-intervention period included two months of data, whereas the post-intervention period included three months of data because of delays in obtaining EMR reports. The unequal timeframes may have biased comparisons of event counts, and missing or incomplete pre-intervention data may have influenced whether findings were statistically significant. Sixth, suicide attempts and suicide completions were rare outcomes, resulting in low post hoc power for these analyses. The project may have been underpowered to detect meaningful differences in these events. Finally, multiple outcomes were tested using lower-tailed two-proportion z-tests without adjustment for multiple comparisons, increasing the possibility of Type I error. The one-tailed approach assumes that the intervention could only reduce, rather than increase, suicide-related outcomes.

Conclusions

Mental health education for correctional staff and officers was associated with statistically significant reductions in documented self-injurious behavior and suicidal ideation among incarcerated individuals at one correctional facility. Although suicide attempts and suicide completions decreased numerically, these changes were not statistically significant. The findings support the potential value of correctional staff education as one component of a broader suicide prevention strategy that includes early symptom recognition, de-escalation, timely referral, access to mental health services, and consistent implementation of established suicide prevention procedures. These results are consistent with prior research emphasizing that suicide prevention in prisons requires both staff preparation and system-level attention to modifiable risk factors [4,7]. Correctional systems have a public health responsibility to identify and respond to mental health concerns and suicide risk among incarcerated individuals. Mental health care and suicide prevention should remain integral components of correctional safety, clinical practice, and institutional accountability.

Recommendations

Future initiatives should provide recurring mental health and suicide prevention education rather than a single training session. Training should include early recognition of mental health symptoms, differentiation between substance-related symptoms and mental illness, de-escalation techniques, suicide risk assessment, referral procedures, and documentation expectations. Ongoing education is supported by literature emphasizing the importance of correctional staff preparedness, experiential training methods, and collaboration with mental health professionals when responding to self-directed violence and psychological distress [4,11,12,15]. Correctional facilities should implement routine monitoring of suicide-related outcomes, including quarterly tracking and trending of suicidal ideation, self-injurious behavior, suicide attempts, suicide completions, referral rates, and time from symptom identification to mental health evaluation or treatment. Monitoring these indicators may help identify areas for improvement and support timely adjustment of suicide prevention procedures.

Correctional facilities should maintain clear procedures for clinically indicated safety placement when an incarcerated individual presents an imminent risk of self-harm, suicide, or serious harm to others. Such placement should be therapeutic, time-limited, closely monitored, and distinguished from punitive isolation or disciplinary segregation. Suicide-resistant observation rooms or higher-acuity mental health housing may be appropriate when used as part of a suicide prevention protocol that includes immediate mental health assessment, ongoing observation, safety planning, removal of lethal means, and timely return to the least restrictive safe setting [27]. Because substance use and withdrawal may contribute to behavioral escalation and suicide risk, correctional systems should ensure access to evidence-based substance use treatment, including medication for opioid use disorder when clinically indicated [28].

Future research should use larger multisite samples, longer and equal pre- and post-intervention timeframes, and staff-level outcomes, including knowledge, confidence, training completion, adherence to procedures, and referral practices. Future work should examine clinical, psychosocial, and environmental risk factors and prevention strategies identified in prison suicide prevention research [7]. Combining staff education with multidisciplinary mental health collaboration, improved access to treatment, and evidence-based approaches to suicide prevention may strengthen correctional systems' ability to respond promptly and effectively when incarcerated individuals demonstrate psychological distress or suicide risk.

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DOI:10.31579/2690-8794/329