IRISH PRISON SERVICE

Self-harm in Irish Prisons 2017

First report from the Self-Harm Assessment and Data Analysis (SADA) Project

October 2018

NSRF
National Suicide Research Foundation

Connecting for Life

Foreword

The Irish Prison Service (IPS) is responsible for the safe custody of persons committed to prison from the courts. The Irish Prison Service (IPS) 2016-2018 Strategic Plan sets out the key strategic actions the Service is taking in order to create a better environment by supporting staff, victims & prisoners and enhancing organisation capacity.

The Irish Prison Service Steering Group for the Prevention of Self-Harm and Death in the Prison Population provided a forum for collating the reports of the local Suicide Prevention Committees and disseminating significant findings throughout the prison system. This Group was renamed in December 2014 as the National Suicide and Harm Prevention Steering Group (NSHPSG).

The NSHPSG monitors the incidence and nature of self-harm and death, reviews each with a view to improving prevention and response measures, and ensures the sharing of relevant information on risk factors and best practice with the local Suicide & Harm Prevention Steering Group. In this context, the Reports of the Inspector of Prisons and the Office of the Inspector of Prisons, into deaths in custody and the recommendations therein are also considered by the National Steering Group. It also examines any recommendations made by the Jury in an inquest which are communicated to the Irish Prison Service by the County Coroner's.

The NSHPSG promotes best practice in preventing and, where necessary, responding to self-harm and death in the prisoner population. Analysis of data on self-harm will inform policy and practice development within the IPS, to seek to reduce the incidence of self-harm among those in custody.

The Steering Group's membership consists of representatives of Senior Prison Management, IPS Headquarters (Care and Rehabilitation, and Operations Directorates), Samaritans Ireland, IPS Healthcare Services, IPS Psychology Service, Prison Chaplaincy Service, Prison Officers Association, Probation Service, and the National Forensic Mental Health Services. A representative from the Department of Justice and Equality also attends the meetings of the National Steering Group.

The multi-disciplinary teams across the prison estate make a significant contribution towards the National Suicide and Harm Prevention Steering Group (NSHPSG) by analysing each instance of self-harm and/or suicide in their respective prisons using the Self-Harm Assessment and Data Analysis (SADA) Project procedure, holding local Steering Group meetings for Suicide and Harm Prevention and making recommendations to local management and the NSHPSG.

'Connecting for Life' is Ireland's National Strategy to Reduce Suicide 2015-2020, which comprises of a cross sectoral group of high level representatives from Government Departments and key state agencies, including the Department of Justice and Equality and the Irish Prison Service. As part of 'Connecting for Life', the Irish Prison Service committed to contributing towards the seven strategic Goals and Objectives, including goal 7; to improve surveillance evaluation and high quality research

relating to suicidal behaviour, and to achieving the objective 7.2; ‘to improve access to timely and high quality data on suicide and self-harm’ by implementing action 7.2.1 ‘Develop Capacity for Observation’.

In support of achieving the aims of the NSHPSG, IPS Strategic Plan and Connecting for Life, the concept of the SADA was developed and implemented across the prison estate by Ms. Sarah Hume, Senior Psychologist, and Mr. Enda Kelly, National Operational Nurse Manager. Deirdre O’Reilly, Chief Pharmacist, played a pivotal role in liaising with HSE National Office for Suicide Prevention to gain the support of the Health Service Executive’s (HSE) National Office of Suicide Prevention (NOSP) and the National Suicide Research Foundation (NSRF) who have kindly assisted the Irish Prison Service with data entry, data analysis, reporting and longitudinal analysis. This will enable the Irish Prison Service to inform policy and practice development in order to seek to reduce the incidence of self-harm among those in custody.

This report presents the first 12 months data on the analysis of all episodes of self-harm (SADA) across the Irish Prison Estate and is the first step in understanding and learning valuable lessons for the future protection of people in our care.

The collaborative approach of this work reflects and reinforces an excellence of clinical, academic and professional practices coming together to provide a robust analysis of our shared interest in making life in prisons safer for all.

Michael Donnellan.

Director General, Irish Prison Service.

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Executive Summary

This is the first report on episodes of self-harm recorded in Irish Prisons arising from the Self-Harm Assessment and Data Analysis (SADA) Project, relating to the year 2017.

Main findings

- Between 01 January and 31 December 2017, there were 223 episodes of self-harm recorded in Irish Prisons, involving 138 individuals. The majority of prisoners were male (80%) and the mean age was 32 years.

- The annual person-based rate of self-harm was 4.0 per 100 prisoners. Thus, an episode of self-harm was recorded for 4% of the prison population. The rate of self-harm was 4.4 times higher among female prisoners (16.0 versus 3.6 per 100). Compared with sentenced prisoners, the rate of self-harm was 2.4 times higher among prisoners on remand (7.4 versus 3.1 per 100). The rate of self-harm was highest among prisoners aged 18-29 years, at 5.0 per 100 prisoners. The rate of self-harm was highest for male prisoners among those aged 18-24 years (5.0 per 100) and for female prisoners among 25-29 year-olds (12.0 per 100).

- Episodes of self-harm were more likely to occur on weekdays, with one in five (22%) episodes occurring on Tuesdays. More than half of episodes (52%) occurred between 2pm and 8pm. Most episodes (60%) occurred while prisoners were unlocked from cells.

- One-quarter of individuals engaged in self-harm more than once during the calendar year, and this was more pronounced for male prisoners – 26% of male prisoners repeated self-harm compared with 16% of female prisoners.

- The most common method of self-harm recorded was self-cutting or scratching, present in 62% of all episodes. The other common method of self-harm was attempted hanging, involved in 21% of episodes. Methods of self-harm were similar for male and female prisoners.

- Three-quarters (77%) of self-harm episodes involved prisoners in single cell accommodation. Considering the overall prison population, 53% were accommodated in single cells in 2017. While 44% of prisoners who engaged in self-harm were in general population accommodation, a further 44% were in protection (including Rule 62 and 63) at the time of the self-harm act.

- No medical treatment was required in more than one-third (39%) of episodes. Almost half (46%) required minimal intervention or local wound management in the prison and one in eight (14%) required hospital (inpatient or outpatient) treatment. In 2017, there were four episodes of self-harm (2%) which resulted in the loss of life. The severity of self-harm was elevated among male prisoners.

- Half (54%) of self-harm episodes were recorded as having no / low degree of suicidal intent, with 29% having medium intent. Approximately one in six (17%) were deemed to have a high degree of suicidal intent.

- A high degree of suicidal intent was evident in 15% of the self-harm episodes that did not require medical treatment. High intent cases were only slightly more prevalent, at 21%, among episodes that required local or outpatient treatment.

- There was a range of contributory factors associated with the episodes of self-harm recorded, relating to environmental, relational, procedural, medical and mental health factors. The majority (58%) of factors related to mental health issues, 38% to relational issues and 36% to environmental issues.

- The four fatal episodes of self-harm involved male prisoners who were on remand. Multiple contributory factors were associated with these deaths.

Discussion points

The annual person-based rate of self-harm reported by the SADA project for 2017 was 4.0 per 100 prisoners. A previous study of self-harm in Irish prisons reported a very similar rate of 4% for the year 2004,[1] whereas a study of self-harm in prisons in England and Wales during 2004-2009 reported a rate of 6%.[2] Thus, comparison of the SADA project findings to these methodologically similar studies suggests that there has been no change in the incidence of self-harm among prisoners in Ireland

[1] National Suicide Research Foundation. (2005). *Deliberate self harm in Irish prisons and places of detention*. Cork.
[2] Hawton, K., et al. (2014). Self-harm in prisons in England and Wales: an epidemiological study of prevalence, risk factors, clustering, and subsequent suicide. *Lancet.* 383(9923): 1147-54.

during the past 10-15 years and that the Irish rate is approximately one third lower than in England and Wales.

Women accounted for approximately 4% of the Irish prison population in 2017[3] but they contributed to a significantly higher proportion of the self-harm episodes that occurred during the year because their incidence of self-harm was four times higher than it was among male prisoners. This is a larger gender difference than observed in self-harm among the general population.[4]

Irish prison population data were available by age for sentenced prisoners. Using these data showed younger prisoners to have the highest rate of self-harm, which is consistent with findings for the general population.[4]

The rate of self-harm was three times higher among prisoners on remand or awaiting trial than it was among sentenced prisoners. This finding is in line with other research[2], and indicates that prisoners on remand are a particularly vulnerable group in relation to suicidal behaviour. Committal to a prison may be an important time to identify risk among individuals and to implement appropriate prevention measures. It is important to note that while 77% of episodes involved prisoners in single cell accommodation, more than half of the prison population are housed in single cell accommodation.[5]

By combining the SADA project data with detailed population data from the Irish Prison Service it has been possible to report the incidence of self-harm in Irish prisons across a number of characteristics such as sex, age (for sentenced prisoners) and sentence status (sentenced versus on remand or awaiting trial), which helps to identify groups and conditions associated with high risk. To do this to a greater extent requires not only the ongoing recording of self-harm episodes by the SADA project but also more comprehensive data on the prison population.

The main method of self-harm recorded was self-cutting or scratching, present in 60% of episodes. While the majority of episodes involving self-cutting were less severe, risk of repetition is elevated among individuals who engage in self-cutting.[6] Episodes of self-cutting requiring extensive treatment

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[3] Irish Prison Service. (2017). Average prison population Jan to Dec 2017.
[4] Griffin, E., et al. (2017). *National Self-Harm Registry Ireland Annual Report 2016*. National Suicide Research Foundation: Cork.
[5] Irish Prison Service. (2017). Census Prison Population October 2017 – Cell occupancy – In-Cell Sanitation. Available from: https://www.irishprisons.ie/wp-content/uploads/documents_pdf/October-2017-In-Cell.pdf
[6] Larkin et al. (2014). Risk factors for repetition of self-harm: a systematic review of prospective hospital-based studies. *PloS One.*

are associated with repeat acts involving highly lethal methods.[7] Attempted hanging was recorded as the method of self-harm in 21% of episodes, and was involved in 75% of deaths following self-harm. This is the first known study to systematically record both the severity (based on type of medical treatment required) and degree of intent associated with episodes of self-harm occurring in Irish prisons. The findings from this report highlight the heterogeneous nature of suicidal behaviour among prisoners. The majority of episodes were deemed to have a low or medium level of severity. However a significant proportion of episodes were associated with a high degree of suicidal intent, indicating that suicidal intent may be high regardless of the method of self-harm or severity of the act.

An innovative aspect of this study is the recording of contributory factors associated with episodes of self-harm. The findings highlight the complexity of the circumstances surrounding suicidal behaviour in prison settings, with more than one contributory factor recorded in a majority of cases. Factors relating to mental health issues/ mental illness were the primary contributory factors recorded – relating to presence of mental disorders, coping and emotional dysregulation, substance misuse and hopelessness. A recent systematic review[8] found that, among Irish prisoners, the prevalence of psychotic disorders (3.6%), substance use disorders (50.9%) and alcohol use disorders (28.3%) were higher than the general population. Prisoners with multiple needs (such as dual diagnosis) may require more tailored supports and interventions. However our findings also highlight prison-specific factors cited as contributing to the episode of self-harm. The majority of these related to the environment of the prisoner, specifically issues surrounding their accommodation as well as legal issues. Procedural issues such as a recent cell move and change in regime or security level, were also commonly cited. Relationship difficulties with staff, family members and friends, as well as with other prisoners were also a common factor.

[7] Larkin, C, et al. (2014). Severity of hospital-treated self-cutting and risk of future self-harm: anational registry study. *Journal of Mental Health*.
[8] Gulati et al. (2018). The prevalence of major mental illness, substance misuse and homelessness in Irish prisoners: systematic review and meta-analyses. *Irish Journal of Psychological Medicine*.

Conclusion

The Irish Prison Service (IPS) is responsible for the safe custody of persons committed to prison from the courts. The Irish Prison Service (IPS) 2016-2018 Strategic Plan[9] sets out the key strategic actions the Service is taking in order to create a better environment by supporting staff, victims and prisoners and enhancing organisation capacity.

The IPS National Suicide and Harm Prevention Steering Group (NSHPSG) promotes best practice in preventing and, where necessary, responding to self-harm and death in the prisoner population. Analysis of data on self-harm will inform policy and practice development within the IPS, to seek to reduce the incidence of self-harm among those in custody. Data are recorded on an on-going basis across the Irish Prison estate, by local multi-disciplinary teams. This ensures that the circumstances of individual episodes of self-harm are reviewed in order to provide appropriate interventions and supports to reduce the risk of further suicidal behaviour. Interim data from the SADA project are reported to local teams as well as to the NSHPSG to inform and activities to enhance safer custody of prisoners.

This first report from the SADA project represents an initial step in understanding and learning valuable lessons for the future protection of people in the care of the IPS. It is intended that this report will be published on an annual basis and that the availability of reports over a number of years will contribute to a longitudinal analysis of self-harm data which can only increase and improve our responses to maintaining safer prisons.

The collaborative approach of this work reflects and reinforces an excellence of clinical, academic and professional practices coming together to provide a robust analysis of our shared interest in making life in prisons safer for all.

[9] Irish Prison Service (2016). Strategic Plan 2016-2018.

Authors

This report was authored by Eve Griffin, Grace Cully and Paul Corcoran from the National Suicide Research Foundation and Sarah Hume – Senior Psychologist, Enda Kelly – National Operational Nurse Manager, and Deirdre O'Reilly – Chief Pharmacist, from the Irish Prison Service. The report is supported by the National Office for Suicide Prevention. The ongoing surveillance of self-harm and suicide in Irish prisons is funded by the Irish Prison Service and the Health Service Executive's (HSE) National Office of Suicide Prevention (NOSP) as part of Connecting for Life – Ireland's National Strategy to Reduce Self-harm and Suicide (2015-2020).[10]

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All members of the National Suicide and Harm Prevention Steering Group

All members of the local Suicide and Harm Reduction Meetings

[10] Department of Health. (2015). Connecting for Life: Ireland's National Strategy to Reduce Self-harm and Suicide (2015-2020). Dublin.

Introduction

Prevalence of suicide and self-harm in prisoners

Self-harm and suicide are major issues in the prison population. [2,11,] Internationally, rates of suicide and lifetime self-harm are higher in prisoners compared to the general population.[11,12] A recent study including 24 high income countries reported considerable variation in annual suicide rates in different countries, with rates ranging from 10-176 per 100,000 prisoners.[11] The rate of suicide in Irish prisons from 2011-2014 was 47 per 100,000 prisoners.[11]

Large-scale epidemiological studies on the prevalence of self-harm in prisons are scarce. Previous small-scale studies have reported prevalence rates of self-harm in custody between 5-24%.[12] One national study of self-harm in prisons in England and Wales, including 139,195 self-harm episodes recorded in 26,510 prisoners between 2004 and 2009, reported that 6% of prisoners self-harmed each year.[11] This study observed a higher rate of self-harm among female (20-24%) compared with male prisoners.[11] More recent reports indicate that the incidence of self-harm in prisoners in England and Wales has increased in recent years.[13,14] A previous report by the National Suicide Research Foundation (NSRF) reported that 170 self-harm episodes occurred in Irish prisons in 2004 which translated to 3.8% of all prisoners.[1]

Repetition of non-fatal self-harm is common among prisoners, particularly among females.[1,2] In England and Wales, the reported average number of episodes per year from 2004 to 2009 among male prisoners was 2 per person compared to an average of 8 episodes per person among females.[2] Consistent with this, a previous Irish study found that, in 2004, 44% of female prisoners and 7% of male prisoners had at least one repeated act of self-harm within one calendar year.[1]

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[11] Fazel, S., et al. (2017). Suicide in prisons: an international study of prevalence and contributory factors. *Lancet Psychiatry.* 4(12): 946-952.
[12] Dixon-Gordon, K et al. (2012). Non-suicidal self-injury within offender populations: a systematic review. *Int J Forensic Ment Health.* **11**(1): 33-50.
[13] Beard, J. et al. (2017). *Prison safety in England and Wales*. House of Commons: London.
[14] HMCIP. (2017). *HM Chief Inspector of Prisons for England and Wales annual report 2016–17*. House of Commons: London.

Risk factors for suicidal behaviour in prisoners

Self-harm is associated with increased risk of suicide in prisoners. [2,15] Risk of suicide has been reported to increase further following self-harm of moderate or high lethality, compared to low lethality, and among prisoners with a history of repetitive self-harm.[2] Additional risk factors for suicide in prisoners include male sex, single cell occupancy, recent suicidal ideation, psychiatric diagnosis, and history of alcohol use problems[2,11,] The prevalence of psychotic disorders, alcohol and drug misuse in Irish prisoners is significantly higher than the rate of these vulnerabilities among the general Irish population.[8]

Self-harm episodes in prison vary in terms of lethality, level of suicidal intent and motivating factors. [2,12] Much of the previous research on risk factors for self-harm in prisons has focused on specific types of self-harming behaviour, such as superficial self-injury in the absence of suicidal intent or episodes that are classified as suicide attempts.[12,16] It is therefore difficult to synthesise and generalise the findings of these studies but there is some consistent evidence that white ethnic origin, previous self-harm and mental disorders are risk factors for self-harm in prisoners. A large-scale study of prisoners in England and Wales identified the following risk factors: female sex, younger age, white ethnic origin, prison type and a life sentence or being un-sentenced.[2]

Method of self-harm and suicide in prisoners

The method most commonly involved in suicide deaths in prisoners is hanging.[16,17] The most common method of self-harm in prisoners is cutting or scratching.[1,2] In the study of prisoners in England and Wales, the majority of self-harm episodes were categorised as low lethality defined as not requiring resuscitation or hospital treatment.[2] Just 1% of non-fatal episodes were of high lethality. The most common methods of high lethality self-harm were hanging and strangulation (44%), overdose, poisoning or swallowing objects not intended for ingestion (25%) and self-cutting (20%). In Ireland, illicit substances, most commonly benzodiazepines, are involved in 68% suicide deaths among those in custody.[18]

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[15] Fazel, S., et al. (2008). Suicide in prisoners: a systematic review of risk factors. *J Clin Psychiatry.* 69(11): 1721-31.
[16] Lohner, J. et al. (2007). Risk factors for self-injurious behaviour in custody: problems of definition and prediction. *Int J Prison Health*. 3(2): 135-161.
[17] Fazel, S., et al. (2011). Prison suicide in 12 countries: an ecological study of 861 suicides during 2003–2007. *Soc Psychiatry Psychiatr Epidemiol.* 46(3): 191-195.
[18] Iqtidar, M., et al. (Under review). Deaths in custody in the Irish prison service: a five year retrospective study of drug toxicology and natural deaths. *BJPsych Open.*

Background to project

To date, research on suicidal behaviour in Irish prisons has been limited to the reporting of number of episodes of self-harm and suicide per prison and number of prisoners involved. Furthermore, there has been an absence of a systematic approach to recording self-harm episodes occurring in Irish prisons and a lack of a service-wide definition of self-harm. *Connecting for Life, Ireland's National Strategy to Reduce Suicide 2015-2020*[10,] comprises of a cross sectoral group of high level representatives from Government Departments and key state agencies, including the Department of Justice and Equality and the Irish Prison Service. *Connecting for Life* highlights prisoners as a priority group with vulnerability to an increased risk of suicidal behaviour. As part of *Connecting for Life,* the Irish Prison Service (IPS) has committed to reviewing, analysing and learning from each episode of self-harm within the prison estate. The Self-Harm Assessment and Data Analysis (SADA) Project will provide robust information relating to the incidence and profile of self-harm within prison settings, identify individual- and context-specific risk factors relating to self-harm and examine patterns of repeat self-harm (both non-fatal and fatal). Uniquely, the monitoring system collects information on the level of medical severity and suicidal intent associated with self-harm episodes occurring in the prison setting in Ireland. Such information can be used as an evidence base to inform the identification and management of those in custody, those engaging in and at-risk of self-harm and to develop effective prevention initiatives. This project contributes to achieving the goals and objectives of *Connecting for Life*, specifically: 7.2.1 'Develop capacity for observation and information gathering on those at risk of or vulnerable suicide and self-harm' and 5.3.1 'Through the Death in Custody/Suicide Prevention Group in each prison, identify lessons learned, oversee the implementation of the corrective action plan, and carry out periodic audits'.

In line with the IPS 2016-2018 Strategic Plan, the National Suicide and Harm Prevention Steering Group (NSHPSG) monitors the incidence and nature of self-harm and death, reviews episodes with a view to improving prevention and response measures, and ensures the sharing of relevant information on risk factors and best practice with the local Suicide & Harm Prevention Steering Groups. A multidisciplinary subgroup of the NSHPSG was tasked with developing and implementing SADA across the prison estate. The Health Service Executive's (HSE) National Office for Suicide Prevention (NOSP) and the National Suicide Research Foundation (NSRF) assist the IPS with data management, data analysis and reporting.

The NSRF have expertise in the development and maintenance of self-harm surveillance systems. The National Self-Harm Registry Ireland is a national system of population monitoring for the occurrence of hospital-treated self-harm. It was established by the NSRF in 2002 and is funded by the HSE NOSP. It is the world's first national registry of cases of intentional self-harm presenting to hospital emergency departments. The template of the Irish Registry was the basis for the WHO Practice Manual for Establishing and Maintaining Surveillance Systems for Suicide Attempts and Self-Harm in 2016.[19] The NSRF is also a WHO collaborating centre for surveillance and research in suicide prevention.

[19] World Health Organization. (2016). *Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm*. World Health Organization: Geneva. 77.

Methods

Definition and terminology

The following definition of self-harm is used: 'self-harm is (non-accidental) self-poisoning or self-injury, irrespective of the apparent purpose of the act'. This definition was developed for the National Clinical Practice Guidelines[20] and is in line with the definition used by the National Self-Harm Registry Ireland. The definition includes acts involving varying degrees of suicidal intent, from low intent to high intent and various underlying motives such as loss of control, cry for help or self-punishment.

Inclusion criteria

The following are considered to be self-harm cases:

- All methods of self-harm i.e. drug overdoses, alcohol overdoses, lacerations, attempted drownings, attempted hangings, burning, gunshot wounds, swallowing non-ingestible substances or objects and other behaviours likely to induce bleeding, bruising and pain etc. where it is clear that the self-harm was intentionally inflicted.
- Food and/or fluid refusal, irrespective of duration.
- Overdose of prescription or illicit substances where there is intent to self-harm.
- Alcohol overdose (e.g. hooch) where the intention was to self-harm.

Exclusion criteria

The following are NOT considered to be self-harm cases:

- Behaviour where there is no intent to self-harm.
- Accidental overdoses e.g. an individual who takes additional medication in the case of illness, without any intention to self-harm.
- Alcohol overdoses alone where the intention was not to self-harm.
- Accidental overdoses of illicit substances used for recreational purposes, without the intention to self-harm.

[20] National Institute for Health and Care Excellence. (2004). Self-harm in over 8s: short-term management and prevention of recurrence. CG16.

- Acts of self-harm by individuals with a profound learning disability. One of the reasons for exclusion is that self-harm is a behavioural outcome of some learning disabilities.

Data recording

Data on each episode are recorded using the standardised Self-Harm Assessment and Data Analysis (SADA) form by IPS staff (Appendix 1). Applying the case-definition and inclusion/ exclusion criteria, episodes are identified and individual SADA forms completed at regular meetings of multidisciplinary prison teams at local Suicide and Harm Prevention meetings. Data is recorded according to a standard operating procedure outlined in the SADA manual. The completed forms are then forwarded to the Care and Rehabilitation Directorate and subsequently transferred to the National Suicide Research Foundation (NSRF). Data are then recorded onto an encrypted computer in the NSRF.

Data protection and confidentiality

Confidentiality is strictly maintained. The National Suicide Research Foundation is registered with the Data Protection Agency and this project with the EU General Data Protection Regulation (2018). Only anonymised data are released in aggregate form in reports. Full names of patients are not recorded. Prisoner initials and PIMS number are recorded, to allow for recording of multiple episodes by the same individual.

Data items

A dataset has been developed from the SADA form (Appendix 1) to determine the extent of self-harm and suicide in Irish prisons, the typology of prisoners engaging in self-harm and the influencing or motivating factors of each episode.

- ### Initials and identifiers
- ### Sex
- ### Age
- ### Prison

  The prison that the prisoner was in at the time of the episode is recorded.

- Date and time of episode
- Method of self-harm

The method(s) of self-harm are recorded in line with the Tenth Revision of the World Health Organisation's (WHO) International Classification of Diseases codes for intentional injury (X60-X84). The main methods are self-cutting/self-harm with a sharp object (X78), overdose of drugs and medications (X60-64), self-poisoning with alcohol (X65), self-harm by hanging, strangulation and suffocation (X70) and self-poisoning which involve the ingestion of chemicals, noxious substances, gases and vapours (X66-X69). Some episodes may involve a combination of methods. In this report, results generally relate to the primary method of self-harm. In keeping with standards recommended by the WHO/ Euro Study on Suicidal Behaviour, [21] this is taken as the most potentially lethal method employed.

- Severity/intent matrix

Episodes of self-harm and suicide are graded according to the severity and level of suicidal intent at the time of the act. Severity is rated along a continuum, from no medical treatment required to hospitalisation and ultimately loss of life. The suicidal intent scale was developed based on the Beck Scale for Suicidal Ideation and ranges from no/ low intent to high intent.[22] The degree of severity and intent associated with each episode of self-harm is decided among the multidisciplinary team in each prison, using standardised guidelines.

- Accommodation

The type of prisoner accommodation at the time of the episode is recorded. The most common type of prisoner accommodation is general population.

- Cell type

Whether a prisoner is in a single or shared cell at the time of the episode is recorded. The recorded percentage of single cell accommodation available for prisoners across the prison estate is 53%.

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[21] Platt, S., et al. (1992). Parasuicide in Europe: the WHO/EURO multicentre study on parasuicide. I. Introduction and preliminary analysis for 1989. *Acta Psychiatr Scand.* 85(2): 97-104.
[22] Beck, A.T., et al. (1979). Assessment of suicidal intention: the scale for suicide ideation. *J Consult Clin Psychol*. 47(2): 343.

- ### Legal Status

  Whether the prisoner is on remand, tried and awaiting sentencing, or sentenced is recorded.

- ### Sentence length and trimester

  Where applicable, the length of the prisoner's sentence and the trimester of the sentence they are in is recorded.

- ### Regime level

  The prisoner's regime status at the time of the episode is recorded. The IPS Incentivised Regimes Policy provides for differentiation of privileges between prisoners depending on their regime level which is determined according to their level of engagement with services and quality of behaviour.[23] The three levels of privilege provided are: basic, standard and enhanced. Newly committed prisoners enter at the standard level of the privilege regime. Based on their standard of behaviour, prisoners can progress to the higher, enhanced level or regress to the lower, basic level.

- ### Contributory factors

  Factors that contributed to or motivated the episode were recorded. Some episodes had multiple contributory factors, in such cases all factors were recorded. Contributory factors were organised into the following five themes: environmental, relational, procedural, medical and mental health.

Calculation of prison rates of self-harm

The annual person-based rate of self-harm in 2017 was calculated for the prison population overall, for male and female prisoners as well as for sentenced prisoners and those on remand. Prison population figures were provided by the Irish Prison Service (IPS) for each day of 2017. The average of these daily populations was used as the estimated prison population for 2017. Crude rates per 100 prisoners were calculated by dividing the number of prisoners who engaged in self-harm (n) by the relevant population figure (p) and multiplying the result by 100, i.e. (n/p)*100. Exact Poisson 95% confidence intervals were calculated for rates using Stata version 12.0.

[23] Irish Prison Service. (2013). *Irish Prison Service Policy for Incentivised Regimes.* Irish Prison Service: Dublin.

Setting and coverage

There are twelve institutions in the Irish Prison Service consisting of ten traditional "closed" institutions and two open centres, which operate with minimal security (www.irishprisons.ie). Of the ten closed institutions, one is a high security prison while the remaining nine are medium security. The majority of female prisoners are accommodated in the Dóchas Centre with the remainder accommodated in Limerick Prison. The average number of persons in custody (including prisoners on remand/ awaiting trial, sentenced and on temporary release) in 2017 was 3,427. Based on a snapshot of the prison population on an arbitrary date in 2017, 96.5% (n=3,308) were male.[3] Of those in custody, 17.6% were on remand while the remainder of the prisoners were sentenced with between 5 and 10 years being the most common sentence length (18.3%).[24] Of the sentenced prisoners, one-third were aged 30-39 years.[25]

Table 1. Prison characteristics and demographics, 2017

	Security	Prison population	On remand[24]	Single cell[5]	Shared cell[5]
Arbour Hill	Medium	132	0.7%	71.9%	28.1%
Castlerea	Medium	274	21.2%	50.4%	49.6%
Cloverhill	Medium	350	1.3%	14.4%	85.6%
Cork	Medium	230	19.7%	20.6%	79.4%
Limerick (M)	Medium	183	34.8%	23.3%	76.7%
Limerick (F)	Medium	22	25.7%		
Loughan House	Low *(open)*	105	-	90.8%	9.2%
Midlands	Medium	803	8.2%	47.8%	52.2%
Mountjoy	Medium	505	5.0%	100.0%	-
Dóchas Centre (F)	Medium	97	24.8%	50.0%	50.0%
Portlaoise	High	219	6.2%	63.7%	36.3%
Shelton Abbey	Low *(open)*	95	-	33.7%	66.3%
Wheatfield	Medium	413	76.0%	62.2%	37.8%
Male		3,308			
Female		119			
Total		3,427	17.6%	53.2%	46.8%

[24] Irish Prison Service. (2017). Sentence length of sentenced prisoners in custody on comparable day each year - 2007 to 2017. Available from: https://www.irishprisons.ie/wp-content/uploads/documents_pdf/SNAPSHOT-Sentence-Length-Year-2007-to-Year-2017.pdf

[25] Irish Prison Service. (2017). Age Profile classified by gender of sentenced prisoners on a specific date. Available from: https://www.irishprisons.ie/wp-content/uploads/documents_pdf/SNAPSHOT-Age-Profile-Year-2007-to-2017.pdf

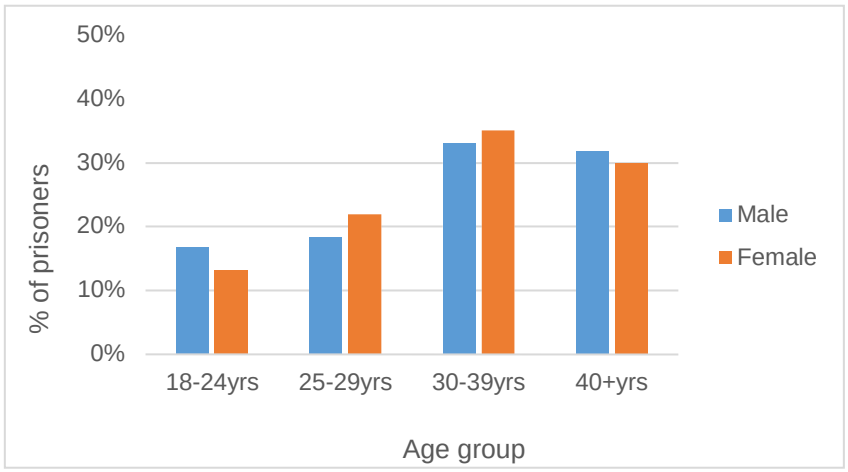

Figure 1. Age group of sentenced prisoners in custody[25]

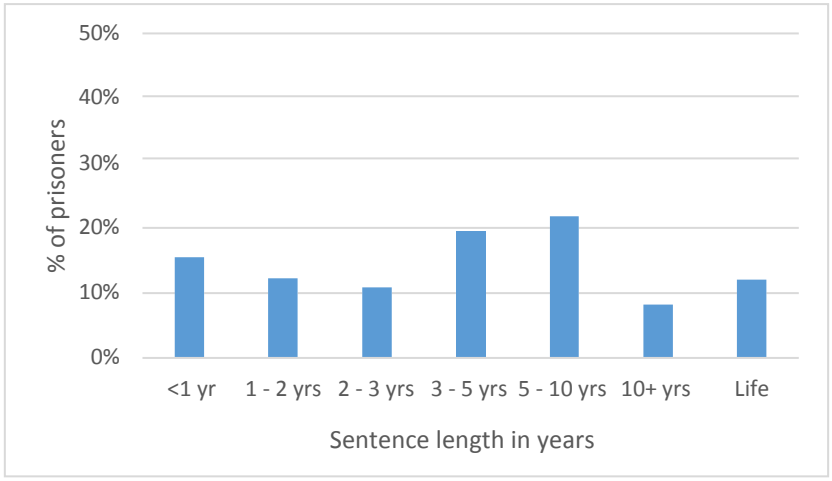

Figure 2. Sentence length of prisoners in custody[24]

Self-harm in Irish prisons 2017

Between 01 January and 31 December 2017, there were a total of 223 episodes of self-harm, involving 138 individuals. The rate of self-harm was calculated based on the number of unique individuals who engaged in self-harm in Irish prisons during the period January to December 2017. The majority of prisoners who engaged in self-harm were male (178; 79.8%). Overall, the average number of persons in prison in 2017 was made up of 3,308 (95.9%) men and 119 (4.3%) women. Therefore, male prisoners accounted for fewer self-harm episodes than one might expect given the proportion of the prison population that they make up. The mean age was 32 years (range 18-58 years). Half of male prisoners (53.8%) were aged between 18 and 29 years, while three-quarters of female prisoners (73.3%) were aged 30-39 years.

The average number of persons in custody (sentenced and on remand/ awaiting trial) in 2017 was 3,427. Thus, the annual rate of self-harm was 4.0 per 100 prisoners, representing 4% of all prisoners. Approximately 4% of male and 16% of female prisoners engaged in self-harm. The rate of self-harm for sentenced prisoners was 3% and 7% for prisoners on remand.

Table 2. Rate of self-harm among Irish prisoners, 2017

	Individuals	Episodes	Rate per 100 (95% CI)
Total	138	223	4.0 (3.4-4.8)
Male	119	178	3.6 (3.0-4.3)
Female	19	45	16.0 (9.6-24.9)
Sentenced	94	156	3.1 (2.5-3.8)
On remand	43	66	7.4 (5.3-9.9)

The rate of self-harm was highest, at 5.0 per 100 prisoners, among those aged 18-29 years. The rate of self-harm decreased with increasing age, lowest among prisoners aged 40+ years (0.9 per 100). The peak rate of self-harm for male prisoners was among 18-24 year-olds (5.2 per 100) and for female prisoners was among 25-29 year-olds (12.0 per 100). Across all age groups, the rate of self-harm was higher among female prisoners, although this is based on very small numbers.

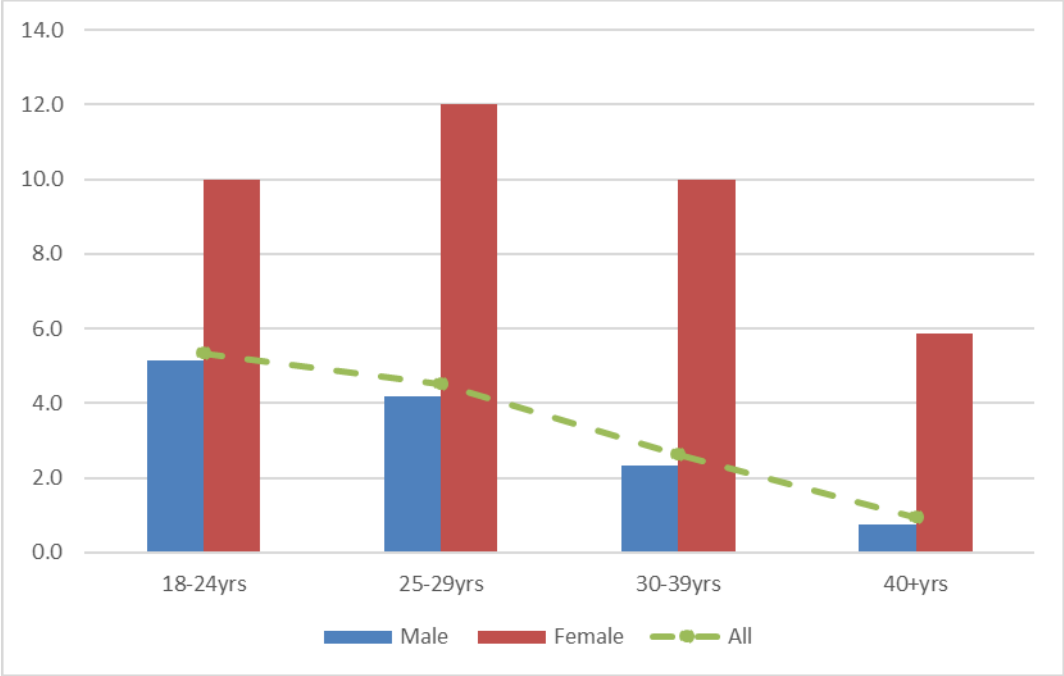

Figure 3. Age-specific rate of self-harm among sentenced prisoners (per 100 prisoners)

Self-harm by time of occurrence

Patterns of self-harm varied according to day of the week. Episodes of self-harm were more likely to occur on weekdays, with three-quarters (73.5%; 164) episodes occurring between Monday and Friday. One in five (22%; 49) episodes occurred on Tuesdays.

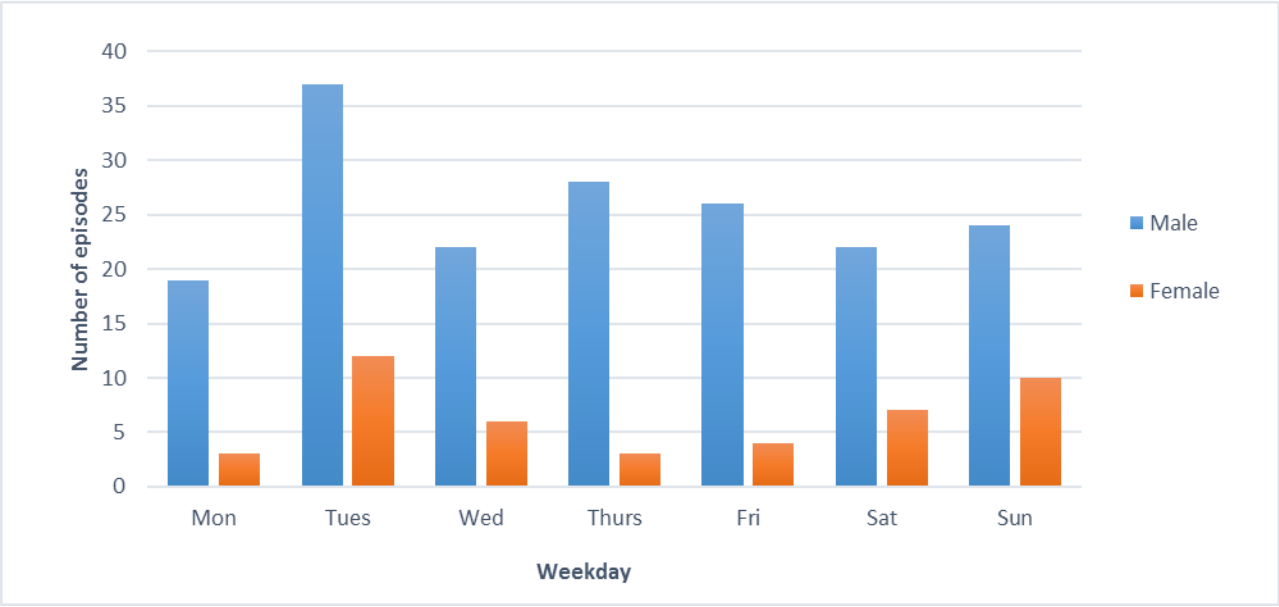

Figure 4. Number of episodes by weekday

The monthly average number of episodes of self-harm was 19. Above average numbers of episodes were recorded in April (n=25) July (n=23) and November (n=26). September and December recorded low number of episodes (n=13 and n=7, respectively).

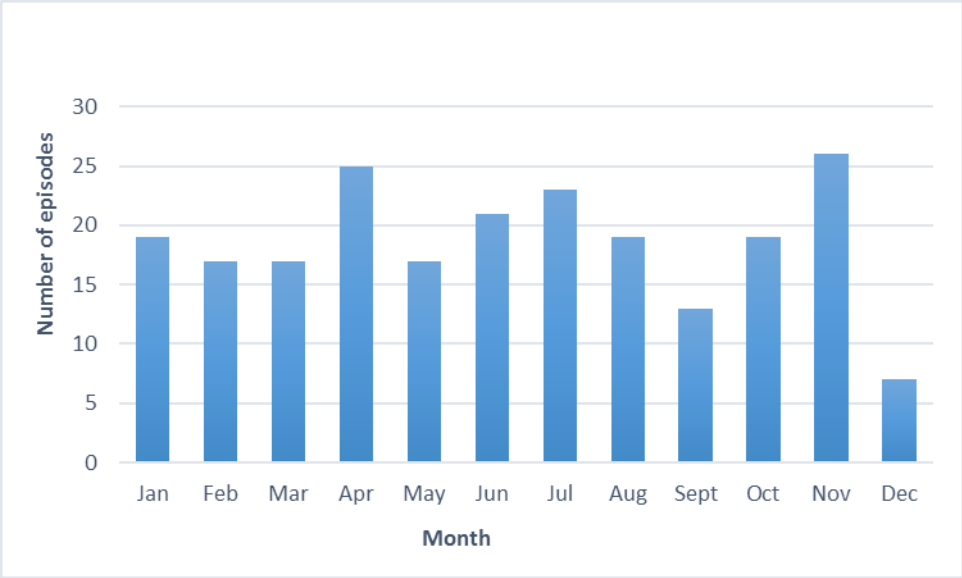

Figure 5. Number of episodes by month of occurrence

The number of episodes of self-harm gradually increased during the day. A sharp peak was observed in the afternoon and early evening, with 52.3% of episodes occurring between 2pm and 8pm. The majority (60.3%) of episodes happened while prisoners were unlocked. The proportion of episodes that occurred while prisoners were unlocked was similar for prisoners in general population accommodation (63.0%) and those who were on protection (61.2%).

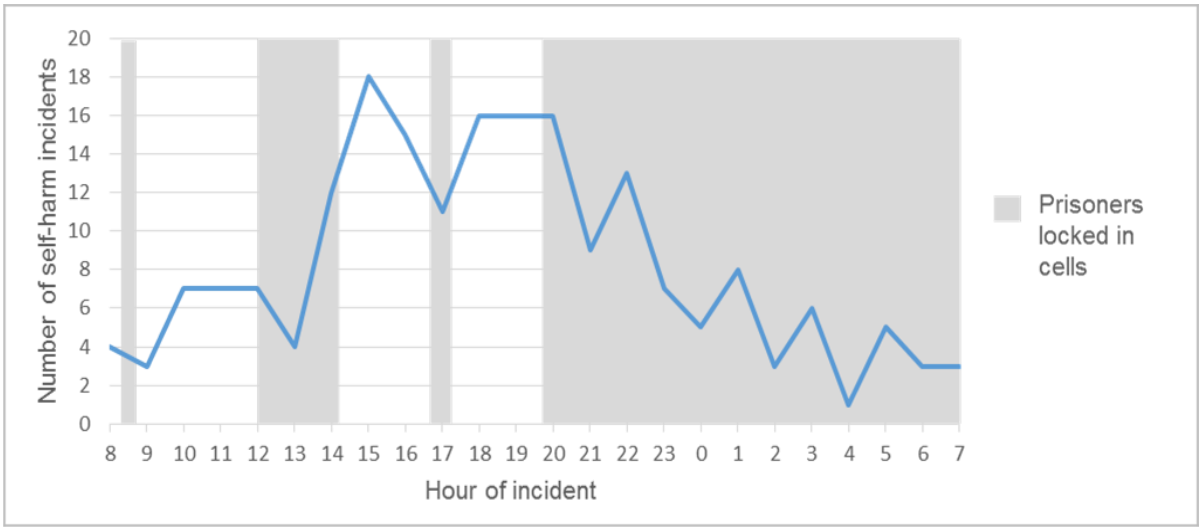

Figure 6. Hour of self-harm episode

Repetition of self-harm

More than one-third (38.1%) of episodes were due to repeat self-harm (n=85). The person-based rate of repetition was 24.6%, implying that 34 individuals had self-harmed more than once. The rate of repetition was higher for male prisoners (26.1% vs. 15.8%).

Method of self-harm

The most common method of self-harm recorded was self-cutting (n=138; 61.9%), followed by attempted hanging (n=47; 21.1%) and blunt objects (n=10; 4.5%).

Table 3. Method of self-harm

	Cutting	Attempted hanging	Blunt objects	Fire/flames	Drug overdose	Other
All	138 (61.9%)	47 (21.1%)	10 (4.5%)	3 (1.3%)	2 (0.9%)	18 (8.1%)
Male	120 (67.4%)	26 (14.6%)	10 (5.6%)	2 (1.1%)	2 (1.1%)	15 (8.4%)
Female	18 (40.0%)	21 (46.7%)	-	1 (2.2%)	-	3 (6.7%)

Prisoner accommodation/ cell type and sentence

The majority of self-harm episodes involved prisoners who were in single cell accommodation (172; 77.1%). Regarding prisoner accommodation, 97 (43.5%) self-harm episodes involved prisoners in protection (including Rule 62 and Rule 63), with 43.5% (n=97) also involving general population prisoners. Eleven (4.9%) self-harm episodes involved prisoners from high support units.

Table 4. Prisoner accommodation

General population	Protection	Special observation (SP)	High support unit (HSU)	Close supervision cell (CSC)	Safety observation cell (SOC)
97 (43.5%)	97 (43.5%)	2 (0.9%)	11 (4.9%)	9 (4.0%)	5 (2.2%)

The majority (156; 70.0%) of self-harm episodes involved sentenced prisoners, while 29.6% (66) were on remand/ awaiting trial at the time of the self-harm episode. Considering sentenced prisoners, half (86; 55.1%) were made by those serving a sentence of less than three years. More than one-third of self-harm episodes occurred in the second trimester of a sentence (62; 38.3%).

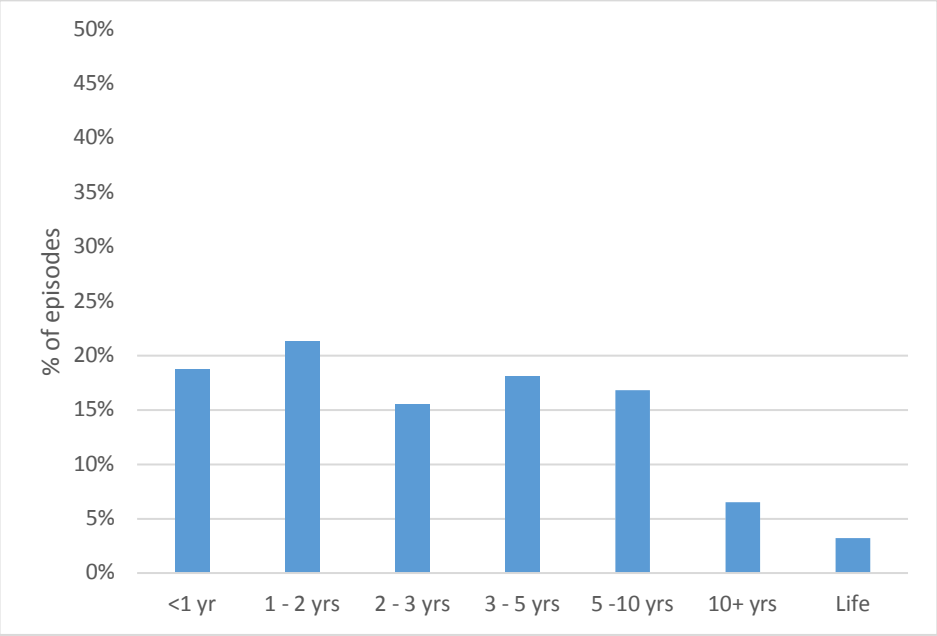

Figure 7. Length of sentence being served (sentenced prisoners)

More than one-quarter of episodes involved prisoners on a standard regime level (62; 27.8%), one in nine were on a basic regime (24; 10.8%) and 38 (17.0%) were on an enhanced regime.[26]

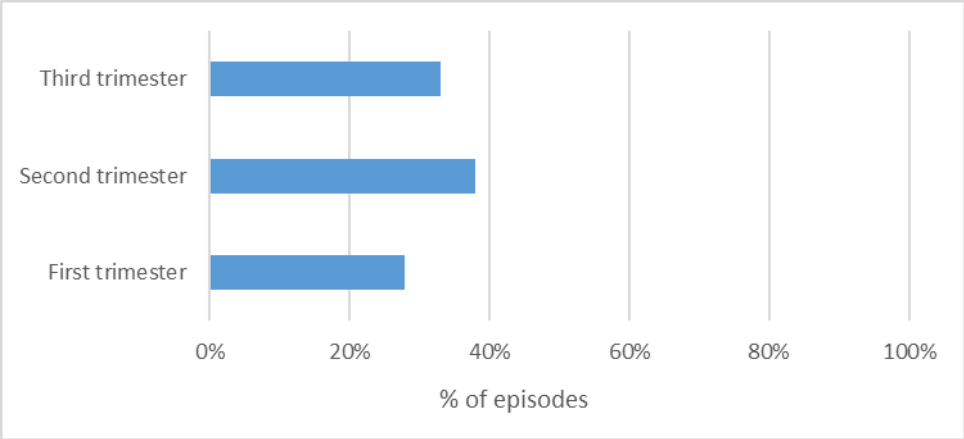

Figure 8. Trimester of sentence in which self-harm occurred.

Recommended next care, severity and intent

In 39.0% of self-harm episodes, no medical treatment was required (n=87). Almost half (102; 45.7%) of all episodes required minimal intervention/ minor dressings or local wound management. One in eight required hospital treatment (30; 13.5%)[27]. During this period, four self-harm acts involved loss of life (1.8%). Self-harm episodes by male prisoners were associated with increased severity – 33.1% of males did not require treatment compared with 62.2% of female prisoners.

Method of self-harm was also associated with differences in severity care required. While self-cutting was the most common method, no self-cutting episodes resulted in loss of life and 11.6%, (n=16) required hospital treatment (outpatient or inpatient). Self-harm with a blunt object was similar with no fatal outcomes and 11.1% (n=1) of episodes requiring hospital treatment. In contrast, overdose was only involved in two episodes but one resulted in loss of life and the other required hospitalisation / intensive care treatment. In addition, 6.5% (n=3) of episodes involving attempted hanging resulted in loss of life and 8.7% required hospital treatment.

[26]Information on regime level was available for 55.6% of episodes because this variable was incorporated into the data collection midway through the calendar year.
[27]Episodes of self-harm requiring hospital treatment will also be recorded by the National Self-Harm Registry Ireland.

Table 5. Severity of self-harm and recommended next care

No treatment needed	Minimal intervention	Local wound management	Outpatient/ A&E treatment	Hospitalisation/ ICU	Loss of Life
87 (39.0%)	55 (24.7%)	47 (21.1%)	26 (11.7%)	4 (1.8%)	4 (1.8%)

Half (121; 54.3%) of self-harm episodes were recorded as having no/ low intent, with less than one-third (65; 29.1%) recorded as having medium intent. Approximately one in six acts was rated as having high intent (37; 16.6%). Suicidal intent varied according to the method involved in the self-harm episode – high intent was recorded in more than two-thirds of attempted hanging episodes (17; 37.0%) while high intent was only recorded in one in ten episodes involving self-cutting (15; 10.9%) and self-harm with blunt object (1; 11.1%).

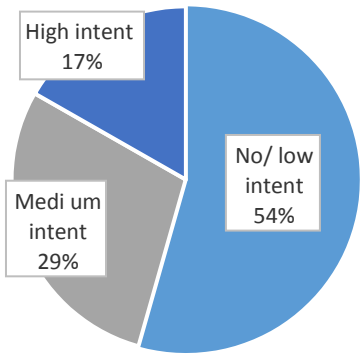

Figure 9. Level of intent associated with self-harm episode

Among those requiring no/ minimal treatment, the majority (61%) were deemed to have no/ low intent, 24% to have medium intent and 15% to have had high intent.

Among those requiring local wound management or outpatient hospital treatment, 44% were deemed to have no/ low intent, 36% to have medium intent and 21% to have had high intent.

Of the eight cases that required hospitalisation or resulted in the loss of life, three of these were deemed as having no/low intent, four to have medium intent and one to have had high intent.

Table 6. Severity/intent matrix

	No treatment needed	Minimal intervention/ minor dressings	Local wound management	Outpatient /A&E treatment	Hospitalisation/ intensive care unit	Loss of life
No/low intent	43 (19.3%)	44 (19.7%)	19 (8.5%)	13 (5.8%)	1 (0.4%)	2 (0.9%)
Medium level of intent	25 (11.2%)	9 (4.0%)	16 (7.2%)	10 (4.5%)	3 (1.3%)	1 (0.4%)
High level of intent	19 (8.5%)	2 (0.9%)	12 (5.4%)	3 (1.3%)	0 (0%)	1 (0.4%)

Contributory factors

Contributory factors were organised into five themes: environmental, relational, procedural, medical and mental health. The majority of contributory factors recorded related to mental health (129; 57.8%), and a further 84 (37.7%) related to relational issues and 81 (36.3%) to environmental issues.[28]

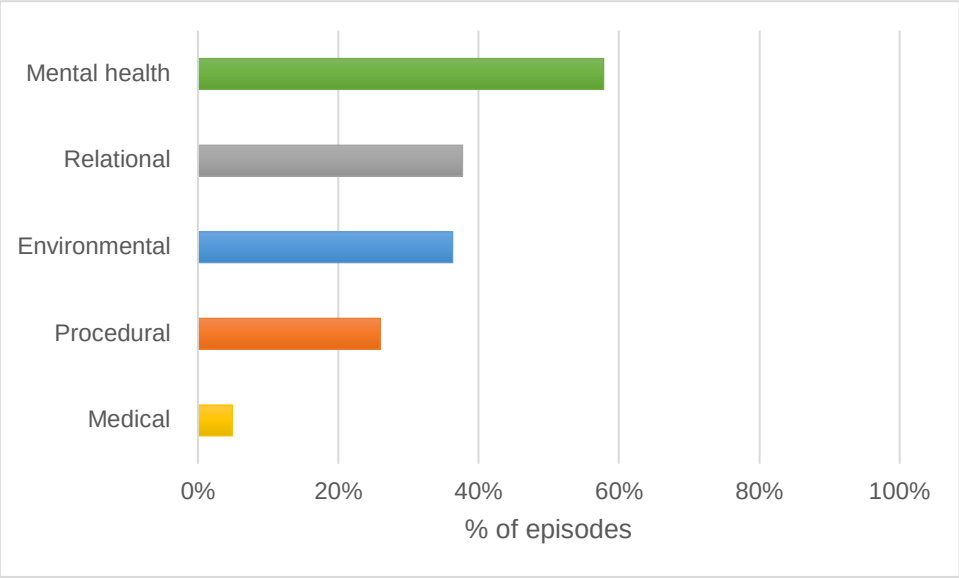

Figure 10. Themes of contributory factors in self-harm episodes

[28]More than one contributory factor could be recorded for each episode

Environmental

Issues with type of accommodation was the most common environmental contributory factor (36; 16%). Accommodation issues reported included wanting to change cell type (e.g. from single to double) or wanting to move to a different accommodation type such as a CSC. Legal issues were a contributory factor in 9.4% of episodes. Legal issues reported included pending charges, ongoing court case, first time in custody and unexpected custody. Desire to move off protection and reduced access to training, education, work or exercise due to staff shortages contributed to 6.7% and 4.5% of self-harm episodes, respectively.

Procedural

Recently moving cell was the most common procedural contributory factor (n=26, 11.7%). Disciplinary issues, having been served a P19 (disciplinary report) or had regime status reduced for disciplinary reasons, was a factor in 7.2% of episodes. Visit, temporary release (TR) or transfer issues (e.g. screened visits, return from TR due to breached conditions, denied transfer) and security level or additional staff for risk behaviours were factors contributing to a minority of episodes (4.0% and 3.1% respectively).

Relational

Relationship difficulties between prisoners and staff were a contributory factor in 10.8% of self-harm episodes. Personal relationship issues, particularly with family and friends, contributed to one in ten episodes. Relationship difficulties with other prisoners, including conflict, being under threat or bullied and gangland involvement, were a factor in 7.6% of episodes. Bereavement and issues with child custody or access were reported in a minority of episodes (3.6% and 0.4%, respectively).

Medical

Medication issues (e.g. poor medication compliance) was reported in 4.5% of episodes while a new diagnosis or worsening symptoms contributed to 0.9% of episodes. No other medical issues were reported as contributory factors.

Mental health

Mental health issues were the most common contributory factor across all themes (n=91, 40.8%). The category of mental health issues includes mental disorders (e.g. depression, personality disorder) as well as problems with coping and emotional regulation. Substance misuse, including drug use as well as drug seeking, was the next most common factor recorded (51; 22.9%). Hopelessness was recorded as a contributory factor in 6.3% and active psychosis / mental illness in 4.5% of self-harm episodes.

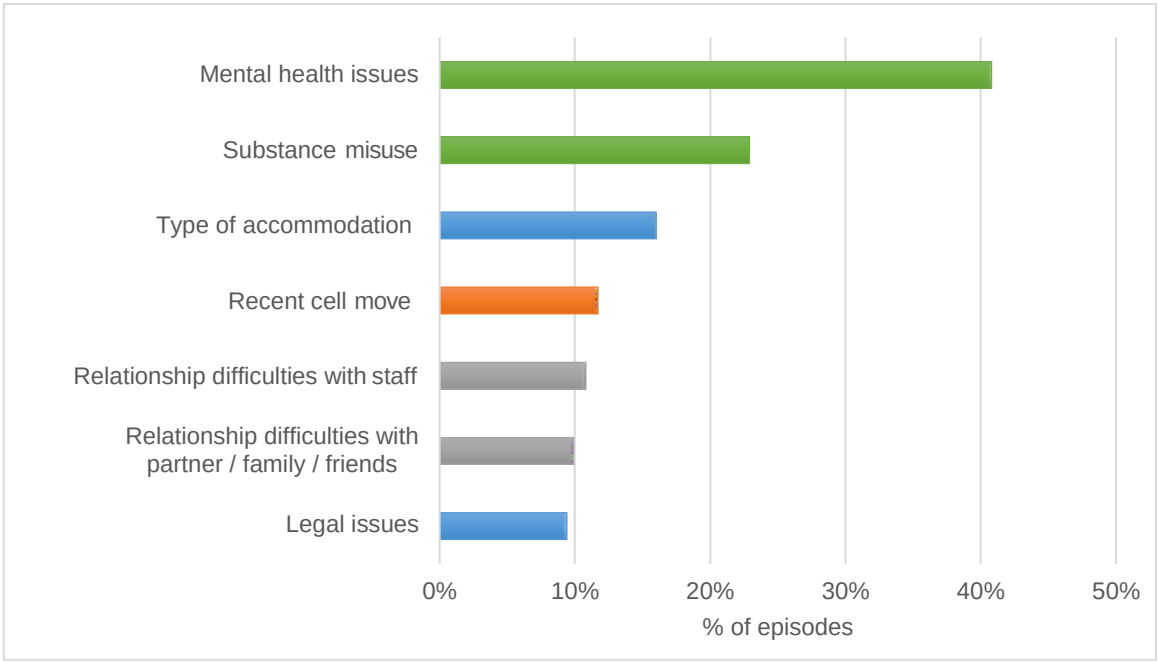

Figure 11. Most common contributory factors

Table 7. Contributory factors and themes

Theme	Contributory factor	Number of episodes	% of episodes
Environmental	Type of accommodation	36	16%
	Legal issues	21	9%
	Reduced regime access - staff shortages	10	5%
Procedural	Recent cell move	26	12%
	Recent P19 / regime status reduced	16	7%
	Protection issues	15	7%
	Visit / temporary release / transfer issues	9	4%
	Security level / additional staff for risk behaviours	7	3%
Relational	Relationship difficulties with staff	24	11%
	Relationship difficulties with partner / family / friends	22	10%
	Relationship difficulties with other prisoners	17	8%
	Bereavement	8	4%
	Child custody/access issues	1	0%
Medical	Medication issues	10	5%
	New diagnosis or worsening symptoms	2	1%
	Chronic pain	0	0%
	Terminal illness	0	0%
Mental health	Mental health issues	96	41%
	Substance misuse	51	23%
	Hopelessness	14	6%
	Active psychosis / mental illness	10	5%

Deaths following self-harm

There were four deaths following a self-harm episode, all involving male prisoners. Hanging was the most common recorded method, involved in 75% of deaths. Of these cases, the majority (75%) were recorded as having no/low or medium intent. All of these prisoners were on remand at the time of death and three were in single-occupancy cells. For three cases, the prisoner was in protective accommodation. A range of contributory factors were recorded, including environmental, personal, relational and mental health factors.

Table 8. Contributory factors related to deaths following self-harm

Theme	Contributory factor
Environmental	Legal issues
	Reduced regime access
	Type of accommodation
Relational	Relationship difficulties with staff / family / friends / other prisoners
Mental health	Mental health issues
	Hopelessness

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Glossary

On remand	In custody awaiting trial
NVRU	National Violence Reduction Unit
HSU	High Support Unit
CSC	Close Supervision Cell – isolation for management/discipline reasons
SOC	Safety Observation Cell – healthcare prescribed seclusion where there is risk of self harm/harm to others
Special Observations	15 minute observation during lock up
P19	Prison Disciplinary report.
Protection	Restricted regime – under Prison Rules 2007, Rule 62 (imposed by Governor due to threat or at risk from other prisoners) or Rule 63 (at own request)

Appendix 1: Self-harm Assessment and Data Analysis form[29]

SADA
Self-harm Assessment & Data Analysis

Prison: _____Initials: _____ PIMS No: _____ Age: _____ Quarter: _____ Date ofIncident_____
Time of Incident:_____ Method: Cutting ☐ Drug Overdose ☐ Alcohol ☐Hanging, strangulation and suffocation ☐ Drowning ☐ Blunt objects ☐ Fire/flames ☐ Steam, vapour and hot objects ☐ Petroleum products, solvents, vapours ☐ Chemicals/noxious substances ☐ Firearm ☐. **Description of incident**_____

Table 1: Severity v Intent Matrix.

Intent \ Severity	No treatment required. A	Minimal intervention/minor dressing. B	Local wound management. C	Outpatient/A&E treatment. D	Hospital/ Intensive Care E	Loss of life. F
High level of intent - Evidence of thoughts, ideation and planning of self-harm or suicide. **3**	**A3**	**B3**	**C3**	**D3**	**E3**	**F3**
Medium level of intent – Some level of thoughts, premeditation, planning. **2**	**A2**	**B2**	**C2**	**D2**	**E2**	**F2**
No/low intent – No thoughts, no plan or premeditation. **1**	**A1**	**B1**	**C1**	**D1**	**E1**	**F1**

Table 2: Typology of Prisoner: Please circle options below.

Gender	Accommodation	Monitoring	Cell sharing	Legal Status	Sentence length	Trimester	Regime level
Male	General Population	Special Observation	Single	Remand	Remand	N/A	Enhanced
	Protection (please circle) Rule 62 Rule 63				<3 mth to < 1yr	1st	Standard
		Normal observation	Double		1yr < 2yrs		
					2yr < 3yr	2nd	Basic
Female	CSC		Triple or more	Sentenced	3yr < 5yr		
	SOC				5yr < 10yr	3rd	
	HSU				10+ yrs		
	NVRU				Life		

Table 3: Contributory Factors.

Code		Contributory Factor	Primary ✓	Secondary ✓	Please describe:
ENVIRONMENTAL (E)	E1	Legal issues (e.g. pending charges, court case, recently convicted, 1st time in custody, unexpected custody).			
	E2	Shortage of staff and/or staffing issues (causing stress/tension/chaos).			
	E3	Reduced access to regime (causing isolation/lack of stimulation).			
	E4	Type of accommodation or cell type (shared/single cell etc).			
PROCEDURAL (P)	P1	Recently placed in SOC/on special observation.			
	P2	Protection issues (e.g. Rule 62/63).			
	P3	Transfer issues (transfer, denied transfer, moved to CSC).			
	P4	Recent P19, reduction in incentivized regime.			
	P5	Recent barrier handling/designated VDP/additional staff/disruptive or oppositional behavior.			
	P6	Denied visit/placed on screened visits.			
	P7	Denied TR/remission or breached TR.			
	P8	To orchestrate access to contraband/other instrumental gain.			
	P9	Pre-release concerns.			
RELATIONAL (R)	R1	Relationship difficulties with other prisoners (e.g. being victimized/bullied, under threat, conflict, peer pressure).			
	R2	Relationship difficulties with staff.			
	R4	Relationship issues with significant others (e.g. friends/family)/ reduction in family or access to community support(s).			
	R5	Bullying/threatening/victimizing others.			
BEREAVEMENT /LOSS (B)	B1	Death or anniversary of death of someone close.			
	B2	Adjustment issues (e.g. loss of freedom, identity, and stigma).			
	B3	Loss of family or intimate relationship.			
	B4	Loss of possession or object.			
	B5	Transfer or release of supportive family member/friend/associate.			
	B6	Child custody/access issues.			
MEDICAL (M)	M1	Medication issues (e.g. non-compliance, admin issues, drug seeking).			
	M2	New diagnosis or worsening symptoms.			
	M3	Chronic pain.			
	M4	Terminal illness.			
MENTAL HEALTH (MH)	MH1	Mental health (e.g. mood disorder, anxiety, PTSD, eating disorder, psychosis, personality disorder, hopelessness/low mood etc). *Where MH1 is identified as a contributory factor, further information should be supplied.			**PLEASE SPECIFY:**
	MH2	Substance use/addiction.			
	MH3	Poor coping/difficulties managing emotions.			
	MH4	Impulsivity.			

[29] Most recent version of data form (September 2018.