

Self-harm in Irish Prisons 2018

Second report from the Self-Harm Assessment and Data

Analysis (SADA) Project

July 2020



Foreword

In 2018, the Irish Prison Service (IPS) presented the first 12 months data on the analysis of all episodes of self-harm (SADA) across the Irish Prison Estate during the year 2017. This report presents the second year of data in the analysis of all episodes of self-harm (SADA) across the Irish Prison Estate during the year 2018.

This data contributes towards meeting the goals and objectives of 'Ireland's National Strategy to Reduce Suicide 2015-2020 'Connecting for Life' of providing high quality data on suicide and self-harm.

This data forms part of the work of National Suicide and Harm Prevention Steering Group (NSHPG). This multi-disciplinary group 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, and provides the following functions:

- Collates the reports of the local Suicide Prevention Committees.
- Monitors the incidence and nature of self-harm and death, reviews each with a view to improving prevention and response measures.
- Disseminates significant findings throughout the prison system.
- Shares relevant information on risk factors and best practice with the local Suicide & Harm Prevention Steering Group.
- Considers reports of the Inspector of Prisons and the Office of the Inspector of Prisons, into deaths in custody and the recommendations therein.
- Examines any recommendations made by the jury in an inquest which are communicated to the Irish Prison Service by the County Coroners.
- Promotes best practice in preventing and, where necessary, responding to self-harm and death in the prisoner population.

The multi-disciplinary teams across the prison estate play a pivotal role in supporting/contributing to 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) form, holding local Steering Group meetings for Suicide and Harm Prevention and making recommendations to local management and the NSHPSG.

This project was the first step in understanding and learning valuable lessons for the future protection of people in our care. Analysis of data on self-harm continues to inform policy and practice

development within the IPS in order to seek to reduce the incidence of self-harm among those in custody.

The Irish Prison Service (IPS) 2019-2022 Strategic Plan sets out five strategic pillars designed to create a better environment by supporting staff, victims & prisoners and creating safe and secure custody in a prison estate that upholds dignity and reflects a modern, progressive penal system, with openness, transparency and accountability at the forefront.

The next phase of this project will be to support the strategy by identifying robust next steps in how the IPS can use this data to enhance the management of individuals in custody who may pose a risk of self-harm and suicide.

This project represents a unique contribution to the treatment and management of persons in custody by integrating academic, professional and clinical best practise and adopting a multi-disciplinary, inter-agency collaboration nationally to making life in prisons safer for all.

Caron McCaffrey

Director General, Irish Prison Service.

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Executive Summary

This is the second annual report on all recorded episodes of self-harm by individuals in the custody of the Irish Prison Service. The report provides data from all prisons in the Republic of Ireland in 2018 arising from the Self-Harm Assessment and Data Analysis (SADA) Project.

Main findings

- *Between 01 January and 31 December 2018, there were 263 episodes of self-harm recorded in Irish Prisons, involving 147 individuals. There were 223 episodes of self-harm by 138 individuals in 2017. Thus, the number of self-harm episodes was 18% higher in 2018 than in 2017 and the number of persons involved increased by 7%. The overall prison population also increased by 7% between 2017 (n=3,427) and 2018 (n=3,690). Therefore, the annual person-based rate of self-harm in 2018, at 4.0 per 100 prisoners, was identical to the rate recorded in 2017. Thus, an episode of self-harm was recorded for 4% of the prison population.*
- *The majority of prisoners who engaged in self-harm were male (n=121; 82.3%) but taking into account the male prison population, their rate of self-harm was 3.4 per 100. Twenty-six female prisoners engaged in self-harm in 2018 equating to a rate of 19.3 per 100, which is 5.7 times higher than the rate among male prisoners.*
- *The rate of self-harm was higher among prisoners on remand than those sentenced (5.0 versus 3.7 per 100) though by a smaller margin than reported for 2017 when the rate of self-harm among prisoners on remand was 7.4 per 100 and the rate among sentenced prisoners was 3.1 per 100.*
- *The rate of self-harm was highest among prisoners aged 18-29 years. The rate of self-harm among prisoners in this age group was 40% higher than in 2017 (7.4 versus 5.3 per 100). Across all age groups, the rate of self-harm was higher among female prisoners.*
- *Almost half of all self-harm incidents (44%) occurred between 2pm and 8pm. Most episodes (60%) occurred while prisoners were unlocked from cells.*

- *One-third (32.7%) of individuals engaged in self-harm more than once during the calendar year. This was more pronounced for female prisoners – 29.8% of male prisoners repeated self-harm (36 out of 121 individuals) compared with 46.2% of female prisoners (12 out of 26 individuals). Two individuals engaged in self-harm more than ten times in 2018.*
- *The most common method of self-harm recorded was self-cutting or scratching, present in 69% of all episodes. The other common method of self-harm was attempted hanging, involved in 20% of episodes.*
- *In line with 2017 figures, three-quarters (73%) of self-harm episodes involved prisoners in single cell accommodation. Considering the overall prison population, 51.9% were accommodated in single cells in 2018. Forty-four percent of prisoners who engaged in self-harm were in general population accommodation and a further 37% were on protection (including Rule 62 and 63) at the time of the self-harm act.*
- *For more than one quarter (27%) of episodes, no medical treatment was required. Over half (59%) required minimal intervention or local wound management in the prison and one in eight (12%) required hospital outpatient or accident and emergency department treatment. Self-harm episodes by male prisoners were associated with increased severity – 87.4% of male prisoners who self-harmed required some medical treatment compared with 30.8% of female prisoners.*
- *Over two-thirds (70%) of self-harm episodes were recorded as having no / low degree of suicidal intent. Seventeen per cent of episodes were recorded as having medium intent and approximately one in eight (13%) were deemed to have a high degree of suicidal intent.*
- *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 (45.6%) of factors related to mental health issues, 32.7% to environmental issues and 22.1% to relational issues.*

Discussion points

The annual person-based rate of self-harm reported by the SADA project for 2018 was 4.0 per 100 prisoners. Previous studies of self-harm in Irish prisons reported a very similar rate of 4% for the years 2004 and 2017^{1,2}, whereas a study of self-harm in prisons in England and Wales during 2004-2009 reported a rate of 6%³. 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 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 2018⁴ 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 six times higher than it was among male prisoners. In 2017, the incidence of self-harm among female prisoners was four times higher than male prisoners. This is a larger gender difference than observed in self-harm among the general population⁵.

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 population⁵. The rate of self-harm was highest among prisoners aged 18-29 years, at 7.4 per 100 prisoners. The rate among prisoners aged 18-29 years was 40% higher in 2018 than it was in 2017.

The rate of self-harm was higher among prisoners on remand or awaiting trial than it was among sentenced prisoners (5.0 versus 3.7 per 100). Although the rate of self-harm among prisoners on remand decreased by 32% in 2018, this finding is in line with other research³, 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 73% of episodes involved prisoners in single

¹ National Suicide Research Foundation. (2005). *Deliberate self harm in Irish prisons and places of detention*. Cork.

² National Suicide Research Foundation. (2018). *Self-harm in Irish Prisons 2017*. Cork.

³ 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.

⁴ Irish Prison Service. (2018). Average prison population Jan to Dec 2018.

⁵ Griffin, E., et al. (2019). *National Self-Harm Registry Ireland Annual Report 2018*. National Suicide Research Foundation: Cork.

cell accommodation, more than half of the prison population are housed in single cell accommodation⁶.

The main method of self-harm recorded was self-cutting or scratching, which was present in 69% of episodes. Self-cutting was involved in 73% of self-harm episodes by males and 57% of episodes by females. While the majority of episodes involving self-cutting were less severe (9.4% required hospital outpatient or accident and emergency department treatment), risk of repetition is elevated among individuals who engage in self-cutting^{7,8}. Attempted hanging was recorded as the method of self-harm in 20% of episodes. Female prisoners were more likely to engage in attempted hanging than males (33% vs 16%). Although this was lower than 2017 (47% v 15%), female prisoners remain significantly more likely to engage in attempted hanging.

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 medical severity (87%). However, a significant proportion of episodes were associated with a high degree of suicidal intent (13%) indicating that suicidal intent may be high regardless of the method of self-harm or severity of the act.

The outcomes in relation to contributory factors highlight the complexity of the circumstances surrounding suicidal behaviour in prison settings, with more than one contributory factor recorded in one fifth of cases (21.2%). Factors relating to mental health issues/ mental illness were the primary contributory factors recorded (46%) – predominantly relating to the presence of mental disorders (17%) and substance misuse (16%). A recent systematic review⁹ 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

⁶ Irish Prison Service. (2018). *Census Prison Population October 2018 – Cell occupancy – In-Cell Sanitation*. Available from: https://www.irishprisons.ie/wp-content/uploads/documents_pdf/October-2018-In-Cell.pdf

⁷ Larkin et al. (2014). Risk factors for repetition of self-harm: a systematic review of prospective hospital-based studies. *PLoS One*.

⁸ Larkin, C, et al. (2014). Severity of hospital-treated self-cutting and risk of future self-harm: a national registry study. *Journal of Mental Health*.

⁹ 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*.

highlight prison-specific factors cited as contributing to the episode of self-harm. The majority of these related to procedural issues (24.3%), such as a recent cell move (13%) and change in regime (6%) or security level (3%). Environmental issues surrounding their accommodation (9%), as well as legal issues (4%), were also commonly cited. Relationship difficulties with staff (8%), family members and friends (7%) as well as with other prisoners (3%) were also a common factor.

Recommendations

The trends outlined in this report underline the need to further develop mental health services for prisoners engaging in self-harm in Ireland. Initiatives to reduce access to means, early intervention and prevention methods are pivotal to reducing the incidence of self-harm and represent the next step in the SADA project. The Irish Prison Service (IPS) Strategy Plan 2019 – 2022¹⁰ identifies ‘improving mental health for those in custody’ and ‘increased prison officer awareness, and confidence in detection and management of mental health difficulties in the custodial population’.

High risk groups

The highest rates of self-harm are seen in young people, with rates among prisoners aged 18-29 years recording a 40% increase in the 2018 calendar year. This finding is consistent with the general population¹¹. There is a need to ensure access to timely and appropriate mental health services, including both appropriate referral and provision of evidence-based mental health intervention are crucial to address the needs of young prisoners.

Reducing the rate of repetition

The current report shows that a relatively high proportion of prisoners engage in self-harm on more than one occasion. Risk of repetition is elevated among individuals who engage in self-cutting⁷, which was the method most commonly recorded in 2018 (69.2% of episodes). Continued efforts should be maintained to prioritise implementation of evidence-based treatments shown to reduce risk of repetition¹².

¹⁰ Irish Prison Service Strategic Plan 2019 – 2022. Available from: https://www.irishprisons.ie/wp-content/uploads/documents_pdf/Document-5_IPS-Strategy-2019_2022.pdf

¹¹ Griffin et al. (2018). Increasing rates of self-harm among children, adolescents and young adults: a 10-year national registry study 2007–2016. *Social Psychiatry and Psychiatric Epidemiology*; 53: 663- 671

¹² Hawton, K., et al. (2016). Psychosocial interventions following self-harm in adults: A systematic review and meta-analysis. *Lancet Psychiatry*. 3(8): 740-50.

Substance misuse and self-harm

In line with the findings in 2017 (23% of episodes), substance abuse, recorded in 16% of episodes, is one of the primary factors associated with self-harm among the prison population in Ireland. There is a need for active consultation and collaboration between the mental health services and addiction treatment services for prisoners who present with dual diagnoses in line with action 2.1.24 of *Reducing Harm, Supporting Recovery*, “to improve outcomes for people with co-morbid severe mental illness and substance misuse problems”¹³.

The findings from this report identify the individual and context-specific risk factors relating to self-harm within the prison setting. The recording of such data is important to increase and improve responses to maintaining safer prisons. The collaborative approach of the SADA Project encompassing clinical, academic and professional practices to provide a robust analysis is critical to this.

Authors

This report was authored by Niall McTernan, Paul Corcoran, Eve Griffin and Grace Cully from the National Suicide Research Foundation, and Sarah Hume – Principal Psychologist, Enda Kelly – National Operational Nurse Manager, and Deirdre O’Reilly – Chief Pharmacist, and Connecting for Life Lead, 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)¹⁴.

¹³ Department of Health. (2017). *Reducing Harm, Supporting Recovery. A health-led response to drug and alcohol use in Ireland (2017-2025)*. Dublin

¹⁴ Department of Health. (2015). *Connecting for Life: Ireland’s National Strategy to Reduce Self-harm and Suicide (2015-2020)*. Dublin.

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The Self-Harm Assessment and Data Analysis (SADA) Project team at the launch of the annual report in 2017. Left to Right: Grace Cully (NSRF), Deirdre O'Reilly (IPS), Sarah Hume (IPS), Paul Corcoran (NSRF), Eve Griffin (NSRF), Enda Kelly (IPS), Michael Donellan (IPS – retired).

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Introduction

Prevalence of suicide and self-harm in prisoners

Self-harm and suicide are major issues in the prison population^{3,12}. Internationally, rates of suicide and lifetime self-harm are higher in prisoners compared to the general population^{12,15}. A recent study including 24 high income countries reported considerable variation in annual suicide rates in different countries, with rates ranging from 10-180 per 100,000 prisoners¹⁵ (see figure 1). Evidence suggests that suicide among prisoners is more common in Europe compared to other world regions, with an average of 62 deaths per 100,000¹⁷. The rate of suicide in Irish prisons from 2011-2014 was 47 per 100,000 prisoners¹⁵, equivalent to 0.047 per 100 prisoners.

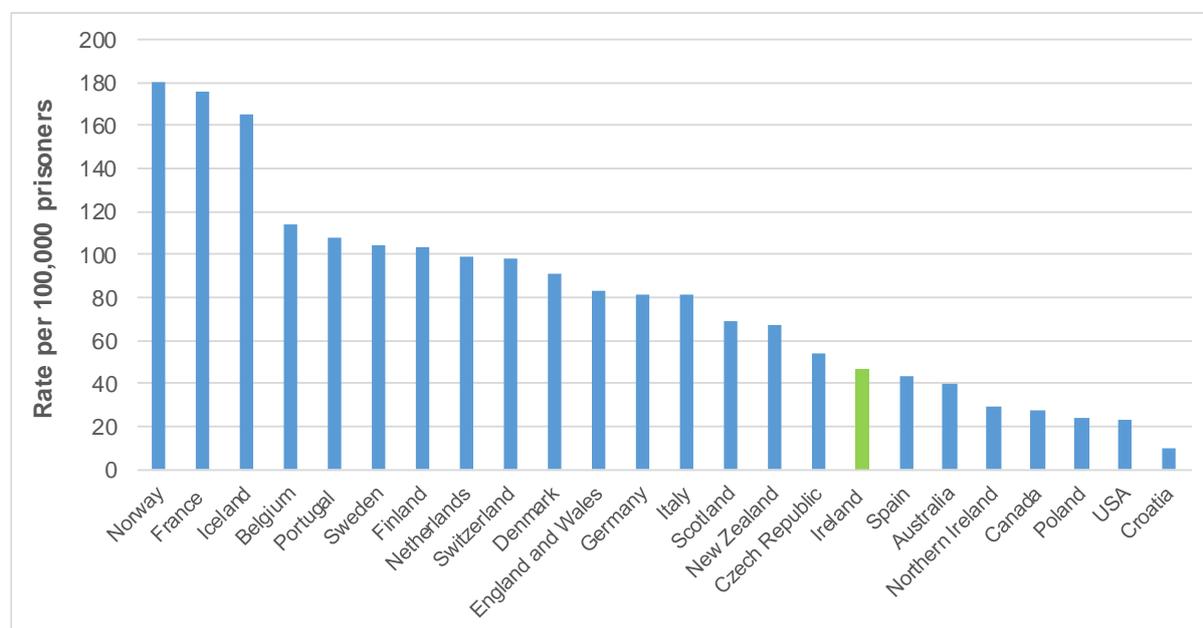


Figure 1. Rates of suicide in prisoners from 2011-2014 by country¹⁵

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 per 100 prisoners^{17,18}. 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 year¹⁵. This study observed a higher rate of self-harm among females

¹⁵ Fazel, S., et al. (2017). Suicide in prisons: an international study of prevalence and contributory factors. *Lancet Psychiatry*, 4(12): 946-952.

¹⁶ 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.

¹⁷ United Nations Office on Drugs and Crime (2014). *World Drug Report 2014*. UNODC, Vienna.

¹⁸ Favril L. (2019). Non-suicidal self-injury and co-occurring suicide attempt in male prisoners, *Psychiatry Research*, Vol 276, Pages 196-202

(20-24%) compared with male prisoners¹⁵. More recent reports indicate that the incidence of self-harm in prisoners in England and Wales has increased in recent years^{19,20}. Previous reports by the National Suicide Research Foundation (NSRF) reported that 170 self-harm episodes occurred in Irish prisons in 2004 and 223 in 2017, which translated to 3.8% and 4% of all prisoners respectively^{1,2}.

Repetition of non-fatal self-harm is common among prisoners, particularly among females^{1,3}. In England and Wales, the reported average number of episodes per year from 2004 to 2009 among male prisoners was two per person compared to an average of eight episodes per person among females³. 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 year¹. However, in 2017, self-harm was more pronounced among male prisoners with 26% of males and 16% of females engaging in self-harm more than once².

Risk factors for suicidal behaviour in prisoners

Self-harm is associated with increased risk of suicide in prisoners^{3,21}. 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-harm³. Additional risk factors for suicide in prisoners include male sex, single cell occupancy, recent suicidal ideation, psychiatric diagnosis, and history of alcohol use problems^{3,15}. The prevalence of axis one mental health diagnosis, alcohol and drug misuse in Irish prisoners is significantly higher than the rate of these vulnerabilities among the general Irish population⁹.

Self-harm episodes in prison vary in terms of lethality, level of suicidal intent and motivating factors^{3,16}. 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^{16,22}. 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-

¹⁹ Beard, J. et al. (2017). *Prison safety in England and Wales*. House of Commons: London.

²⁰ HMCIP. (2017). *HM Chief Inspector of Prisons for England and Wales annual report 2016–17*. House of Commons: London

²¹ Fazel, S., et al. (2008). Suicide in prisoners: a systematic review of risk factors. *J Clin Psychiatry*. 69(11): 1721-31

²² 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.

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-sentenced³. A recent study of 542 prison entrants in England found that the strongest risk factors were previous self-harm in prison and current suicidal ideation²³. In Ireland, the rate of self-harm was 4.4 times higher among female prisoners in 2017 and highest among prisoners aged 18-29 years. Moreover, the rate of self-harm was 2.4 times higher among prisoners on remand².

Method of self-harm and suicide in prisoners

The method most commonly involved in suicide deaths in prisoners is hanging^{22,24}. The most common method of self-harm in prisoners is cutting or scratching^{1,2,3}. 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 treatment³. 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, the SADA project identified that one in six episodes (17%) were deemed to have a high degree of suicidal intent in 2017². Illicit substances, most commonly benzodiazepines, are involved in 68% of suicide deaths among those in custody in the Irish Prison service²⁵.

²³ Ryland H, Gould C, McGeorge T, Hawton K, Fazel S. Predicting self-harm in prisoners: Risk factors and a prognostic model in a cohort of 542 prison entrants. *Eur Psychiatry*. 2020;63(1):e42

²⁴ 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.

²⁵ Iqtidar, M., et al. (2018). Deaths in custody in the Irish prison service: a five-year retrospective study of drug toxicology and natural deaths. *BJPsych Open* 4(5): 401-403.

Background to project

*Connecting for Life, Ireland's National Strategy to Reduce Suicide 2015-2020*¹⁴ 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 provides robust information relating to the incidence and profile of self-harm within prison settings, it identifies individual- and context-specific risk factors relating to self-harm and examines 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 2019-2022 Strategic Plan¹⁰, the National Suicide and Harm Prevention Steering Group (NSHPSG) monitors the incidence and nature of self-harm and death by suicide, 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. The IPS is currently working on options to improve the assessment and management of self-harm in Irish Prisons.

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 2016.²⁶ The NSRF is also a WHO collaborating centre for surveillance and research in suicide prevention.

²⁶ 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 Guidelines²⁷ 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.
- 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.

²⁷ National Institute for Health and Care Excellence. (2004). *Self-harm in over 8s: short-term management and prevention of recurrence*. CG16.

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 are 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 complies with the EU General Data Protection Regulation (2018). A Data Processing Agreement between the IPS and the NSRF is in place. Only anonymised data are released in aggregate form in reports. Full names of prisoners are not recorded. Prisoner initials and PIMS (Prisoner Information Management System) 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.

- Prison
The prison that the prisoner was in at the time of the episode is recorded.
- Initials and Identifiers
- Age
- Quarter
- 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 Behaviour²⁸, this is taken as the most potentially lethal method employed.

- Description of incident

- 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 admission to hospital or ICU 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 intent²⁹. 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 based on subjective reporting from the prisoner and objective evidence available amongst members of the MDT.

- Gender

- 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 51.9%.

- Legal Status

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

²⁸ 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.

²⁹ Beck, A.T., et al. (1979). Assessment of suicidal intention: the scale for suicide ideation. *J Consult Clin Psychol.* 47(2): 343.

- 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 behaviour³⁰. 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. Information on contributory factors was available for 85.9% of episodes (n=226) because a new variable was incorporated into the data collection for four prisons at the end of the calendar year.

Calculation of prison rates of self-harm

The annual person-based rate of self-harm in 2018 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 2018. The average of these daily populations was used as the estimated prison population for 2018. 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.

³⁰ 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 2018 was 3,690. On average 96.4% (n=3,556) were male and 3.6% (n=134) were female⁴. Of those in custody, an average of 18.3% were on remand while the remainder of the prisoners were sentenced. The most common sentence length, based on a snapshot of the prison population on an arbitrary date in 2018³¹, was between 5 and 10 years (17.7%), followed by 3 to 5 years (16.6%), under 1 year (12.2%), 1 to 2 years (11.4%), life (9.2%), 2 to 3 years (8.6%), and 10 or more years (6.1%) (See figure 3). Overall, the age profile of male and female sentenced prisoners is similar (see figure 2). For both sexes, there is a concentration of prisoners in the age range 30-39 years³².

Table 1. Prison characteristics and demographics, 2018

	Security	Prison population	On remand	Single cell	Shared cell
Arbour Hill	Medium	136	1.2%	69.3%	30.7%
Castlerea	Medium	286	20.8%	44.7%	55.3%
Cloverhill	Medium	396	80.9%	14.0%	86.0%
Cork	Medium	253	21.9%	14.9%	85.1%
Limerick (M)	Medium	195	35.9%	29.4%	70.6%
Limerick (F)	Medium	23	40.1%		
Loughan House	Low(open)	108	-	66.4%	33.6%
Midlands	Medium	814	9.8%	44.1%	55.9%
Mountjoy	Medium	628	5.9%	100.0%	-
Dóchas Centre (F)	Medium	111	26.5%	27.9%	72.1%
Portlaoise	High	226	6.2%	65.4%	34.6%
Shelton Abbey	Low(open)	90	-	36.8%	63.2%
Wheatfield	Medium	426	0.2%	64.8%	35.2%
Male		3,556			
Female		134			
Total		3,690	18.3%	51.9%	48.1%

³¹ Irish Prison Service. (2018). *Sentence length of sentenced prisoners in custody on November 30th, 2018*

³² Irish Prison Service. (2018). *Age Profile classified by gender of sentenced prisoners on November 30th, 2018*.

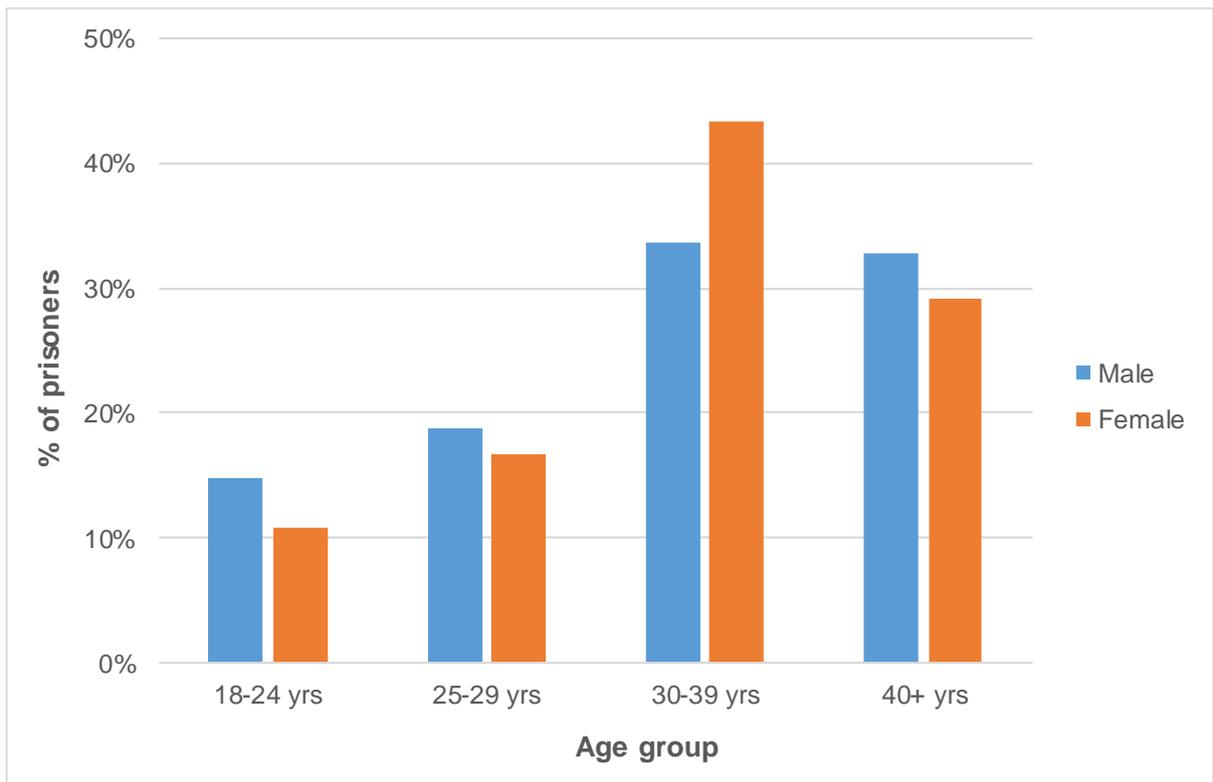


Figure 2. Age group of sentenced prisoners in custody on an arbitrary date in 2018

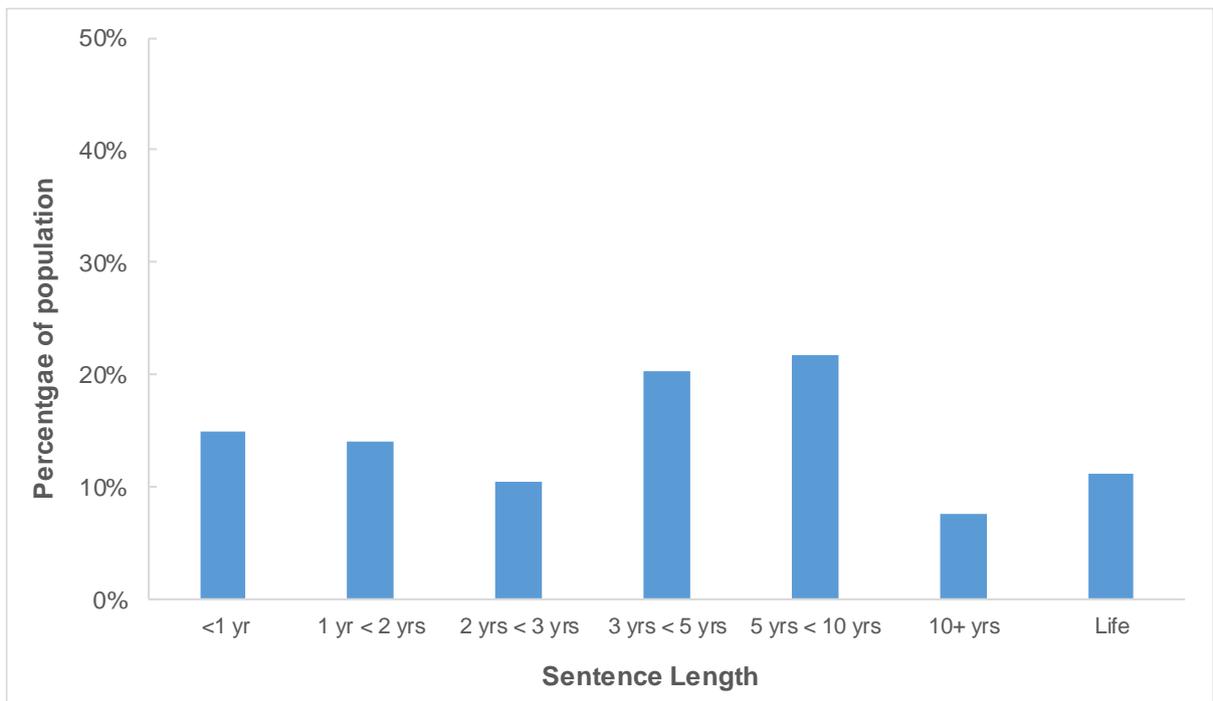


Figure 3. Sentence length of prisoners in custody on an arbitrary date in 2018

Self-harm in Irish Prisons 2018

Between 01 January and 31 December 2018, there were a total of 263 episodes of self-harm, involving 147 individuals. The number of self-harm episodes was 18% higher than 2017 and the number of persons involved increased by 7%.

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 2018. The average number of persons in custody (sentenced and on remand/ awaiting trial) in 2018 was 3,690. Thus, the annual rate of self-harm was 4.0 per 100 prisoners, representing 4% of all prisoners, the same as 2017. Approximately 3% of male and 19% of female prisoners engaged in self-harm, consequently the rate of self-harm among female prisoners was 5.7 times higher than males (19.3 versus 3.4 per 100). The rate of self-harm among female prisoners was 21% higher than 2017 (19.3 versus 16.0 per 100) with twenty-six females engaging in self-harm in 2018 compared to 19 in 2017. The male rate remained relatively unchanged (3.4 versus 3.6 per 100).

The rate of self-harm for sentenced prisoners was 3.7% and 5.0% for prisoners on remand. The rate of self-harm among prisoners on remand decreased by 32% in 2018, with a rate of 7.4 per 100 recorded in 2017. Correspondingly, the rate among sentenced prisoners was 19% higher than 2017 (3.7 versus 3.1).

Table 2. Rate of self-harm among Irish prisoners, 2018

	Individuals	Episodes	Rate per 100 (95% CI)
Total	147	263	4.0 (3.4-4.7)
Male	121	198	3.4 (2.8-4.1)
Female	26	65	19.3 (13.0-26.9)
Sentenced	113	181	3.7 (3.1-4.5)
On remand	34	82	5.0 (3.5-6.9)

The majority of prisoners who engaged in self-harm were male (121; 82.3%). Overall, the average number of persons in prison in 2018 was made up of 3,556 (96.4%) men and 134 (3.6%) women. The mean age was 32 years (range 18-54 years). Half of male prisoners (56%) were aged between 18 and 29 years, while almost two thirds of female prisoners (61.5%) were aged 30-49 years.

The rate of self-harm was highest, at 7.4 per 100 prisoners, among those aged 18-29 years. Rates among prisoners aged 18-29 years were 40% higher than the 2017 calendar year (5.3 per 100). Across all ages groups, the rate of self-harm was higher among female prisoners (see figure 4), although this is based on very small numbers.

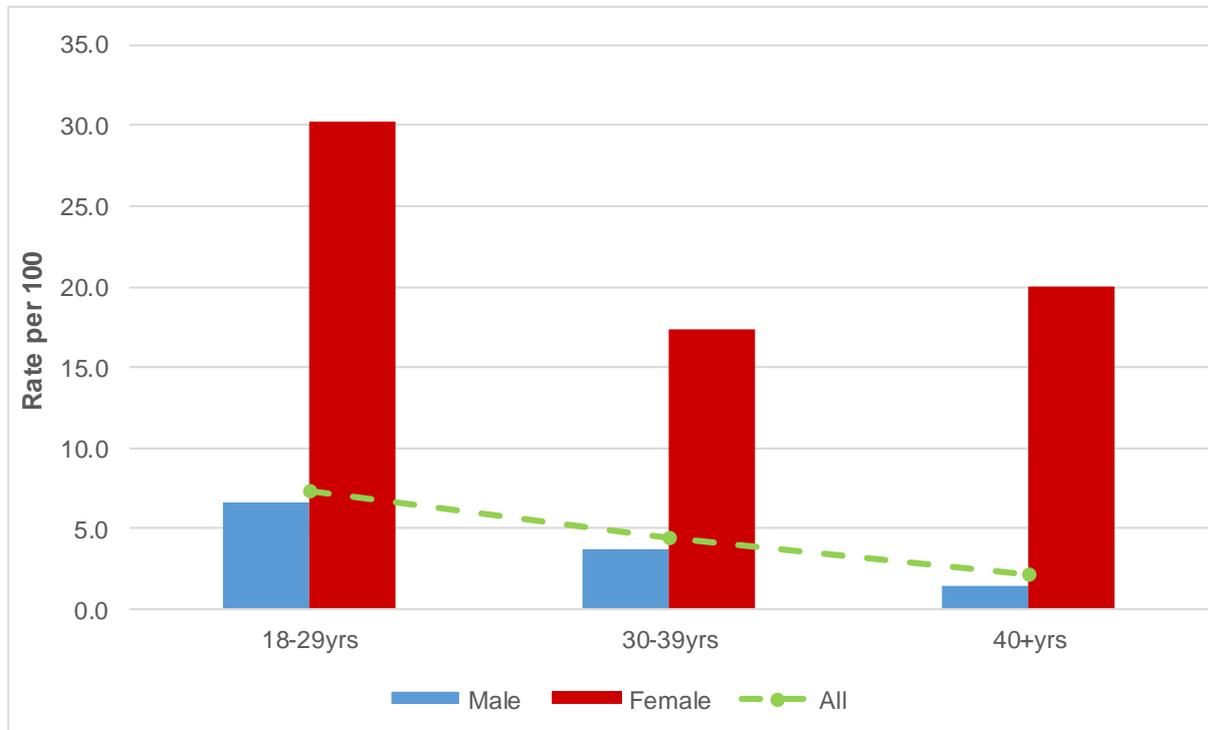


Figure 4. Age-specific rate of self-harm among sentenced prisoners (per 100 prisoners) in 2018

Self-harm by time of occurrence

Patterns of self-harm varied according to day of the week. The number of episodes which occurred on Tuesdays (18%) and Fridays (18%) was above average but not by a striking margin (see figure 5).

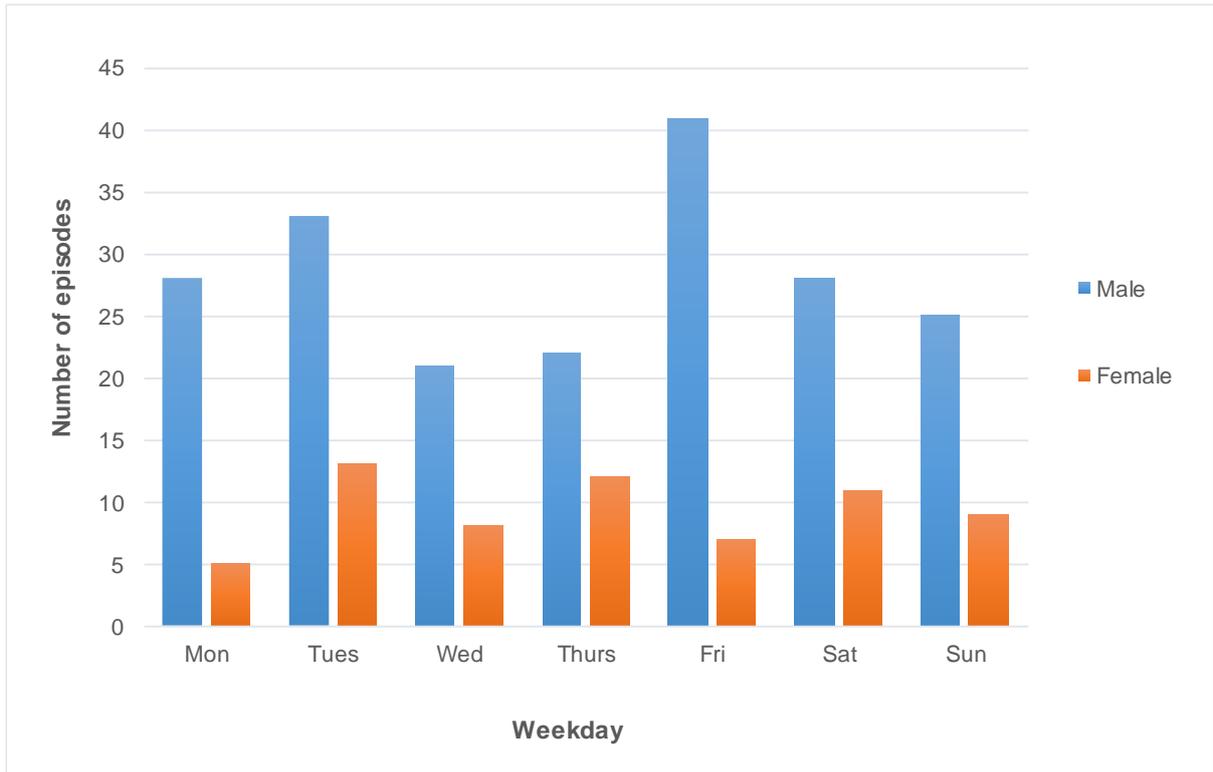


Figure 5. Number of episodes by weekday

The monthly average number of episodes of self-harm was 22. The observed number of self-harm episode fluctuated by month from 11 in October to 30 in November (see figure 5).

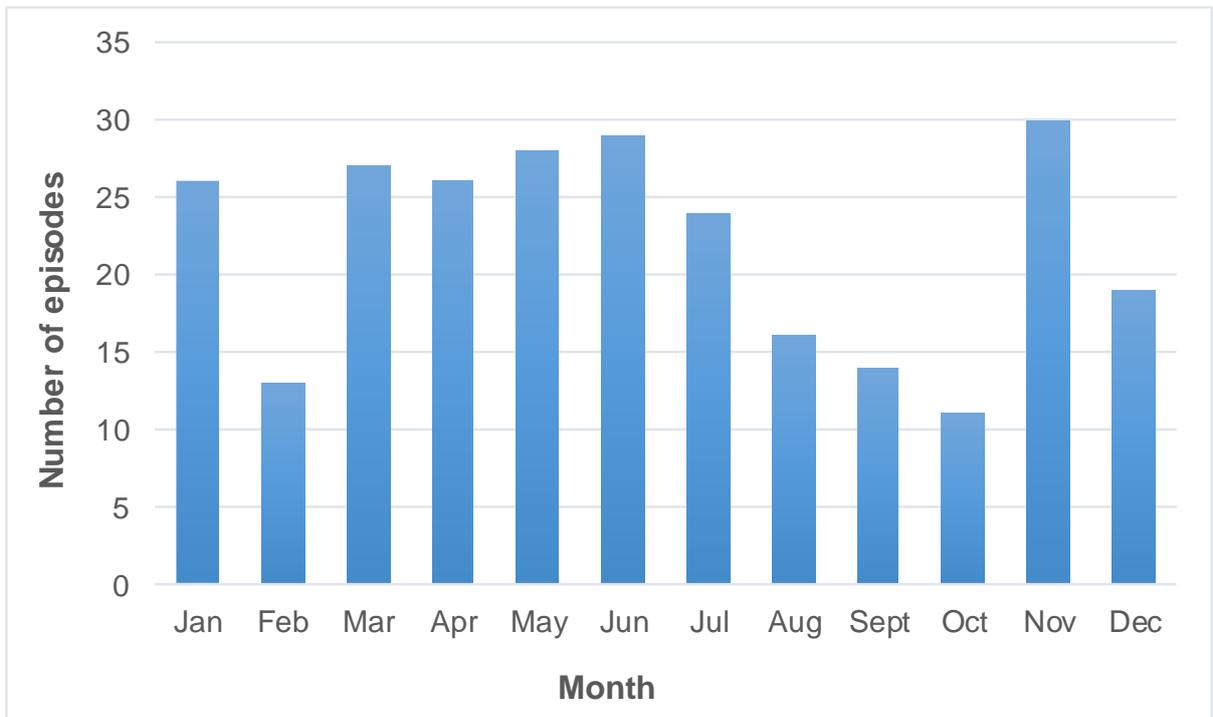


Figure 6. Number of episodes by month of occurrence

Analogous with 2017, the number of episodes of self-harm gradually increased during the day. A sharp peak was observed in the afternoon and early evening, with 44.5% of episodes occurring between 2pm and 8pm. The majority (59.7%) of episodes happened while prisoners were unlocked (see figure 7). The proportion of episodes that occurred during periods of unlock was similar for prisoners in general population accommodation (58.4%) and those who were on protection (55.2%). This suggests that regardless of whether the prisoner is locked up or not (i.e. on protection/general population), a high proportion of incidents typically occur during periods of unlock.

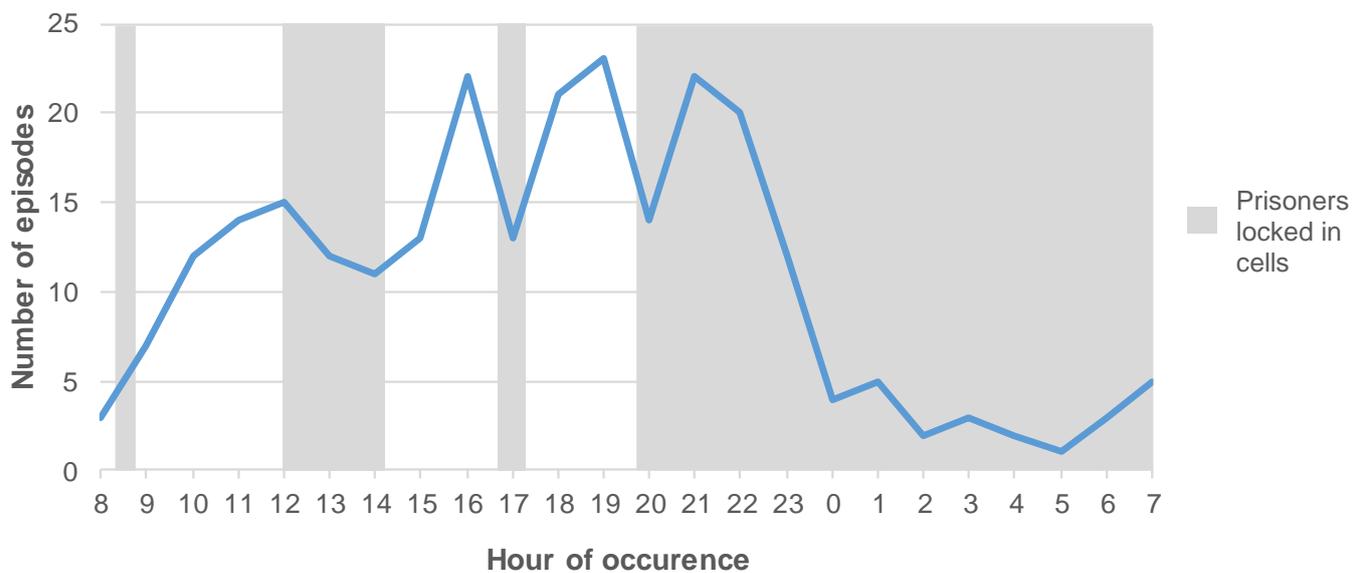


Figure 7. Hour of self-harm episode

Repetition of self-harm

Almost half (44.1%) of all episodes were due to repeat self-harm (n=116). The person-based rate of repetition was 32.7%, implying that 48 individuals had self-harmed more than once. The rate of repetition was higher for female prisoners (46.2% vs. 29.8%). Two individuals engaged in self-harm more than ten times in 2018.

Method of self-harm

The most common method of self-harm recorded was self-cutting (n=180; 69.2%). Self-cutting was involved in 73% of male episodes and 57% of female episodes. Attempted hanging (n=51; 19.6%) and blunt objects (n=12; 4.6%) were the only other common methods of self-harm (see table 3).

Table 3. Method of self-harm

	Cutting	Attempted hanging	Blunt objects	Other
All	180 (69.2%)	51 (19.6%)	12 (4.6%)	17 (6.5%)
Male	145 (72.9%)	31 (15.6%)	11 (5.5%)	12 (6%)
Female	35 (57.4%)	20 (32.8%)	1 (1.6%)	5 (8.2%)

Prisoner accommodation/ cell type and sentence

In line with 2017, the majority of self-harm episodes involved prisoners who were in single cell accommodation (191; 72.6%). 51.9% of the overall prison population are housed in single cell accommodation, based on a snapshot of the prison population on an arbitrary date in 2018²⁹. Regarding prisoner accommodation, 97 (36.9%) self-harm episodes involved prisoners on protection (including Rule 62 and Rule 63), compared with 43.7% (n=115) involving general population prisoners. Seventeen (6.5%) self-harm episodes involved prisoners from a High Support Unit. Four episodes (1.5%) occurred while the individual was placed in a Safety Observation Cell, 20 (7.6%) occurred while the individual was placed in a Close Supervision Cell (CSC) and eight (3%) occurred while the individual was placed on special observations (15 minute checks during lock up) (see table 4).

Table 4. Prisoner accommodation

General population	Protection	Special observation (SO)	High support unit (HSU)	Close supervision cell (CSC)	Safety observation cell (SOC)
115 (43.7%)	97 (36.9%)	8 (3%)	17 (6.5%)	20 (7.6%)	4 (1.5%)

The majority (179; 68.1%) of self-harm episodes involved sentenced prisoners, while 30.4% (80) were on remand/ awaiting trial at the time of the self-harm episode. Considering sentenced prisoners, the highest proportion (109; 60.9%) were serving a sentence of less than three years, with 28% serving less than one year (see figure 8).

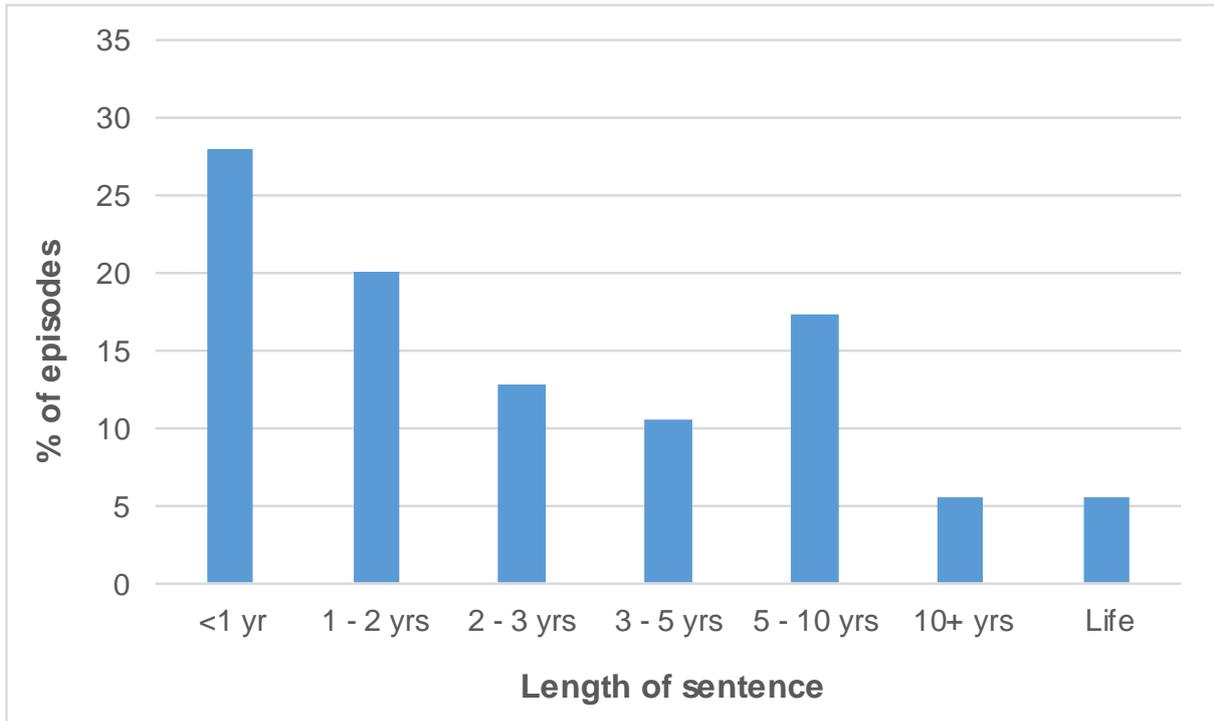


Figure 8. Length of sentence being served (sentenced prisoners)

More than one-third of self-harm episodes occurred in the second trimester of a sentence (72; 40.7%), with 28.8% occurring in the first trimester and 30.5% in the third trimester (See Figure 9).

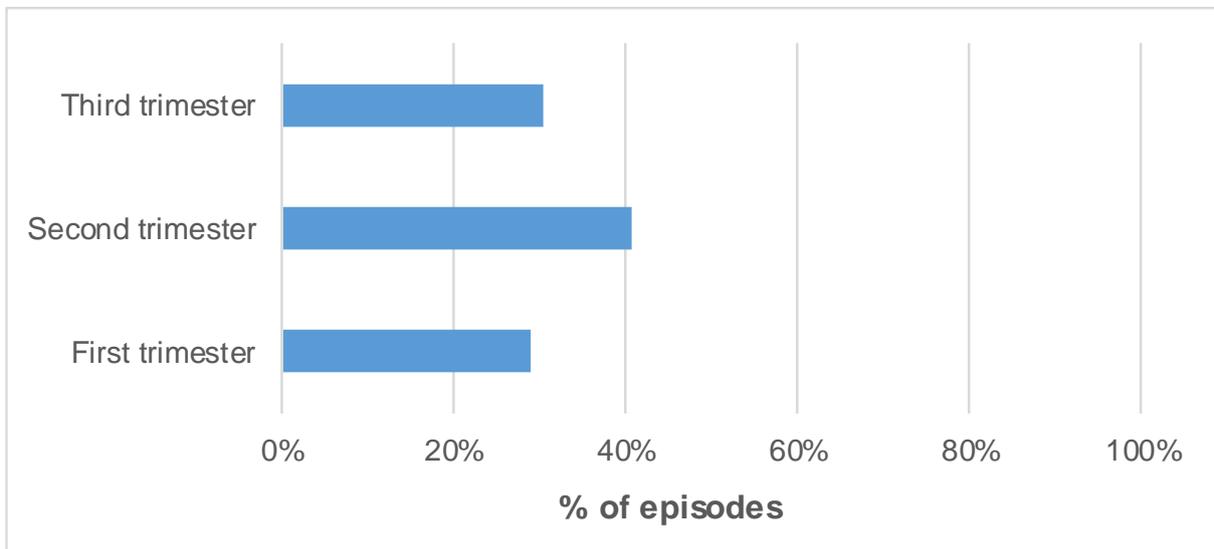


Figure 9. Trimester of sentence in which self-harm occurred

The highest proportion of episodes involved prisoners on a standard regime level (114; 43.3%), one in six were on a basic regime (47; 17.9%) and 102 (38.8%) were on an enhanced regime.

Recommended next care, severity and intent

For one quarter (70; 26.6%) of self-harm episodes, no medical treatment was required. Over half (156; 59.3%) of all episodes required minimal intervention/ minor dressings or local wound management. One in eight required hospital outpatient or accident and emergency department treatment (31; 11.8%)³³. During this period, six self-harm acts involved admission to hospital or ICU or loss of life (2.3%) (see Table 5). Self-harm episodes by male prisoners were associated with increased severity – 87.4% of males who self-harmed required treatment compared with 30.8% of female prisoners.

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

No treatment needed	Minimal intervention	Local wound management	Outpatient/ A&E treatment	Admission to Hospital / ICU / Loss of Life
70 (26.6%)	86 (32.7%)	70 (26.6%)	31 (11.8%)	6 (2.3%)

Method of self-harm was also associated with differences in severity of care required. While self-cutting was the most common method, no self-cutting episodes resulted in loss of life and 9.4%, (n=17) required hospital outpatient or accident and emergency department treatment. In contrast, self-harm with a blunt object had no fatal outcomes but 58.3% (n=7) of episodes required hospital outpatient or accident and emergency department treatment. Additionally, 11.8% (n=6) of episodes involving attempted hanging required hospital outpatient or accident and emergency department treatment and fewer than five episodes (<1%) resulted in admission to hospital or ICU or loss of life.

Over two thirds (184; 70%) of self-harm episodes were recorded as having no/ low intent, with less than one-fifth (45; 17.1%) recorded as having medium intent. Approximately one in eight acts were rated as having high intent (33; 12.5%) (see figure 10). Suicidal intent varied according to the method involved in the self-harm episode – high intent was recorded in more than half of episodes (7; 58.3%) involving self-harm with a blunt object and one quarter of attempted hanging episodes (13; 25.5%), while high intent was only recorded in 6% of episodes involving self-cutting (n=11).

³³ Episodes of self-harm requiring hospital treatment will also be recorded by the National Self-Harm Registry Ireland.

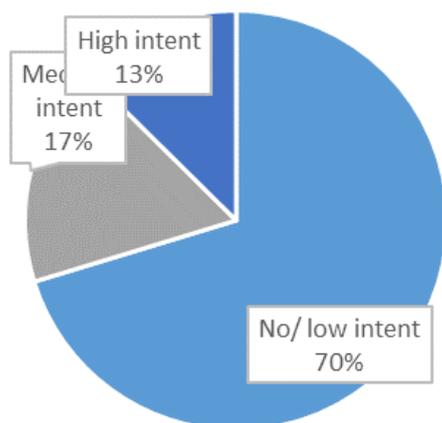


Figure 10. Level of intent associated with self-harm episode

Among those requiring no/minimal treatment, the majority (78.6%) were deemed to have no/low intent, 12.9% to have medium intent and 7.1% to have had high intent. Among those requiring local wound management 51.4% were deemed to have no/low intent, 27.1% to have medium intent and 21.4% to have had high intent.

The six most severe self-harm acts, requiring admission to hospital or ICU or resulting in loss of life, included cases assessed as having no/low intent, medium intent and high intent.

Table 6. Severity/intent matrix

	No treatment needed	Minimal intervention/ minor dressings	Local wound management	Outpatient /A&E treatment	Admission to hospital / ICU/ Loss of Life
No/low intent	55 (29.9%)	75 (40.8%)	36 (19.6%)	16 (8.7%)	<5 (1%)
Medium level of intent	9 (20.0%)	7 (15.6%)	19 (42.2%)	8 (17.8%)	<5 (4.4%)
High level of intent	5 (15.2%)	<5 (12.1%)	15 (45.5%)	7 (21.2%)	<5 (6.1%)

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 (120; 45.6%), a further eighty-six (32.7%) to environmental issues^{34,35}, sixty-four (24.3%) to procedural issues and fifty-eight (22.1%) related to relational issues (see figure 11).

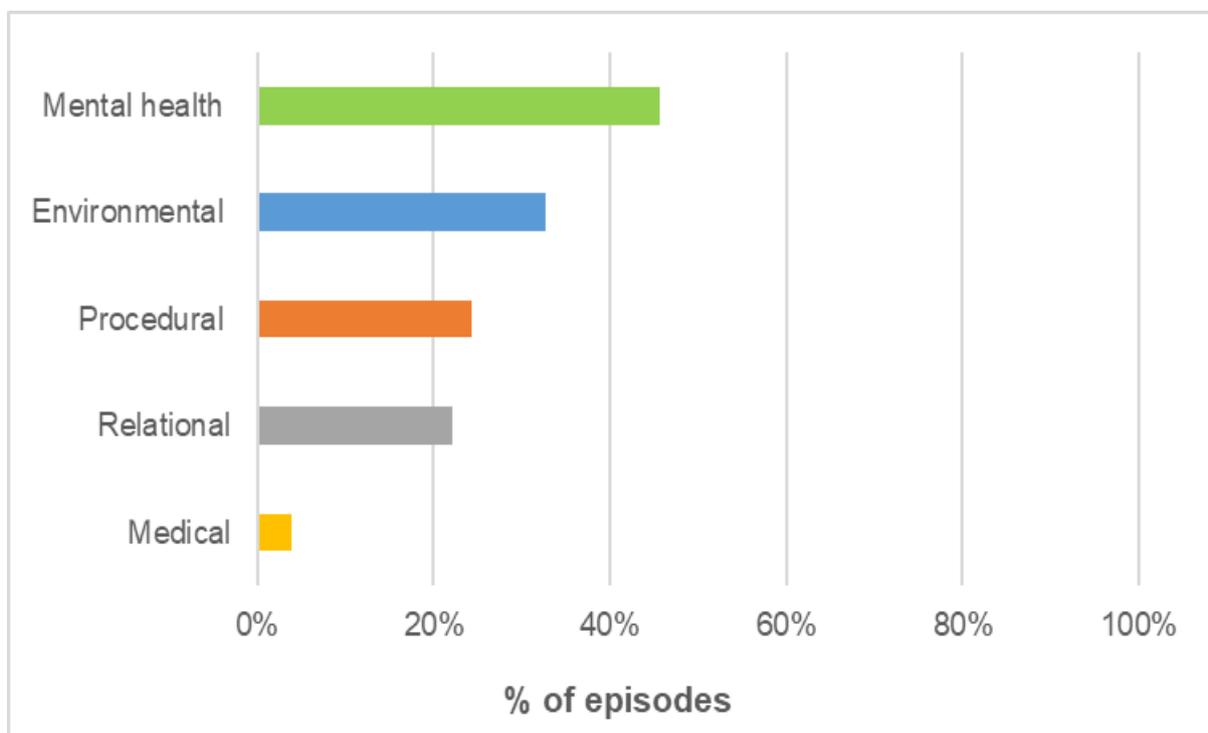


Figure 11. Themes of contributory factors in self-harm episodes

Environmental

Wanting to change cell type (e.g. from single to double) or wanting to move to a different accommodation type was the most common environmental contributory factor (33; 13%). Other environmental factors reported included issues with type of accommodation (23; 9%) and access to illicit substances (21; 8%). Legal issues were a contributory factor in 4% of episodes. Legal issues reported included pending charges, ongoing court case, first time in custody and unexpected custody. Reduced access to training, education, work or exercise contributed to 3.8% of self-harm episodes.

³⁴ More than one contributory factor could be recorded for each episode

³⁵ Information on contributory factors was available for 85.9% of episodes (n=226) because a new variable was incorporated into the data collection for four prisons at the end of the calendar year.

Procedural

Recently moving cell was the most common procedural contributory factor (n=33, 13%). Disciplinary issues, having been served a P19 (disciplinary report) or having had regime status reduced for disciplinary reasons, was a factor in 6% of episodes. Visit, temporary release (TR) or transfer issues (e.g. screened visits, return from TR due to breached conditions, denied transfer) (5.7%) and security level was a factor contributing to a minority of episodes (3.4%).

Relational

Relationship difficulties with other prisoners, including conflict, being under threat or bullied and gangland involvement, were a factor in 8% of episodes. Personal relationship issues, particularly with family and friends, contributed to one in twenty episodes (6.8%). Relationship difficulties between prisoners and staff were a contributory factor in 2.7% of self-harm episodes. Bereavement and issues with child custody or access were reported in a minority of episodes (2.7% and 2.7%, respectively).

Medical

Medication issues (e.g. poor medication compliance) were reported in 2.3% of episodes. Terminal illness and chronic pain were reported in 2% and under 1% of episodes, respectively.

Mental health

Mental health issues were the most common contributory factor across all themes (n=120, 45.6%). 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 (43; 16.3%). Personality disorder was recorded as a contributory factor in 14.4% and active psychosis/mental illness in 3% of self-harm episodes.

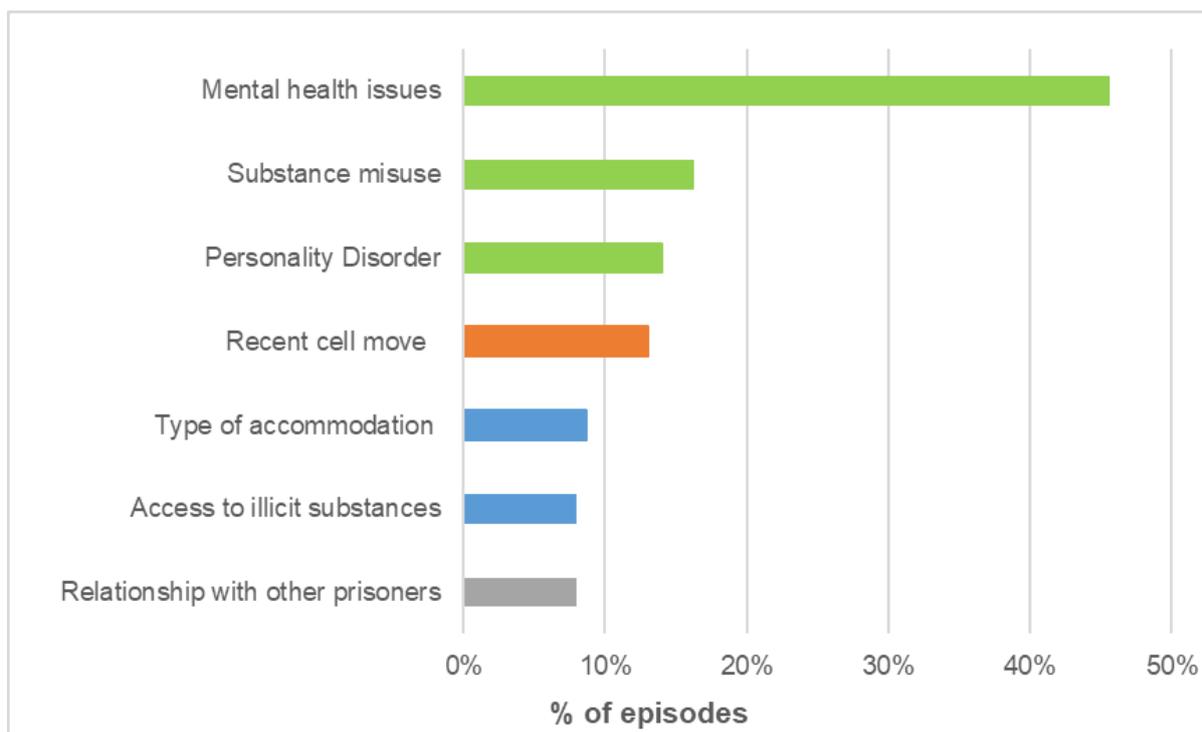


Figure 12. Most common contributory factors

Theme	Contributory factor	Number of episodes	% of episodes
Environmental	Type of accommodation	23	9%
	Access to illicit substances	21	8%
	Restricted access to activities	10	4%
	Legal issues	10	4%
Procedural	Recent cell move	33	13%
	Recent P19 / regime status reduced	16	6%
	Visit / temporary release / transfer issues	15	6%
	Security level / additional staff for risk behav	9	3%
	Protection issues	<5	2%
Relational	Relationship difficulties with other prisoners	21	8%
	Relationship difficulties with partner / family	18	7%
	Under threat/bullying	17	7%
	Relationship difficulties with staff	7	3%
	Bereavement	7	3%
	Child custody/access issues	7	3%
Medical	Medication issues	6	2%
	Terminal illness	<5	2%
	Chronic pain	<5	<1%
Mental health	Mental health issues	120	46%
	Substance misuse	43	16%
	Personality Disorder	38	14%
	Active psychosis / mental illness	8	3%
	Hopelessness	<5	1%

Table 7. Contributory factors and themes

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Glossary

On remand	In custody awaiting trial or sentencing
VDP	Violent & Disruptive Prisoner
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

Prison: _____ Initials: _____ PIMS No: _____ Age: _____ Quarter: _____

Date of incident: _____ Time of Incident: _____ Method: Cutting Drug Overdose Alcohol
 Hanging, strangulation, 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:

Severity	No treatment required.	Minimal intervention/minor dressing.	Local wound management.	Outpatient/A&E treatment.	Hospital/ Intensive Care	Loss of life.
Intent	A	B	C	D	E	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:	Gender	Accommodation	Cell sharing	Legal Status	Sentence length	Trimester	Regime level
	Male	General Population	Single	Remand	Remand	N/A	Enhanced
		Protection (please circle) Rule 62 Rule 63			<3 mth to < 1yr	1 st	Standard
		Special Observation	Double		1yr < 2yrs	2 nd	Basic
	Female	CSC	Triple or more	Sentenced	2yr < 3yr		
		SOC			3yr < 5yr		
		HSU			5yr < 10yr		
VDP	10+ yrs	Life					

Table 3: Contributory Factors:

	Code		Primary Contributory Factor (Please tick)	Other Contributory Factors (Please tick)	Please describe:
ENVIRONMENTAL (E)	E1	Type of accommodation e.g. shared/single cell			
	E2	Security level			
	E3	Recent moved cell/transfer			
	E4	Extra staff allocated for risk behaviours			
	E5	Access to illicit substances			
	E6	Newly convicted			
	E7	First time in custody			
	E8	Unexpected sentence/remand			
	E9	Return from TR having breached conditions/with contraband			
	E10	Other (Please specify)			
RELATIONAL (R)	R1	Relationship difficulties			
	R2	Prisoner/staff relationships issues			
	R3	Potential risk behaviours			
	R4	Under threat/bullying			
	R5	Pressure from other prisoners/conflict/gangland involvement			
	R6	Other (Please specify)			
PROCEDURAL (P)	P1	Regime status e.g. punishment, CSC, SOC			
	P2	Protection e.g. Rule 62/63			
	P3	Recent cell move/transfer			
	P4	Recent P19			
	P5	Restricted access to training, education, work, exercise.			
	P6	Denied visit, TR, transfer			
	P7	Other (Please specify)			
PERSONAL (P)	PE1	Family relationships			
	PE2	Friendships			
	PE3	Child custody/access issues			
	PE4	Pending charges			
	PE5	Bereavement/loss			
	PE6	Other			
	M1	Mental health issues			

MENTAL HEALTH/ MEDICAL (M)	M2	Addiction – drug use/drug seeking			
	M3	Current mental illness/active psychosis			
	M4	Terminal illness			
	M5	Chronic pain			
	M6	New diagnosis or worsening symptoms			
	M7	Hopelessness for the future.			
	M8	Medication			
	M9	Personality Disorder			
	M10	PTSD			
	M11	Other (Please specify)			