Seirbhís Phríosúin na hÉireann
Irish Prison Service

Self-harm in Irish Prisons 2019

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

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Seirbhís Phríosúin
na hÉireann
Irish Prison Service

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Foreword

Welcome to the third annual Irish Prison Service (IPS) SADA Report, which progresses our detailed and analytical surveillance of all episodes of self-harm and suicide across the IPS Estate.

The publication of this report is due to the continued work and determination of staff across all prisons who work diligently in responding to and recording the impact of prisoners' distress each and every day.

It is also achieved by the excellent partnership arrangements the IPS has with the National Office for Suicide Prevention (NOSP) and the National Suicide Research Foundation (NSRF), who provide the research, statistical and analytical skills to provide such academic reports.

In 2015, the IPS committed to the aims of the National Strategy to Reduce Suicide 2015 – 2024 ("Connecting for Life") and sought to improve on both the reporting, review and response to incidents of self-harm and suicide across the service. Since its inception in 2016 the vision for the SADA Project has always been to accrue high quality, reliable and robust data from within the IPS to influence and guide future policy and practice development in achieving a reduction in both self-harm and suicides in the prison environment. A major part of this drive to reduce incidents of self-harm and suicide in the IPS estate was to truly understand the multiple factors that influence these behaviours and develop bespoke responses to meaningfully impact on and prevent future incidents. The research that we now have available to us following the publication of our Third Annual Report provides a quality reference basis and a significant amount of evidence to allow us to move to the next step of developing appropriate and effective interventions for people in distress, enhancing current interventions and supports.

Research and investigation into possible models of intervention has been ongoing for some time and as we publish this report, further work is ongoing in procuring external professional expertise in working with the IPS to develop a mode of intervention based on a recognised international and effective model that can be adopted specifically for use within the IPS. The data provided from the analysis of the 3 years of SADA reporting has proved vital in shaping this response and it is hoped

that our annual report for 2021 will compliment a bespoke report on the introduction and effectiveness of this new intervention.

As it stands, it is hoped to have this new model of intervention in place during the second quarter of 2021, which will include staff information and training sessions across disciplines.

It is my hope that with the continuance of SADA, the introduction of an effective model of intervention and the sustained hard work and support of all the local multi-disciplinary teams we will see a marked reduction in the levels of self-harm and suicide within our service over the coming years.

Caron McCaffrey

Director General, Irish Prison Service.

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Executive Summary

This is the third annual report on all recorded episodes of self-harm by individuals in the custody of the IPS. The report provides data from all prisons in the Republic of Ireland in 2019 arising from the Self-Harm Assessment and Data Analysis (SADA) Project.

Main findings

- *Between 01 January and 31 December 2019, there were 203 episodes of self-harm recorded in Irish Prisons, involving 109 individuals. There were 270 episodes of self-harm involving 150 individuals in 2018[1]. Thus, the number of self-harm episodes was 25% lower in 2019 than in 2018 and the number of persons involved decreased by 27%. The overall prison population increased by 8% between 2018 (n=3,690) and 2019 (n=3,971). The annual person-based rate of self-harm in 2019, at 2.9 per 100 prisoners, was significantly lower (29%) than the rate recorded in 2017 and 2018 (4.0 and 4.1 per 100, respectively). Thus, an episode of self-harm was recorded for 3% of the prison population.*
- *The majority of prisoners who engaged in self-harm were male (n=85; 78.0%) but taking into account the male prison population, their rate of self-harm was 2.4 per 100. The male rate decreased by 31% from 2019 to 2018 (2.4 versus 3.5 per 100). Twenty-four female prisoners engaged in self-harm in 2019 equating to a rate of 19.8 per 100, which is 8.2 times higher than the rate among male prisoners. The rate of self-harm among female prisoners was 3% higher than 2018 (19.8 versus 19.3 per 100). The rate of self-harm was highest among sentenced prisoners aged 18-29 years. The rate of self-harm among prisoners in this age group was 40% lower than in 2018 (5.7 versus 3.4 per 100). Across all age groups, the rate of self-harm was higher among female sentenced prisoners.*
- *The rate of self-harm was 2.5 times higher among prisoners on remand than those sentenced (5.7 versus 2.3 per 100), a higher margin than reported for 2018 when the rate of self-harm among prisoners on remand was 5.3 per 100 and the rate among sentenced prisoners was 3.8 per 100.*

- *One-third (33.9%) of individuals engaged in self-harm more than once during the calendar year. This was more pronounced for female prisoners – 29.4% of male prisoners repeated self-harm (25 out of 85 individuals) compared with 50.0% of female prisoners (12 out of 24 individuals). A small number of individuals engaged in self-harm more than ten times in 2019.*
- *The most common method of self-harm recorded was self-cutting or scratching, present in 64.7% of all episodes. The other common method of self-harm was attempted hanging, involved in 21.1% of episodes.*
- *Two thirds (68.0%) of self-harm episodes involved prisoners in single cell accommodation. Considering the overall prison population, 51.9% were accommodated in single cells in 2019. Sixty-four percent of prisoners who engaged in self-harm were in general population accommodation and a further 17.2% were on protection (including Rule 62 and 63) at the time of the self-harm act.*
- *For almost one third (31.0%) of episodes, no medical treatment was required. Half of episodes (49.8%) required minimal intervention or local wound management in the prison and one in seven (15.3%) required hospital outpatient or accident and emergency department treatment. Self-harm episodes by male prisoners were associated with increased severity – 82.4% of male prisoners who self-harmed required some medical treatment compared with 41.8% of female prisoners.*
- *More than two-thirds (69.0%) of self-harm episodes were recorded as having no / low degree of suicidal intent. Twenty-two per cent of episodes were recorded as having medium intent and approximately one in eleven (8.9%) 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 (56.2%) of factors related to mental health issues, 17.6% to relational issues and 11.9% to environmental issues.*

[1]Figures for 2018 have been updated to include an additional 7 incidents which were late registered

Discussion

Internationally, rates of suicide and lifetime self-harm are higher in prisoners compared to the general population[2,3]. 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 prisoners[2] (see figure 1). The rate of suicide in Irish prisons from 2011-2014 was 47 per 100,000 prisoners[2], equivalent to 0.047 per 100 prisoners. Previous reports by the NSRF reported that 170 self-harm episodes occurred in Irish prisons in 2004, 223 in 2017 and 270 in 2018, which translated to 3.8%, 4.0% and 4.1% of all prisoners respectively[4,5,6]. A study of self-harm in prisons in England and Wales during 2004-2009 reported a rate of 6.0%[2] .The annual person-based rate of self-harm reported by the SADA project for 2019 was 2.9 per 100 prisoners. The Irish rate is approximately half the rate in England and Wales.

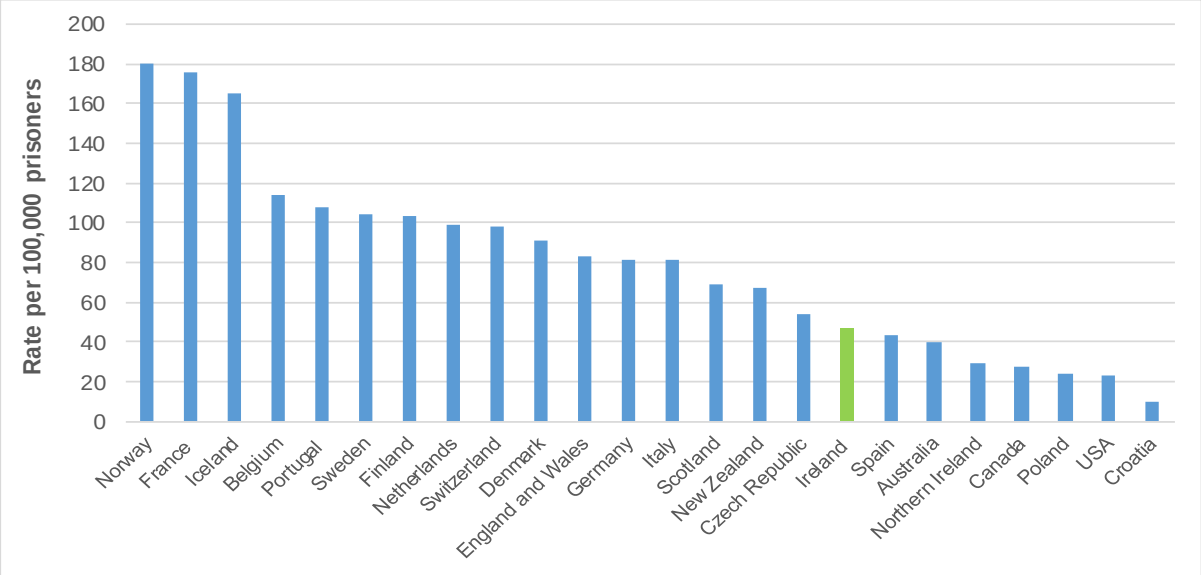

Figure 1. Rates of suicide in prisoners from 2011-2014 by country[2]

Women accounted for approximately 4% of the Irish prison population in 2019[7] 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 eight times higher than it was among male prisoners. In 2018, the

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

[3] 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.

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

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

[6] National Suicide Research Foundation. (2020). *Self-harm in Irish Prisons 2018*. Cork.

[7] Irish Prison Service. (2020). Average prison population Jan to Dec 2019.

incidence of self-harm among female prisoners was six times higher than male prisoners and in 2017 it was four times higher. This is a larger gender difference than observed in hospital-presented self-harm among the general population and appears to be increasing[8]. It should be noted however, that self-harm episodes in the general population refer only to those which result in a presentation to hospital making comparisons difficult.

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 from 2018[6] and for hospital-presented self-harm in the general population[8]. The rate of self-harm was highest among sentenced prisoners aged 18-29 years, at 3.4 per 100 prisoners. The rate among sentenced prisoners aged 18-29 years was 40% lower in 2019 than it was in 2018 (5.7 versus 3.4).

The rate of self-harm was 2.5 times higher among prisoners on remand or awaiting trial than it was among sentenced prisoners (5.7 versus 2.3 per 100). This finding is in line with previous years (1.4 and 2.4 times higher in 2018 and 2017)[5,6] and research in England and Wales which identified a life sentence or being un-sentenced as risk factors for self-harm in prisoners[9]. Indicating that prisoners on remand are a group that are particularly vulnerable to suicidal behaviour. Single cell occupancy has also been identified as a risk factor for suicidal behaviour[2,9]. Sixty-eight percent of episodes in 2019 involved prisoners in single cell accommodation but it is important to note that just over half (51.9%) of the prison population are housed in single cell accommodation[10].

International research suggests that the method most commonly involved in suicide deaths in prisoners is hanging[11,12]. The most common method of self-harm in prisoners is cutting or scratching[4,5,6,9]. Consistent with this, the main method of self-harm recorded in 2019 was self-cutting or scratching, which was present in 64.7% of episodes. Self-cutting was involved in 70.5% of self-harm episodes by males and 52.3% of episodes by females. While the majority of episodes involving self-cutting were less severe (15.2% required hospital outpatient or accident and emergency department

[8] Joyce M., et al. (2020). *National Self-Harm Registry Ireland Annual Report 2019*. National Suicide Research Foundation: Cork.

[9] 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

[10] Irish Prison Service (2019). Census Prison Population October 2019 – Cell occupancy – In-Cell Sanitation. Available from: https://www.irishprisons.ie/wp-content/uploads/documents_pdf/October-2019-In-Cell.pdf

[11] 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.

[12] 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.

treatment), risk of repetition is elevated among individuals who engage in self-cutting[13,14]. Attempted hanging was recorded as the method of self-harm in 21.1% of episodes. Female prisoners were more likely to engage in attempted hanging than males (27.7% vs 18.0%). This is consistent with 2018 findings (31.3% v 15.5%)[6] indicating that female prisoners remain significantly more likely to engage in attempted hanging.

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[9]. 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[9]. Just 1% of non-fatal episodes were of high lethality. In Ireland, the SADA project identified that one in eight episodes (12.5%) were deemed to have a high degree of suicidal intent in 2018[6].

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 intent (91.1%). However, a significant proportion of episodes were associated with a high degree of suicidal intent (8.9%) indicating that suicidal intent may be high regardless of the method of self-harm or severity of the act.

The outcomes of this report 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 over half of cases (56.7%). Factors relating to mental health issues/ mental illness were the primary contributory factors recorded (44.3%) – predominantly relating to poor coping skills and difficulties managing emotions (29.1%) and substance misuse (19.2%). A recent systematic review[15] 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. Our findings also highlight prison-specific factors cited as contributing to the episode of

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

[14] 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*.

[15] 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

self-harm. The majority of these related to procedural issues (10.1%), such as issues related to transfer (6.4%) and protection (2.5%), in addition to being recently issued a P19 or a reduction in incentivised regime (2.0%).

Environmental issues (11.9%) relating to type of accommodation or cell type (8.4%), reduced access to regime (4.4%), legal issues (3.0%) and to orchestrate access to contraband (2.5%), were commonly cited. Relationship difficulties with significant others (7.4%), relationship difficulties with other prisoners (5.9%), the death or anniversary of someone close (5.4%) and relationship difficulties with staff (2.0%) were also common factors.

This is line with international evidence which identifies specific environmental risk factors for self-harm in prisoners, including solitary confinement, disciplinary violations, and being a victim of sexual or physical harassment while incarcarated[16].

Recommendations

The decrease in the rate of self-harm in 2019 among sentenced prisoners can largely be attributed to males aged 30-39 years (-61%) and 18-29 years (-42%) who engaged in self-cutting (-35%). The overall female rate increased by 3%.

Despite a sizeable decrease in incidents in 2019, the trends outlined in this report underline the need to implement prevention measures such as reception screening for suicide risk and safety planning for prisoners engaging in self-harm in Ireland. In addition, a prison-wide approach towards preventing self-harm in Irish prisons is fundamental to further reducing the incidence of self-harm.

Implementation of safety planning

The incidence of self-harm among female prisoners was eight times higher than male prisoners. In 2018 and 2017, it was six and four times higher. This is a larger gender difference than observed in hospital-presented self-harm among the general population and appears to be increasing[8]. Gender specific safety planning should be prioritised in the absence of validated risk assessment approaches[17].

[16] Favril L, Yu R, Hawton K, Fazel S. Risk factors for self-harm in prison: a systematic review and meta-analysis. Lancet Psychiatry 2020; 7: 682–91

[17] 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

Implementation of prevention measures for remand prisoners

The rate of self-harm was 2.5 times higher among prisoners on remand or awaiting trial than it was among sentenced prisoners (5.7 versus 2.3 per 100). This finding is in line with previous years (1.4 and 2.4 times higher in 2018 and 2017) and other research[9] and indicates that prisoners on remand are a group that are particularly vulnerable to suicidal behaviour. Committal to a prison may be an important time to identify risk among individuals and to implement appropriate prevention measures such as reception screening for suicide risk[18] and increased training for Prison Officers in the detection and management of mental health difficulties in the custodial population, in line with IPS Strategic Plan 2019 – 2022[19].

Prison-wide approach towards preventing self-harm in prison

The wide range of contributory factors highlight the need for an all-inclusive, prison-wide approach towards preventing self-harm in Irish prisons. Research suggests that this should include both population and specific priority group strategies, with multiagency collaboration between psychological, criminal justice and social care services[16].

Authors

This report was authored by Niall McTernan, Paul Corcoran, Eve Griffin and Grace Cully from the NSRF, and Sarah Hume – Acting Head of Psychology, Enda Kelly – National Operational Nurse Manager, and Deirdre O'Reilly – Chief Pharmacist, and Connecting for Life Lead, from the IPS. The report is supported by the NOSP. ongoing surveillance of self-harm and suicide in Irish prisons is funded by the IPS 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 (2015-2024)[20].

[18] Marzano L, Hawton K, Rivlin A, et al. Prevention of suicidal behavior in prisons. Crisis 2016; 37: 323–34

[19] 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

[20] Department of Health. (2015*). Connecting for Life: Ireland's National Strategy to Reduce Self-harm and Suicide (2015-2024).* Dublin

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Introduction

Connecting for Life, Ireland's National Strategy to Reduce Suicide 2015-2024[20] highlights prisoners as a priority group with vulnerability to an increased risk of suicidal behaviour. As part of *Connecting for Life,* the IPS (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 began monitoring self-harm in Irish prisons in 2017. It 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 Plan[19], 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) NOSP and the 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[21]. The NSRF was re-designated as a WHO collaborating centre for surveillance and research in suicide prevention in 2019.

[21] 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[22] 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.

[22] 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 NSRF. Data are then recorded onto an encrypted computer in the NSRF.

Data protection and confidentiality

Confidentiality is strictly maintained. The NSRF 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 Behaviour[23], 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 intent[24]. 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.

[23] 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.
[24] 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 behaviour[25]. 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 merged because a new variable was incorporated into the data collection for the majority of prisons/ incidents (68.5% ; 139) at the beginning of the 2019 calendar year

Calculation of prison rates of self-harm

The annual person-based rate of self-harm in 2019 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 IPS for each day of 2019. The average of these daily populations was used as the estimated prison population for 2019. 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.

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

Setting and coverage

There are twelve institutions in the IPS 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 2019 was 3,971. On average 95.7% (n=3,801) were male and 4.3% (n=170) were female[7]. Of those in custody, an average of 17.8% 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 2019[26], was between 5 and 10 years (21.6%), followed by 3 to 5 years (19.3%), under 1 year (15.5%), 1 to 2 years (13.0%), 2 to 3 years (11.7%), life (11.4%), and 10 or more years (7.5%) (See figure 2). Overall, the age profile of male and female sentenced prisoners is similar (see figure 3). For both sexes, there is a concentration of prisoners in the age ranges of 30-39 years and 40+years[27].

Table 1. Prison characteristics and demographics, 2019

	Security	Prison population	On remand	Single cell	Shared cell
Arbour Hill	Medium	135	0.7%	69.9%	30.1%
Castlerea	Medium	306	20.3%	51.2%	48.8%
Cloverhill	Medium	400	81.5%	12.5%	77.4%
Cork	Medium	291	20.3%	12.5%	87.5%
Limerick (M)	Medium	215	36.3%	37.4%	62.6%
Limerick (F)	Medium	36	19.4%		
Loughan House	Low(open)	106	-	64.1%	35.9%
Midlands	Medium	840	8.8%	40.5%	59.5%
Mountjoy	Medium	684	5.6%	100.0%	-
Dóchas Centre (F)	Medium	134	26.9%	38.5%	61.5%
Portlaoise	High	232	3.4%	61.7%	38.3%
Shelton Abbey	Low(open)	102	-	35.8%	64.2%
Wheatfield	Medium	490	3.7%	68.9%	31.1%
Male		3,801			
Female		170			
Total		3,971	17.8%	51.9%	45.2%

[26] Irish Prison Service. (2019). *Sentence length of sentenced prisoners in custody on November 30th, 2019*
[27] Irish Prison Service. (2019). *Age Profile classified by gender of sentenced prisoners on November 30th, 2019*.

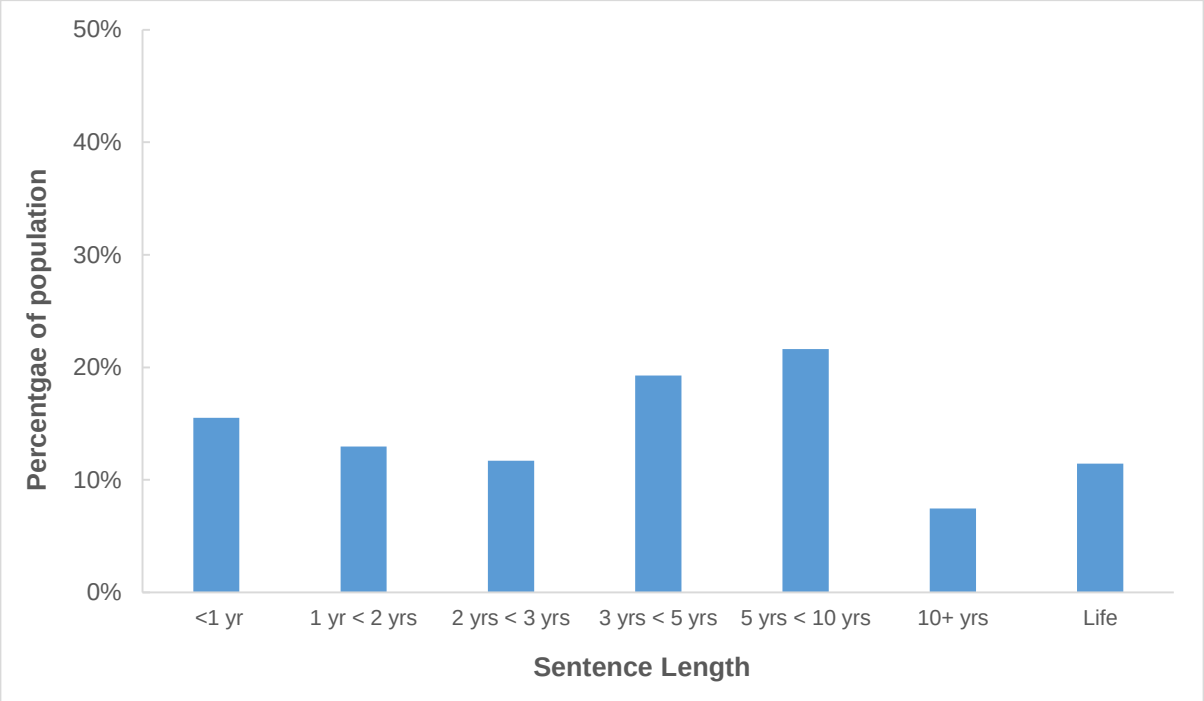

Figure 2. Sentence length of prisoners in custody on an arbitrary date in 2019

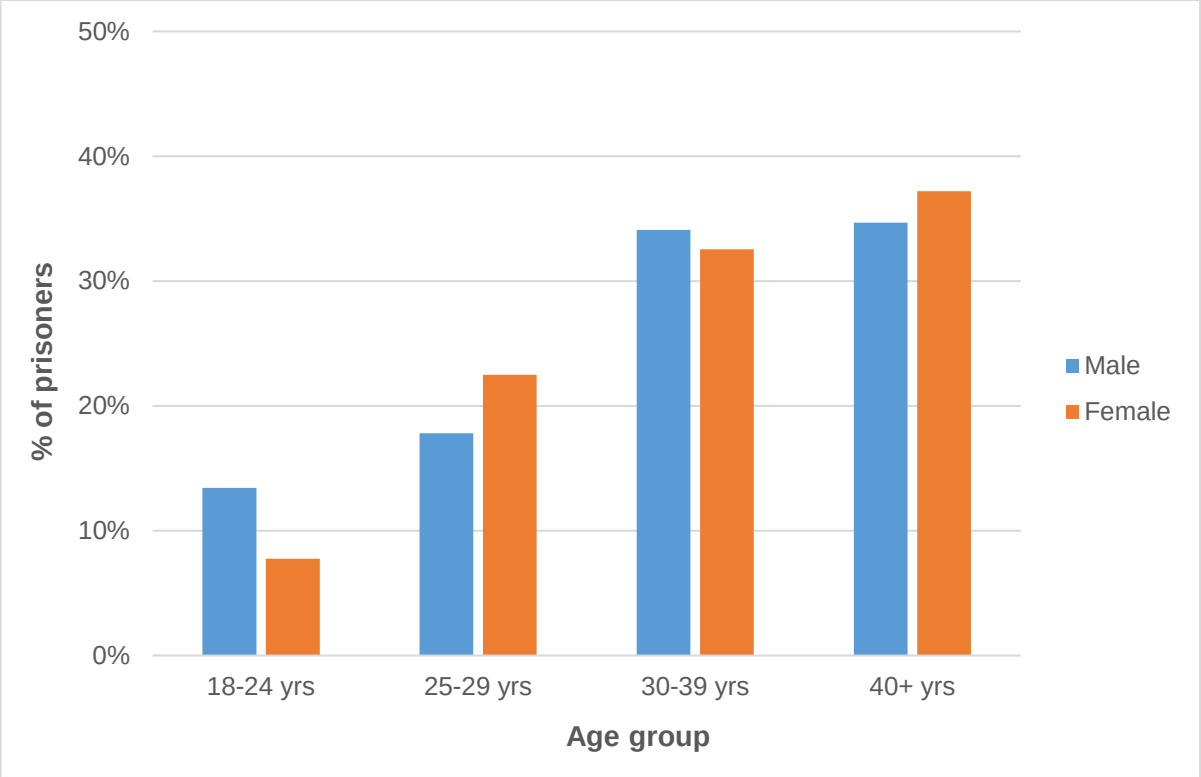

Figure 3. Age group of sentenced prisoners in custody on an arbitrary date in 2019

Self-harm in Irish Prisons 2019

Between 01 January and 31 December 2019, there were a total of 203 episodes of self-harm, involving 109 individuals. The number of self-harm incidents was 25% lower than 2018 and the number of persons involved decreased by 27%.

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 2019. The average number of persons in custody (sentenced and on remand/ awaiting trial) in 2019 was 3,971. Thus, the annual rate of self-harm was 2.9 per 100 prisoners, representing 3% of all prisoners, 29% lower than 2018 when a rate of 4.1 per 100 was recorded. The rate of self-harm among female prisoners was 8 times higher than males (19.8 versus 2.4 per 100). The rate of self-harm among female prisoners was 3% higher than 2018 (19.8 versus 19.3 per 100) with 24 females engaging in self-harm in 2019 compared to 26 in 2018. The male rate decreased sharply by 31% (2.4 versus 3.5 per 100).

The rate of self-harm for sentenced prisoners was 2.3% and 5.7% for prisoners on remand. The rate of self-harm among prisoners on remand was 8% higher than 2018 (5.7 versus 5.3). Correspondingly, there was almost a 39% decrease in the rate among sentenced prisoners (2.3 versus 3.8).

Table 2. Rate of self-harm among Irish prisoners, 2019

	Individuals	Episodes	Rate per 100 (95% CI)
Total	109	203	2.9 (2.4-3.5)
Male	85	136	2.4 (1.9-2.9)
Female	24	67	19.8 (13.1-28.1)
Sentenced	69	120	2.3 (1.8-2.9)
On remand	40	83	5.7 (4.1-7.6)

The majority of prisoners who engaged in self-harm were male (85; 78.0%). Overall, the average number of persons in prison in 2019 was made up of 3,801 (95.7%) men and 170 (4.3%) women. The mean age was 32 years (range 18-68 years). Half of male prisoners (54.1%) were aged between 18 and 29 years, while the majority of female prisoners (70.8%) were aged 30-49 years.

The rate of self-harm among sentenced prisoners was highest, at 3.4 per 100, among those aged 18-29 years. Rates among prisoners aged 18-29 years were 40% lower than the 2018 calendar year (5.7 v 3.4 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.

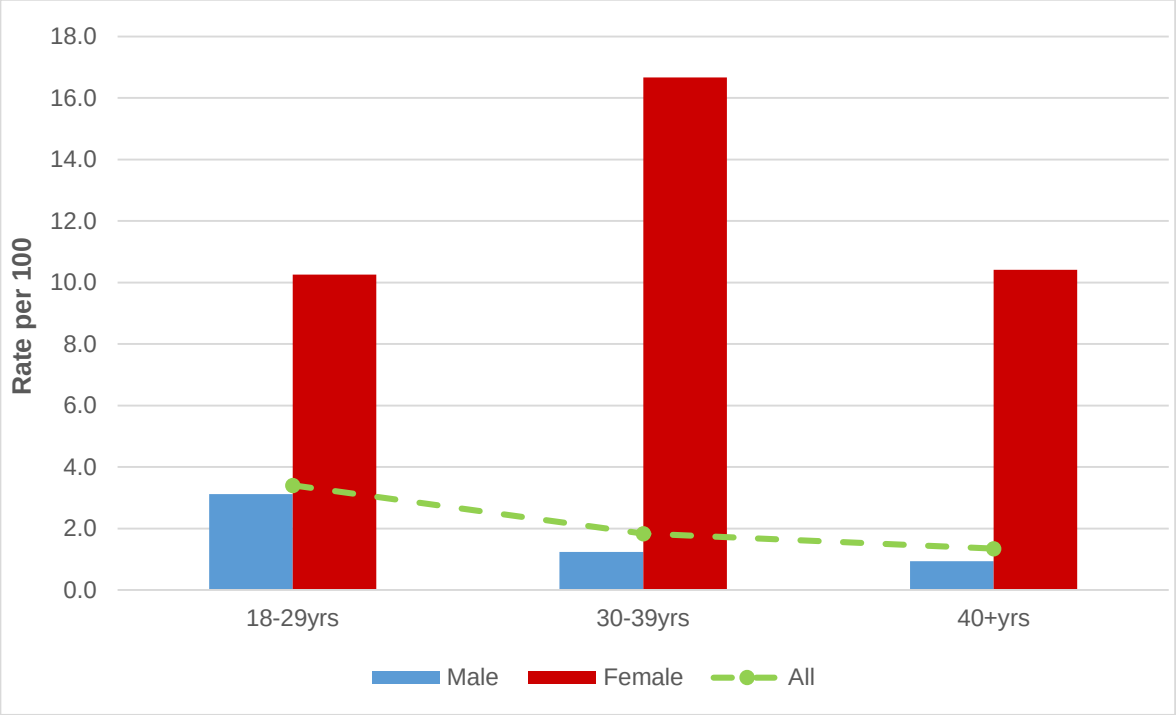

Figure 4. Age-specific rate of self-harm among sentenced prisoners (per 100 prisoners) in 2019

Self-harm by time of occurrence

Patterns of self-harm varied according to the day of the week. The number of episodes which occurred on Thursdays (19.2%) were above average (see figure 5).

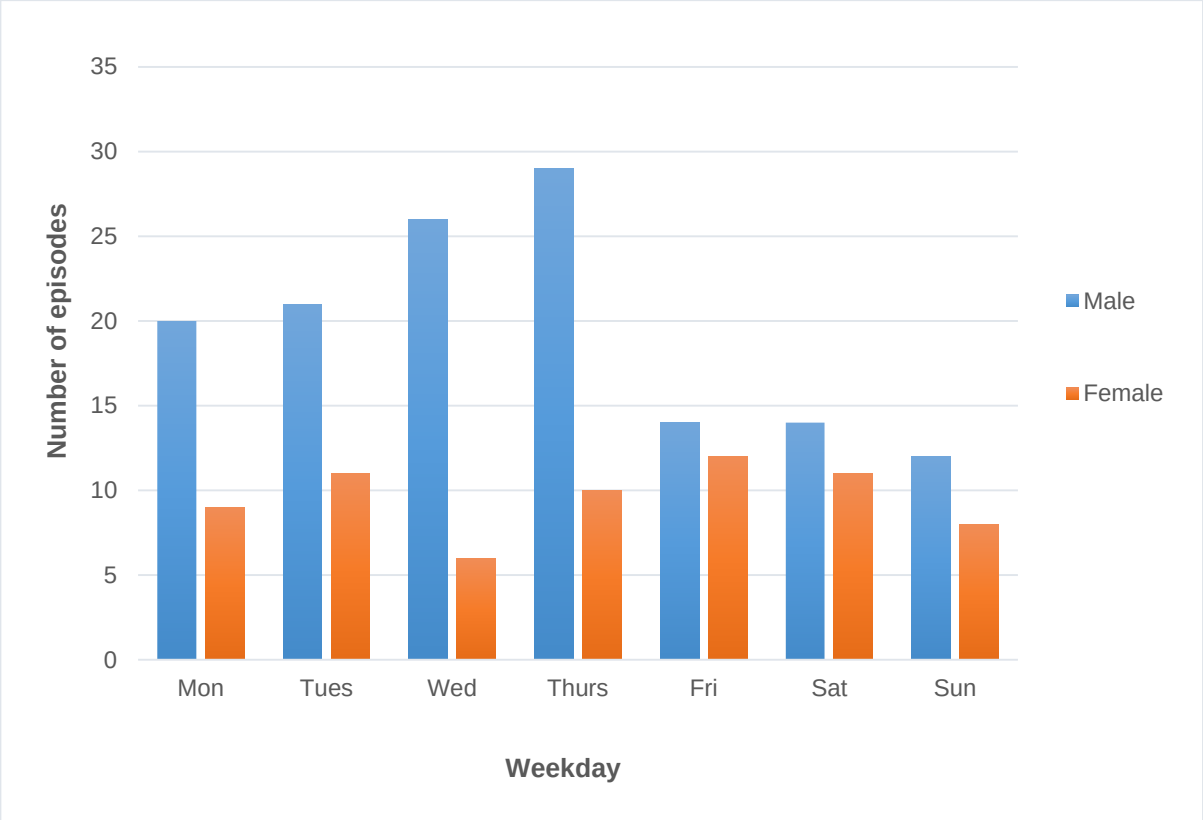

Figure 5. Number of episodes by weekday

The monthly average number of episodes of self-harm was 17. The observed number of self-harm episode fluctuated by month from 6 in February to 26 in January (see figure 6).

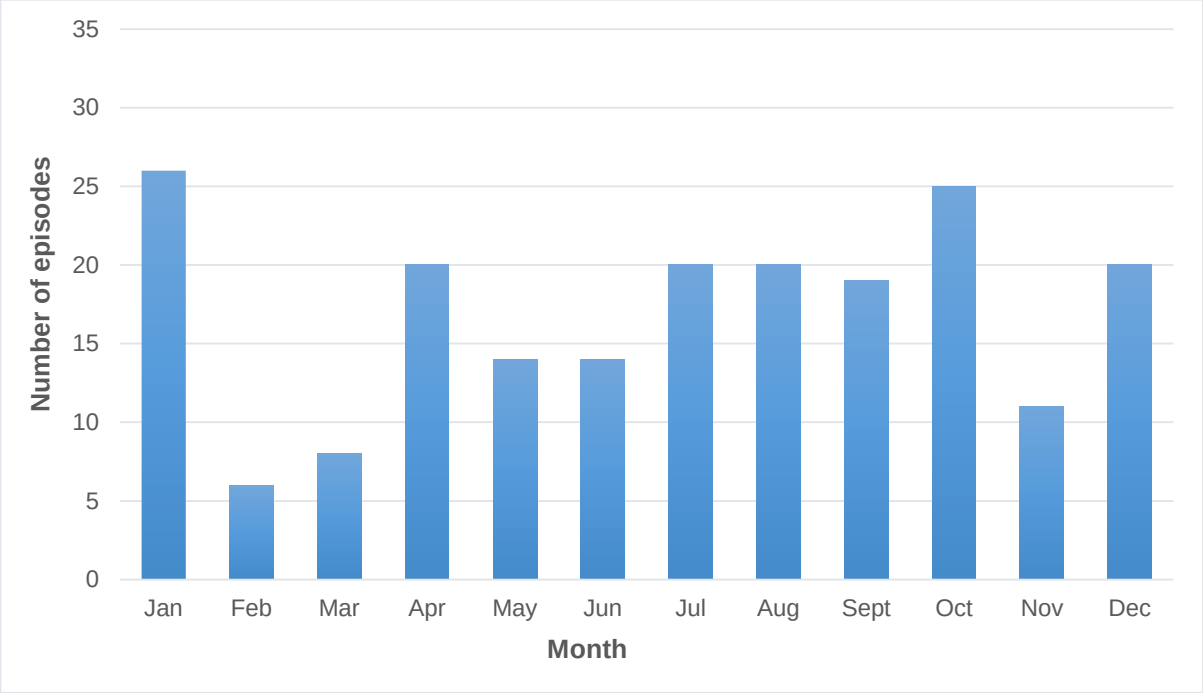

Figure 6. Number of episodes by month of occurrence

Analoguous with 2018, the number of episodes of self-harm gradually increased during the day. A sharp peak was observed in the afternoon and early evening, with 51.7% of episodes occurring between 2pm and 8pm. The majority (59.1%) 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 (61.2%) and those who were on protection (51.4%). 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.

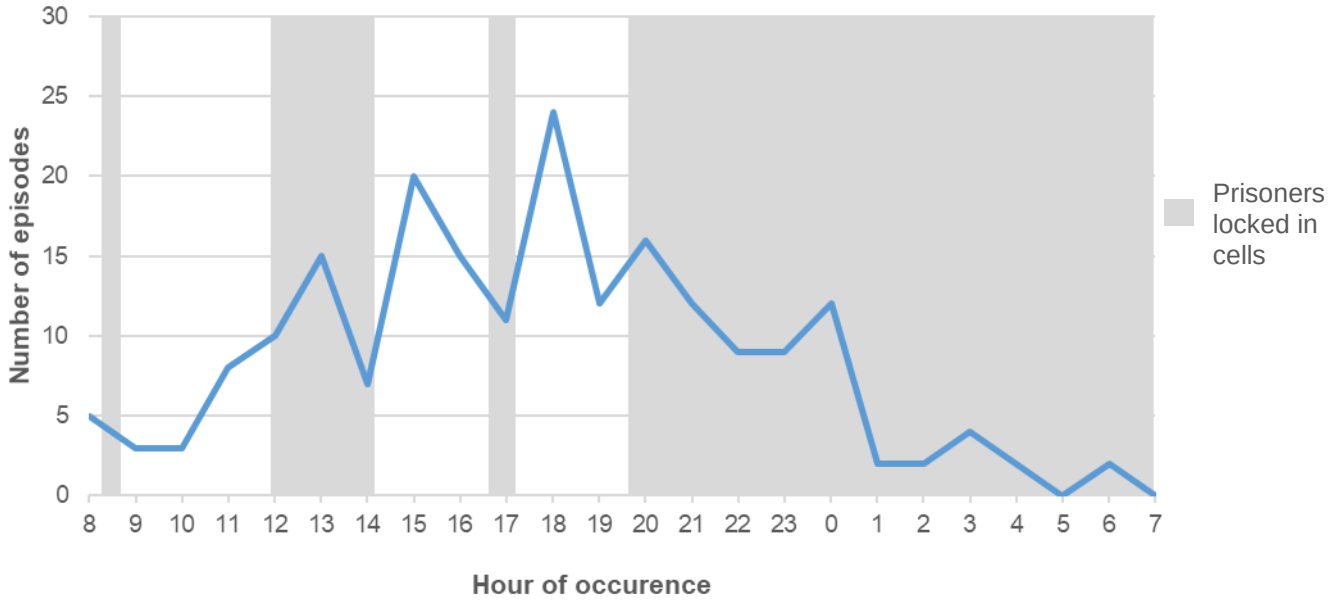

Figure 7. Hour of self-harm episode

Repetition of self-harm

Almost half (46.3%) of all episodes were due to repeat self-harm (n=94). The person-based rate of repetition was 33.9%, implying that 37 individuals had self-harmed more than once. The rate of repetition was higher for female prisoners (50.0% vs. 29.4%). A small number of individuals engaged in self-harm more than ten times in 2019.

Method of self-harm

The most common method of self-harm recorded was self-cutting (n=132; 64.7%). Self-cutting was involved in 70.5% of male episodes and 52.3% of female episodes. Attempted hanging (n=43; 21.1%), chemical/noxious substances (n=10: 4.9%), blunt objects (n=8; 3.9%) and intentional drug overdose (n=6; 2.9%) were the only other common methods of self-harm (see table 3).

Table 3. Method of self-harm

	Cutting	Attempted hanging	Blunt objects	Chemical/ noxious substances	Intentional Overdose	Other
All	132 (64.7%)	43 (21.1%)	<10 (3.9%)	10 (4.9%)	<10 (2.9%)	<5 (1.0%)
Male	98 (70.5%)	25 (18.0%)	<10 (5.0%)	<5 (<1%)	<10 (2.2%)	<5 (1.4%)
Female	34 (52.3%)	18 (27.7%)	<5 (1.5%)	<10 (13.8%)	<5 (4.6%)	0 (0.0%)

Prisoner accommodation/ cell type and sentence

In line with 2018, the majority of self-harm episodes involved prisoners who were in single cell accommodation (138; 68.0%). Of the overall prison population, 51.9% are housed in single cell accommodation, based on a snapshot of the prison population on an arbitrary date in 2019[10]. Regarding prisoner accommodation, 35 (17.2%) self-harm episodes involved prisoners on protection (Rule 62 and Rule 63), compared with 63.6% (n=129) involving general population prisoners. Seven (3.4%) self-harm episodes involved prisoners in a High Support Unit. Nine episodes (4.4%) occurred while the individual was placed in a Safety Observation Cell, 21 (10.3%) occurred while the individual was placed in a Close Supervision Cell (CSC) and under five episodes (1.0%) 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 (SP)	High support unit (HSU)	Close supervision cell (CSC)	Safety observation cell (SOC)
129 (63.5%)	35 (17.2%)	<5 (1.0%)	7 (3.4%)	21 (10.3%)	9 (4.4%)

The majority (120; 59.1%) of self-harm episodes involved sentenced prisoners, while 40.9% (n=83) were on remand/ awaiting trial at the time of the self-harm episode. Considering sentenced prisoners, the highest proportion (65; 54.1%) were serving a sentence of more than three years, with 18.3% serving a sentence of 5 to 10 years (see figure 8).

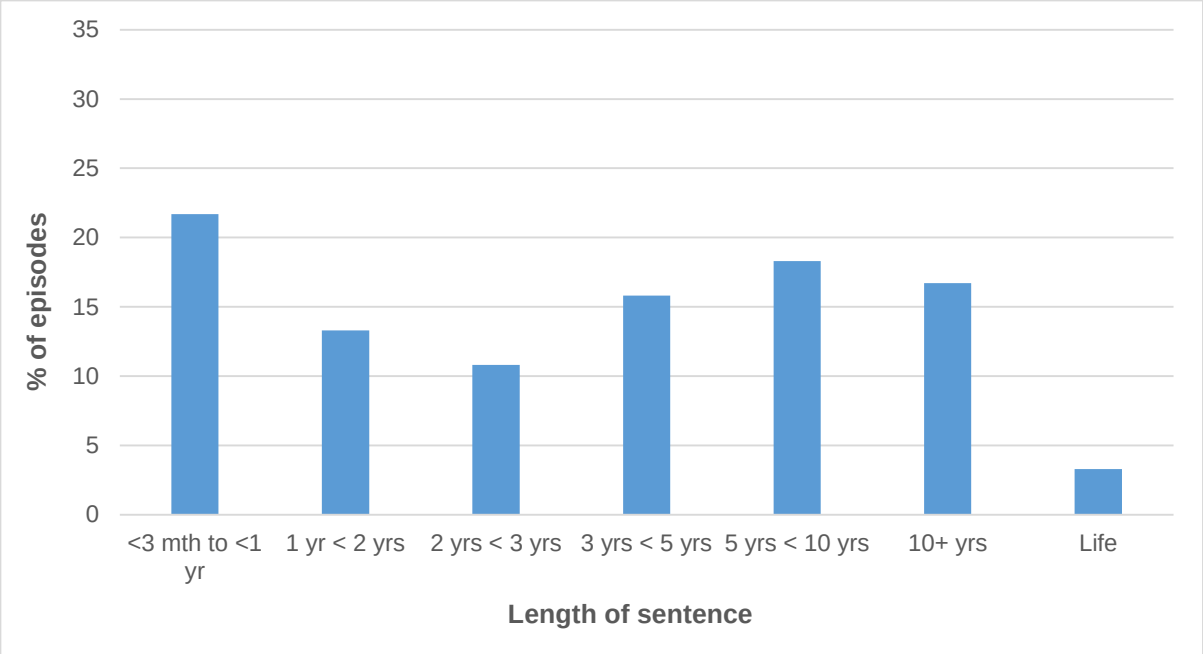

Figure 8. Length of sentence being served (sentenced prisoners)

More than one-third of self-harm episodes occurred in the third trimester of a sentence (48; 41.4%), with 28.4% occurring in the first trimester and 30.2% in the second trimester (See Figure 9).

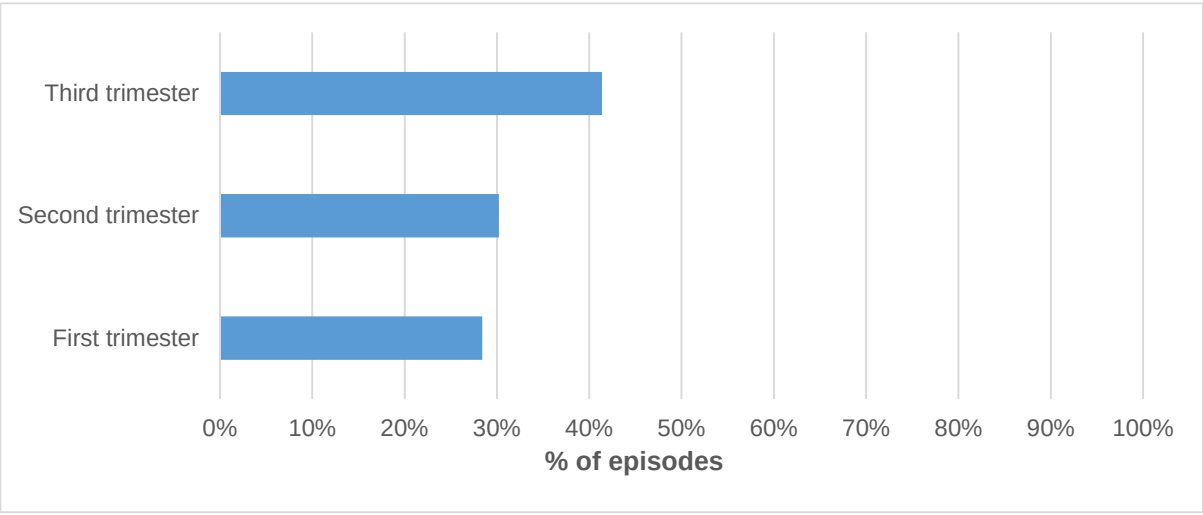

Figure 9. Trimester of sentence in which self-harm occurred

The highest proportion of episodes involved prisoners on a standard regime level (95; 46.8%), 94 (46.3%) were on an enhanced regime, and one in fourteen were on a basic regime (14; 6.9%).

Recommended next care, severity and intent

For almost one third (63; 31.0%) of self-harm episodes, no medical treatment was required. Half of all episodes (101; 49.8%) required minimal intervention/ minor dressings or local wound management. One in six required hospital outpatient or accident and emergency department treatment (31; 15.3%)[28]. During this period, eight self-harm acts involved admission to hospital or ICU or loss of life (4.0%) (see Table 5). Self-harm episodes by male prisoners were associated with increased severity – 82.4% of males who self-harmed required treatment compared with 41.8% 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
63 (31.0%)	71 (35%)	30 (14.8%)	31 (15.3%)	8 (4.0%)

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 15.2%, (n=20) required hospital outpatient or accident and emergency department treatment. Similarly, self-harm with a blunt object had no fatal outcomes but 25.0% (n=<5) of episodes required hospital outpatient or accident and emergency department treatment. Additionally, 11.6% (n=5) of episodes involving attempted hanging required hospital outpatient or accident and emergency department treatment and fewer than five episodes (9.3%) resulted in admission to hospital or ICU or loss of life. Fifty percent of episodes (n=<5) involving intentional drug overdose required hospital outpatient or accident and emergency department treatment and 16.7% (n=<5) resulted in admission to hospital or ICU or loss of life.

Consistent with 2018, two thirds (140; 69.0%) of self-harm episodes were recorded as having no/ low intent, with one fifth (45; 22.2%) recorded as having medium intent. Approximately one in eleven acts were rated as having high intent (18; 8.9%) (see figure 10). Suicidal intent varied according to the method involved in the self-harm episode – high intent was recorded in one quarter of attempted hanging episodes (10; 23.3%), while high intent was only recorded in 12.5% (n=<5) of episodes involving blunt objects, 10% of episodes involving chemical/noxious substances (n=<5) and 4.5% of episodes involving self-cutting (n=6).

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

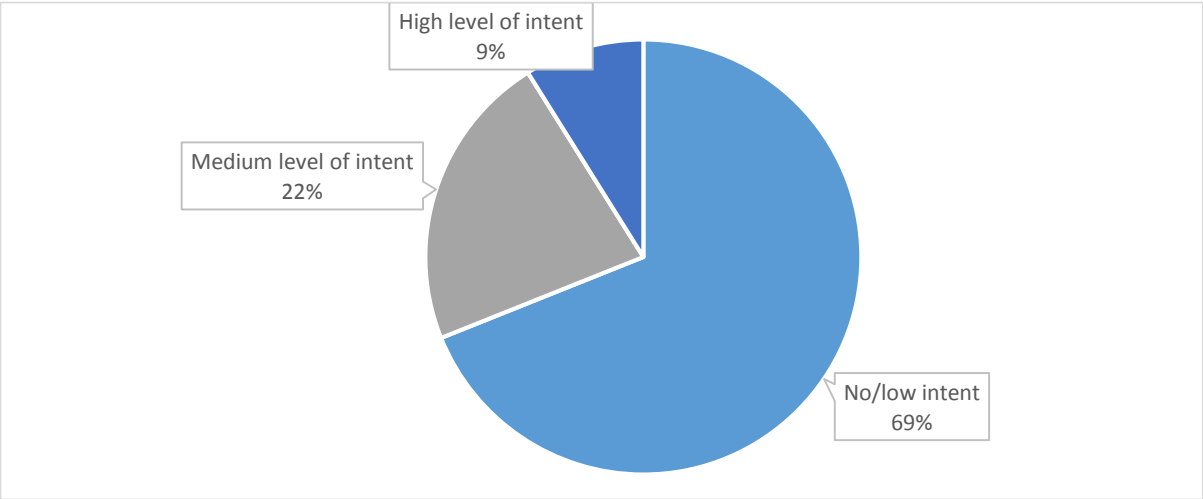

Figure 10. Level of intent associated with self-harm episode

Among those requiring no/minimal treatment, the majority (77.8%) were deemed to have no/low intent, 19.0% to have medium intent and 3.2% to have had high intent. Among those requiring local wound management 60.0% were deemed to have no/low intent, 26.7% to have medium intent and 13.3% to have had high intent.

The eight 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 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	49 (35.0%)	55 (39.3%)	18 (12.9%)	15 (10.7%)	<5 (2.1%)
Medium level of intent	12 (26.7%)	12 (26.7%)	8 (17.8%)	12 (26.7%)	<5 (2.2%)
High level of intent	<5 (11.1%)	<5 (22.2%)	<5 (22.2%)	<5 (22.2%)	<5 (22.2%)

Contributory factors

Contributory factors were organised into five themes: environmental, relational, procedural, medical, personal and mental health. The majority of contributory factors recorded related to mental health (217; 56.2%), a further 68 (17.6%) to relational issues, 46 (11.9%) to environmental issues, and 39 (10.1%) related to procedural issues (see figure 11) [29,30].

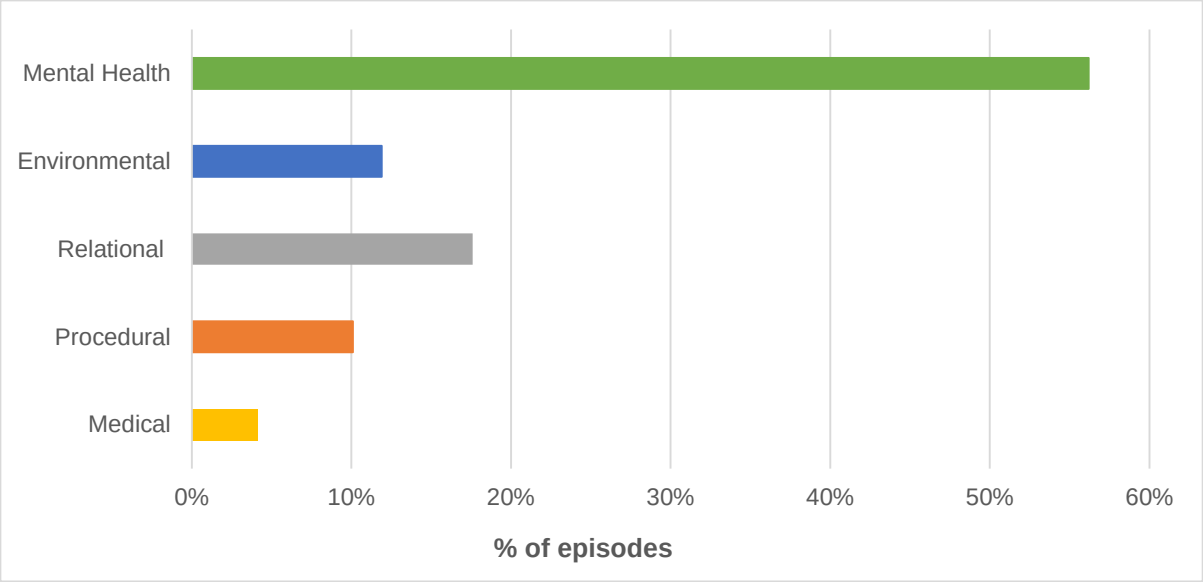

Figure 11. Themes of contributory factors in self-harm episodes

Environmental

Accommodation or cell type (shared/ single) was the most common environmental contributory factor (17; 8.4%). Other environmental factors reported included reduced access to regime (9; 4.4%) often causing isolation and lack of stimulation, to orchestrate access to contraband/other instrumental gain (5; 2.5%) and adjustment issues (3; 1.5%). Legal issues were a contributory factor in 3.0% of episodes. Legal issues reported included pending charges, court case, recently convicted, first time in custody, and unexpected custody.

[29] More than one contributory factor could be recorded for each episode
[30] Information on contributory factors was merged because a new variable was incorporated into the data collection for the majority of prisons/incidents (68.5% ; 139) at the beginning of the 2019 calendar year.

Procedural

Transfer issues (transfer, denied transfer, moved to CSC) was the most common procedural contributory factor (n=13, 6.4%). There were fewer than five incidents involving protection issues (e.g. Rule 62/63) (2.5%), disciplinary issues such as having been served a P19 disciplinary report (2.0%), denied TR/remission or breached TR (1.0%) and denied visit/placed on screened visits (<1%).

Relational

Relationship issues with significant others, including friends/family and reduction in family or access to community support(s) were factors in 7.4% of incidents. Relationship difficulties with other prisoners, including conflict, being under threat or victimized/bullied, gangland involvement and peer pressure, were a factor in one in seventeen episodes (5.9%). Death or anniversary of death of someone close was associated with 5.4% of incidents. Relationship difficulties between prisoners and staff were a contributory factor in 2.0% of self-harm episodes. Child custody or access were reported in a minority of episodes (<1%). Transfer or release of supportive family member/friend/associate and loss of family or intimate relationship were seldom reported (<1%).

Medical

Medication issues (e.g. poor medication compliance, admin issues and drug seeking) were reported in 6.9% of episodes. Chronic pain and new diagnosis or worsening symptoms were reported in under 1% of episodes, respectively.

Mental health

Mental health issues were the most common contributory factor across all themes (n=90, 44.3%). The category of mental health issues includes mental disorders (mood disorder, anxiety, PTSD, eating disorder, psychosis, personality disorder), as well as problems with hopelessness/low mood. Poor coping/difficulties managing emotions was the next most common factor recorded in 29.1% of incidents (n=59). Substance misuse and addiction, including drug use, as well as drug seeking, was in recorded in 19.2% of episodes (n=39). Impulsivity was recorded as a contributory factor in 12.3% of self-harm episodes.

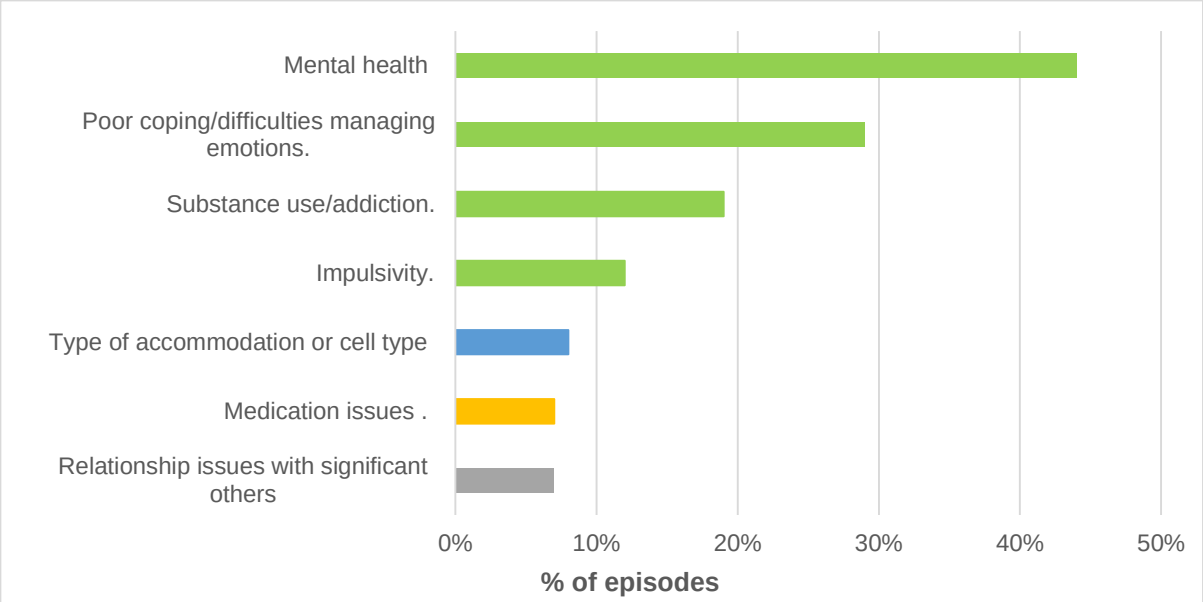

Figure 12. Most common contributory factors

Theme	Contributory factor	Number of episodes	% of episodes
Environmental	Type of accommodation or cell type.	17	8%
	Reduced access to regime.	9	4%
	Legal issues.	6	3%
	To orchestrate access to contraband	5	2%
Procedural	Transfer issues.	13	6%
	Protection issues (e.g. Rule 62/63).	5	2%
	Recent P19, reduction in incentivized regime	<5	2%
	Denied TR/remission or breached TR.	<5	1%
	Denied visit/placed on screened visits.	<5	<1%
Relational	Relationship issues with significant others	15	7%
	Relationship difficulties with other prisoners	12	6%
	Death or anniversary of death of someone c	12	5%
	Relationship difficulties with staff.	<5	2%
	Child custody/access issues.	<5	1%
	Bullying/threatening/victimizing others.	<5	<1%
Medical	Medication issues	14	7%
	Chronic pain	<5	1%
	New diagnosis or worsening symptoms	<5	<1%
Mental health	Mental health (e.g. mood disorder, anxiety, F	90	44%
	Poor coping/difficulties managing emotions.	59	29%
	Substance use/addiction.	39	19%
	Impulsivity.	25	12%

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

IRISH PRISON SERVICE

SADA
Self-harm Assessment & Data Analysis

Prison		Accommodation	
Prisoner #		Cell Type	
Age		Sentence Length	
Gender		Trimester	
Method of Self Harm		Legal Status	
Date/Time of Incident		Most Serious Offence	
Location of Incident		Monitoring Level	
Alone/In Company		Regime Level	

Brief description of Incident

	SEVERITY							
INTENT	No treatment required.	No treatment required.	Minimal intervention/minor dressing.	Local wound management.	Outpatient/A&E treatment.	Hospital/ Intensive Care	Loss Of Life	
	High level of intent - Evidence of thoughts, ideation and planning of self-harm or suicide.							
	Medium level of intent – Some level of thoughts, premeditation, planning.							
	No/low intent – No thoughts, no plan or premeditation.							

Code		Contributory Factor	Primary	Secondary	Please Describe
ENVIRONMENTAL	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.			
PROCEDURAL	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	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	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	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	MH1	Mental health (e.g. mood disorder, anxiety, PTSD, eating disorder, psychosis, personality disorder, hopelessness/low mood etc). ** Where MH1 is identified, further information should be supplied:*			
	MH2	Substance use/addiction.			
	MH3	Poor coping/difficulties managing emotions.			
	MH4	Impulsivity.			