Seirbhís Phríosúin na hÉireann
Irish Prison Service

2024 REPORT

SELF-HARM IN IRISH PRISONS

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

September 2025

National Suicide Research Foundation

Seirbhís Phríosúin na hÉireann
Irish Prison Service

Connecting for Life

Ceanncheathrú Sheirbhís Phríosúin na hÉireann, Páirc Ghnó an ÚFT, Bóthar Bhéal Átha na Lao, An Longfort N39 A308
Irish Prison Service Headquarters, IDA Business Park, Ballinalee Road, Longford N39 A308
T +353 43 333 5100 | www.irishprisons.ie | Email: info@irishprisons.ie

Authors

This report was authored by Kerrie Gallagher, Paul Corcoran and Eve Griffin from the National Suicide Research Foundation, and Sarah Hume – Principal Psychologist, and Enda Kelly – National Operational Nurse Manager, and Connecting for Life Lead, from the Irish Prison Service. The report is supported by the HSE 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 (2015-2024)*[1].

Suggested citation: Gallagher K, Griffin E, Kelly E, Hume S, Corcoran P (2024). Self-harm in Irish Prisons 2024 – Sixth report from the Self-Harm Assessment and Data Analysis (SADA) Project: Irish Prison Service/National Suicide Research Foundation.

Acknowledgements

Dr Emma Regan	*Irish Prison Service*
Ms Marie O'Connor	*Irish Prison Service*
Ms Gemma Cox	*HSE National Office for Suicide Prevention*
Ms Sofia Bettella	*National Suicide Research Foundation/UCC*

All members of the *National Suicide and Harm Prevention Steering Group*

All members of the local *Suicide and Harm Reduction Meetings*, who play a pivotal role in collecting data to support this project.

Foreword

Welcome to the sixth annual Self-Harm Assessment and Data Analysis (SADA) Report, presenting findings from across the Irish Prison Service estate for the year 2024. This report offers a detailed account of all recorded episodes of self-harm and suicide, providing critical insights into patterns, risk factors, and responses within prison settings. It forms part of our ongoing commitment to safeguarding the health and wellbeing of people in custody and enhancing the standard of care within our services.

The SADA Project remains a key action under Connecting for Life, Ireland's national strategy to reduce suicide, and aligns closely with the goals of the Irish Prison Service Strategy 2023–2027. Together, these frameworks guide our efforts to monitor and reduce the incidence of self-harm in prisons through evidence-informed interventions, cross-sector collaboration, and system-wide learning.

The continued success of the SADA initiative is made possible by the dedication of prison staff and multi-disciplinary teams working across all facilities. Their vigilance and professionalism ensure that each episode is accurately recorded, reviewed, and responded to with appropriate care. The partnership with the National Suicide Research Foundation (NSRF) and the National Office for Suicide Prevention (NOSP) has been instrumental in ensuring that data are not only gathered but rigorously analysed and applied to policy and practice.

This year's report reflects our strengthened focus on prevention, early identification, and coordinated care. It also reaffirms our commitment to evidence-based approaches that protect the most vulnerable individuals in our care. As we continue to embed this work within our operational and strategic planning, we aim to build on existing progress and develop further measures that promote a safer, more responsive prison environment.

I would like to thank everyone involved in the compilation of this report and in the ongoing delivery of this important work. Your commitment plays a vital role in advancing our shared goal of reducing self-harm and supporting positive mental health outcomes across the prison system.

Caron McCaffrey

Director General, Irish Prison Service

CONTENTS

Executive Summary

This sixth annual report provides a comprehensive overview of all recorded episodes of self-harm among individuals in the custody of the Irish Prison Service. It presents national data collected across all prisons in the Republic of Ireland during the 2024 calendar year as part of the Self-Harm Assessment and Data Analysis (SADA) Project – a collaborative initiative aimed at monitoring, understanding, and ultimately preventing harm to self in custodial settings[2].

The report analyses 203 self-harm episodes involving 142 individuals, providing insights into nature, and characteristics of self-harming behaviour in Irish prisons. Each episode was documented using a standardised assessment form completed by trained prison staff, enabling a consistent and detailed dataset. The analysis explores key variables including demographics, methods of self-harm, frequency and timing of incidents, and the contextual and contributory factors involved.

The report includes year-on-year comparisons where relevant, highlights notable shifts in patterns, and presents visual summaries to support interpretation. It also draws attention to periods of elevated risk (e.g. specific times of day or months of the year) and population subgroups who may be particularly vulnerable, such as those on remand. Visual summaries are included throughout to support interpretation and accessibility of the findings.

In addition to describing patterns of self-harm, the report highlights areas where targeted interventions and enhanced supports may be required. The findings are intended to inform prison policy, staff training, healthcare provision, and suicide and self-harm prevention strategies. By systematically tracking trends and identifying emerging concerns, the SADA Project continues to provide a vital evidence base for strengthening care pathways, safeguarding prisoner wellbeing, and supporting the Irish Prison Service in its ongoing efforts to reduce self-harm in custody.

Main findings

- **Overall incidence:** In 2024, a total of 203 self-harm episodes were recorded involving 142 individuals, marking a 46% decrease in episodes and a 39% decrease in individuals compared to 2023.

- **Gender and age trends:** Most prisoners who engaged in self-harm in 2024 were male (*n*=122; 85.9%). While females accounted for a smaller proportion (*n*=20; 14.1%), their person-based rate of self-harm (12.7 per 100 prisoners) remained substantially higher than that of males (2.9 per 100 prisoners). Most individuals who self-harmed were aged between 18 and 39 years.

- **Methods of self-harm**: As with previous years, cutting was the most common method, accounting for over half of all recorded episodes. Other frequently used methods included ligaturing, overdose, and use of blunt objects. Hanging was used in the three episodes that tragically resulted in loss of life.

- **Timing:** Most self-harm episodes occurred between 2pm and 8pm, accounting for the largest incidence of self-harm, followed by the late evening period (8pm–12am). Episodes were distributed across all days of the week, with slightly higher proportions recorded on Tuesdays, Wednesdays, Fridays, and Saturdays.

- **Repetition:** Nearly one in five individuals who engaged in self-harm did so on more than one occasion. Females had slightly higher repetition rates than males. Repeat self-harmers accounted for a disproportionate share of the total number of episodes.

- **Medical interventions**: Most episodes required only minor or no medical intervention. However, a notable proportion required local wound management or hospital treatment, while three incidents tragically resulted in loss of life.

- **Contributory factors:** The most recorded contributory factors were mental health difficulties, substance misuse, interpersonal conflict, and stressors linked to imprisonment (e.g., court dates, family separation, or bereavement). Multiple contributory factors were often noted for the same incident, highlighting the complex and multifactorial nature of self-harm in prison settings.

Recommendations

The findings of this report highlight the complex and multifaceted nature of self-harm in Irish prisons, underscoring the need for coordinated, evidence-based responses. While progress has been made in recognising and addressing self-harm, gaps remain in assessment, continuity of care, and targeted interventions for high-risk groups. To strengthen prevention and support efforts, a series of priority recommendations are proposed. These focus on enhancing the integration of mental health and addiction care, improving pathways between prison and community services, ensuring robust assessment at committal, and delivering sustained, tailored support for individuals who repeatedly self-harm. Together, these measures aim to reduce self-harm incidence, improve prisoner wellbeing, and ensure that responses are both consistent and compassionate across the prison system.

1. IMPLEMENT A DUAL DIAGNOSIS MODEL OF CARE

Implement a prison-wide dual diagnosis model of care that recognises and addresses the complex interplay between mental health disorders and substance misuse, both of which are highly prevalent among individuals who engage in self-harm. This model must ensure that assessment, treatment, and care planning are fully integrated, with close collaboration between mental health and addiction services[3,4].

Key elements include:

- Comprehensive screening for both mental health difficulties and substance misuse at committal
- Joint care planning between mental health professionals, addiction counsellors, and prison healthcare staff
- Delivery of evidence-based interventions and relapse prevention strategies adapted for the prison environment[3,4].
- Maintenance of continuity of care through active follow-up and integrated support during prison transfers and post-release, ensuring re-engagement of treatment upon return to the community.

2. STRENGTHEN HSE AND COMMUNITY LINKS AT COMMITAL AND POST-RELEASE

Continuity of care between prison and community-based health services is often disrupted, and many individuals disengage from services once released[5]. To address this, it is recommended that stronger, more formalised pathways be established between the Health Service Executive (HSE), community-based support services, and the Irish Prison Service to ensure seamless care transitions both at committal and following release. This reflects the priorities set out in Sharing the Vision (2025–2027 implementation plan)[6], which emphasises recovery-oriented, trauma-informed, and human rights-based approaches, and meaningful co-production with experts by experience. It is also consistent with Connecting for Life (suicide and self-harm reduction)[1], Pathways to Wellbeing (a whole-of-government wellbeing strategy)[7], and the forthcoming national digital mental health strategy[8].

Recommendations include:

- Developing **information-sharing protocols** to ensure timely transfer of medical and mental health records at committal[6,9].
- Embedding **pre-release planning** with joint input from prison and community service providers to maintain continuity of mental health, addiction, and primary care.
- Establishing **active referral and handover processes** to HSE and NGO services post-release, with clear accountability to prevent treatment gaps.
- Creating a **collaborative aftercare framework** to support reintegration, relapse prevention, and ongoing mental health stability[6,9].

3. ENHANCED COMMITAL ASSESSMENTS

Committal assessments should be enhanced in scope, depth, and consistency to better identify the risk of self-harm, suicide, and complex healthcare needs at the earliest opportunity. Assessments should be holistic, addressing mental health, substance use, medical and trauma histories, literacy levels, social circumstances, protective factors and emerging conditions such as ADHD and autism, which are increasingly prevalent in mental health presentations[10–12]. Validated screening tools for suicide/self-harm risk, dual diagnosis, and

other relevant conditions should be embedded. This approach reflects Sharing the Vision principles of integration, co-production, and human rights, and aligns with national priorities in dual diagnosis, early intervention in psychosis, and ADHD/autism care pathways[6].

Recommendations include:

- Ensuring all assessments are **trauma-informed, culturally sensitive, and gender-responsive**[6,10].
- Providing **specialist training** for staff conducting assessments.
- Involving **multidisciplinary teams early** to coordinate care and reduce intervention delays.
- Exploring **involvement of experts by experience** in assessment and care planning to enhance person-centred approaches[6].

4. TARGETED SUPPORT FOR REPEAT SELF-HARMING

Individuals who repeatedly engage in self-harm represent a particularly vulnerable subgroup within the prison population. In 2024, nearly one in five prisoners who self-harmed engaged in multiple episodes, with females exhibiting slightly higher repetition rates. These individuals often have complex needs, including co-occurring mental health disorders, substance misuse issues, and histories of trauma or abuse[13]. Addressing this challenge requires the development of long-term, individualised care plans that move beyond reactive, incident-focused responses. Such plans should emphasise continuity of care, evidence-based, recovery oriented therapeutic interventions, and proactive monitoring, enabling early identification of escalating risk[10]. This approach is consistent with the five core values of *Sharing the Vision* – recovery, trauma-informed, human rights, value, and learning – and with *Connecting for Life*[1], which prioritises suicide and self-harm prevention, dual diagnosis services, and expanded crisis resolution teams. Innovative approaches such as social prescribing, alongside meaningful involvement of experts by experience in design and delivery should be explored.

Recommendations include:

- Developing **long-term, individualised care plans** that extend beyond reactive incident management.
- Ensuring **continuity of care** and access to evidence-based, recovery-oriented therapeutic interventions.
- Implementing **proactive monitoring systems** to identify escalating risk early.
- Strengthening **links to community supports** pre- and post-release to support recovery and prevent relapse.

Introduction

Self-harm among individuals in prison is a complex issue, which is shaped by a range of individual, social, and environmental factors [14]. This report presents the findings of the Self-Harm Assessment and Data Analysis (SADA) Project for the year 2024, offering an in-depth analysis of the extent and nature of self-harm across all Irish Prison Service institutions. It explores trends in incidence, repetition, severity, and intent, and identifies contributory factors that can help inform prevention and response strategies at both operational and policy levels.

The SADA Project is a collaborative initiative led by the Irish Prison Service and the National Suicide Research Foundation (NSRF), a World Health Organization Collaborating Centre for Surveillance and Research in Suicide Prevention [2]. Since its establishment in 2017, the project has played a central role in building an evidence base on self-harm in Irish prisons. Now in its sixth reporting cycle, SADA continues to support national efforts to reduce suicide and self-harm in custodial settings.

The findings of this report contribute directly to the implementation of *Connecting for Life*, Ireland's national strategy to reduce suicide, which identifies people in custody as a group requiring specific focus and tailored interventions [1]. In parallel, the report aligns with the strategic objectives of the Irish Prison Service Strategy 2023–2027 [15], which prioritises the development of safer prison environments, ongoing monitoring of self-harm and suicide, and the promotion of inter-agency collaboration to strengthen mental health responses.

Over time, SADA reports have consistently highlighted elevated rates of self-harm among specific subgroups, including younger individuals, those on remand, and women in custody. In earlier reporting years, self-harm among women in prison was found to be significantly higher than among men, while prisoners on remand demonstrated greater vulnerability than those serving sentences[2]. These patterns remain a concern in 2024 and underscore the need for targeted, recovery-oriented prevention strategies and gender- and trauma-informed care approaches.

Evidence consistently highlights the interplay of multiple vulnerabilities among those who self-harm in custody, with self-harm often co-occurring with complex mental health needs, substance misuse, and histories of trauma or abuse[14,16,17]. Research has also emphasised the importance of continuity of care between prison and community services, particularly at points of transition such as committal and release, when the risk of self-harm and suicide is heightened[18]. Environmental and relational stressors such as overcrowding, and limited family contact, continue to be recognised as significant contextual drivers.

By providing updated insights into the complexity of self-harm in custody, this report aims to support informed policy development, service planning, and staff training. It also seeks to contribute to wider discussions on the intersection of mental health, justice, and human rights in the Irish prison system.

Methods

Definition and terminology

For the purposes of this report, self-harm is defined as *any non-accidental act of self-poisoning or self-injury, regardless of the person's intent or the motivation behind the behaviour*. This definition was developed for the National Clinical Practice Guidelines[19] and is in line with the definition used by the National Self-Harm Registry Ireland. It encompasses a broad spectrum of behaviours, from those associated with suicidal intent to actions driven by emotional distress, a sense of hopelessness, loss of control, or self-punishment.

Inclusion criteria

An episode is considered to be self-harm if it involves engagement in any of the following behaviours:

- **Intentional overdose** involving prescription medications, illicit substances, and/or alcohol.
- **Self-inflicted injury**, such as lacerations, burning, gunshot wounds, attempted hanging, or attempted drowning.
- **Ingestion or insertion** of non-ingestible substances or objects, or other actions likely to result in physical harm (e.g. bleeding, bruising, or pain), where the intent to self-injure is evident.
- **Refusal of food and/or fluids**, regardless of the duration.

In all instances, there must be a reasonable indication that the act was carried out with the intention of causing harm to oneself, irrespective of the underlying motive or level of suicidal intent.

Exclusion criteria

Behaviours are not classified as self-harm where:

- There is **no evidence of intent** to cause self-injury or self-poisoning.
- The incident was **accidental** (e.g., unintentional overdose due to misjudged medication uses or recreational drug use without self-harm intent).
- Alcohol or drug intoxication occurs without any indication of self-harm motivation.
- The individual has a profound learning disability, and the behaviour is understood as a symptom or feature of the disability, rather than a deliberate act of self-harm.

Data collection process

Data on each episode of self-harm are recorded using the standardised SADA form by the multi-disciplinary team in each prison (Appendix 1), including prison staff and representatives from psychology, primary care, psychiatry and other relevant service providers involved with the person in custody. The form consists of four sections: (1) demographic information; (2) severity and intent matrix; (3) typology of prisoner; (4) contributory factors and is completed using a standard operating procedure outlined in the SADA manual.

Applying the case-definition and inclusion/exclusion criteria, episodes are identified and discussed at regular meetings of the multi-disciplinary team to assess for accuracy. A data set was developed from the SADA data collection form, including demographic information (sex and age), circumstances of the self-harm episode and prison-related information and typology. 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

All data collected through the SADA project are handled in strict accordance with data protection legislation, including the EU General Data Protection Regulation (GDPR, 2018). A formal Data Processing Agreement is in place between the Irish Prison Service and the National Suicide Research Foundation. No personal identifiers, such as names, are collected. Each individual is assigned a unique identifier based on their initials and Prisoner Information Management System (PIMS) number, allowing for the tracking of multiple incidents involving the same person while maintaining anonymity. All data are reported in aggregate form, with no information that could identify individuals included in any public outputs.

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.

PRISONER NUMBER

AGE

GENDER

ETHNICITY

The prisoner's ethnicity is recorded directly from their health records, which are accessible to the lead author in their role as an employee of the Irish Prison Service. Ethnicity is classified using the standard categories outlined by the Central Statistics Office.

OFFENCE TYPE

Reason for prisoner's conviction.

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 [20], this is taken as the most potentially lethal method employed.

SEVERITY/INTENT MATRIX

A measure of severity was developed based on physical consequences of the episode, ranging from 1 to 6, from no treatment required (1) to hospitalisation (5) and death (6). A measure of suicidal intent associated with the self-harm episode was developed based on the Beck Suicide Intent Scale (SIS)[21], ranging from 1 to 3, including no/low intent (no thoughts, no plan or premeditation) (1), medium level of intent (some level of thoughts, premeditation, planning) (2) and high level of intent (evidence of thoughts, ideation and planning) (3). A coding guide based on the items of the Beck SIS is used when assigning an intent score and was informed by subjective reporting from the prisoner and objective evidence[21]. Severity and intent are coded together on the "severity/intent matrix", a table with intent across the top and severity at the side where the act is be plotted to allow for the consideration of both components in relation to each other.

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.

LEGAL STATUS

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

SENTENCE LENGTH AND TRIMESTER

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

REGIME LEVEL

The prisoner's regime status at the time of the episode is recorded. The IPS Incentivised Regimes Policy provides for differentiation of privileges between prisoners depending on their regime level which is determined according to their level of engagement with services and quality of behaviour. 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[22].

CONTRIBUTORY FACTORS

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

Calculation of prison rates of self-harm

The annual person-based rate of self-harm in 2024 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 2024. The average of these daily populations was used as the estimated prison population for both years. 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.

Setting and coverage

The Irish prison system is made up of 13 institutions, which vary in terms of their security levels, physical infrastructure, and the population they accommodate. Of these, 10 are classified as traditional closed prisons, characterised by high levels of internal and perimeter security. In addition, there are two open centres, which operate with minimal internal and external security measures. These centres are typically used to accommodate prisoners nearing the end of their sentences, who are considered to pose a low risk and are often engaged in work, training, or education in preparation for reintegration into the community. The system also includes one semi-open facility -the Training Unit. This facility maintains traditional perimeter security but features minimal internal security. It is primarily used to accommodate older male prisoners.

Female prisoners in Ireland are held primarily in the Dóchas Centre, which is located on the grounds of Mountjoy Prison in Dublin. A smaller number of female prisoners are also accommodated in Limerick Prison, which houses both male and female populations in separate units (see Fig. 1).

Fig 1. The Irish Prison Service Estate

Source: Irish Prison Service Annual Report 2023

The average number of persons in custody across the Irish prison system was 4,941. On average 94.9% (n=4,690) were male and 5.1% (n=251) were female. Overall, the age profile of male and female sentenced prisoners is similar (see Fig. 2). The age distribution of sentenced prisoners was broadly similar for males and females, with the majority of individuals concentrated in the 30–39 and 40+ age groups [23]. Younger age groups (18–29 years) accounted for a smaller proportion of the population [23]. Of those in custody, close to one in five were on remand (19.1%), while the remainder of the prisoners were sentenced. Based on a snapshot of the prison population on arbitrary date, the most common sentence lengths were between 5 and 10 years (23.4%) and 3 to 5 years [24]. Males were more likely than females to be serving longer sentences, while females were more often serving shorter sentences of less than three years (see Fig 3).

Table 1. *Prison characteristics and demographics, 2024*

PRISON	SECURITY	PRISONERS IN CUSTODY	ON REMAND	SINGLE CELL	SHARED CELL
Arbour Hill	Medium	135	0	72.7%	27.3%
Castlerea	Medium	494	83	25.9%	68.9%
Cloverhill	Medium	885	387	9.8%	73.8%
Cork	Medium	518	113	9.7%	63.0%
Limerick (F)	Medium	463	74	37.7%	56.7%
Limerick (M)	Medium	120	19	31.6%	68.4%
Loughan House	Low(open)	134	0	58.5%	41.5%
Midlands	Medium	1088	85	28.8%	66.4%
Mountjoy	Medium	1040	30	61.0%	39.3%
Dóchas Centre (F)	Medium	291	48	11.7%	59.0%
Portlaoise	High	263	21	47.9%	50.8%
Shelton Abbey	Low(open)	107	0	32.1%	63.3%
Training Unit	Low(open)	99	0	100%	0.0%
Wheatfield	Medium	754	85	13.6%	64.2%
Total		4941	945	36.0%	57.6%
Male		4690	878		
Female		251	67		

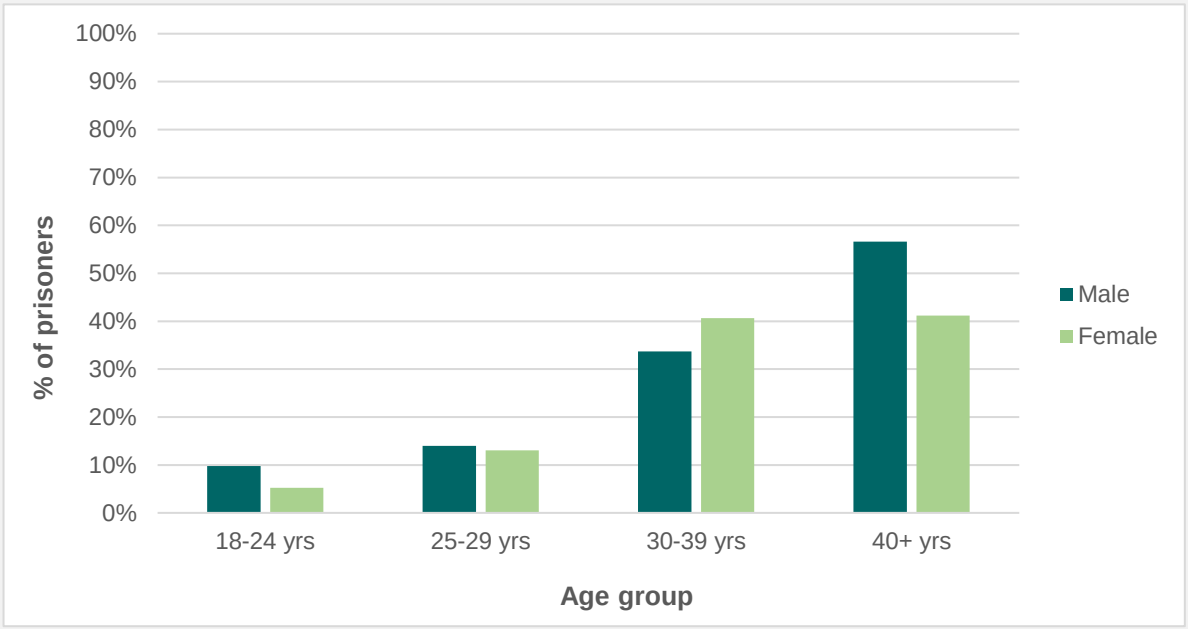

Fig. 2 *Age group of sentenced prisoners in custody on an arbitrary date, 2024*

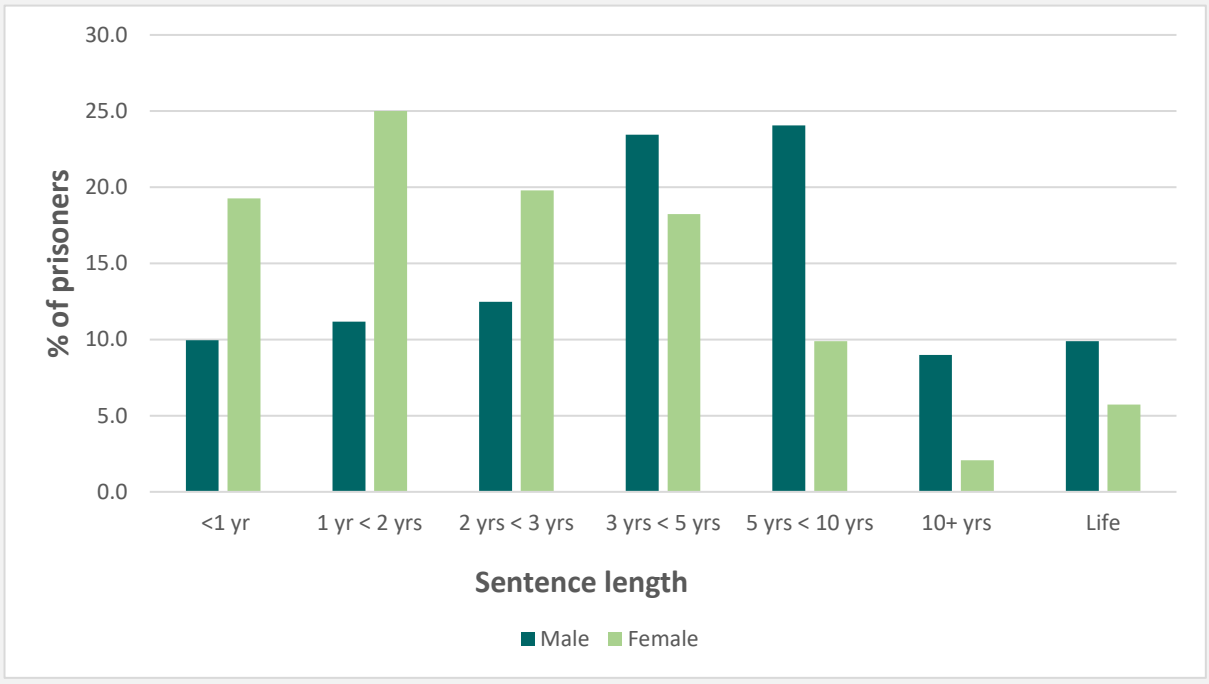

Fig. 3 *Sentence length of prisoners in custody on an arbitrary date, 2024*

Self-harm in Irish Prisons – 2024

Between 1 January and 31 December 2024, a total of 203 self-harm episodes were recorded in Irish prisons, involving 142 individuals. This marks a 46% reduction in the number of self-harm episodes compared to the previous year (*n*=376), and a 39% decrease in the number of individuals involved (*n*=232 in 2023).

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 2024 to December 2024. The annual rate of self-harm in 2024 was 3.2 per 100 prisoners (95% CI: 2.7-3.8) (see Table 2).

Between 2022 and 2024, overall self-harm rates in Irish prisons have remained relatively stable, but subgroup analyses reveal important variations. Among male prisoners, rates have increased incrementally over the three years, rising from 2.1 per 100 in 2022 to 2.6 in 2023 and 2.9 in 2024. Female prisoners, in contrast, continue to have considerably higher rates than males but have experienced a consistent reduction, falling from 17.2 per 100 in 2022 to 16.5 in 2023 and 12.7 in 2024.

Differences are also evident when examining sentence status. For sentenced prisoners, self-harm rates rose from 2.0 per 100 in 2022 to 3.0 in 2023 and remained steady at 3.0 in 2024. Among remand prisoners, however, rates have consistently been higher, increasing from 4.8 per 100 in 2022 to 4.9 in 2023 and further to 5.9 in 2024. By 2024, remand prisoners were engaging in self-harm at more than double the rate of sentenced prisoners, underscoring their continued status as a high-risk group.

Table 2. *Rate of self-harm among Irish prisoners, 2024*

Total	Individuals	Episodes	Rate per 100 (95% CI)
Total	142	203	3.2 (2.7-3.8)
Male	122	169	2.9 (2.4-3.4)
Female	20	34	12.7 (7.9-18.9)
Sentenced	90	67	3.0 (2.5-3.7)
On remand	52	136	5.9 (4.5-7.7)

The majority of self-harm episodes involved males (*n*=169; 83.8%). The mean age of individuals who engaged in self-harm was 34.4 years, with a range of 19 to 80 years. Most individuals who engaged in self-harm were White Irish (76.4%), followed by Irish Travellers (13.3%) and individuals from other White backgrounds (4.9%).

Self-harm rates in 2024 differed by both age and gender (see Fig.4). Among sentenced male prisoners, rates were 5.3 per 100 in the 18–29 age group, 3.5 per 100 among those aged 30–39, and 1.8 per 100 among prisoners aged 40 years and older. For sentenced female prisoners, rates were consistently higher than those observed among males. Self-harm occurred at a rate of 14.2 per 100 among women aged 18–29, 11.5 per 100 among those aged 30–39, and 7.6 per 100 in the 40+ age group.

Overall, this shows that younger prisoners accounted for the highest rates of self-harm in both genders, and that female prisoners had elevated rates of self-harm across all age categories when compared with their male counterparts.

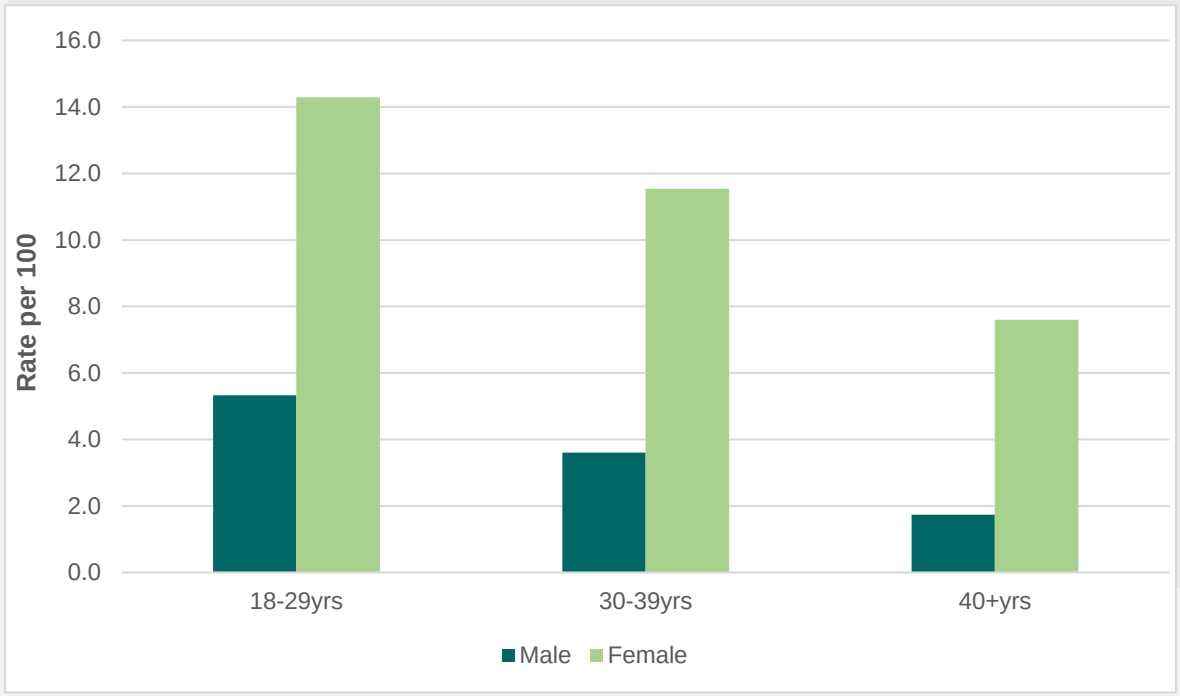

Fig. 4 *Age-specific rates of self-harm among sentenced prisoners (per 100) in 2024, by gender*

Self-harm by time of occurrence

Self-harm episodes in 2024 occurred across all days of the week (see Fig. 5), with the highest proportions recorded followed by Tuesdays (17.2%) followed by Wednesdays (16.8%) and Saturdays (16.3%), and Fridays (15.8%). Among males, the most common days for self-harm were Wednesday and Saturday (17.8% each), while for females, the highest proportions occurred on Tuesday (23.5%) and Monday (17.6%). Sunday had the lowest overall proportion of incidents (8.9%), with similar distributions among both males (8.9%) and females (8.8%).

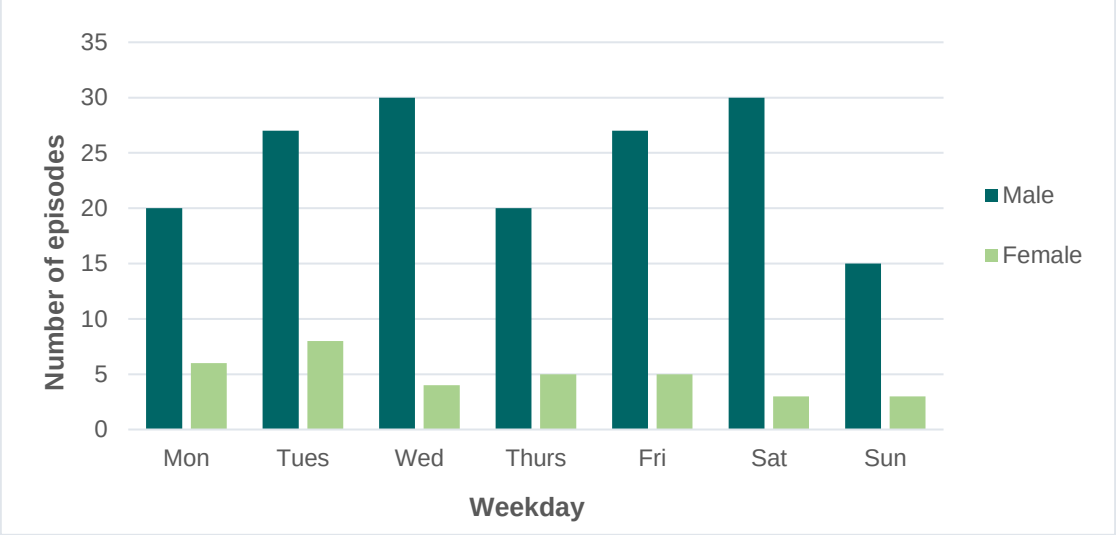

Fig. 5 *Number of episodes by day of occurrence, 2024*

The number of self-harm episodes varied over the course of 2024, indicating fluctuations in monthly incidence. The highest numbers were recorded in October (*n*=24), April (*n*=23), and July (*n*=22), suggesting potential seasonal or environmental factors influencing self-harm behaviours during these periods. Conversely, the lowest number of episodes occurred in December (*n*=6), followed by March and September, each with 11 recorded episodes. Overall, the average number of self-harm episodes per month was approximately 16.9, reflecting a steady but variable pattern across the year (see Fig. 6).

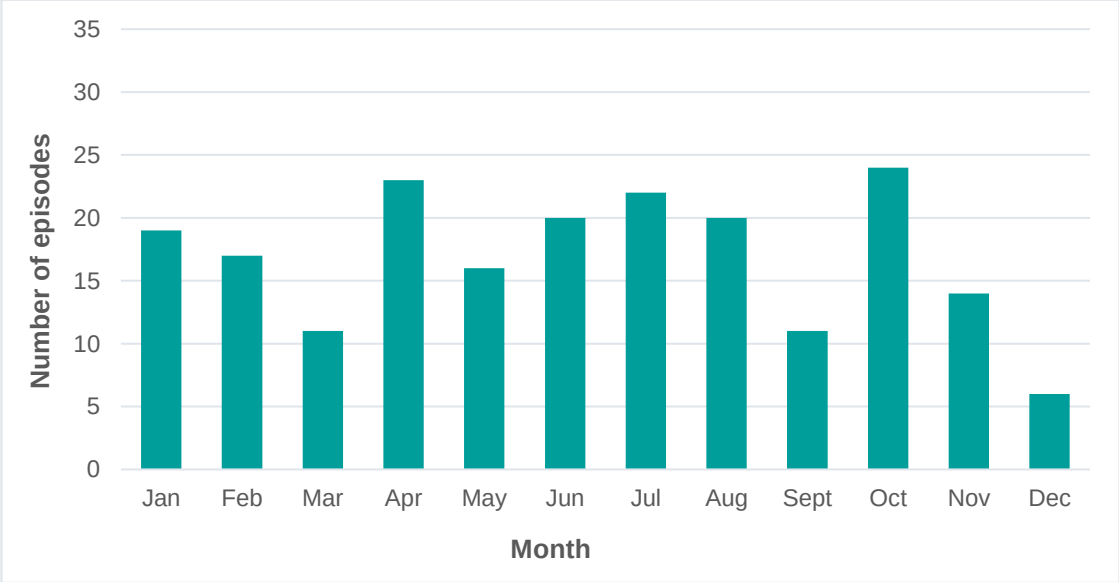

Fig. 6 *Number of episodes by month of occurrence, 2024*

The timing of self-harm episodes varied throughout the day, with a clear peak during daytime hours. Analysis by hour of occurrence shows that the highest number of episodes occurred between 2 p.m. and 8p.m (50.7%). Very few episodes occurred during the early morning hours. (see Fig. 7). Overall, the majority of self-harm episodes (65.5%) occurred while prisoners were unlocked, meaning they had access to common areas or were outside their cells. In contrast, 34.5% of episodes took place during lockup periods, when individuals were confined to their cells. This may have implications for the role of meaningful activity in the incidence of self-harm. It might be clinically useful to review an individual's pattern of self-harm, particularly the timing of their self-harm and to increase meaningful activity during high risk periods in order to try to reduce their self-harm.

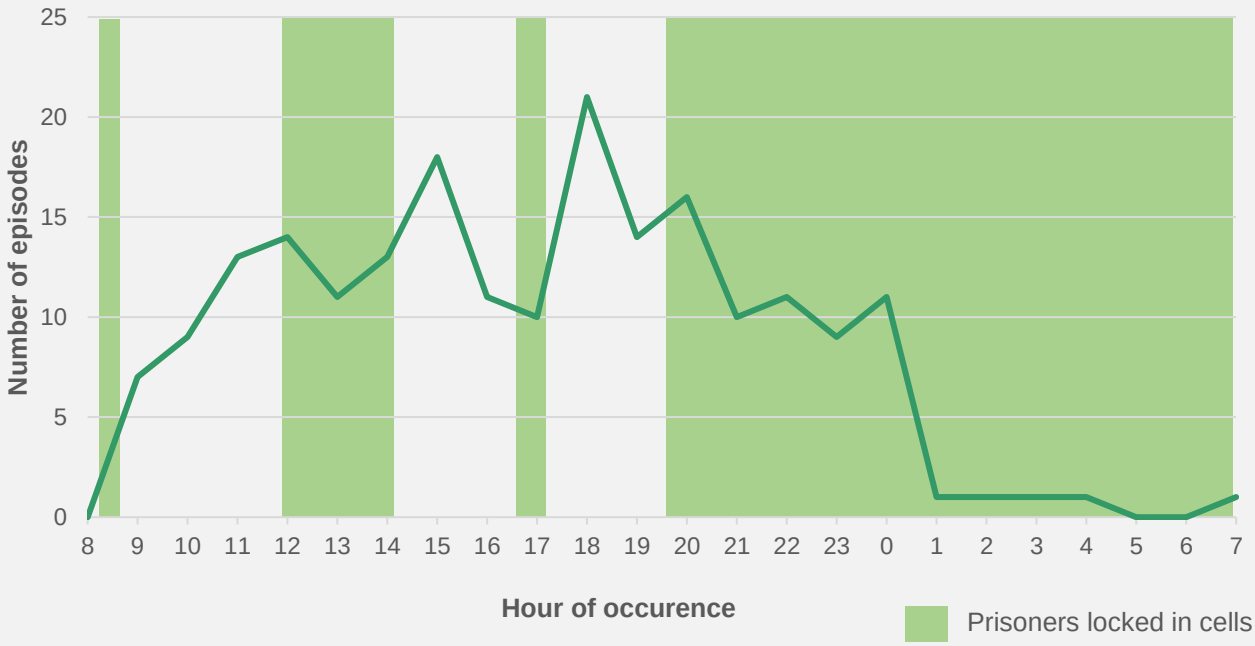

Fig. 7 *Number of episodes by hour of occurrence, 2024*

Repetition of self-harm

Repetition of self-harm was a notable feature in 2024, with 30.0% of all episodes involving individuals who engaged in self-harm more than once. Person-based repetition rates show that nearly one in five individuals (19.7%) engaged in more than one episode of self-harm during the year. When disaggregated by sex, 18.9% of males and 25.0% of females Who self-harmed went on to repeat. While males accounted for the majority of total episodes, a higher proportion of females engaged in repeated self-harm. This pattern highlights the importance of gender-responsive mental health supports and targeted interventions for those at risk of recurrent self-harm in custody.

Method of self-harm

In 2024, cutting remained the most frequently used method of self-harm in Irish prisons, accounting for almost two-thirds of all episodes (65.0%, *n*=132). This pattern was consistent across both genders, with cutting recorded in 66.3% of male episodes (*n*=112) and 58.8% of female episodes (*n*=20). Attempted hanging represented the second most common method overall, comprising 14.4% of episodes (*n*=29). This was more prevalent among males (16.0%, *n*=27) compared to females (5.9%, *n*=2).

Intentional overdose was reported in 3.4% of all episodes (*n*=7), though the gender distribution was uneven: overdoses were relatively rare among males (1.2%, *n*=2) but more common among females (14.7%, *n*=5). Fire or flames (3.4%, *n*=7) and blunt objects (7.4%, *n*=15) accounted for smaller but notable proportions of incidents, with both methods observed in both male and female prisoners. Use of steam, hot vapour, or hot objects was the least frequently recorded method (0.5%, *n*=1). A further 5.9% of episodes (*n*=12) were categorised under other specified methods.

The data highlight both consistencies and gender-specific variations in self-harm methods. While cutting dominates across the prison population, females were proportionally more likely than males to engage in overdose, whereas males were more likely to use hanging. These

distinctions reinforce the importance of gender-responsive prevention and intervention strategies that address the particular methods of self-harm most associated with each group. (see Table 3).

Table 3. *Method of self-harm, 2024*

Method	Cutting	Attempted hanging	Intentional overdose	Fire/flames	Blunt objects	Steam, hot vapour and hot objects	Other specified methods
Total	132 (65.0%)	29 (14.4%)	7 (3.4%)	7 (3.4%)	15 (7.4%)	1 (0.5%)	12 (5.9%)
Male	112 (66.3%)	27 (16.0%)	2 (1.2%)	5 (3.0%)	12 (7.1%)	1 (0.5%)	10 (5.9%)
Female	20 (58.8%)	2 (5.9%)	5 (14.7%)	2 (5.9%)	3 (8.8%)	0 (0.0%)	2 (5.9%)

Prisoner accommodation/ cell type and sentence

Self-harm episodes in 2024 occurred across all types of accommodation within the prison system, though the majority took place in the general prison population (see Table 4). Of the 203 recorded episodes, two-thirds (67.0%, *n*=136) were among prisoners housed in the general population. A further 21.7% (*n*=44) of episodes were reported among those on protection (Rule 62 and Rule 63), reflecting the heightened vulnerabilities within this subgroup.

Smaller proportions of episodes were observed in more specialised regimes: 7.9% (*n*=16) of self-harm episodes occurred in the Special Observation Cells (SOC), which are designed for prisoners requiring close monitoring, while 3.4% (*n*=7) took place within the Close Supervision Cells (CSC), typically used for prisoners presenting acute risks to themselves or others.

These findings indicate that while self-harm is most frequently reported among prisoners in the general population, there remains a notable concentration of incidents within specialised and protected settings. Among episodes of self-harm where cell-sharing information was available, half occurred among prisoners accommodated in double cells (50.0%). A further

38.0% involved individuals in single cells, while 12.0% took place among those in triple or larger cells. Cell-sharing information was not recorded for a small proportion of episodes (9.4%), which should be considered when interpreting these findings.

Table 4. *Prisoner accommodation, 2024*

General population	Safety observation cell (SOC)	Closed supervision cell (CSC)	Protection
136 (67.0%)	16 (7.9%)	7 (3.4%)	44 (21.7%)

Among sentenced prisoners who engaged in self-harm in 2024, the distribution of incidents by index act spanned across all sentence lengths (see Fig. 8). Shorter sentences were particularly common, with almost one quarter of cases (24.4%) involving prisoners serving less than one year and a further 12.2% serving between one and two years. Prisoners serving between two and three years accounted for one fifth of cases (20.0%). Those serving medium-length sentences of three to five years and five to ten years each represented 14.4% of cases. Longer sentences were less frequently observed, with 6.7% of self-harm incidents occurring among individuals serving ten years or more, and 7.8% among those serving life sentences. These findings highlight that self-harm, as measured by index act, occurs across all sentence lengths, though in line with previous years, it is most commonly recorded among individuals serving shorter custodial terms. This underlines the importance of comprehensive and timely committal assessments to identify risk factors early, particularly for those entering custody on shorter sentences where opportunities for ongoing intervention may be limited.

Fig. 8 *Self-harm by sentence length and index act, 2024*

Self-harm episodes were distributed relatively evenly across the three trimesters of the year (see Fig. 9). The first and second trimesters each accounted for just over one third of incidents (35.5% and 35.0%, respectively), while the third trimester accounted for 29.6% of episodes. These findings indicate that self-harm occurs consistently throughout the year, with no single period showing a disproportionate concentration of incidents. This highlights the importance of maintaining consistent, year-round prevention and intervention measures, ensuring that resources and monitoring do not disproportionately focus on any particular time of year.

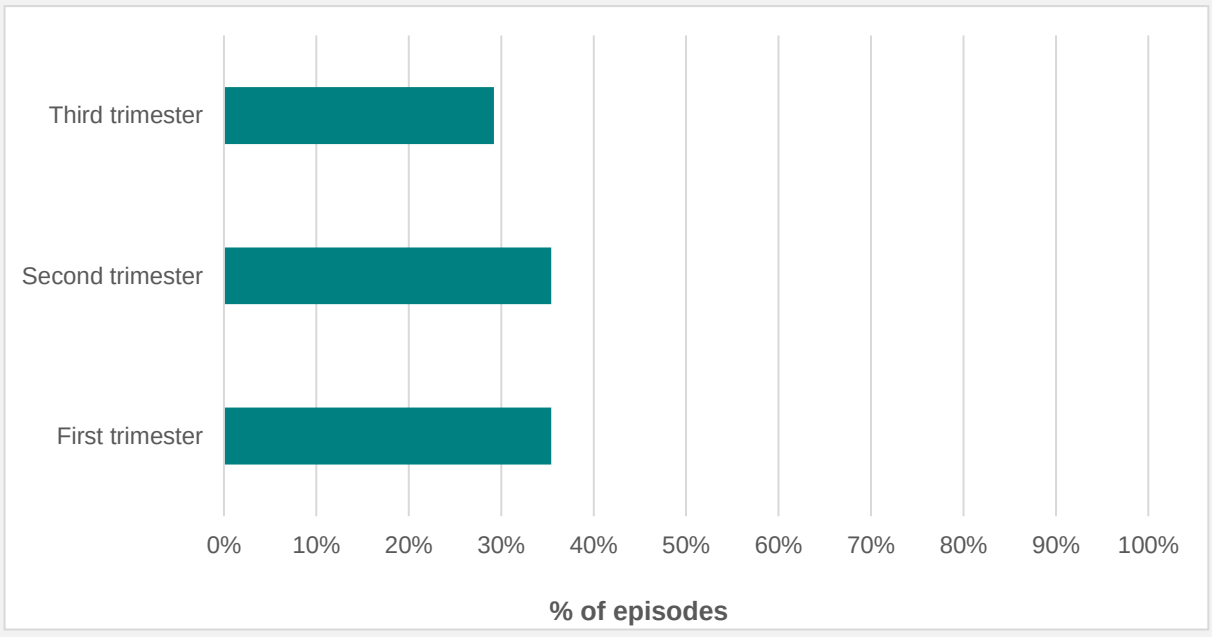

Fig. 9 *Self-harm by trimester, 2024*

In 2024, self-harm episodes occurred across all regime levels within the prison system. The majority of episodes were reported among prisoners on the standard regime, accounting for 60.6% of all episodes. A further 24.1% occurred among those on the enhanced regime, while 15.3% were reported among individuals on the basic regime.

Treatment, severity and intent

The majority of self-harm episodes recorded in 2024 did not necessitate hospital-level medical intervention. In nearly one-third of all incidents (32.5%, *n*=66), no treatment was required following the episode. Minimal intervention, such as the application of a minor dressing or basic first aid, accounted for the largest proportion of cases (40.9%, *n*=83). Local wound management—requiring more structured but non-hospital care—was provided in 13.8% of episodes (*n*=28).

A smaller but clinically significant proportion of incidents required treatment outside the immediate prison healthcare setting. Outpatient or Accident & Emergency (A&E) treatment was required in 10.3% of cases (*n*=21), and 1.0% (*n*=2) of episodes resulted in hospitalisation. Sadly, there were three self-harm incidents (1.5%) that resulted in loss of life.

While the majority of incidents were medically minor and managed on-site within prison healthcare facilities, the data highlight that a considerable number of episodes still demand more intensive medical resources. This inevitably places pressure on healthcare service provision and demonstrates the hard work of nursing colleagues in the prison. This not only has implications for healthcare workload within the prison system but also underscores the need for ongoing prevention strategies, early intervention, and targeted supports to reduce the severity and frequency of self-harm incidents in custody.

Table 5. Severity of self-harm, 2024

No treatment needed	Minimal intervention/ minor dressing	Local wound management	Outpatient/A&E treatment	Hospitalisation	Loss of life
66 (32.5%)	83 (40.9%)	28 (13.8%)	21 (10.3%)	2 (1.0%)	3 (1.5%)

An analysis of treatment severity by method of self-harm revealed distinct patterns in medical outcomes (see Fig. 10). Cutting was the most frequently reported method (65.0%, *n*=132), with the majority of incidents requiring either minimal intervention (50.0%) or no treatment (25.0%). A smaller proportion required local wound management (18.2%) or outpatient treatment (6.8%), and no cutting incidents resulted in hospitalisation or loss of life.

Hanging accounted for 14.3% (*n*=29) of incidents and, while over half (55.2%) required no treatment and 24.1% required only minor dressings, this method was responsible for all recorded fatalities (n = 3; 10.3%). Blunt object use (7.4%, *n*=15) often necessitated higher levels of care, with 26.7% of episodes requiring outpatient treatment and 6.7% requiring hospitalisation, though no deaths were reported.

Intentional overdose (3.4%, *n*=7) was associated with more severe medical responses, with 85.7% of these incidents managed in outpatient or A&E settings and 14.3% requiring hospitalisation. Fire-related self-harm (3.4%, *n*=7) was typically less severe, with 42.9% requiring no treatment and 57.1% requiring minor intervention. Other specified methods (5.9%, *n*=12) were predominantly minor, with 83.3% requiring no treatment and 16.7% minor dressings, and no cases requiring advanced medical care. These findings highlight that while cutting is the most common method of self-harm, hanging poses the greatest risk of fatal outcomes, and overdose and blunt object use are more likely to require hospital-based medical intervention.

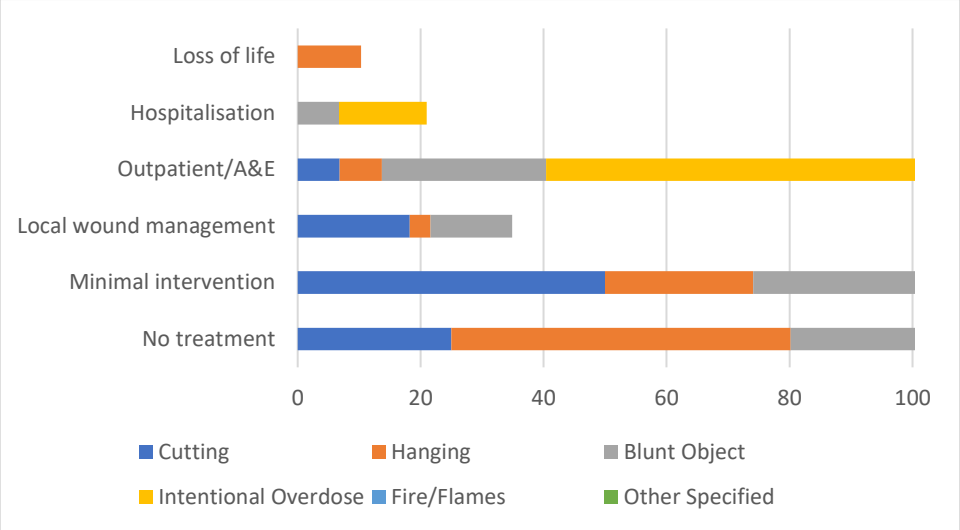

Fig. 10 *Level of medical intervention required following self-harm, by method, 2024*

An analysis of intent to harm among individuals who engaged in self-harm during 2024 (see Fig. 11) indicates that most episodes were assessed as having no or low suicidal intent (58.1%, *n*=118). This suggests that a significant portion of self-harming behaviour in prison may be driven by factors other than a direct intent to end life, such as coping with distress, expressing emotional pain, or managing interpersonal or environmental stressors.

However, a notable proportion of incidents (33.0%, *n*= 67) were assessed as demonstrating a moderate level of intent, suggesting a degree of ambivalence toward life and possible suicidal motivation. Furthermore, 8.9% of episodes (*n*=18) were identified as having a high level of intent, indicating a smaller but significant group of prisoners at markedly elevated risk of suicide.

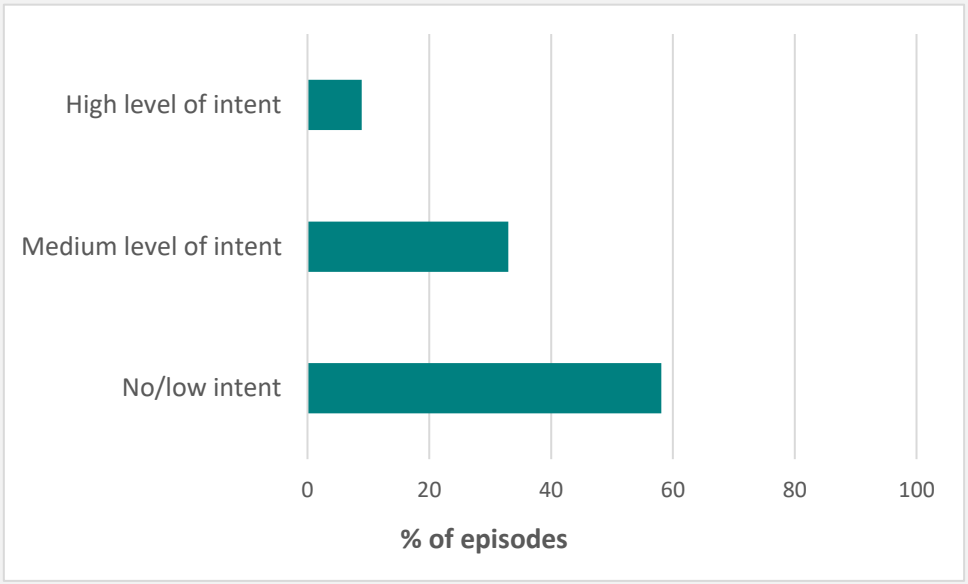

Figure 11. *Level of intent associated with self-harm episode, 2024*

Analysis of self-harm incidents by intent to harm and medical severity shows distinct patterns that help in understanding the risk profile of prisoners engaging in self-harm (Table 6).

Among episodes with no or low intent (58.1%, *n*=118), nearly 80% required no treatment or only minimal intervention (31.4% and 48.3% respectively). Only a small proportion (0.8%) required hospitalisation, and no fatalities were recorded in this group.

For episodes classified as medium intent (33.0%, *n*=67), medical severity increased: 37.3% required no treatment, 31.3% required minimal intervention, and 13.4% necessitated outpatient or A&E treatment. While no cases in this category resulted in hospitalisation or death, these findings indicate more serious injuries compared to the low-intent group.

Episodes with high suicidal intent (8.9%, *n*=18) demonstrated the greatest severity. A higher percentage required outpatient treatment (11.1%), hospitalisation (5.6%), or resulted in loss of life (16.7%), accounting for all three fatalities reported in 2024. Only 22.2% of high-intent incidents required no treatment, highlighting that this group is associated with more severe medical outcomes.

Overall, this analysis reveals that while most self-harm incidents in prison involve low suicidal intent and minor medical intervention, a smaller but clinically significant subset of episodes demonstrates high intent and substantially greater severity, including fatal outcomes.

Table 6. *Severity/intent matrix, 2024*

	No treatment needed	Minimal intervention/ minor dressings	Local wound management	Outpatient/ A&E treatment	Hospitalisation	Loss of life
No/low intent	37 (31.4%)	57 (48.3%)	13 (11.0%)	10 (8.5%)	1 (0.8%)	0 (0.0%)
Medium level of intent	25 (37.3%)	21 (31.3%)	12 (17.9%)	9 (13.4%)	0 (0.0%)	0 (0.0%)
High level of intent	4 (22.2%)	5 (27.8%)	3 (16.7%)	2 (11.1%)	1 (5.6%)	3 (16.7%)

Contributory factors

Contributory factors associated with self-harm are categorised into five main themes: mental health, environmental, relational, procedural, and medical. Consistent with previous years, the majority of recorded factors were related to mental health (86.7%), underscoring its central role in self-harming behaviour among prisoners. This was followed by environmental factors (47.8%), which include aspects such as prison conditions, and relational issues (38.4%), such as conflicts with peers or staff, or difficulties maintaining family contact. Medical factors were identified in 21.7% of cases. These findings emphasise the complex and multifaceted drivers of self-harm in custody (see Fig. 12*).

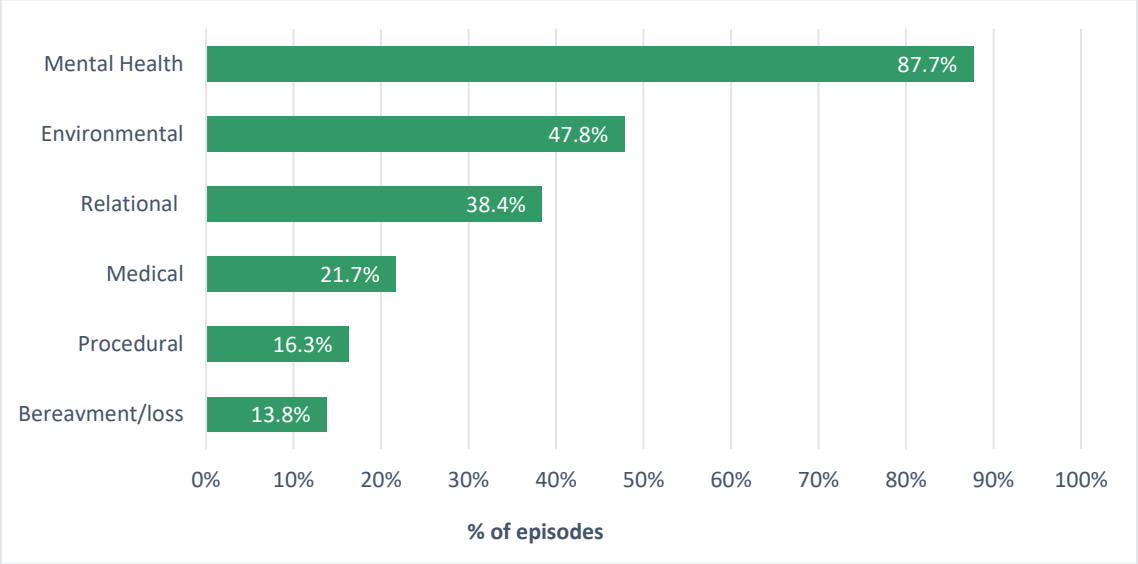

Fig 12. *Themes of contributory factors in self-harm episodes, 2024*

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

- **MENTAL HEALTH**

  In 2024, mental health was cited as a contributory factor in 86.7% of all recorded self-harm episodes in Irish prisons, reflecting its ongoing significance in the context of self-injurious behaviour in custody. This overarching category comprises four key subthemes. Mental health diagnoses or indicators of poor mental health – such as depression, anxiety, PTSD, or low mood – were reported in 57.1% of cases. Difficulties coping or managing emotions were identified in 54.2% of episodes, while substance misuse and addiction were noted in 42.9%. Impulsivity was cited in 24.6% of incidents. These findings highlight the complex and often overlapping psychological and behavioural challenges facing individuals who engage in self-harm, reinforcing the need for comprehensive, trauma-informed, and multidisciplinary responses within the prison system.

- **ENVIRONMENTAL**

  Environmental factors were identified as contributory in 47.8% of self-harm episodes in 2024, underscoring the impact of prison conditions on prisoner wellbeing. Among these, legal issues were the most commonly cited environmental factor, recorded in 24.6% of cases. Accommodation type – such as being housed in shared or overcrowded cells – was noted in 20.7% of episodes, which may reflect the psychological strain associated with limited privacy or overcrowded conditions. Although less frequently reported, regime restrictions (2.5%) and staff shortages (0.5%) were also identified as contributing factors. These findings align with broader concerns regarding prison overcrowding and its potential to exacerbate stress, reduce access to purposeful activity, and strain relationships between prisoners and staff. Taken together, the data suggest that institutional conditions and pressures within the prison environment can play a significant role in self-harm risk, particularly in contexts where resources and space are stretched.

- **PROCEDURAL**

  Procedural factors were identified as contributing to 17.2% of self-harm episodes in 2024, reflecting the impact that aspects of prison administration and disciplinary practices can have on prisoner wellbeing. The most frequently reported procedural issue was transfer-related, cited in 10.8% of all episodes. Other procedural concerns included recent placement in a Safety Observation Cell (SOC) and receipt of disciplinary reports (P19), and orchestrating access to contraband – recorded in 3.0% of episodes. Additional factors, such as protection issues (2.5%), pre-release concerns (2.5%), (3.0%), were recorded less frequently. Only one episode (0.5%) was linked to recent barrier handling, and none were associated with denied or screened visits. While each of these individual factors was infrequently cited, collectively they highlight how prison routines, security processes, and disruptions to stability – such as transfers or regime changes – can act as contributing for self-harm in the prison environment.

- **RELATIONAL**

  Relational issues were identified as contributory factors in 38.4% of self-harm episodes in 2024. The most frequently reported issue involved difficulties with other prisoners, cited in 21.2% of episodes. Relationship issues with significant others – such as partners or family members – were recorded in 11.8% of episodes, while conflicts or strained interactions with prison staff were noted in 8.9%. child custody or access issues were reported as a contributing factor in 1.0% of self-harm episodes. No episodes were attributed to bullying, threatening, or victimising others. These findings indicate that interpersonal stress, both within and beyond the prison environment, continues to play a significant role in self-harming behaviour among prisoners, underscoring the importance of supporting healthy communication and connection.

- **MEDICAL**

Medical issues were identified as contributory factors in 21.7% of self-harm episodes in 2024. The most commonly reported sub-factor was medication-related issues, cited in 19.2% of cases. These included instances of non-compliance, medication-seeking behaviour, and problems related to the administration of prescribed medication (such as missed or delayed doses, errors in dispensing, or supervision issues) or its availability (such as restricted prescribing, limited supply, or temporary shortages within the prison setting). A small number of episodes (3.0%) were linked to the recent onset of illness or a deterioration in existing health symptoms. No episodes were attributed to chronic pain or terminal illness. While these medical concerns were less prevalent than psychological or environmental factors, they nonetheless represent an important dimension of self-harm risk in custody.

- **BEREAVEMENT/LOSS**

Bereavement and loss-related factors were cited in a small number of self-harm episodes in 2024, though they remain important triggers for emotional distress in custody. The most common factor in this category was the death or anniversary of the death of someone close, reported in 7.9% of cases. Other less frequent factors included adjustment issues (2.0%), the recent loss of a family member or intimate relationship (2.0%), and the loss of a personal possession or object (1.0%). While each was reported in a relatively small proportion of cases, these stressors can have a significant emotional impact on individuals in a prison environment, particularly in the absence of adequate supports or opportunities for grieving.

In summary, a range of contributory factors were identified in association with self-harm episodes in 2024 (see Fig. 13). The most frequently recorded factors related to mental health difficulties (e.g. mood and anxiety disorders, psychosis, PTSD, eating disorders, personality difficulties), present in almost one third of episodes. Issues with poor coping and emotional regulation and substance use/addiction were also commonly noted, each associated with over one quarter of incidents. Impulsivity was highlighted in a smaller but still notable proportion of cases.

Other contributory factors included legal issues, type of accommodation or cell placement, and medication-related concerns (e.g. non-compliance, administrative errors, or drug-seeking behaviours). A smaller number of episodes were linked to interpersonal tensions, such as relationship difficulties with other prisoners. These findings illustrate the multifaceted nature of self-harm risk in prison settings, often arising from a complex interaction between individual vulnerabilities, institutional factors, and broader contextual stressors.

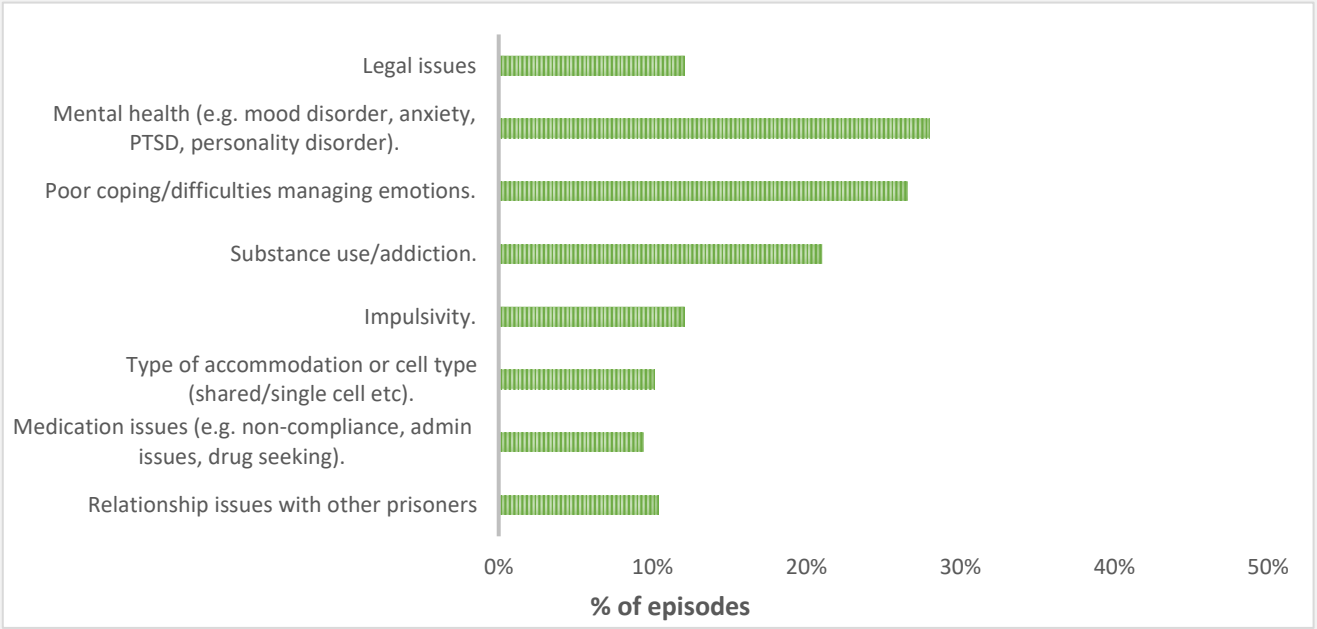

Fig 13. *Most cited contributory factors associated with self-harm episodes, 2024*

References

1. Department of Health. *Connecting for Life: Ireland's National Strategy to Reduce Self-Harm and Suicide (2015-2024)*. Department of Health; 2015.

2. National Suicide Research Foundation. The Self-Harm Assessment and Data Analysis (SADA) Project. 2024. Accessed June 27, 2025. https://www.nsrf.ie/strategic-research-clusters/the-self-harm-assessment-and-data-analysis-sada-project/

3. Health Service Executive, National Clinical Programme. Model of Care for People with Mental Disorder and Co-existing Substance Use Disorder (Dual Diagnosis). Published online 2023. https://www.hse.ie/eng/about/who/cspd/ncps/mental-health/dual-diagnosis-ncp/dual-diagnosis-model-of-care.pdf

4. Wright N, Walters P, Strang J. Dual diagnosis in prisons: management of co-existing substance use and mental health disorders. *Advances in Dual Diagnosis*. 2016;9(1). doi:10.1108/ADD-12-2015-0025

5. Hopkin G, Evans-Lacko S, Forrester A, Shaw J, Thornicroft G. Interventions at the Transition from Prison to the Community for Prisoners with Mental Illness: A Systematic Review. *Adm Policy Ment Health*. 2018;45(4):623-634. doi:10.1007/s10488-018-0848-z

6. Department of Health. Sharing the vision: a mental health policy for everyone. Implementation Plan 2025-2027. *Goverment of Ireland*. Published online 2025. https://www.hse.ie/eng/about/who/mentalhealth/sharing-the-vision/sharing-the-vision-a-mental-health-policy-for-everyone-implementation-plan-2025-to-2027.pdf

7. Department of Health. Pathways to Wellbeing: National Mental Health Promotion Plan 2024–2030. Published online 2024. https://www.gov.ie/ga/an-roinn-sl%c3%a1inte/foilseachain/pathways-to-wellbeing-national-mental-health-promotion-plan/

8. Kennedy S, Fitzgerald R, Melia R. Engaging Stakeholders in the Development of a National Digital Mental Health Strategy: Reflexive Thematic Analysis. *J Med Internet Res*. 2025;27:e71601. doi:10.2196/71601

9. Substance Abuse and Mental Health Services Administration (SAMHSA. *Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide. HHS Publication No. (SMA) 16-4998*. Substance Abuse and Mental Health Services Administration (SAMHSA; 2017. https://library.samhsa.gov/sites/default/files/sma16-4998.pdf

10. National Institute for Health and Care Excellence (NICE). Mental health of adults in contact with the criminal justice system (NICE Guideline No. NG66). Published online 2017. https://www.nice.org.uk/guidance/ng66

11. French B, Nalbant G, Wright H, et al. The impacts associated with having ADHD: an umbrella review. *Front Psychiatry*. 2024;15:1343314. doi:10.3389/fpsyt.2024.1343314

12. Lai MC, Kassee C, Besney R, et al. Prevalence of co-occurring mental health diagnoses in the autism population: a systematic review and meta-analysis. *The Lancet Psychiatry*. 2019;6(10):819-829. doi:10.1016/S2215-0366(19)30289-5

13. McLeod KE, Wong KA, Rajaratnam S, et al. Health conditions among women in prisons: a systematic review. *The Lancet Public Health*. 2025;10(7):e609-e624. doi:10.1016/S2468-2667(25)00092-1

14. Favril L, Yu R, Hawton K, Fazel S. Risk factors for self-harm in prison: a systematic review and meta-analysis. *The Lancet Psychiatry*. 2020;7(8):682-691.

15. Irish Prison Service. Service strategy 2023–2027. Published online 2023. Accessed February 2, 2025. https://www.irishprisons.ie/wp-content/uploads/documents_pdf/IPS_Service_Strategy-2023-2027-1.pdf

16. Favril L, Shaw J, Fazel S. Prevalence and risk factors for suicide attempts in prison. *Clinical Psychology Review*. 2022;97:102190. doi:10.1016/j.cpr.2022.102190

17. Hawton K, Linsell L, Adeniji T, Sariaslan A, Fazel S. Self-harm in prisons in England and Wales: an epidemiological study of prevalence, risk factors, clustering, and subsequent suicide. *The Lancet*. 2014;383(9923):1147-1154.

18. Zlodre J, Fazel S. All-Cause and External Mortality in Released Prisoners: Systematic Review and Meta-Analysis. *Am J Public Health*. 2012;102(12):e67-e75. doi:10.2105/AJPH.2012.300764

19. National Institute for Health and Care Excellence. *Self-Harm in over 8s: Short-Term Management and Prevention of Recurrence*. National Institute for Health and Care Excellence; 2004.

20. Platt S, Bille-Brahe U, Kerkhof A, et al. Parasiticide in Europe: the WHO/EURO multicentre study on parasuicide. I. Introduction and preliminary analysis for 1989. *Acta Psychiatrica Scandinavica*. 1992;85(2):97-104.

21. Beck AT, Kovacs M, Weissman A. Assessment of suicidal intention: the Scale for Suicide Ideation. *Journal of consulting and clinical psychology*. 1979;47(2):343.

22. Irish Prison Service. *Irish Prison Service Policy for Incentivised Regimes*. Irish Prison Service; 2013.

24. Irish Prison Service. *Sentence Length of Sentenced Prisoners in Custody on November 30th, 2024*. Irish Prison Service; 2025.

List of tables and figures

LIST OF TABLES

LIST OF FIGURES

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.			