Seirbhís Phríosúin na hÉireann
Irish Prison Service

2025 REPORT

SELF-HARM IN IRISH PRISONS

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

NOVEMBER, 2026

Seirbhís Phríosúin na hÉireann
Irish Prison Service
NSRF National Suicide Research Foundation
Connecting for Life

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Foreword

Welcome to the seventh annual Irish Prison Service SADA Report, presenting our national surveillance of self-harm in custody during 2025.

Behind every episode recorded in this report is a person experiencing distress. Understanding when and why self-harm occurs is essential to ensuring that we can recognise vulnerability, respond effectively and, wherever possible, prevent harm before it occurs. The SADA Project provides us with the evidence to learn from these incidents and to continually strengthen the supports available to people in our care.

The findings presented in this report allow us to identify patterns of self-harm, understand factors that may contribute to risk and highlight areas where prevention and intervention can be strengthened. This commitment to high-quality surveillance and learning also supports the objectives of Ireland's national suicide reduction strategy, *Connecting for Life 2026–2035*, particularly its focus on improving data, research and evaluation in self-harm and suicide prevention.

This work would not be possible without the dedication of staff across the Irish Prison Service. Prison staff respond to people in distress every day, and their careful recording of self-harm incidents enables us to build a clearer understanding of the needs of those in our custody. I would like to acknowledge their continued commitment to providing safe and compassionate care.

SADA is also underpinned by strong partnership working. I would like to recognise the continued collaboration of the National Suicide Research Foundation and the National Office for Suicide Prevention; whose research and analytical expertise are integral to the ongoing development of the project.

The value of SADA lies not simply in recording self-harm, but in learning from what the data tell us and translating that learning into prevention. The findings of this report will continue to inform our policies, services, staff and future research as we work collectively to reduce self-harm and suicide and create safer prison environments for everyone.

I would like to thank all those who contributed to the 2025 SADA Report and, more importantly, to the ongoing work of supporting people experiencing distress across the Irish Prison Service.

Caron McCaffrey

Director General, Irish Prison Service

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This report was authored by Ava Delaney from the Irish Prison Service (IPS) and National Suicide Research Foundation (NSRF), Paul Corcoran and Eve Griffin from the NSRF, Orla Gallagher, Anne Collins, Sarah Hume, and Enda Kelly (IPS). The report is supported by the HSE National Office for Suicide Prevention. The continuous monitoring 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 (2026-2035).*

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Glossary

On remand	*In custody awaiting trial or sentencing*
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*
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)*

Executive Summary

The seventh annual report of the Self-Harm Assessment and Data Analysis (SADA) Project provides a comprehensive overview of all recorded episodes of self-harm among people in the custody of the Irish Prison Service (IPS), produced by a collaboration between HSE National Office for Suicide Prevention, National Suicide Research Foundation and the Irish Prison Service[2]. The report presents data collected across all prisons in the Republic of Ireland between 1 January and 31 December 2025. Through the systematic collection and analysis of self-harm data, the SADA Project provides an important national surveillance mechanism for monitoring and understanding suicidal and self-harming behaviour within custodial environments. In doing so, the project seeks to identify emerging patterns, populations at increased risk and potentially modifiable factors that may inform prevention and intervention strategies.

During 2025, 248 episodes of self-harm involving 158 individuals were recorded. This report provides a detailed examination of the nature and characteristics of these episodes, recognising that self-harm in custody is a complex behaviour influenced by the interaction of individual, psychological, social and custodial factors. Episodes were documented using a standardised assessment form completed by trained prison staff, supporting a consistent approach to data collection across the prison estate. Analysis considers key demographic and custodial characteristics, methods of self-harm, repetition, severity and intent, alongside the frequency and timing of episodes.

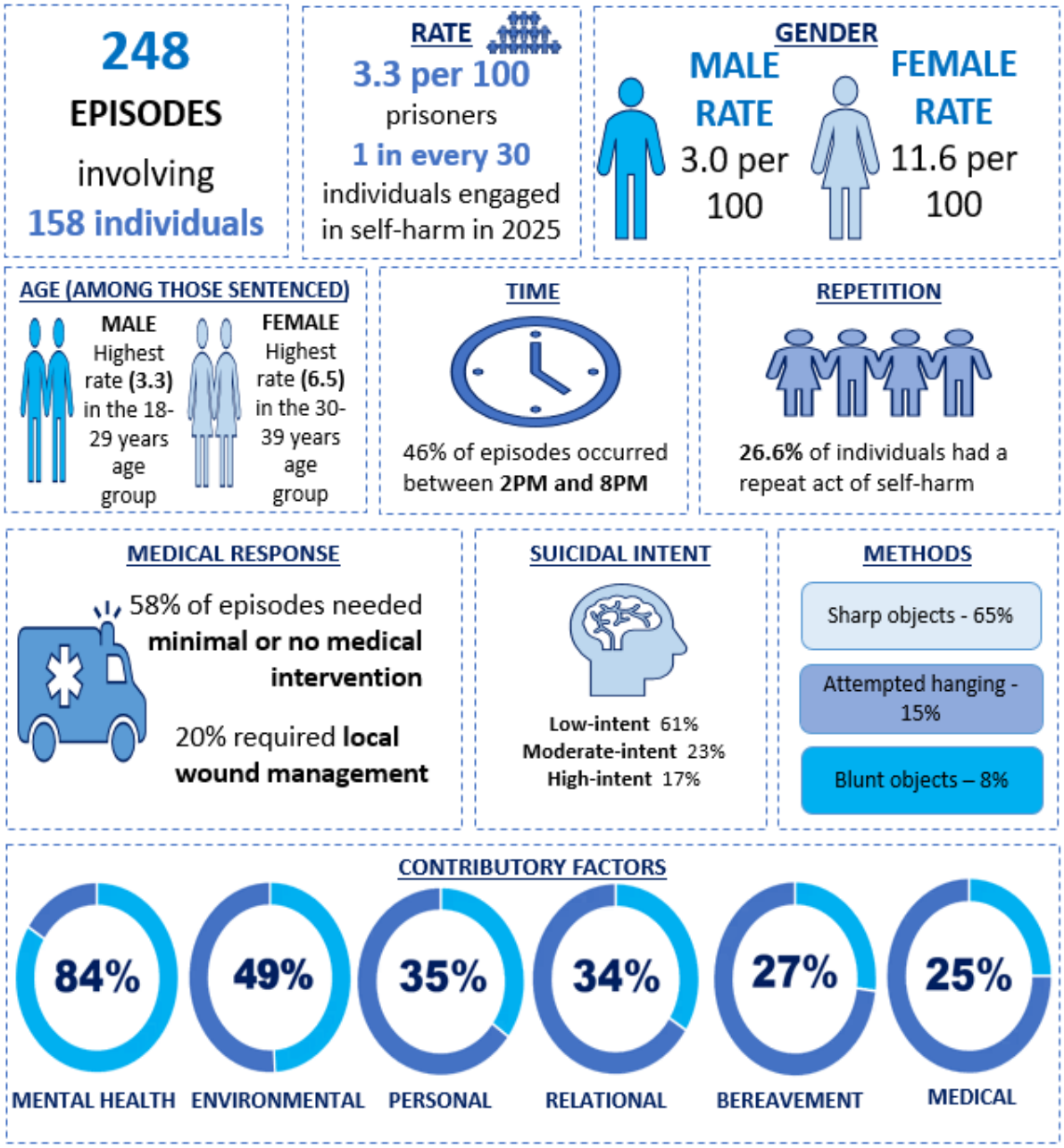
Particular attention is given to the circumstances considered to have contributed to self-harm. Contributory factors are examined across five broad domains: environmental, relational, bereavement, medical and mental health. Multiple factors may be identified in relation to a single episode, reflecting the complexity and co-occurrence of difficulties experienced by individuals who self-harm. Examining these factors alongside the characteristics of individual episodes provides greater insight into not only who is self-harming and how, but also the circumstances in which self-harm occurs.

Year-on-year comparisons are presented to monitor changes in the incidence and characteristics of self-harm over time. This longitudinal approach enables the IPS to identify emerging or persistent trends, examine changes in the profile of self-harm and consider how the needs of the prison population may be evolving. Analysis of the timing and distribution of episodes also assists in identifying periods of elevated occurrence, including particular times of the day or periods of the year, while examination of demographic and custodial characteristics highlights population subgroups that may experience disproportionate levels of self-harm.

Importantly, the value of SADA extends beyond the monitoring and reporting of incidents. The findings provide an evidence base to inform prison policy, staff awareness and training, service planning and evaluation, and the development of targeted self-harm and suicide-prevention initiatives. Prison-level findings can further support individual establishments in identifying local patterns and areas for intervention, while national surveillance enables broader trends to be monitored across the IPS. Through continued analysis of self-harm in custody, SADA supports the development of increasingly proactive, targeted and evidence-informed approaches to prevention, with the overarching aim of reducing self-harm and improving the safety and wellbeing of people in custody.

Main Findings

Between 01 January and 31 December 2025, there were 248 episodes of self-harm recorded in Irish Prisons. The number of self-harm episodes increased from 203 episodes involving 142 individuals in 2024, to 248 involving 158 individuals in 2025. In 2025, the prison population increased by 9.7%.



Introduction

Greater self-harm rates tend to be observed amongst people in custody compared to the general population. Self-harm occurrences are multi-faceted and complex. Recognising this, Connecting for Life- Ireland's National Strategy to Reduce Suicide 2026-2035, identifies individuals in custody as a priority group for targeted prevention. As part of this initiative, the Irish Prison Service aims to reviewing, analysing, and learning from all episodes of self-harm related behaviour promptly, within the prison estate.

The SADA project was established in 2017 to monitor self-harm episodes, including medical severity, suicidal intent, and patterns of repetition. This evidence paves the way for improved identification, intervention, and management of individuals in custody who are engaging in, or at risk of, self-harm. This enables the construction of effective prevention initiatives.

Oversight is provided by the National Suicide and Harm Prevention Steering Group (NSHPSG), whose role is to monitor incidents, review prevention and response measures whilst ultimately sharing and guiding best evidence-informed practice across the prison estate. Currently, the IPS is developing improved assessment and management approaches, including a stepped-care psychological model introduced in 2023 to address emotion dysregulation in prison settings.

The Health Service Executive's National Office for Suicide Prevention (NOSP) and the National Suicide Research Foundation (NSRF) support the IPS through data management, analysis, and reporting. The NSRF has extensive expertise in self-harm surveillance, having established the National Self-Harm Registry Ireland in 2002. This stands as the world's first national registry of hospital-treated self-harm. This model informed the World Health Organisation's Practice Manual for Establishing and Maintaining Surveillance Systems for Suicide Attempts and Self-Harm (2016). In 2023, the NSRF was re-designated as a WHO Collaborating Centre for surveillance and research in suicide prevention.

This report presents the most recent findings from the SADA project, for the year 2025, describing the incidence and nature of self-harm in Irish prisons, examining associated risk factors, and highlighting opportunities for prevention.

Methods

Definitions 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 and is in line with the definition used by the National Self-Harm Registry Ireland. It encompasses a broad spectrum of behaviours, from those linked with suicidal intent to actions reinforced by emotional distress, a sense of hopelessness, loss of control, or self-punishment.

Inclusion and Exclusion Criterion

Inclusion criteria states that in all circumstances 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 are any of the events not to be considered as self-harm, as shown in the table below.

Table 1. *Inclusion and exclusion criteria*

Inclusion criteria
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.

Exclusion criteria
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.

The SADA project records all incidents of self-harm occurring in custody, some of which sadly may result in fatality. Due to the small number of such incidents and their sensitive nature, they are not elaborated on in detail in the report, particularly where coronial proceedings have not concluded. These incidents remain included within the overall surveillance and monitoring undertaken through SADA.

Data Collection Process

Data on every incident of self-harm is recorded using the standardised SADA form by the multi-disciplinary team in each prison, including prison staff and representatives from psychology, primary care, psychiatry and other relevant service providers involved with the person in custody. 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. The completed forms are uploaded onto a secure shared drive, whereby the prison team and research team have access to only. Data is transferred from the SADA forms onto a database, and encrypted. The form consists of four sections:

1. Demographic information;
2. Severity and intent matrix;
3. Typology of the individual;
4. Staff-identified contributory factors;

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.

Setting and Coverage

There are 14 institutions in the Irish Prison System consisting of 11 traditional “closed” institutions, two open centres- Shelton Abbey and Loughan House, which operate with minimal internal and perimeter security, and one “semi-open" facility with traditional perimeter security but minimal internal security (the Training Unit). The majority of females are accommodated in the purpose built “Dóchas Centre”, which is also known as Mountjoy Female, and the remainder are located in a separate part of Limerick Prison. All prison characteristics and demographics have been derived from the 2025 IPS census data.

Table 2. *Prison characteristics and demographics*

PRISON	SECURITY	PRISONERS IN CUSTODY	ON REMAND	Single-person cell	Double-person cell	3+4-person cell
Arbour Hill	Medium	135	0	95	42	0
Castlerea	Medium	440	98	120	236	87
Cloverhill	Medium	498	375	44	66	443
Cork	Medium	367	109	15	170	198
Limerick (F)	Medium	86	20	21	66	0
Limerick (M)	Medium	381	71	126	186	87
Loughan House	Low(open)	130	54	94	42	0
Midlands	Medium	1,026	98	256	518	274
Mountjoy	Medium	1,000	33	567	426	0
Dóchas Centre	Medium	194	51	20	78	109
Portlaoise	High	276	34	85	170	15
Shelton Abbey	Low(open)	104	11	41	18	55
Training Unit	Low(open)	97	0	97	0	0
Wheatfield	Medium	684	160	199	466	24
Total		**5,418**	**1,114**	**1780**	**2,484**	**1,292**
Male		**5,138**	**1,043**	**1,739**	**2,340**	**1,183**
Female		**280**	**71**	**41**	**1440**	**109**

Prison Demographics

The average number of persons in custody across the Irish prison system was 5,418. On average 94.8% (*n*=5,138) were male and 5.2% (*n*=280) were female. Overall, the age profile of male and female sentenced prisoners is similar (see Figure 1). 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. Younger age groups (18–29 years) accounted for a smaller proportion of the population. Of those in custody, 30% were on remand, 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 (24.0%) and 3 to 5 years (23.1%) [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 Figure 2). A notable gender difference is observed with those serving less than one year of a sentence, where the female rate is double that of males (20.3 and 9.8, respectively).

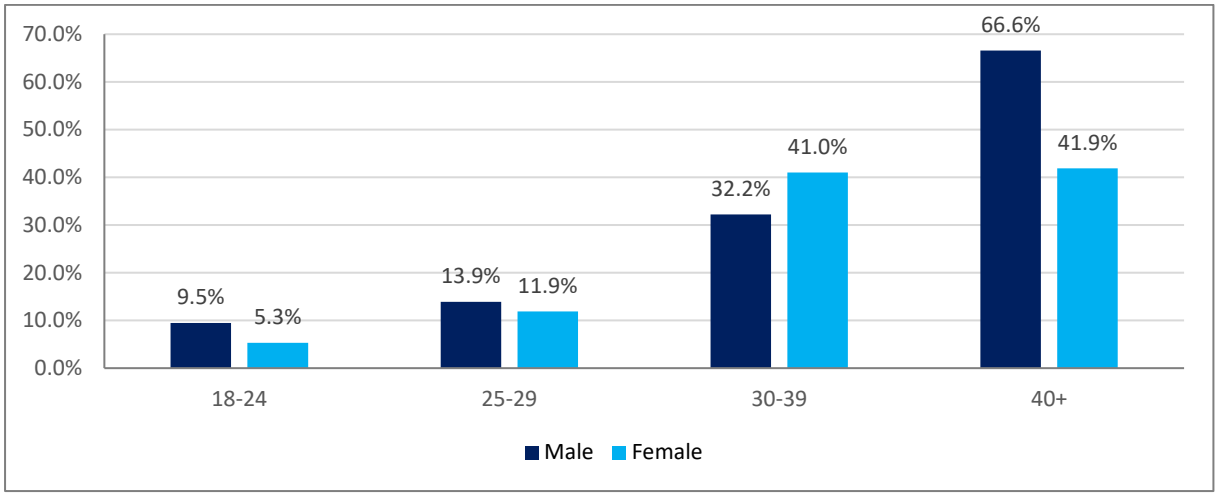


Figure 1. *Age group of sentenced individuals on an arbitrary date in 2025.*

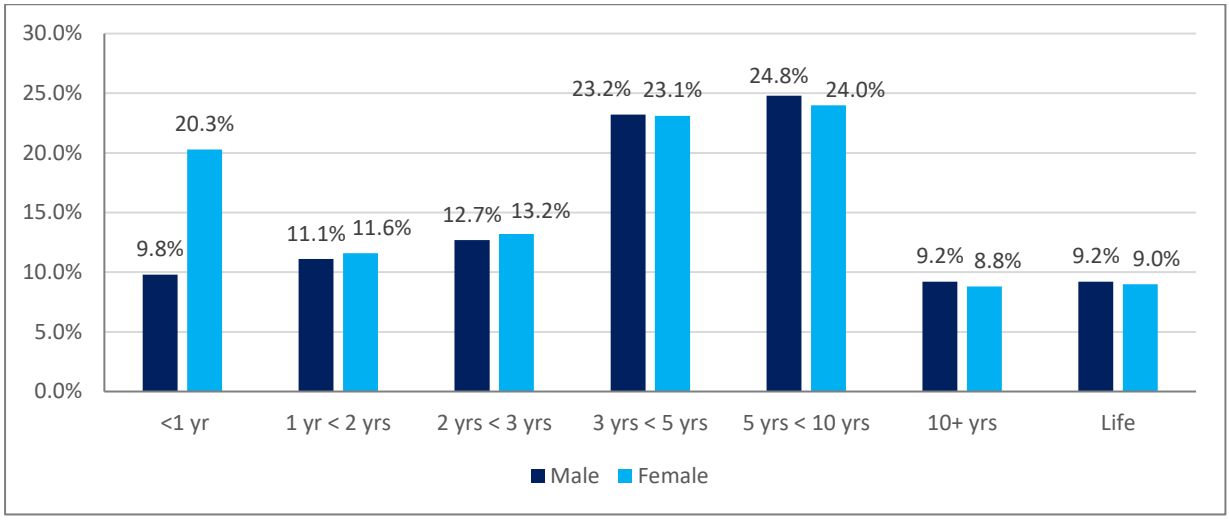


Figure 2. *Sentence length on an arbitrary date in 2025.*

Self-harm in Irish Prisons in 2025

Trends

Between 1 January and 31 December 2025, a total of 248 self-harm episodes were recorded in Irish prisons, involving 158 individuals, which rose from 203 episodes and 142 individuals in 2024.

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 2025 to December 2025. The prison population increased by 9.7% in 2025. The annual rate of self-harm in 2025 was 3.3 per 100 prisoners (95% CI: 2.8-3.8).

***Table 3**. Incidence of self-harm among individuals in custody in Ireland.*

	Episodes	Individuals	Population[1]	Rate per 100 (95% CI)
Total	248	158	4,856	3.3 (2.8-3.8)[2]
Male	223	140	4,701	3.0 (2.5-3.5)
Female	25	18	155	11.6 (7.0-17.1)
Sentenced	163	101	3,742	2.7 (2.2-3.3)
On remand	85	57	1,114	5.1 (3.9-6.6)

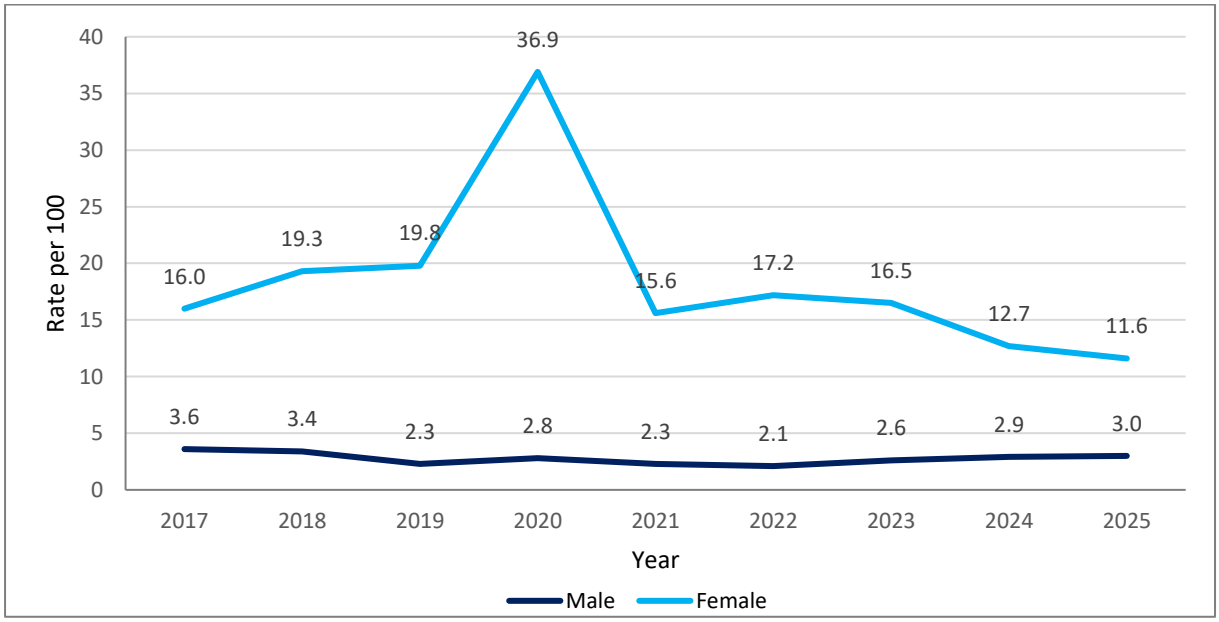


***Figure 3.** Rate of self-harm by sex, 2017-2025.*

Among males, there was a degree of decrease in the rate from 3.6 per 100 in 2017 to 2.1 per 100 in 2022 and then a return/increase to a rate of 2.9 per 100 in 2024 and 2025. Females, in contrast, continue to have considerably higher rates than males but have experienced a consistent reduction, as shown in the figure below. Consistent with international evidence, females continue to experience a higher rate than males in custody, which may reflect the greater prevalence of trauma, substance misuse, and mental health difficulties experienced by women, alongside stressors such as separation from children and family[6]. These findings highlight the importance of gender-responsive approaches that recognise the differing needs and experiences in custody.

[1] The population figure was calculated by subtracting the number of individuals on temporary release from those in custody.

[2] 95% CI is the confidence interval for the rate per 100.

Table 4. *Rate of self-harm of sentenced and remand individuals.*

Self-harm Incidence			Population	Rate per 100	
Year	Episodes	Individuals	Total	Total Sentenced	Total Remand
2017	223	138	3,427	3.1 per 100	7.4 per 100
2018	263	147	3,690	3.7 per 100	5.0 per 100
2019	203	109	3,971	2.3 per 100	5.7 per 100
2020	225	126	3,823	1.5 per 100	3.0 per 100
2021	196	91	3,792	1.5 per 100	3.1 per 100
2022	161	100	4,122	2.0 per 100	4.8 per 100
2023	215	132	4,582	3.0 per 100	4.9 per 100
2024	203	142	4,941	3.0 per 100	5.9 per 100
2025	248	158	5,418	2.7 per 100	5.1 per 100

Although increases were observed in both self-harm episodes and individuals who engaged in self-harm, this occurred alongside a 9.7% increase in the average number of individuals in custody. These increases in absolute numbers should be interpreted in the context of the substantial growth in the prison population. Individuals on remand continued to experience a substantially higher rate of self-harm than sentenced individuals. The higher rate among those on remand may outline the heightened uncertainty and disruption associated with this period of custody[8].

Repetition

As in previous years, repetition of self-harm was a notable feature in 2025. A total of 248 acts of self-harm by 158 prisoners implies that repeat acts accounted 90 or 36.3% of all self-harm acts. At an individual level, 42 of the 158 (26.6%) prisoners who self-harmed in 2025 had a repeat act during the year. When disaggregated by sex, 28.4% of males (40 of 140) and 11.1% of females (2 of 18) repeat self-harmed. This pattern highlights the importance of gender-responsive mental health supports and targeted interventions for those at risk of recurrent self-harm in custody.

Incidence by age group among sentenced individuals

Table 5. *Incidence of self-harm by sex and age group among sentenced individuals.*

	Self-harm incidence			Sentenced population			Rate per 100 (95%CI)[3]		
Age (years)	Male	Female	Total	Male	Female	Total	Male	Female	Total
18-29	33	1	34	1,007	39	1,046	3.3 (2.3-4.6)	2.6 (0.1-13.5)	3.3 (2.3-4.5)
30-39	35	6	41	1,380	93	1,473	2.5 (1.8-3.5)	6.5 (2.4-13.5)	2.8 (2.0-3.8)
40+	21	5	26	1,899	95	1,994	1.1 (0.7-1.7)	5.3 (1.7-11.9)	1.3 (0.9-1.9)
Total	89	12	101	4,286	227	4,513	2.1 (1.7-2.5)	5.3 (2.8-9.1)	2.2 (1.8-2.7)

[3] 95% CI is the confidence interval for the rate per 100.

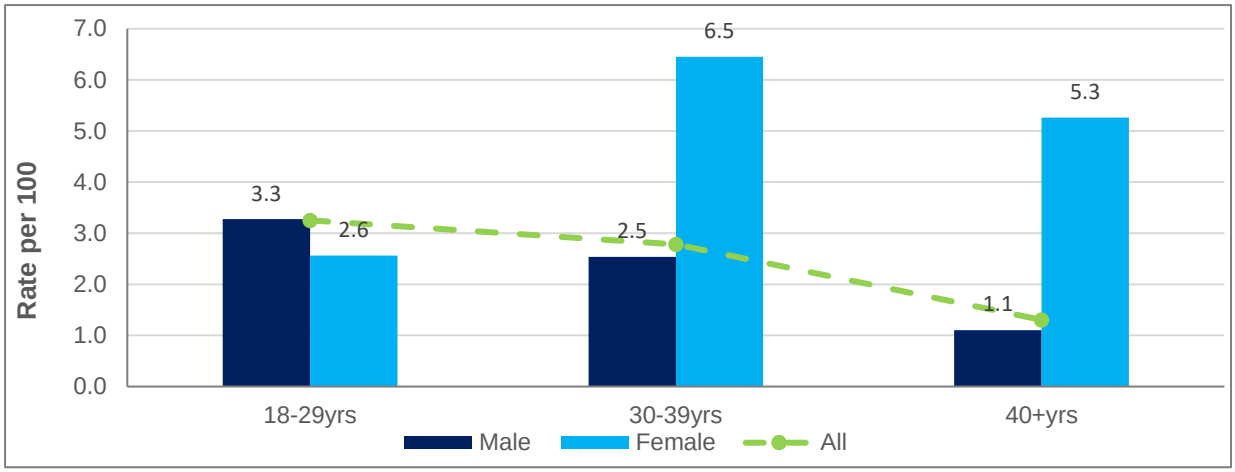


***Figure 4**. Age-specific rate of self-harm among sentenced prisoners in 2025.*

The self-harm rate in 2025 differed by both age and gender (see Figure 4). Among males, the rate was 3.3 per 100 in the 18–29 age group, 2.5 per 100 among those aged 30–39, and 1.1 per 100 among prisoners aged 40 years and older. Despite being the smallest subgroup of the population in 2025, female prisoners had an elevated rate of self-harm across all age categories when compared with their male counterparts. Self-harm occurred at a rate of 2.6 per 100 among women aged 18–29, 6.5 per 100 among those aged 30–39, and 5.3 per 100 in the 40+ age group.

The highest total rate of self-harm was observed in the 18-29 years age group, where it is 3.3. This is consistent with previous years, whereby the highest rates were also noted in the 18-29 years group. Younger adults in custody may experience a combination of vulnerabilities relevant to self-harm, including mental-health difficulties, addiction, trauma, difficulties coping with distress and environmental stressors. Notably, there was a rate of 6.5 within the female group aged 30-39 years. This may reflect the mental health needs within the female population in custody. This is a period of elevated risk, where there is separation from families and heightened uncertainty.

Ethnicity

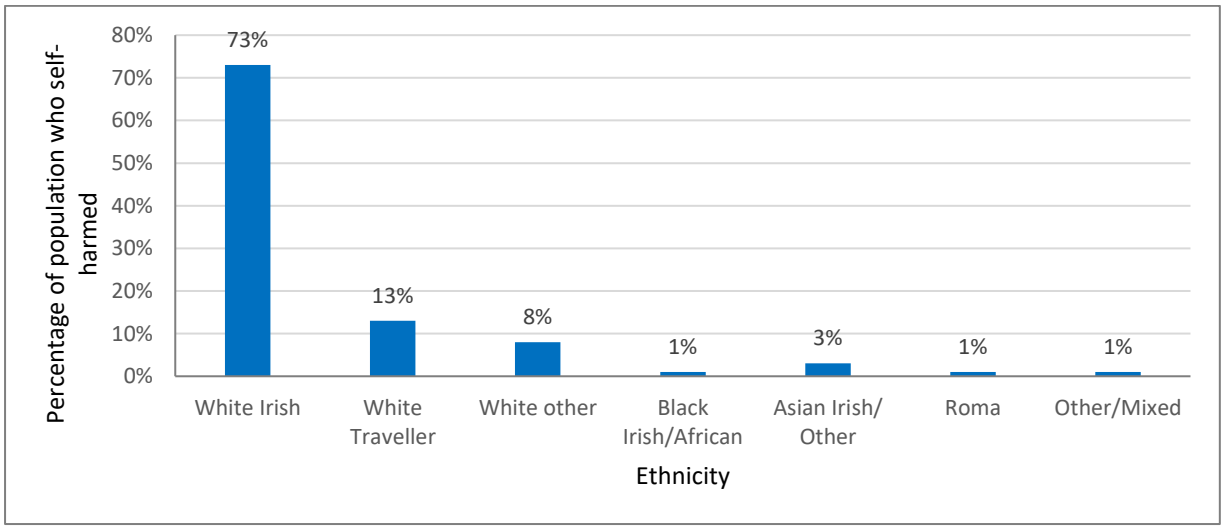


***Figure 5**. Ethnicity of those who self-harmed.*

The majority of individuals who self-harmed were recorded as White Irish (73%) or White Traveller (13%). This pattern should be interpreted in the context of the wider Irish population, whereby these groups account for a substantial proportion of individuals in custody. Consequently, the distribution shown describes the ethnic profile of individuals who self-harmed and should not, without population-specific denominators, be interpreted as demonstrating higher risk of self-harm associated with ethnicity.

Type of self-harm

In 2025, sharp objects remained the most frequently used type of self-harm in Irish prisons, accounting for over two-thirds of all episodes (66.5%, *n*=165). This pattern was consistent across both genders, with sharp objects recorded in 65% of male episodes (*n*=145) and 80% of female episodes (*n*=20). Attempted hanging/strangulation represented the second most common method overall, comprising 15% of episodes (*n*=34) for males and 8% (*n=2*) for females. Episodes involving sharp objects rose by 25% since 2024 where (*n=132),* and attempted hanging/strangulation by 24% (*n=27* in 2024).

The data highlight both consistencies and gender-specific variations in self-harm methods. In contrast to other years, males were proportionally more likely than females to engage in intentional overdose, whereas females were more likely to use fire. 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.

Table 6. *Type of self-harm.*

Type of self-harm	Male	%	Female	%	Total	%
Sharp objects	145	65.0%	20	80.0%	**165**	**66.5%**
Attempted hanging/strangulation	34	15.2%	2	8.0%	**36**	**14.5%**
Blunt objects	17	7.6%	2	8.0%	**19**	**7.7%**
Intentional overdose	2	0.9%	0	0.0%	**2**	**0.8%**
Fire/flames	5	2.2%	1	4.0%	**6**	**2.4%**
Other (Food refusal, biting)	16	7.2%	0	0.0%	**16**	**6.5%**
Chemical/noxious	1	0.5%	0	0.0%	**1**	**0.4%**
Steam, hot vapour and hot objects	3	1.4%	0	0.0%	**3**	**1.2%**
Petroleum products, solvents, vapours	0	0.0%	0	0.0%	**0**	**0.0%**
Total	223	100.0%	25	100.0%	**248**	**100.0%**

Treatment, severity and intent

The majority of self-harm episodes recorded in 2025 did not necessitate hospital-level medical intervention. In nearly one-third of all incidents (30.2%, *n*=75), no treatment was required following the episode. Minimal intervention, such as the application of a minor dressing or basic first aid, accounted for 27.4% of the cases (*n*=68). Local wound management—requiring more structured but non-hospital care—was provided in 19.8% of episodes (*n*=49).

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 20.2% of cases (*n*=50), and 2.4% (*n*=6) of episodes resulted in hospitalisation/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 7. *Severity of self-harm.*

No treatment needed	Minimal intervention/ minor dressing	Local wound management	Outpatient/A&E treatment	Hospitalisation/Loss of life
75 (30.2%)	68 (27.4%)	49 (19.8%)	50 (20.2%)	6 (2.4%)

An analysis of treatment and severity by method of self-harm revealed distinct patterns in medical outcomes (see Figure 6). In contrast with previous years, a large portion of those who used sharp objects required local wound management (*n=40*, 81.6%). 54.7% of sharp object episodes required no intervention (*n=41*). Three episodes of sharp objects led to hospitalisation/loss of life.

Attempted hanging/strangulation accounted for 14.5% (*n*=36) of incidents while 24% required no treatment (*n=18*) and one quarter (13.2%, *n*=9) required only minor dressings.

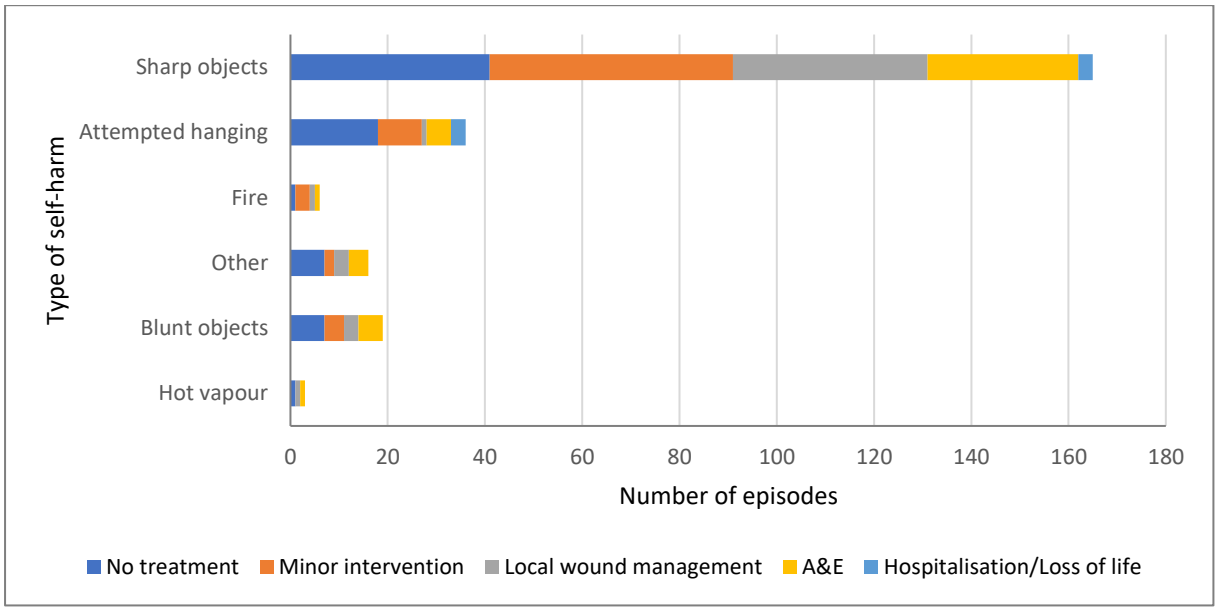


Figure 6*. Level of medical intervention required.*

An analysis of intent to harm among individuals who engaged in self-harm during 2025 (see Figure 7) indicates that most episodes were assessed as having no or low suicidal intent (60.9%, *n*=151). 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 (22.6%, *n*= 56) were assessed as demonstrating a moderate level of intent, suggesting a degree of ambivalence toward life and possible suicidal motivation. Furthermore, 16.5% of episodes (*n*=41) were identified as having a high level of intent,

indicating a smaller but significant group of prisoners at markedly elevated risk of suicide. The occurrence of episodes with high intent has doubled since 2024 (8.9%, *n*=18).

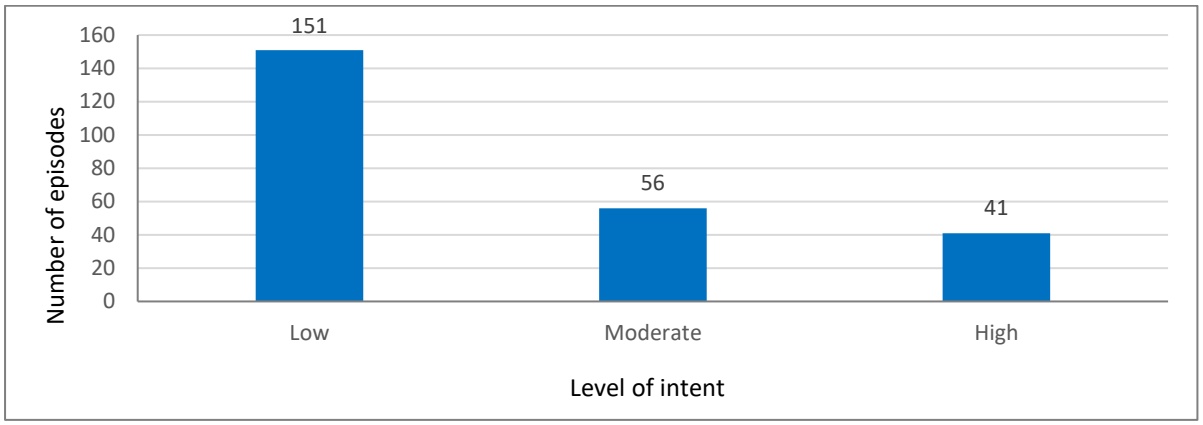


Figure 7. *Intent to cause harm during episode.*

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 8).

Among episodes with no or low intent (60.9%, *n*=151), 34.4% (n=52) required no treatment, and 33.8% (*n*=51) only minimal intervention. Local wound management was observed in 14.6% (*n*=22) of the cases. Notably, 15.9% (*n*=24) resulted in A&E, and 1.3% (n=2) in hospitalisation/loss of life.

In contrast to other years, for episodes classified as medium intent (22.6%, *n*=56), medical severity decreased: 30.4% (*n*=17) required no treatment, 17.9% (*n*=10) required minimal intervention, 26.8% (*n*=15) required local wound management, and 25.0% (*n*=14) necessitated outpatient or A&E treatment.

Episodes with high suicidal intent (16.5%, *n*=41) demonstrated the greatest severity. This figure has doubled since 2024 (*n*=18). 14.6% (*n*=6) required no treatment or minor intervention (17.1%, *n*=7), 29.3% (*n*=12) required local wound management, 29.3% (*n*=12) required A&E treatment, whilst 9.8% (*n*=4) required hospitalisation/loss of life.

Table 8. *Severity/intent matrix.*

Intent	No treatment	Minor intervention	Local wound management	A&E	Hospitalisation/Loss of life
Low	52 (34.4%)	51 (33.8%)	22 (14.6%)	24 (15.9%)	2 (1.3%)
Moderate	17 (30.4%)	10 (17.9%)	15 (26.8%)	14 (25.0%)	0 (0.0%)
High	6 (14.6%)	7 (17.1%)	12 (29.3%)	12 (29.3%)	4 (9.8%)

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.

Variation by time

Table 9. *Self-harm episodes by quarter of the year.*

Quarter of Year	Number of episodes	Percentage
Q1 (January-March)	57	23.0%
Q2 (April-June)	57	23.0%
Q3 (July-September)	76	30.6%
Q4 (October-November)	58	23.4%

The number of self-harm episodes varied over the course of 2025, indicating fluctuations in monthly incidence. The highest numbers were recorded in September (*n*=35), October (*n*=28), and February (*n*=25), suggesting potential seasonal or environmental factors influencing self-harm behaviours during these periods. In line with previous years, the lowest number of episodes occurred in December (*n*=12). This was followed by March (*n*=14) and June (*n*=16). Overall, the average number of self-harm episodes per month was approximately 20.7, reflecting a steady but variable pattern across the year (see Figure 8).

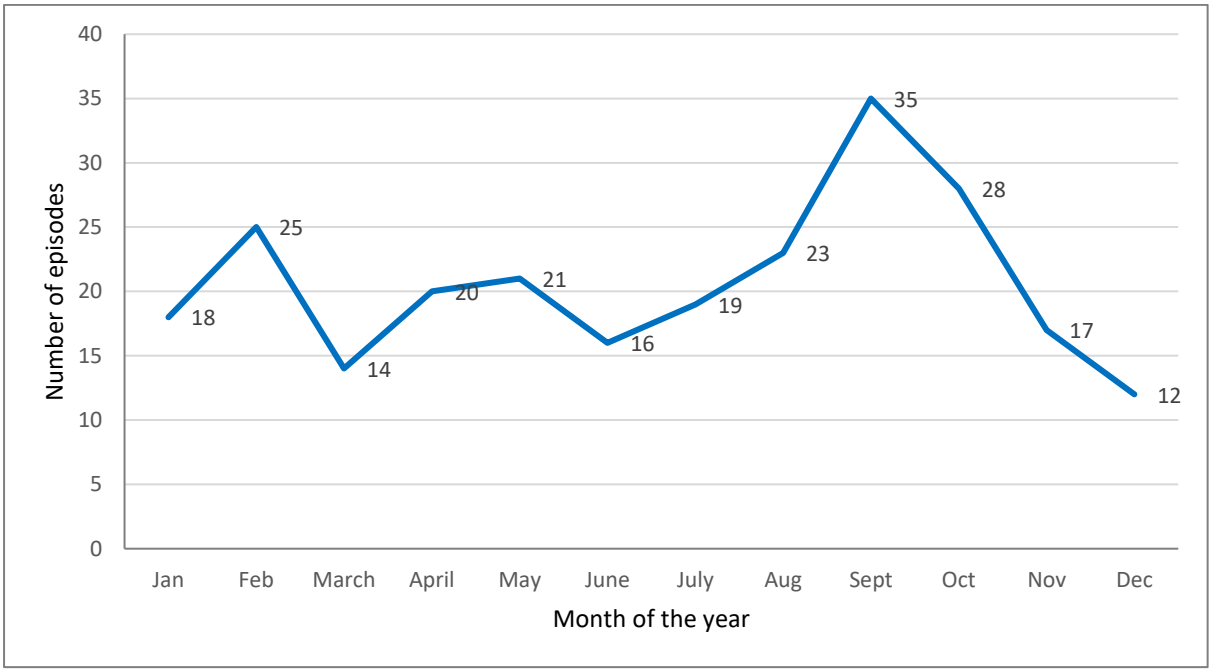


Figure 8. *Monthly distribution of self-harm episodes.*

Self-harm episodes in 2025 occurred across all days of the week (see Figure 9), with the highest proportions recorded on Thursday (16.1%) and Fridays (16.1%) for males, and Thursdays (28%) for females. Saturday had the lowest proportion of self-harm at (8.1%).

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 8 p.m. (46.0%). Very few episodes occurred during the early morning hours. (see Figure 10). Overall, the majority of self-harm episodes (67.7%) occurred while prisoners were unlocked, meaning they had access to common areas or were outside their cells. In contrast, 32.3% of episodes took place during lockup periods, when individuals were confined to their cells. These patterns suggest that both the level of staff supervision and the availability of daily routines may play a role in influencing the

timing and opportunity for self-harm in custody. This underlines the importance of meaningful activity during the prison day, and of staffing levels in order to reduce the incidence of self-harm.

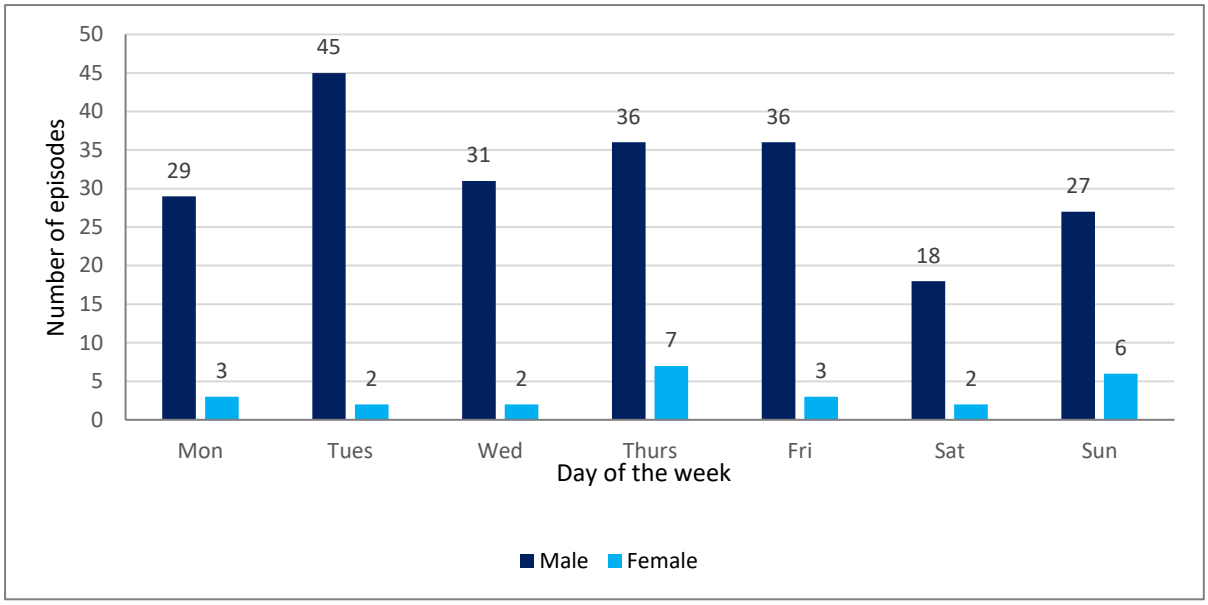


Figure 9. *Daily distribution of self-harm episodes.*

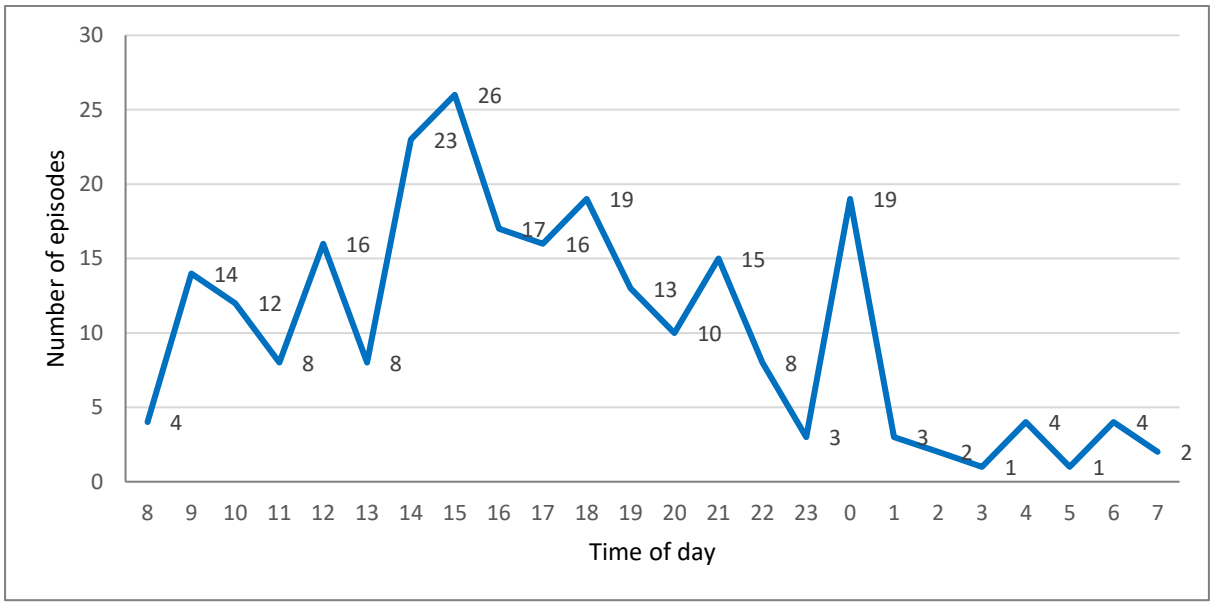


Figure 10. *Hourly variation of self-harm episodes.*

Accommodation type

Self-harm episodes in 2025 occurred across all types of accommodation within the prison system, though the majority took place in the general prison population. Of the 248 recorded episodes, over half (57.7%, *n*=143) were among prisoners housed in the general population. A further 31.1% (*n*=77) of episodes were reported among those on protection, reflecting the heightened vulnerabilities within this subgroup. Smaller portions of episodes were observed in Safety Observation Cells, Close Supervision Cells, High Support Unit and the National Violence Reduction Unit.

Almost three-quarters of episodes occurred among individuals accommodated in single cells (69.4%). A further 20.6% involved individuals in double cells, while 8.9% took place among those in triple or larger cells. A small proportion took place whilst individuals were in hospital or being transported (1.2%).

Sentence length

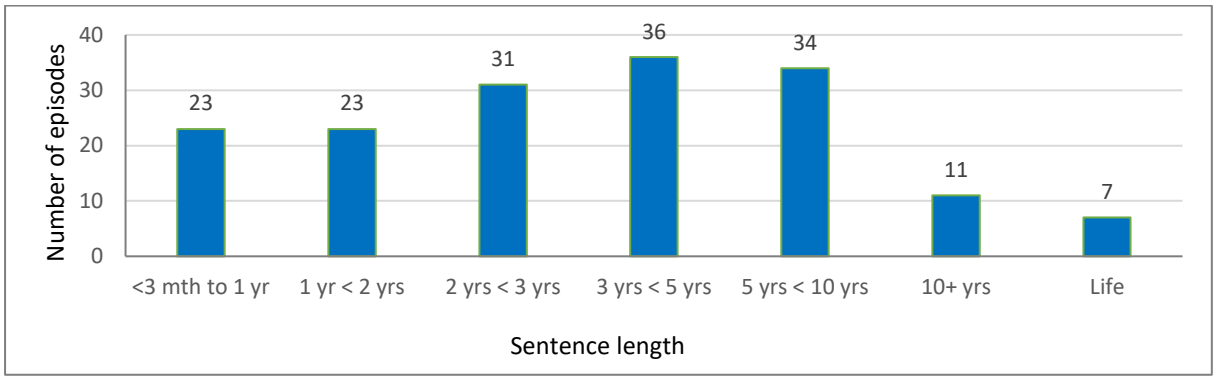


Figure 11. *Sentence length of those who self-harmed.*

Among prisoners who engaged in self-harm in 2025, the distribution of incidents by index act spanned across all sentence lengths (see Figure 11). Shorter sentences were particularly common, with 31.1% of those who self-harmed serving less than 3 years. Those serving medium-length sentences of three to five years and five to ten years each represented 14.5% and 13.7% respectively of cases. Longer sentences were less frequently observed, with 4.4% of self-harm incidents occurring among individuals serving ten years or more, and 2.8% among those serving life sentences. These findings highlight that self-harm 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.

In comparison to Figure 2, which outlines the distribution of sentence length amongst the total population, similar trends were noted. The highest proportions for both sexes were observed among those serving sentence between five to ten years (24.8 per 100 males, 24.0 per 100 females), followed by sentences of three to five years (23.2 and 23.1 per 100, respectively).

Regime level

The incentivised Regimes Policy was introduced across all prisons in 2012, and it provides for a differentiation of privileges between people in custody according to their behaviour in custody and level of engagement with services. The objective is to provide tangible incentives to reinforce prosocial behaviour, supporting a safer environment. In 2025, 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 56.9% of all episodes. A further 34.7% occurred among those on the basic regime, while 8.5% were reported among individuals on the enhanced regime.

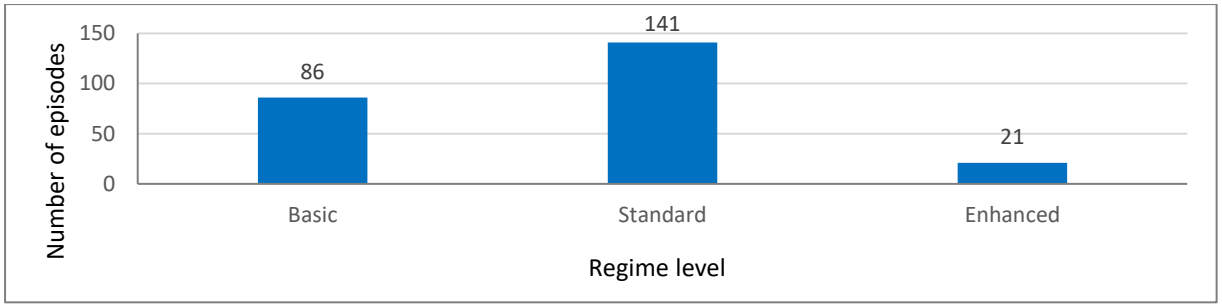


Figure 12. *Regime level of those who self-harmed.*

Contributory Factors

Contributory factors associated with self-harm are categorised into five main themes: mental health, environmental, relational, personal, and medical. In line with previous years, the majority of recorded factors were related to mental health (83.5%), which reinforces its link to self-harming episodes within the prison setting. This was followed by environmental factors (49.2%), which include aspects such as prison conditions, personal issues (35.1%) such as transfer issues, and relational issues (33.5%), such as conflicts with peers or staff, or difficulties maintaining family contact. Medical factors were identified in 24.6% of cases. Bereavement (26.6%) refers to any loss one experiences in custody, for example the loss of a friendship. These findings emphasise the complex and multifaceted drivers of self-harm in custody (see Figure 13). Within each contributory factor, there will be a list of potential sub-factors as included on the SADA Form.

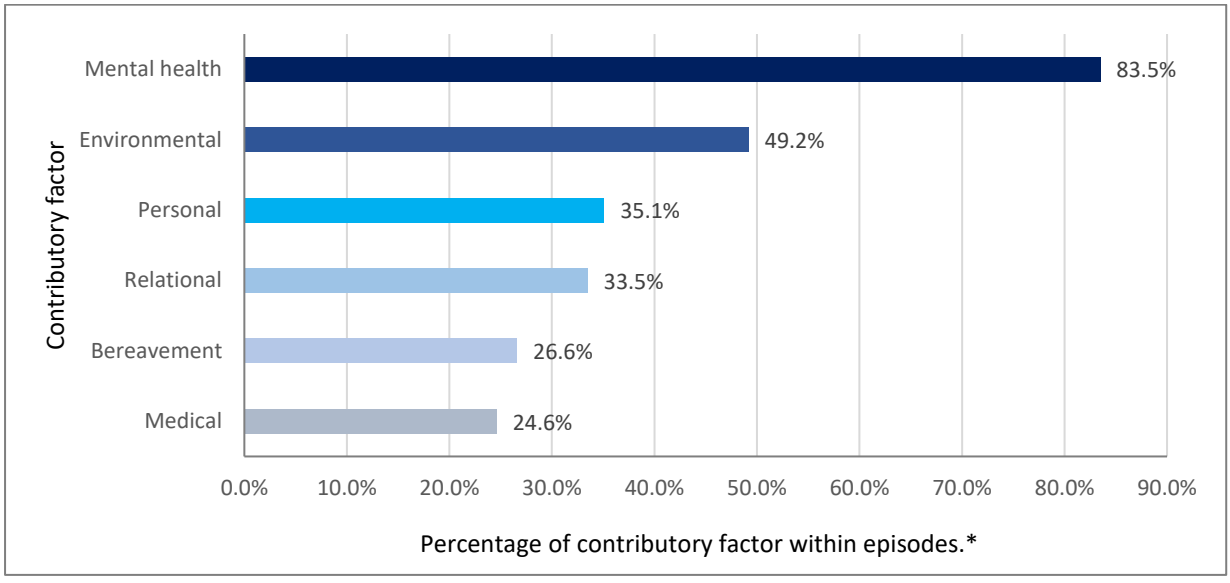


Figure 13. *Contributory factors of self-harm episodes.*

**There can be more than one contributory factor recorded for an episode.*

MENTAL HEALTH

In 2025, mental health was cited as a contributory factor in 83.5% of all recorded self-harm episodes in Irish prisons, reflecting its ongoing significance in the context of self-injurious behaviour in custody.

- Mental health (e.g. mood disorder, anxiety, PTSD, eating disorder, psychosis, personality disorder, hopelessness/low mood etc).

- Substance use/addiction.
- Poor coping/difficulties managing emotions.
- Impulsivity.
- Previous trauma

ENVIRONMENTAL

Environmental factors were identified as contributory in 49.2% of self-harm episodes in 2025, underscoring the impact of prison conditions on prisoner wellbeing. Features of the custodial environment that may contribute to distress, including accommodation, cell sharing issues, reduced regime.

- Legal issues (e.g. pending charges, court case, recently convicted, first time in custody, unexpected custody).
- Shortage of staff and/or staffing issues (causing stress/tension/chaos).
- Reduced access to regime (causing isolation/lack of stimulation).
- Type of accommodation or cell type (shared/single cell etc).

PERSONAL

Personal factors were identified as contributing to 35.1% of self-harm episodes in 2025, reflecting the impact that aspects of prison environment can have on prisoner wellbeing. They highlight how prison routines, security processes, and disruptions to stability – such as transfers or regime changes can cause uncertainty for an individual.

- Recently placed in Safety Observation Cell/on special observation.
- Protection issues (e.g. Rule 62/63).
- Transfer issues (transfer, denied transfer).
- Reduction in incentivized regime.
- Recent barrier handling/designated VDP/additional staff/disruptive or oppositional behaviour.
- Placed on screened visits.
- Denied Temporary Release/remission or breached Temporary Release.
- To orchestrate access to contraband/other instrumental gain.
- Pre-release concerns.

RELATIONAL

Relational issues were identified as contributory factors in 33.5% of self-harm episodes in 2025. This outlines the difficulties individuals have with respect to building and maintaining relationships with others.

- Relationship difficulties with other prisoners (e.g. being victimized/bullied, under threat, conflict, peer pressure).
- Relationship difficulties with staff.
- Relationship issues with significant others (e.g. friends/family)/ reduction in family or access to community support(s).
- Bullying/threatening/victimizing others.

MEDICAL

Medical issues were identified as contributory factors in 24.6% of self-harm episodes in 2025. These include physical health or treatment-related difficulties that may contribute to distress within custody.

- Medication issues (e.g. non-compliance, admin issues, drug seeking).
- New diagnosis or worsening symptoms.
- Chronic pain.
- Terminal illness.

BEREAVEMENT/LOSS

Bereavement and loss-related factors were cited in 26.6% of self-harm episodes in 2025. Distress linked to the death or loss of someone or something. This can be loss of something or someone valuable to an individual's life.

- Death or anniversary of death of someone close.
- Adjustment issues (e.g. loss of freedom, identity, and stigma).
- Loss of family or intimate relationship.
- Loss of possession or object.
- Transfer or release of supportive family member/friend/associate.
- Child custody/access issues.

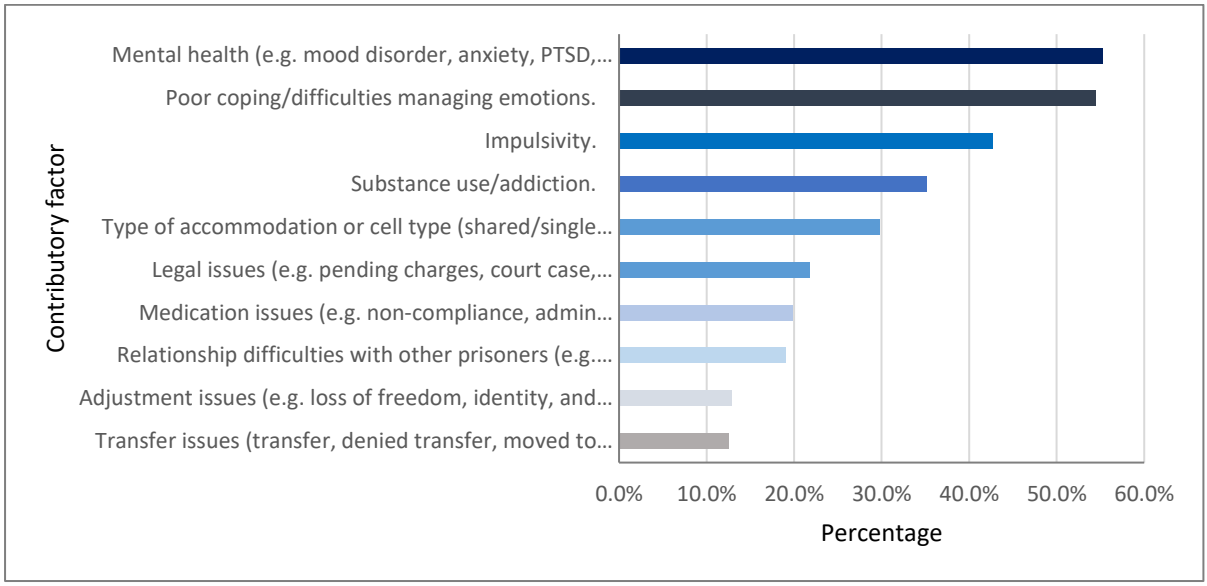


***Figure 14**. Breakdown of most prevalent contributory sub-factors.*

Recommendations

The findings of the 2025 report outline the multifaceted nature of self-harm in custody. This iterates the importance of continued, coordinated, evidence-based responses. While positive progress has been made since the publication of the previous report (new Standard Operating Procedure for Safety Observation Cells and commencement of joint care planning between mental health professionals and addiction counsellors), there remains gaps in assessment, intervention for high-risk groups, and integrated care models. The recommendations focus on implementing an integrated model of care, incorporating and distributing SADA data to facilitate staff education and prevention measures, and enhancement of committal assessments. Together, these measures aim to reduce self-harm incidence, improve wellbeing for those in custody, and ensure that responses are both consistent and compassionate across the prison system. Some of the below implications are similar to that in the 2024 report, as the trends are patterns remain the same.

IMPLEMENT AN INTEGRATED, LAYERED MODEL OF MENTAL HEALTH AND ADDICTION CARE

Co-occurring mental health and addiction needs are particularly relevant in understanding and responding to self-harm in custody. An integrated, layered model of mental health and addiction care recognises that these needs may occur together and that individuals may require different combinations and intensities of support at different times. Within this model, dual diagnosis is considered across the whole pathway of care, rather than as a separate service. This may range from early identification and prevention at the whole-population level, through primary care and brief psychological or addiction interventions, to structured secondary care and specialist multidisciplinary input for individuals with more complex or enduring needs. Importantly, the model allows mental health, psychological and addiction supports to be provided concurrently where required, rather than requiring one difficulty to be addressed before another. The continued development of this integrated and layered approach therefore represents an important priority for self-harm prevention. SADA findings can support this work by identifying patterns of co-occurring mental health, addiction and self-harm needs and helping to inform the appropriate level and combination of support.

INCORPORATE SADA FINDINGS INTO STAFF TRAINING

Prison officers have day-to-day contact with those in custody, and may be well placed to recognise changes in behaviour or circumstances associated with increased vulnerability. Psychological models demonstrate that self-harm can arise through interactions between individual vulnerabilities, emotional distress and situational stressors. Incorporating SADA findings into recruit training, and Continuing Professional Development for established prison officers, may provide them with evidence-based knowledge of how self-harm presents within each prison. It would highlight high-risk periods (e.g. between 2PM-8PM), warning signs, and appropriate pathways for raising concerns. This recommendation is consistent with evidence supporting staff training in the recognition and management of self-harm and suicide. The National Institute for Health and Care Excellence (NICE) recommends role-specific training[5], thus incorporating evidence extracted from the prisons would provide individuals with an insight into expectations and trends of self-harm in Irish prisons.

TRANSLATE SADA DATA TO LOCAL PRISON ACTION

Self-harm occurs through an interaction between individual vulnerability and the environment, meaning national trends may not fully represent the circumstances operating within individual prisons. Differences in population, accommodation and environmental stressors may contribute to different patterns between establishment. SADA may increasingly function as a tool for local reduction of self-harm as well as national surveillance. Each prison may benefit from receiving regular prison-level analysis/local prevention priorities.

ENHANCE COMMITTAL HEALTH ASSESSMENTS

Self-harm risk is dynamic rather than static. The absence of immediate intent at committal does not indicate an absence of future vulnerability. Committal assessments may distinguish between immediate risk and future vulnerability. Previous self-harm, suicidal ideation and psychiatric morbidity are among factors most strongly associated with self-harm in custodial settings[6]. However, individual predictions remain challenging, highlighting the importance of developing evidence-based approaches to identifying future vulnerability rather than relying solely on presentation on committal. Research into the efficacy of factors identified at committal would achieve data-driven insights to improve mental health support and suicide prevention strategies within the prison system. A collaborative study between IPS and NSRF in this is area is currently being planned.

TARGETED CARE PATHWAYS FOR HIGHER-RISK GROUPS

Individual case management can play a key role in identifying and addressing underlying factors contributing to self-harm. Interventions should include safety planning, regular follow-ups with mental health professionals, and support to help individuals develop healthier coping mechanisms. Additionally, programmes should address challenges that may disproportionately affect females, such as coping with adjustment issues, with menopause, grief, and maintaining connections with family and the community. Tailored mental health services that consider these unique psychological stressors are important and may reduce the risk of self-harm among females.

Similarly, those on remand tend to pose a greater risk at self-harm, according to the data from previous years. Remand can be a period of uncertainty, involving adjustment to custody alongside ongoing legal proceedings, stress over case outcomes and potential disruption to family and relationships. These feelings may contribute to experiences of defeat, humiliation, uncertainty and entrapment. This is consistent with the Integrated Motivational-volitional model of suicidal behaviour, which proposes that these experiences coupled with the presence of other vulnerabilities, increase the likelihood of suicidal behaviours. Consideration and timely follow-up could be given to increased mental health monitoring and opportunities for support during periods of heightened legal uncertainty, such as upcoming court dates.

Conclusion

The 2025 SADA findings reinforce the complex and multifaceted nature of self-harm within Irish prisons, reflecting the interaction of individual, psychological, social and environmental factors. The 248 episodes involving 158 individuals demonstrate the continued importance of systematic surveillance, while patterns relating to contributory circumstances, timing and individual vulnerability highlight opportunities for earlier and more targeted prevention. Continued translation of SADA findings into staff training, local prison-level action and enhanced assessment practices will strengthen the capacity of the Irish Prison Service to respond proactively to emerging risk. Through ongoing monitoring and evidence-informed intervention, the SADA Project provides an important foundation for improving the safety and wellbeing of people in custody and supporting the prevention of self-harm and suicide across the prison estate.

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