Addressing Self injury and Suicide: the perspective of prisoners in Ireland of the risk, contributory and protective factors and barriers to support.

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Addressing Self injury and Suicide: the perspective of prisoners in Ireland of the risk, contributory and protective factors and barriers to support.

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Contents

Contents of Tables

Table of Figures

Abstract

Background: Self-harm and suicide present a major issue in the prison population (Harris et al., 2015, Hawton et al., 2014 & 2016). International rates of suicide and lifetime self-harm are higher in prisoners than the general population (Hawton et al., 2016, Fazel et al., 2017). There is a five to six fold increase of risk of death by suicide for men in custody and a 15 to 18 fold inflation of risk of death by suicide for women in custody when compared to the general population (Towl and Crighton, 2017).

Since 2017, there has been a multi-agency effort in Irish prisons to improve the monitoring of the incidence and profile of self-harm, which has led to a better understanding of the characteristics and profile of prisoners who engage in self injury (McTernan et al., 2023). However, it remains unclear why some individuals in prison harm themselves, why some individuals do not harm themselves, and why some desist and others persist with their self harm (Forrestor et al, 2014). There is increasing evidence that demonstrates potential benefits of prevention measures used to reduce self-harm and suicide (e.g. Howard & Pope 2019, Walker et al., 2022). There are no qualitative studies that have collected and shared individuals' experiences of self harm and/or suicide in prisons in Ireland.

Objectives: This PhD aimed to explore, from the perspective of people in custody, what factors contribute to self-harm and suicide, what works to prevent it, and what supports desistance. This was done through the lens of the developmental trauma model (Lewis, 1990), the tripartite schema (Smith et al., 2019) and the Power Threat Meaning Framework (Johnstone & Boyle, 2018a). This aimed to inform effective ways for prison managers and staff to respond to incidents of self-harm and provide appropriate, helpful care.

Method: This PhD used a qualitative approach. 15 men in custody with a history of self harm and/or attempted suicide were interviewed across eight prisons in Ireland. Data was collected about the profile of self harm and/or attempted suicide, including

their history of self-harm across prison and community settings, sample demographics, and psychometric measures. Men were selected from three groups including i) those who have engaged in repeat self-harm, ii) those who have attempted suicide and iii) those who have engaged in both self-harm and suicidal behaviour (many of whom had desisted from self-harm and suicide). Thematic Analysis (TA) was used to generate a detailed description of their perspectives of what factors contribute towards their self-harm and/or attempted suicide (including individual risk factors, the risk environment and contributory factors) and factors that may promote desistance from self-harm and suicide and interventions.
Results: In this PhD, six themes were identified as relevant to self-harm and suicide in prisons, including 1. Nature of harm, 2. Risk Factors, 3. Link to Violence, 4. Factors contributing to self-harm and suicide, 5. Barriers to Support and 6. Protective Factors and Interventions. Key findings showed that the nature of harm involved acts of self-harm, suicide and both suicide and self-harm in prisons in Ireland, from which intentionality could not be inferred. Risk factors identified by participants as relevant to their self-harm and suicide included a history of substance use, being on remand, previous history of custodial sentence(s), lack of visits, neurodiversity and the presence of Adverse Childhood Experiences (ACEs)'s. These are all, however, typical prisoner population characteristics (McDermott & Willmott, 2018). Contributory factors identified by participants included substance use, stress and anxiety, arising in the context of recent committal to prison, mental health difficulties (e.g. emotion regulation difficulties & Axis 1 disorders[1]), feelings of loneliness, isolation, hopelessness and despair, adjustment issues, neurodiversity, loss of relationships through bereavement or loss, and relational difficulties with staff and other prisoners. Five key factors were identified that underlie the level of risk posed by the environment included lack of structured activity, staffing shortages /overcrowding, large prisons, prison culture that does not support showing vulnerability, and lack of procedural justice. Factors that may increase risk of harm include the use of a Special Observation Cell and lack of trauma informed practice. Barriers to support identified included mistrust, lack of available support, shame, punitive response and prison culture. Lastly, protective factors that promoted desistance from self-harm and suicide attempts or strategies that prevent or reduce risk of harm to self included recovery from substance use, family connections, involvement in structured activities and psychological therapies, taking personal

[1] Footnote: Axis 1 Disorders include all clinical disorders such as Schizophrenia, mood/anxiety/eating/ sleep disorders.

responsibility, intervention focusing on prevention (not crisis management), continuity of medical care (including effective communication about clinical decisions), trusting relationships with staff in which they feel they are treated as individuals, and that their rehabilitation matters, and a culture that makes it safe for them to reveal their vulnerabilities and to seek support. This study offers both unique contributions and integrated learning. This includes an understanding of the aetiology of self harm and suicide, the role of repetition, and the relationships between self harm and suicide. It also identified intertwined cycles of adversity, trauma and self harm and/or attempted suicide and the unique contributions and shared insights of prisoners.

Conclusions: These findings are contextualised within the strengths (e.g. innovative methodology combining both self-harm and suicide, first qualitative study in Irish prisons, new data exploring prisoner experiences and perspectives) and limitations (e.g. male sample only which included those who have desisted, self reported data, poor response rate to psychometrics). Potential implications and future directions are considered for policy (e.g. benefits of trauma informed prisons, a recovery based model for mental health and substance use and a focus on prevention) and practice (e.g. enhanced family contact, greater access to structured activities and psychological therapies, specialist units and supports for specifics cohorts, and promoting a culture that instills hope, embraces vulnerability, treats people with respect, courtesy and as individuals, making sure they feel that they matter and that we care about their rehabilitation), theory (e.g. aetology of self harm and suicide as similar entities, role of procedural justice), and research (e.g. importance of adaptive methodologies) within Ireland & other jurisdictions.

Key words.

Self-harm, suicide, custody, prison, substance use, mental health.

Chapter 1. Introduction

This PhD thesis presents novel and original research exploring the management of self-harm and suicide in the Irish Prison Service (IPS), which was explored through the lens of the tripartite schema (Smith et al., 2019), the developmental trauma model (Lewis, 1990) and the Power Threat Meaning Framework (Johnstown & Boyle, 2018). This first, introductory chapter will set out the context of the research by providing background information about self harm and suicide, the motivation for undertaking the research, and the importance of the research. It will discuss key concepts, terminology, and points of interest. It will introduce the concepts of self harm and suicide, and provide a definition or self-harm and suicidality, mental health and substance use. It will identify the costs of self-harm behaviour in prison. It will then provide a rationale for the focus of this PhD and outline the aims and objectives of the thesis, including the research questions. It will present the expected value of this PhD research for the Irish Prison Service and for society in general. This Chapter will then outline the structure of the thesis.

Background

Mental Health of Prisoners

The European Drug Report identified that up to 65% of people in prison have a mental health disorder (European Monitoring Centre for Drugs and Drug Addiction, 2021). Mental health refers to a state of wellbeing that helps us to cope with the normal stresses of life, to work and contribute to our communities, and to develop as people. It includes how we think, feel and behave, interact with other people look after ourselves and others and take part in and enjoy our lives. Mental health can vary on a contimum from positive healthy functionning to severe impact on everyday life. A person experiencing a mental health difficulty may seek and receive a diagnosis from a mental health professional such as a psychiatrist for a mental health condition is an illness or disorder that affects your thinking, feeling, behavior, or mood (e.g. Axis I – is comprised of disorders that currently exist like schizophrenia and mood/anxiety/eating/sleep disorders. Axis II – comprises personality disorders such as obsessive-compulsive disorder in adults and developmental problems in children and adolescents). Healthcare professionals use guidelines in the Diagnostic and Statistical Manual of Mental Disorders to diagnose mental health conditions.

People with 'comorbid' disorders have an elevated risk of suicide, and is one of the leading causes of death among people in prisons. In other words, if more than one 'mental disorder' has been diagnosed, the risk of self harm may be further inflated. It has also been shown that people in prison with dual diagnosis (e.g. have both a substance use problem and a mental health issue such as depression or an anxiety disorder) also display a higher incidence of injury (including self-harm) upon release from prison (EMCDDA, 2021).

Mental Health Morbidity

Prisoners have high levels of mental health 'morbidity', certainly according to psychiatric models of understanding mental health (Fazel, 2012). Adverse health events disproportionately affect individuals in custody, often as a result of trauma, violence, substance use and other risk factors such as self-harming behaviours. The term 'morbidity' may, however, be considered an anachronistic term. A more useful way to contextualise prisoner's mental health can be found within a Biopsychosocial (BPS) model, first described by Engel (1977), which offers a holistic description of the biological (individuals' nervous or immune systems), psychological (individual factors such as their experience and behaviour) and social factors (e.g. family & community), that interact to influence the presence and severity of mental health issues in the population. Several studies have established that women in custody have often experienced traumatic physical and mental health experiences prior to imprisonment (Towl & Crighton, 1998; O'Brien, et al., 2003; Jenkins, et al., 2005). On entering prison, many have experienced chaotic lifestyles involving substance misuse, mental health problems, homelessness and multiple sources of past trauma (Ministry of Justice, 2018).

Substance use

Substance use is the continued use of alcohol, illegal drugs, or the misuse of prescription or over-the-counter medicines with negative consequences (American Psychiatric Association, 2022; Weiss & Liebschutz 2024). These consequences may involve problems at work, school, home or in interpersonal relationships, problems with the law, health problems, physical risks that come with using drugs in dangerous situations. Substances that are commonly used include Alcohol, Amphetamines, Cocaine, Inhalants, LSD, Marijuana, PCP, Prescription medicines.

Self harm and suicide

Self-harm and suicide present a major problem in the prison population (Hawton et al., 2014 & 2016). It is well-documented that incarcerated individuals are at an increased risk of deliberate self-harm and suicide (WHO, 2007; Tomaszewska, Baker, Isaksen, & Scowcroft, 2019).

Definition of self-harm and suicidality

This section will define self-harm and suicidality. Self-harm behaviours can be divided into self-harm behaviours and suicidal processes (e.g. suicidal ideation, threat, attempt, and completion). Acts of self-harm can be divided into self-harm behaviours and suicidal processes (e.g. suicidal ideation, threat, attempt, and completion). Acts of self-harm can be an expression of personal distress and the person may directly intend to injure him/herself, with little or no suicidal intent. However, acts may also include intent to kill oneself (e.g. suicide). The UK Ministry of Justice formally records self-harm as "any act where a prisoner deliberately harms themselves irrespective of the method, intent or severity of any injury" (Ministry of Justice, 2018). Self-harm is defined in the NICE guidelines as 'self-poisoning or self-harm, irrespective of the apparent purpose of the act'. This definition has been adopted by the IPS to define acts of (non-accidental) self-harm, which is in line with the definition used by the National Self-Harm Registry Ireland.

Suicide is the act of intentionally causing one's own death (Stedman's medical dictionary, 2006). Attempted suicide or non-fatal suicide involves self-harm with at least some desire to end one's one life that does not result in death (Krug, 2002). Marzano et al., (2010) considered near-lethal self-harm as a distinct entity, delineating these acts from what historically would have been categorised within 'attempted suicide' or 'parasuicide' (McHugh & Towl, 1997).

Impact of self-harm behaviour in prison

This section will explore the impact and costs associated with self-harm behaviour. Self-harm is a major international public health concern because of its associations with physical injury and increased lifetime suicide risk (Hawton, et al., 2014), and because self-destructive and suicidal behaviours are linked to interpersonal trauma (Van der Kolk et al., 1996). There is a higher prevalence of self-harm history among prisoners who suicide than among the general population, and higher levels of suicidal ideation among self-injurers in prison (Dear et al., 1998, Eyland et al., 1997). Individuals who self-harm often repeat self-harm, which has been shown to increase

the risk of suicide (Owens, Horrick and House, 2002). Those who have previously attempted suicide are at higher risk for further attempts (WHO, 2016). Suicide has a significant impact on the many people affected by an incident (Blaaauw & Kerkhof, 2001), including prison management who are responsible for safeguarding the health and safety of prisoners, and prison officers who may be traumatised by discovering the deceased, may be concerned about the threat of further possible suicides, or may feel guilty for not having correctly interpreted the signs that indicated a suicide risk. Fellow prisoners who may blame prison officers or the regime for the suicide. It will also negatively impact relatives and partners who have lost a loved one, which is often more painful in prison due to lack of information about the circumstances surrounding the death.

The findings of a study by Smyth and Kaminski (2010) suggest that self-harm behaviours carry more significant resource costs to the prison service than suicidal processes. This includes increased health resources, such as staffing, use of force, and the medical responses (i.e. treated in house or requiring hospitalisation) and the protocol response due to augmented mental health issues, institutional restrictions and disciplinary problems (Smith and Kameski, 2010). Smith et al., (2019) maintain that these routine hospitalisations place additional demands on prison systems; particularly due to the additional staff time needed for transportation and security, as well as significanrt medical expenditures for the often life threatening trauma that require invasive medical procedures.

Rationale for current PhD research

This section will explain the rationale for the current PhD research. The high prevalence of self-harm in prison, with a high rate of repetition, presents a particular challenge in the management or risk of self-harm. Self-harm presents significant concern because it has been associated with physical injury and increased risk of suicide in prisoners (Hawton et al., 2014; Harris Review, 2015), with repetition of self-harm, which has also been shown to increase the risk of suicide (Owens, Horrick and House, 2002), is associated with high-risk, often lethal, self-harming behaviours (Walker & Towl, 2018), costs to the prison system (Smyth, Slade & Kaminski, 2019) and a negative impact on those affected by an incident (Blaaauw & Kerkhof, 2001).

Nature of harm

A wide range of patterns and methods have been identified for self-harm and suicidality, and there is diversity in the intended motivation for prisoner's use of self-harm. It is critical that we understand the nature of harm, including the motivations preceding acts of self-harm in order to ensure we are delivering effective interventions (Walker et al., 2017). Understanding and monitoring of self-harm would enable the development of effective programmes and assist in identifying at risk prisoners (Mcarthur, 1999). This PhD explores the nature of harm engaged in by people in custody.

Risk and contributory factors for self-harm and suicide in prison

We also need to gain an understanding of what factors put people at risk of, or contributes to, episodes of self-harm. Clinical practice guidelines for the management of self-harm (National Institute for Clinical Excellence: 2004) recommend a thorough assessment of mental health and social needs, precipitating factors and the risk of further self-harm or suicide among self-injuring individuals with whom they come into contact. The suicidal process in prisoners is a complex interplay of background factors, adverse life events, mental health and psychological problems and cognitive processes. Understanding and recognising these various aspects of the process is likely to improve suicide prevention in prisons. Forrester (2014) identified the need to explore why most people in custody do not self-harm and why some who harm themselves are propelled towards suicide whereas others are not. In order to enable individuals to effectively reduce their risk of harm, policymakers and service providers need to focus and redirect interventions towards the risk environment, in particular, the physical environment (e.g. the space within which prisoners live), the social environment, (the social situations and places in which harm is produced and reduced), and the economic and policy environment. There is limited research contextualising either the risk environment, or the individual factors that produce or mediate the risk of harm. Developing a better understanding of the association between Adverse Childhood Experience's (ACE's) and self-harm or suicidality in the prison population, as well as the link between violence and or aggression and self-harm, may help to identify where preventative work can be directed. Examination of cultural and environmental risk factors specifically, in addition to protective factors is also warranted (Perry, 2020;

Borschmann et al., 2017). This PhD explores the factors that contribute to people ib custody engaging in self-harm and suicide.

Facilitators and barriers to desistance.

To identify and develop prevention and therapeutic interventions, it is important to understand the factors that contribute to desistance from self-harm in prisons. There is a need to understand why some people repeat self-harm or engage in suicidal processes and why others desist. As stated by Pope (2018), we know more about risk factors than protective factors. This PhD explores the factors that may support people in custody to desist from self-harm and suicide.

Prevention measures for self-harm and suicide

It is important to reduce the risk of self-harm by people in custody and to improve the management of self-harm and suicide. Prison provides a unique opportunity to identify and support individuals who may be at risk of self-harm. The European Committee for the Prevention of Torture have criticised deaths in custody that were preventable and have commented on the high rates of self-harm and suicide in Irish prisons (CPT, 2015 & 2024). Addressing the risk of harm to self by prisoners will make prisons safer for all. There is far less research on self-harm behaviour by comparison to suicide and therefore fewer evidence based strategies for managing self-harm. Further research is required to identify what works to reduce or manage self-harm in prison settings. In a study by Howard & Pope (2019), they recognised the value of considering the resource that men who have learned to cope differently provide and the potential benefits of their involvement in providing care to this group. They identified that critical factors that support desistance from self-harm include feeling important, encouraging hope for the future and promoting change, trusting relationships with genuine care, understanding the motivation for self-harm, developing strategies to cope and critical turning points for change such as persons, situations or units that enable people to feel safe, believed in and supported. They concluded that understanding the experiences of people who have successfully learned to cope differently and refrain from harming themselves can helpfully inform methods or strategies to tackle this problem. This PhD explores the factors that may protect against self-harm and suicide, and the strategies that may help prevent self-harm and suicide.

The role of user-led research

There is a growing number of studies in the community who have recognised the role of user-led evidence in research. In a qualitative interview study by Sinclair & Green (2005), they explored patient's experiences of deliberate self-harm, and it was argued that appropriate interventions should acknowledge "diverse populations and diverse service needs". A study by Hume & Platt (2007) investigated service user perspectives of the treatments received following self-harm, and found that patients had a preference for provision of immediate aftercare and that personal circumstances and life history are major influences on the choice of interventions for self-harm. There is little research exploring the experiences and perspectives of people in custody. The engagement of service users' experiences in exploring appropriate interventions for self-harm has been relatively neglected compared to clinical studies focusing on the management and prevention of self-harm (Hume & Platt, 2007). There are very few studies exploring the perspective of individuals in custody, and none have been completed in Ireland. Current and future regimes for managing self-harm and/or suicidality in the Irish Prison Service have a significant impact on people in custody, and thus it is essential that their voices are listened to. Research exploring the lived experiences of people in custody may be useful (Carter et al., 2022, Walker et al., 2021, Fitzalan & Pope 2019). It is important that service users are involved, and individuals' lived experiences is collected and shared. The NICE guidelines (2004) recommend that "[a] study using an appropriate and rigorously applied qualitative methodology should be undertaken to explore user experiences of services". Despite potential concerns about involving vulnerable individuals in research into self-harm and suicide in case it might cause distress and suicidal feelings, Biddle et al., (2012) reported that research participants had an overall positive experience, with 50-70% reporting improved mood, and 18-27% reporting lowered mood, with most anticipating it would only be transient and was outweighed by their desire to contribute to research. This PHD involves asking people in custody to share their perspectives on the management of self-harm and suicide.

Role of the researcher

Since 2016, the researcher has been very involved in implementing Ireland's national strategy 'Connecting for Life', which aims to reduce suicide. As an active member of the National Suicide and Harm Prevention Steering Group (NSHPSG), the researcher has pioneered the design and implementation of data collection methods for every episode of self-harm and suicide in Irish prisons under the 'SADA' project. With five

years of data gathered, the researcher began to reflect on how we could use the data collected by the IPS to further improve the way self-harm and suicide in prisons is managed and to inform policy development. Data collected between 2016 and 2020 in Irish Prisons only gives a glimpse into self harm and suicide by prisoners and needs to be explored further. The data has consistently informed the IPS of the contributory factors that lead people in custody to hurt themselves, which pointed to mental health as a primary driver of self-harm and suicide. However, the term 'mental health' can often be too broad to fully make sense of what that means. This necessitates a deeper exploration of the factors that put people at risk of harm to self and how to reduce incidents of self-harm. To fully understand this, it requires an understanding of the perspectives of people who have engaged in self-harm and suicide attempts in prisons. The positionality of the researcher will be explored later.

Current PhD:

This section will describe the PhD research in more detail. This PhD presents findings from research undertaken in eight prisons with men in custody across Ireland. This PhD research aimed to understand, from the perspective of people in custody, the risk and contributory factors that may increase the likelihood of self-harm and suicide, the factors that may protect against self-harm and suicide, and the barriers to support. It involved those who have self-injured, those who have engaged in suicide, and those who have engaged in self-harm and suicide in prison. It included those who have desisted from self-harm or suicide. This research was completed through the lens of the developmental trauma model (Lewis, 1990) the tripartite schema (Smith et al., 2019) and the Power Threat Meaning Framework (Johnstone & Boyle, 2018). More specifically, it explored from their perspectives the factors that place them at risk of, or increase the likelihood of self-harm and suicide, or the factors that may protect them against self-harm and suicide in custody, and the barriers that may exist to support. The research explored individual/ background risk factors, the contributory factors including the risk environment within which they live (i.e. the physical, social, economic and policy environment), the resources and strategies people in custody use to manage risk, and potential prevention and treatment strategies for self-harm (formal and informal).

Whilst rates of self harm and suicide are higher amongst women, the study focused on men due to the relative persistence over time between 2017 and 2021 in the number of men engaging in self-harm, the increased severity associated with

episodes of self-harm amongst men (McTiernan et al., 2021) and the fluctuation in prevalance but significant reduction in the number of women engaging in self-harm in Irish prisons, which can be accounted for by a generally small number of women (McTiernan et al., 2023).

Conducting in depth semi-structured interviews with people in custody about their self-harm behaviour has helped us understand the individual risk factors, and how the contributory factors including the risk environment within which prisoner's live, produces and or mediates the individual's risk of harm. It explored how people in custody can develop strategies to manage and reduce the risk of harm, what factors may protect an individual against harm to self, and how the risk environment can be enhanced from the prisoner's perspective to ensure safer custody. It contributed to a better understanding of the risk, contributory and protective factors, as well as the barriers to support, for self-harm and suicide in custody.

This PhD research has helped us better understand the aetiology, management and prevention of self-harm and suicidality in prisons. It added to the debate on the aetiology of self-harm and suicide, and provided a new theoretical framework to understand whether self-harm and attempted suicide are similar entities. This research is groundbreaking in that it has contributed towards new research by providing the first qualitative study of male prisoner's experiences in Ireland of self harm and suicide in prisons. It contributed towards new methods by analysing both self-harm and suicide in one study. It provided new data by directly exploring participant experiences and perspectives, rather than a broader overview achieved through data analysis, inspectorial or evaluation and by exploring multiple dimensions together. It provided new data by directly exploring participant experiences and perspectives, rather than a broader overview achieved through data analysis, inspectorial or evaluation and by exploring multiple dimensions together. It added to the debate on the aetiology of self-harm and suicide, and provided a new theoretical framework to understand whether self-harm and suicide are similar entities. This research has addressed gaps in the literature on strategies or interventions for managing self-harm in prisons. This research offers new and interesting insight into interventions that should be used to address self-harm and suicide. This PhD helped to identify what works to reduce and/or manage self-harm and suicide among people in custody and help inform effective ways for prison managers and staff to respond to incidents of self-harm and suicide and provide

appropriate, helpful care. Relatively little is known about managing self-harm and suicide in individuals in this specific context so by drawing on the perspective of people in custody and their lived experiences, this provided a useful, and much needed insight into their experiences and challenges of being in custody, whilst considering potential environmental, psycho-social factors and implications. This PhD shed light on the preventative interventions prisons should implement to reduce risk of harm in male prisoners. The findings will have a significant impact on policy and practice. This study makes recommendations for positive changes to policy and practice that will have a meaningful impact on prisoner's lives.

Research Question(s)

This section will outline the objectives of this PhD and the research questions being asked by this PhD. Table 1 outlines the objectives of this PhD research.

Table 1

Objectives for the PhD Research.

Objective	What?
1.	To explore the risk and contributory factors for self-harm and suicide for men in custody.
2.	To explore the facilitators and barriers to desistance.
3.	To identify what works to reduce and/or manage self-harm among men in custody in order to help inform effective ways for prison managers and staff to respond to incidents of self-harm and provide safer custody.

The questions being asked by this research include:

1. **What are the individual risk factors for men in custody who harm themselves?**

- Why do some men in custody harm themselves?
- What are the background factors that can place people at risk of harm?

2. **What are the institutional risk factors?**

- What aspects of the physical, social and economic environment in the everyday lives of men in custody that can place an individual at risk of harm?
- How does the policy environment influence the risk environment within which they live?

3. **What are the contributory factors that explain why men in custody engage in self–harm and suicide?**

- What are the reasons some men in custody engage in self-harm and suicide?
- Why do some men repeat self-harm and/or engage in suicidal processes?

4. **What works to reduce or manage self-harm in prisons?**

- What is prisoner's experience of current policies and procedures used to manage risk of harm?
- What works to reduce self-harm and suicide?
- What could be done to improve the risk environment or to create safer custody?
- What strategies do people in custody employ to reduce the risk of harm?
- How do people in custody, who have previously self-harmed but no longer do so, describe their experience of learning to manage their self-harming? What helped or hindered the change process?
- What are the facilitators and barriers to reducing their self-harm or suicide in their daily lives?

The expected value of this PhD research for i) the Irish Prison Service and ii) for society in general is:

The Irish Prison Service

- It will explore the reasons why some people in custody engage in self-harm through the lens of the developmental trauma model (Lewis, 1990) and the Power Threat Meaning Framework (Johnstone & Boyle, 1990).
- It will capture prisoner's experience of the risk environment in prison that places an individual at risk of harm.
- It will provide an opportunity for prisoners to share their experiences and perspectives of the risk environment and to promote a meaningful understanding of service user experience.
- It will explore the nature and conceptualisation of self-harm and suicide through the lens of the tripartite schema (Smith et al., 2019).
- It will have a practical application to the Criminal Justice System by making recommendations about the management and treatment of prisoners at risk of self-harm and/or suicidality, thereby contributing to the effective management of self-harm and/or suicidality in prison.

- The impact of this PhD will be evidenced in the development and implementation of new policies and practice to manage self-harm and suicide. This includes the continued and renewed application of policy and practice that is effective, as well as changes to policy and practice where improvements can be made, which is informed by the experiences of people in custody.
- It aims to reduce the number of episodes of self-harm and/or suicidality, both in the mainstream prison population, but also in the community upon release from prison. This will contribute towards safer custody and safer communities.
- This aims to positively impact prison management, Prison Officers and prisoners, by creating a safer environment for all and enhancing the wellbeing of prisoners.
- The current PhD research has the potential to make a significant contribution in both preventing episodes of self-harm and suicidality, and/or reducing the number of episodes of self-harm and/or suicidality, which should reduce deaths in custody, and contribute towards safer custody.

Society in general

- The PhD research will support families of prisoners by preventing or reducing severity of self-harm and suicidality in custody, and ensuring safer custody.
- Given the correlation between self-harm and/or suicidality in custody and self-harm and/or suicidality upon release, it is possible that the PhD research may also contribute to a reduction in the likelihood of repeat self-harm and/or suicidality in the community.
- The PhD research should also be of use to other agencies increasingly seeking to involve service users in their work, particularly where this involves collecting and sharing evidence about individuals' lived experiences for advocacy campaigns and research.
- It will also contribute towards the aims and objectives of ireland's national strategy 'Connecting for Life', which aims to reduce suicide.

Thesis Outline

In the second chapter, it will outline the prison context, including the international human rights standards, the prison response to management and prevention of self-harm and suicide and the Irish Prison Service's response to self-harm and suicide in prison.

In Chapter three, it will present a review of the literature and will introduce the themes identified in the literature on self injury and suicide in prison. It will outline the prevalence of self-harm and suicide, the role of repetition, the nature of harm, the methods used by people in custody to self-harm and attempt suicide, the lethality, severity, and timing of incidents, risk factors for self-harm and suicide, their motivation for self-harm and suicidality, the impact of the prison environment, the factors that promote desistance from self-harm in prison and the strategies that can be used to prevent or reduce self-harm in custody. It will critically introduce the developmental trauma model (Lewis, 1990), the tripartite schema (Smith et al., 2019) and the Power Threat Meaning Framework (Johnstone & Boyle, 2018) as the theoretical framework underpinning this thesis.

In Chapter four, It will present the research methodology used in this qualitative study exploring prisoners' understanding of the origins and experiences of their self-harm and suicidal behaviour. It will introduce the design and methods, participant sample, data collecton methods, the nature of informed consent, post interview support, data analysis, ethics approval and personel involved in this research, including any conflict of interest. It will consider reflexivity by examining the researcher's professional role, beliefs, judgements and practices during the research process and how these may have influenced the research.

Chapter five will introduce the quantitative data including the demographics and characteristics of the sample (age, history of offending, P19's, substance use, and social factors), results of the psychometric measures, and data from the SADA forms (sentence length, trimester, intent and severity, and contributory factors for their self harm and suicide). This chapters will present the raw data, and compare findings to the academic literature.

Chapter six, seven, eight and nine will present the qualitative findings of this PhD research. Each Chapter will introduce the themes identified by participants during interviews such as the nature of their harm (Chapter 6), the risk factors and contributory factors for their self-harm and suicide (Chapter 7), the barriers to support (Chapter 8) and the protective factors and interventions that may reduce self-harm and suicide (Chapter 9). Each Chapter will discuss the findings about the participant's understanding of the nature of harm, the risk factors for their self-harm and suicide, the factors contributing to self-harm and suicide, the link to violence,

barriers to support, and protective factors. It will explain the data, offer an analysis and synthesis of the data within the contect of the academic literature and discuss the implications of these findings both in terms of the theoretical framework.

Chapter 10 will explore the findings in the wider context and implications for prison practice. Finally, it will draw out some key conclusions and recommendations in Chapter eleven. It will explore the implications and future directions, and consider the usefulness, sustainability, potential for transferability to other contexts of the work. It will explore the implications for practice and for further study in the field and suggested next steps, and provide recommendations for policy and practice. The strengths and limitations will be considered, before summarising the findings and providing final conclusions. This section will highlight the importance of this PhD, both in terms of new theoretical advances, new data, new approach combining the study of both self harm and suicide, and achieving meaningful impact on policy and practice. Throughout this thesis it will offer some reflections from an academic, clinical /professional and personal perspective throughout the PhD journey.

Chapter Summary

Self-harm and suicide present a significant concern for the criminal justice system. The importance of enhancing effective management and intervention strategies to ensure safer custody has been highlighted to protect against risk of harm to self. This PhD aimed to provide new findings about why people in custody in Ireland hurt themselves and to bring about meaningful change to policy and practice in order to reduce the risk of self-harm and attempted suicide in a custodial setting. It approached this by interviewing people in prison who have engaged in self-harm and/or suicide, including those who have desisted about the reasons why they engaged in self-harm and suicide, what might help them (or what has helped them) to desist, and the strategies they use to support desistance. It made recommendations for the management of self-harm and suicide in Irish prisons.

The next Chapter will present the broader prison context within which this research is located, including the obligations placed on prisons, the prison response to self-harm and suicide in Ireland. It will provide a critical analysis and comparative insights to other jurisdictions.

Chapter 2: The Prison Context

In order to fully understand the nature of this research, it is important to understand the prison context. This Chapter will describe the wider context of the Irish prison system, including the obligations placed on prison authorities to prevent suicides in prison and to investigate those which occur. It will also present the prison response to the management and prevention of self-harm and suicide both internationally and more specifically in Ireland. It will also incorporate critical commentary from the Inspector of Prisons and the Council of Europe's Committee for the Prevention of Torture (CPT). The researcher has privileged and unique access to prisons, including data and information about the IPS due to the researcher's professional role. This Chapter is important because it provides an understanding of what is expected based on standards required by prison authorities, what measures are typically in place in prison systems, and also, what arrangements are in place for the care of prisoners in an Irish context.

European and International Human Rights Standards

Both European and International human right standards place obligations on prison authorities to take reasonable steps to prevent suicides in prison and to investigate those which do occur. The obligation to protect the right to life of everyone in their territory has been advanced by the European Convention of Human Rights under Article 2 (the right to life) (Kelly, 2005) and has been incorporated into Irish Law as the Irish Human Rights and Equality Commission Act 2014. This incorporates taking preventative action in relation to avoidable deaths. The European Prison Rules, dating from 2006, provide standards to all states which are parties to the Council of Europe. Whilst not legally binding, and cannot be imposed on prison systems, the European Court of Human Rights refers to them regularly in its analysis of whether there has been a breach of the European Convention on Human Rights in a particular case (Van Zyl Smit & Snacken, 2009). The Court has previously considered the issue of suicide in prison. Internationally, the United Nations Standard Minimum Rules (known as the Mandela Rules), which were adopted in 2015, also adds to the broad international consensus about the human rights standards which should apply in the prison context. The United Nations Standard Minimum Rules for the Treatment of Prisoners provides global, international standards. The Nelson minimum prison conditions, provide guidance, and set clear benchmarks for prison staff on how to uphold safety, security and human dignity. This includes the

provision of Humane Treatment, Non-Discrimination, Normalization, Safety and Security, and Tailored Rehabilitation.

The Council of Europe's Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment (CPT) has created a series of authoritative standards recognised across Europe for human rights protection for prisoners. The CPT has provided a blueprint for prison systems seeking to prevent torture and inhuman and degrading treatment and has had a significant influence on penal practice in Europe. The CPT is comprised of a group of experts who have extensive powers to visit and report on places where people are deprived of their liberty (e.g. prisons, police stations, immigration detention centres, psychiatric institutions and social care homes) in all 47 member states. It does not have powers of enforcement, but relies on publication of its reports and a moral standing to promote the adoption of its recommendations. Since the establishment of the CPT, it has carried out hundreds of country visits and made recommendations across many aspects of penal policy and practice, including on the question of the prevention and investigation of suicides in prison.

These human rights instruments set a minimum standard of treatment for prisoners and influence the content of penal policies and practices, and have major implications for the management and prevention of self-harm and suicidality in prisons.

Prison response to management and prevention of self-harm and suicide

The policy environment may play a critical role in the aetiology and management of self-harm and suicide. Strategies to address self-harm and suicide in prison are developed so that the rate of self-harm is reduced, or the behaviour prevented. Research on suicide has led to the development of evidence informed suicide standards in America (e.g. American Counselling Association, 2003, National Commission on Correctional Healthcare (NCCHC), 2001, 2008).

Despite the disproportionate prevalence of suicide and self-harm in prisons, there is limited and often vague research findings on best practices in the specific management of acute suicide risk and of the aftermath of a death by suicide in prison. A systematic analysis conducted by Stijelja et al., (2022) on the management of suicide risk and self-harm in prisons found that multi-component approaches to

the prevention of suicide and self-harm were most effective. Multi-component interventions included:

- Sufficient screening for risk
- Staff training in CPR and in crisis-intervention
- Supervision of high-risk prisoners
- Proper communication between staff and inmates
- Post-suicide administrative reviews
- Staff debriefing
- Improved clinical procedures
- Improved process for reviewing suicides and reviewing restricted access to means and provision of mental health treatment and support for prisoners

According to Mcarthur & Camilleri (1990), prisons tend to rely on 1) comprehensive screening to identify 'at risk' prisoners (e.g. those at risk of self-harm and suicide), 2) access to timely and appropriate intervention, 3) use of a variety of accommodation strategies (e.g. use of shared accommodation, safety observation cells, and cameras for observation), 4) supports such as psychology, psychiatry, peer support programmes and visitor supports, 5) management such as monitoring prisoners, referral and case management plans, and 6) environmental strategies such as suicide prevention frameworks which attempt to reduce the stressors in prison (e.g. regime activities, relief of overcrowding, committal induction, and strategies to improve use of punishment and segregation). This response focuses more traditionally on the prevention of suicide.

Clinicians have observed a jarring dissonance between the restrictive and invasive act of isolating and observing individuals, even if for the purposes of their own safety, and the therapeutic models, approaches and interventions that are utilised to support those in crisis (Gaglione, 2021). Due to the well-documented negative impact of solitary confinement, those considered to be at acute risk of suicide should not be isolated – even if this is done for practical safeguarding reasons e.g. observation – and it is recommended that such individuals are provided with companionship and support (WHO, 2007; Favril, 2021). This crucial recommendation is supported by research conducted during the COVID-19 pandemic, where the pronounced negative impact of isolation on prisoner mental health, sense of self, and social engagement was almost universally reported (Garrihy, Marder, & Gilheaney, 2023). Furthermore, it is recommended that

individuals who are at acute risk of suicide should be housed in the least restrictive setting which allows for adequate supervision. While measures should be taken to make the environment 'suicide safe' (e.g. limiting ligature points), it is noted that physical restraint does not prevent suicide in the medium or long-term, nor does it change the individuals' thoughts of suicide. In Ireland, specialised observation cells can be utilised in the case of a prisoner being at high-risk of suicide or self-harm, and whilst this measure is distinct from solitary confinement, alternatives should be considered in light of the widely-reported negative impacts of isolation.

In May 2023, the International Guiding Statement on Alternatives to Solitary Confinement was published, providing both procedural guidance and a list of viable alternatives to solitary confinement (Physicians for Human Rights & Antigone, 2023). Heavy emphasis was placed on the necessity of providing individualised care plans for those experiencing mental health crisis and acts of violence and self-harm in prisons. The need for both an immediate assessment by a mental health professional, and an exhaustive investigation by an independent body of mental health professionals with complete documentation of the case, was also highlighted. The guiding statement was also clear in its stance that the power to recommend a transfer out of prison should lie with this independent investigating body.

Alternative measures listed in the guiding statement are as follows:

- Reduce friction/violence/self-harm via tackling overcrowding
- Personalised care plans
- Activities/maximising time out of cell
- Building social/relational skills
- Training for staff in recognition and de-escalation
- Periodic review of the responses of health professionals and prison staff to incidents of self-harm and suicide attempts by a body of health professionals independent of the prison and criminal legal system.

In reviewing the literature on existing interventions, Carter et al., (2022) caution that conclusions cannot be easily drawn on the efficacy of different types of interventions designed to prevent suicidal thoughts and behaviours for those in contact with the criminal justice system due to methodological constraints. Similarly, Winicov (2019) highlights that synthesising the literature on interventions for preventing suicide and self-harm amongst people in prison is made all the more

challenging by the diversity in terminology used across research studies (e.g. self-injury, self-harm, non-suicidal self-injury, deliberate self-harm, suicidal behaviour).

Peer support initiatives have also been utilised in suicide and self-harm prevention in prisons. Some examples of international practice include:

- Samaritans 'Listener' Peer Support Scheme, applied in the UK & Ireland. This scheme was introduced 33 years ago, and relies on the development and maintenance of strong relationships between prison staff, Samaritans branch volunteers, and prisoners who support their peers in prison as Listeners (Tomaszewska et al., 2019).
- Peer Observer Programme (POP), applied in North Carolina, USA. This programme was piloted in 2019 with Peer Observers being trained to obtain, record and report any concerning observations or emergencies relating to prisoners on suicide watch (Hazlett, Slater, & Mautz, 2022). Peer Observers work on a one-to-one basis, in four-hour shifts, and must attend a debriefing session after each shift.
- Brother's Keepers (through the Humane Prison Hospice Project), applied in the USA. The original remit of this scheme was to train prisoners to provide compassionate end-of-life care and grief support, but the training is now expanding to cover crisis intervention, including supporting peers suffering from depression and suicidal ideation (Humane Prison Hospice Project, 2024).

Research findings on the effectiveness of peer support schemes in the prevention of suicide and self-harm in prisons acknowledge the value of such programmes to both at-risk prisoners and to the peer support volunteers. At-risk prisoners may benefit from being supported by someone with a shared experience of incarceration, and who is separate from general prison staff, whilst peer support volunteers avail of skills training and an opportunity to contribute to the community – both of which can positively influence mental health (Hazlett et al., 2022). There is also some suggestion that peer observation programmes can help to reduce the overall length of time a prisoner spends on suicide watch/observation, although further research is needed to ascertain the generalisability of this finding (Junker, Beeler, & Bates, 2005). However, caution should also be exercised in relation to the risks of utilising peer support in prisons, particularly regarding the well-being of peer support volunteers (Buck et al., 2023).

Ryland, Gould, Hawton & Fazel (2020) evaluated a model to predict self harm in male prisoners which demographic, clinical, and social risk factors. the strongest associations with self-harm in the first 6 months of prison entry were previous self-harm inside prison (aHR 9.3 [95% CI: 3.3–26.6]) and current thoughts of self-harm (aHR 7.6 [2.1–27.4]). However, they highlighted some of the challenges for developing an effective screening tool for identifying prisoners at high risk of self-harm and suggested that the absence of current valid screening tools for suicide risk, safety planning for all prisoners should be considered.

Screening of prisoners for risk of suicide is widely accepted as imperative in preventing death by suicide (WHO, 2007; Favril, 2021). Screening, identification and risk assessment tools have however been subject to criticism both in their design and use (Armstrong & McGhee, 2019). Trying to identify those at inflated risk of suicide is indeed beset with many problems, including lack of reliability, potential for false negatives due to fluctuation over time, limited research on the predictive validity of such tools for offender populations, lack of transferability of existing scales due to use of psychiatric sample, significant expense and a lack of a gold standard (Towl & Walker, 2015). Another consideration is that most prisoners have many of the factors associated with a higher lifetime risk of suicide (Hawton et al., 2002; Shaw et al., 2004; Towl & Forbes, 2002; Towl & Hudson, 1997; Walker, 2015). Experts caution that screening should not be limited to intake only, and state that it should be an ongoing process that is conducted in tandem with observations by prison staff, who know the signs of suicide risk. This process is considered to be the gold standard in preventing suicidal thoughts or ideation from escalating into suicidal behaviour, and in enabling appropriate referrals for intervention (Favril., 2021).

Horton et al., (2018) found that prospective self-harm was not predicted by pre-existing screening instruments related to self-harm and suicide in prisoners identified as at increased risk (on open Assessment, Care in Custody and Teamwork (ACCT) monitoring). This includes a variety of well known screening tools such as the Prison Screening Questionnaire (PriSnQuest) (Shaw et al., 2003); the BSL-23-F (Bohus et al., 2009); the Self-harm Inventory (SHI) (Sansone et al., 1998); the Patient Health questionnaire (PHQ-9) (Kroenke et al., 2001); and the Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM) (Evans et al., 2000). This suggests that

such screening instruments do not have any meaningful ability to predict self-harm or suicide. Indeed it could be argued that their major utility of such instruments may be solely for the benefit of professionals either in training or for the purposes of updating Continuing Professional Development (CPD) portfolios.

McDermott & Willmot (2018) criticised suicide prevention strategies in HM Prison & Probation Service, which they believed were focused on the search for a single or simple solution to the 'problem' of self-harming behaviour, which underestimates the realities of a "complex, multifaceted problem". Since then, there has been a welcome shift in practice away from trying to assess risk and likelihood of harm in order to predict those who will hurt themselves because it tends not to be reliable. For example, the UK moved away from reliance on identification of 'at risk' prisoners to more proactive and positive strategies for prisoners generally. The primary formal process used by HMPPS in the UK for providing safer custody is the ACCT procedure. This includes a collaborative assessment of risk and need, creating action and care plans which identify the best way to monitor and supervise prisoners identified as at risk (e.g. frequent observation and monitoring, intervention to support mental health, in cell activities, regime activities, support from peers/family and staff such as chaplaincy), and periodic multi-disciplinary reviews until the risk posed to the prisoner has reduced.

When reviewing best practice in the management of self-harm in prisons, it is also worth considering how to manage the aftermath of a suicide. Some research highlights the importance of preventing a so-called contagion effect, which can occur when suicide or self-harm is witnessed, particularly in groups of younger individuals (Konrad et al., 2007). Recommendations include the identification and removal of acutely suicidal individuals to a psychiatric facility, and the careful management of information sharing about a suicide (WHO., 2007). Staff debriefing following a death by suicide is also considered vital, as is organisational reflection on how future deaths by suicide can be prevented (WHO, 2007; Stijelja et al., 2022).

Irish Prison Service (Irish Prison Service)

Firstly, it is important to position this research within the context of the IPS, including the Irish Prison estate, the Irish Prison population, the Irish Prison staff population, the IPS as an organisation, its resulting culture, and relevant national and

international legislation. This Chapter will then explore the Irish Prison Service response to self-harm in prison.

Irish Prison Estate

The IPS prison estate comprises 12 closed prisons, which includes one high-security prison, and two open centres. Two closed prisons accommodates female prisoners only, and all other prisons accommodates male prisoners only (Irish Prison Service, 2021a).

Irish Prisoner Population

The prisoner population is 4,514 (Irish Prison Service, 2024)[2] at the time of writing. The rate of imprisonment is relatively low, currently at 89 people per 100,000 in the population[3] (World Prison Brief, 2024) based on an estimated national population of 5.36 million at end of January 2024 (Irish Central Statistics Office figures). However, the prison population in Ireland has fluctuated considerably in recent years, with an increasing population, and the prison estate currently operating at beyond its capacity, at a figure of 105% (Irish Prison Service, 2024). Recently, the profile of the Irish Prison population reflects an older/aging population, an increased number of remand prisoners, and a larger proportion and number of women prisoners compared to previous years (Irish Prison Service, 2019a).

Pre-trial detainees / remand prisoners (percentage of prison population)	19.3% *(26.1.2024)* Further Information
Female prisoners (percentage of prison population)	4.9% *(26.1.2024)* Further Information
Juveniles / minors / young prisoners incl. definition (percentage of prison population)	0.6% *(31.1.2022 - under 18)*
Foreign prisoners (percentage of prison population)	15.4% *(31.1.2022)*
Number of establishments / institutions	12 *(2024)*

[2] Accurate as of 1/2/24 https://www.irishprisons.ie/2024-prison-populations/
[3] Accurate as of 02/03/2024. See below for ranking of European prison populations from highest to lowest: https://www.prisonstudies.org/highest-to-lowest/prison_population_rate?field_region_taxonomy_tid=14

Official capacity of prison system	4 514 *(26.1.2024)*
Occupancy level (based on official capacity)	105.1%

Recent figures highlighted in a Dail Eireann Debate on February 22 2024 stated that courts committed 7946 people to prison in 2023, which is an increase of 13% since 2022, and 30% since 2021. The overall daily average number imprisoned in 2023 was 4583. On 16 February 2024, there were 4783 in prison (106% of the overall capacity). Of these, 950 (19.8%) were remanded in custody awaiting trial, and the remaining were either sentenced or held under other conditions including immigration detention, European arrest extradition, and indefinite contempt of court.

The most recently available statistics (Irish Prison Service, 2021a) show that of the 5,179 persons committed to Irish prisons in 2021, 4,692 were male and 487 were female. Most committed persons were aged 25-34 (41%), followed by 35 to 44 year olds (26%), 18 to 24 year olds (16%), 45 to 54 year olds (12%), and those aged over 55 years (5%). The average age of prisoners was 37 years. Of the 3,941 sentenced prisoners in Irish prisons in 2021, most were sentenced for burglary, theft, robbery and related offences (22.4%), followed by offences against the government, justice procedures and organisation of crime (14.5%); homicide, attempts/threats to murder, assaults & harassments (13.8%); damage to property/the environment and public order/social code offences (11.7%); road and traffic offences (10.1%); controlled drug offences (8.5%); weapons and explosive offences (4.4%); sexual offences (3.1%); dangerous or negligent acts (2.0%); fraud/deception and related offences (2%); unclassified offences (1.2%); and kidnapping and related offences (0.5%). Most prisoners were serving sentences of five to ten years (24.42%), followed by sentences of three to five years (21.82%); one to three years (21.41%); life sentences (12.04%); sentences under one year (11.94%); and sentences over ten years (8.36%).

Irish Prison Service Staffing and Organisational Structure

At the end of 2021, 3,474.35 full-time staff were employed by the Irish Prison Service, including prison staff, civilian staff, and Irish Prison Service headquarter (HQ) staff (Irish Prison Service, 2021a). The highest number of staff in any prison are

prison officers, who are managed by promoted grades such as Assistant Chief Officers, Chief Officers, and Governor Grades. Additional staff occupy administrative (e.g. clerical officers), operational (e.g. search, escorts) and multi-disciplinary roles (e.g. healthcare, psychology, education, welfare) (Office of the Inspector of Prisons [OIP], 2015). Irish Prisons have one of the most favourable staff to prisoner ratios in Europe (1:1.5). However, they still experience considerable staff shortages, which negatively affect prisoners' access to healthcare, activities and overall out-of-cell time. This has been observed most frequently towards the end of each working quarter, where overtime hours are typically no longer available. It has also been noted that the large volume of uniformed staff required to conduct escorts largely impacts on staff shortages (Council of Europe [CoE], 2020).

A Director General leads the IPS, supported by five directors of: (1) human resources, (2) custody, security & operations, (3) finance and estates, (4) corporate services, ICT, health & safety, and (5) care and rehabilitation. By comparison to prison staff, IPS HQ staff are largely civil servants based in Co. Longford (OIP, 2015). Previous reports on the IPS, conducted by external bodies such as the IOP (2015), have observed a distinct and disconnected culture in the Irish Prison Service, particularly between prison staff and HQ staff. Prison staff have generally perceived HQ staff to have little knowledge or experience of prison work, with HQ staff generally perceiving prison staff to be 'dubious of the progressive initiatives they aim to implement' (OIP, 2015; Porporino, 2015). However, improving organisational culture has become an area of strategic importance within the Irish Prison Service in recent years (Irish Prison Service, 2019a), and organisational culture is included in the Employee Experience pillar in the IPS Strategy, 2023-2027.

Legislative Context in the Irish Prison Service

The IPS operates in line with national and international legislation. The daily management of the IPS is primarily guided by the Irish Prison Rules (2007), and their subsequent amendments in 2014, 2017 and 2020. The Irish Prison Rules (2007) contain 122 Rules in 16 parts, and determine how the IPS must operate in relation to the reception/registration of prisoners; the treatment of prisoners; control, discipline and sanctions; young prisoners; and remand prisoners. Parts seven and eight dictate the respective duties of prison governors and prison officers. Parts 10 to 15 regulate the provision of services including healthcare, probation, education, psychology and chaplaincy. Additional Irish legislation guiding the work of the Irish Prison Service include the Prisons Act (2007, 2015); the Prisons (Visiting Committees) Act (1925);

the Criminal Justice Act (1960, 2007); the Criminal Justice (Miscellaneous Provisions) Act (1997); and the Transfer of Sentenced Persons Act (1995, 1997) (Irish Prison Service, 2021a).

The Irish Prison Service also takes into consideration various international human rights standards including the Universal Declaration of Human Rights; the European Convention on Human Rights; the United Nations (UN) Standard Minimum Rules for the Treatment of Prisoners; the European Prison Rules (2006); the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; the United Nations Covenant on Civil and Political Rights; and the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (Irish Prison Service, 2021a). The IPS is also subject to recommendations made by the Office of the Inspector of Prisons (Irish Prison Service, 2021a).

Prevalence of mental health issues in Irish Prisons

Information on the level of mental health conditions in the prison population is derived from the first systematic and representative survey of mental health in the Irish Prison population (Kennedy et al., 2003). It was found that drugs and alcohol dependence and harmful use were by far the most common problems, present in between 61% and 79% of prisoners. Typically, prisoners were using multiple intoxicants, including alcohol, benzodiazepines, opiates, cannabis and stimulants. For all mental illnesses combined, rates ranged from 16% of male committals to 27% of sentenced men, while in women committed to prison the rate was 41%, with 60% of sentenced women having a mental illness. For the more severe mental illnesses, rates of psychosis were 3.9% amongst men committed to prison, 7.6% amongst men on remand and 2.7% amongst sentenced men. Women prisoners had psychosis in 5.4%.

Kennedy et al., (2003) identified a higher prevalence of severe mental illnesses in all parts of the Irish prison populations when compared to international averages for men on remand. The rate of psychosis in remand prisoners was much higher than in comparable samples from abroad. Major depressive disorder was present in 10% of male remand prisoners, which included 5% of male sentenced prisoners and 16% of female sentenced prisoners. On committal, 5.4% of men and 8.5% of women had a diagnosis of a major depressive disorder. Most prisoners with a diagnosis of mental

illness including psychoses also had problems with drugs and alcohol (Kennedy et al., 2003). Prevalence rates for intellectual disability is approx. 6 per 1,000 in the general population. Research conducted in 2018 by Gulati et al., (2018), indicates that there could be 28% of the Irish prison population with an IQ under 70. This equates to 1,337 persons based on the current prison population but does not provide an indication of intellectual disability. There are no prevalence rates for personality disorder in the IPS, but internationally it is reported that 60% to 70% of prison populations have personality difficulties, compared to between 4-11% of the general population (Abdullah et al., 2020), very typically resulting from multiple complex trauma during childhood (between 2865-3342) persons based on the current prison population).

An initiative being developed in partnership with the HSE aims to capture more information relating to mental health and addiction across the irish Prison Service estate. This will involve the study of Mental Health conditions (including intellectual disability) across the prisoner population. The Irish Prison Service is currently working with the HSE/NFMHS to progress this work. It is anticipated that levels of mental health conditions in the prison population will be updated through a needs analysis (as recommended in Sharing the Vision, 2020, recommendation 54) in the coming years.

The Irish Prison Service response to self-harm in prison

'Connecting for Life[4]' is Ireland's national strategy to reduce suicide from 2015-2024. It has provided a comprehensive plan, based on the best international evidence, for how Ireland can reduce levels of suicide and self-harm in Ireland by involving the whole community, the whole of government and all of society working in unison. Within the IPS, the National Suicide and Harm Prevention Steering Group (NSHPSG) is a multi-disciplinary group that monitors the incidence and nature of self-harm and intentional death, with a view to promoting best practice in preventing and, where necessary, responding to self-harm and intentional death in the prisoner population. The IOP reviews all deaths in custody and makes recommendations to improve policy and practice in light of all deaths. Under the auspices of Connecting for Life, the NSHPSG has been collecting data on episodes of self-harm using the 'SADA' project since 2017. This involves collecting data the

[4] Connecting for Life: Ireland's National Strategy to Reduce Suicide 2015 – 2024, Department of Health, Published 24 June 2015, updated 15 February 2024

typology of prisoner, severity & intent, and contributory factors for every incident of self-harm. Recently focus has shifted towards using the data to inform and improve policy and practice.

Mental Health Services in Prisons

Mental Health Services in prison are provided by IPS Healthcare, inreach Psychiatric and IPS Psychological Services. The IPS has a number of processes to support and manage prisoners who are at risk of engaging in self-harm or have self-injured. This includes comprehensive screening on committal to identify those most at risk, use of accommodation strategies such as the use of Safety Observation Cells (SOC) and Health Care Special Monitoring (HCSM) and intervention pathways to manage prisoners at risk of harm to self. In a report on its seventh periodic visit to Ireland in 2019, the Council of Europe's Committee for the Prevention of Torture (CPT) was critical of the use of special observation cells in prisons and called for their use to be reviewed. Irish Prisons do not have a process used in the UK similar to the Assessment, Care in Custody and Teamwork (ACCT).to support people at risk of self-harm and suicide. In terms of examples of international practice for the management and prevention of suicidal behaviour, several external psychiatric facilities have been commended for their approach. The Mauer Forensic Hospital in Austria has a forensic psychiatry team available to treat prisoners, and has been heralded by the Council of Europe's CPT as exemplary as a model for secure psychiatric establishments with its non-carceral design (CPT, 2023). In France, 'Specially Adapted Hospital Units' (UHSA) exist within public psychiatric hospitals, and serve as an example of successful collaboration between health services (who have authority over care) and prison administrations (who have authority over perimeter security, entry/exit, and transfers) (Foyet et al., 2022).

Committal Interview

All prisoners are medically assessed by a nurse and General Practioner (GP) on committal to prison. This includes a mental health assessment, which can be employed to develop an individual care plan. Where clinically indicated, the prisoner is referred to a forensic clinician (e.g. Psychiatrist, Psychologist) who, subject to his/her findings, may make certain recommendations to the Governor for the care of the prisoner. For persons coming into custody presenting with an addiction or dependence on prescription medications, either procured legitimately or illegally, they will undergo a full health assessment prior to a plan of treatment being agreed.

Most often this will focus on a symptomatic detox taking account of any co-morbidities and maintaining the optimal level of health and functioning.

The IPS works with the Health Service Executive (HSE)/National Forensic Mental Health Service (NFMHS) to ensure the appropriate provision of Psychiatric Services to those in custody with a psychiatric diagnosis such as Schizophrenia, Psychosis and Major Mood Disorder in all closed prisons. The National Forensic Mental Health Services has a caseload of up to approximately 350 patients who are ordinarily in the custody of the IPS (i.e. approx. 6.5% of the total prison population). In-reach Psychiatric services are available in all prisons through collaboration with the NFMHS, or consultant led psychiatry services, to provide forensic mental health sessions weekly in these prisons. Consultant Forensic Psychiatrists are supported by Community Psychiatric Nurses (CPNs), Social Workers, and Housing Support workers in certain prisons.

Central Mental Hospital

The irish Prison Service has access to a limited number of beds in the Central Mental Hospital (CMH) in Portrane, which is a tertiary care facility for prisoners suffering from a severe mental illness who require residential mental health treatment. A waiting list for the admission of prisoners to the CMH is operated by the NFMHS and is reviewed on a weekly basis. Over the last nine years, the number of prisoners on the waiting list has generally fluctuated between 5 and 33 prisoners. A Thematic Inspection Report by the Inspector of Prison (2023) provided an evaluation of the provision of psychiatric care in the Irish Prison System. The report criticised the large numbers of prisoners in Irish Prisons with serious mental illness, some of whom present significant behavioural and management difficulties, who are not receiving the high quality and effective care and treatment they deserve within prison, and often cannot access prompt transfer to a psychiatric hospital. They maintained that this deficit in care can place such prisoners and staff at risk of harm, is disruptive to the required good order within the prison system, and amounts to neglect in treatment provision which causes potential human suffering, and could, on occasion, be construed as ill-treatment.

The IPS, in collaboration with the NFMHS, has established two dedicated areas where high support is provided to vulnerable prisoners with mental illness – D2 wing in Cloverhill Prison (for remand prisoners) and the High Support Unit (HSU) in

Mountjoy (for sentenced prisoners). Both units provide a dedicated area within the prison where mentally ill and vulnerable prisoners, who present with a risk of harm to self or to others, can be separated from the general prison population and are closely monitored in a safer environment. The HSU manage vulnerable and mentally ill prisoners in a more effective and humanitarian environment and have resulted is greater access to care and regular reviews by the prison in-reach team. D2 in Cloverhill has 22 cells including two SOCs. The maximum capacity of D2 landing is 27 prisoners and can accommodate those presenting with vulnerability to those with severe mental illness. The CPT (2019) observed that Irish prisons continue to hold severely mentally ill persons and the high support units provide a stepping stone towards admission to a psychiatric hospital or a step-down unit for managing persons returned to prison from a psychiatric facility. They stated that it is essential that they be provided with the appropriate resources, and a programme of structured activities, including occupational therapy sessions, should be developed for prisoners held on these units.

Future Model of Care

The Irish Prison Service has met with the Departments of Justice and Health, the HSE and the NFMHS in relation to a future model of care for mental health. The work of the Inter-departmental Group on Mental Health and the recently published Department of Health Policy (Sharing the Vision) will form part of this work. A Task Force was established to address the issue of increasing the capacity of Forensic Mental Health services across the prison estate and for those who require admission to the CMH has been included in the Programme for Government as part on the Prison and Penal Reform and commits to “Establish a high-level cross-departmental and cross-agency taskforce to consider the mental health and addiction challenges of those imprisoned, and primary care support on release”.

Healthcare

Healthcare provide primary care service which includes use of medication, and safety planning. If a prisoner is identified as being at risk during or after committal to prison, a risk assessment for location of a prisoner in a safety observation cell is conducted by healthcare. A guide is provided to support nursing staff in the assessment of suicide risk. If someone is identified as at risk, they may be placed in a Special Observation Cell (SOC) under healthcare special monitoring. Such SOC’s are designed to eliminate potential hanging points such as exposed bars or rails, light

fittings and plumbing and to maximise observation of prisoners. A person may be placed on healthcare special monitoring and are subject to the 'Monitoring of Prisoners during Periods of Lock Up' Policy, whereby checks are carried out every 15 minutes by a prison officer, plus two hourly checks by a nurse. However the CPT (2024) considers that the SOC system remains unfit for purpose for the management of those at risk of self-harm and does not provide a care-oriented and therapeutic environment and, in many cases, only exacerbates the person's situation.

The role of prison officers

Prison Officers are encouraged to develop positive relationships with prisoners. Such relationships are promoted and developed through the Recruit Prison Officer (RPO) training, where Recruit Prison Officers are provided with training in interpersonal effectiveness. This is based on the premise of 'every contact counts' and provides practical skills to support staff to listen to prisoners, validate their issues without collusion and manage challenging behaviour. However, the Office of the Inspector of Prisons (2015) highlighted the incessant pressure to conform to behaviour which was at best unprofessional and at worst misogynistic and even misanthropic. They maintain that the demands to uniformly conform leads some staff to act in ways which are inappropriate, with severe personal repercussions for those who step out of line either by refusing to take part in inappropriate behaviour or by drawing it to the attention of superiors, and an unwillingness or inability of superiors to take corrective action.

Psychology Service

The Psychology Service is a national, public service, employed directly by the IPS. The IPS Psychology Service's model of care dovetails with that of Sharing the Vision (2020)[5], and the HSE, in being bio-psycho-social, strengths-based, and organising services through a layered care model. The Service is integrated in nature in that it provides both for the mental health need and criminogenic or offence-related need of people in custody (in some jurisdictions, these roles are separated and two distinct teams of Psychologists carry out assessment and intervention for mental health need and criminogenic need). Approximately 50 percent of referrals to the

[5] *'Sharing the Vision - A Mental Health Policy for Everyone' is Ireland's national mental health policy was published in June 2020. It is a policy framework for the continued development and enhancement of mental health services in Ireland from 2020 to 2030. It replaces the previous policy, 'A Vision for Change'.*

Psychology Service are specifically in relation to the mental health of people in custody. These referrals include: Mood and Anxiety Disorders, Disorders of Personality and Behaviour, Post Traumatic Stress Disorder (PTSD) inc. complex PTSD, Self-Harm and Suicidal Behaviour, Eating Disorders, Psychosis and Schizophrenia and Addiction, In addition, the Service works with people presenting with Autistic Spectrum Disorders, intellectual difficulties, Attention Deficit Hyperactivity Disorder, cognitive decline and traumatic brain injuries. Irish Prison Service Psychologists provide each layer of assessment and intervention intensity to meet the needs of people with mental health difficulties ranging from whole population approaches (such as the Prison TV channel) to primary, secondary and tertiary care. At any one time approximately half the total prison population are engaging with or waiting to see a Psychologist in the Irish Prison Service. In a review of the IPS Psychology service (Porporino, 2015)., the level of resourcing was deemed to be well below accepted international standards at a ratio of only one psychologist for every 220 prisoners. The minimum ratio of a full-time qualified mental health care professional (licensed psychologist or other mental health care professional practitioner credentialed for independent practice) to adult inmates is 1 for every 150 to 160 general population inmates, and specialised units: (e.g., drug treatment and special management units for mentally ill inmates), the minimally acceptable ratio is 1 full-time qualified mental health care professional for every 50 to 75 adult inmates (Porporino, 2015).

Mental Health Training

The IPS has developed a mental health awareness-training programme, which is currently being delivered to all staff. This training uses a biopsychosocial understanding of mental health difficulties and is delivered by Nurses and Psychologists. Training on Seclusion Policy and Critical Incident Stress Management are also provided by the IPS.

Structured Regime

The IPS places a strong emphasis on physical activity/exercise, and engagement in a daily regime. There is provision of vocational training activities for prisoners, including prison training workshops (e.g. catering, laundry services and industrial cleaning, work training activities (e.g. printing, computers, Braille, woodwork, metalwork, construction, craft and horticulture), and externally accredited courses (e.g. City & Guilds, the Scottish Qualifications Authority (SQA), Food Safety

Authority of Ireland (FSAI), ECDL and other certifying bodies. It aims to provide as much employment as possible in prison and to give opportunities to acquire skills which help secure employment on release. The Work Training Service in partnership with Prison Education and the Irish Association for the Social Integration of Offenders (IASIO) deliver interpersonal skills courses with FETAC accreditation. There is no doubt however that over-crowding and staff shortages have had a significant negative impact on the risks to the safety of both staff and prisoners, by negatively impacting on the quality of staff-prisoner relationships and reducing access to time out of cell and time in purposeful activity. The Inspector of Prisons (2023) recommended that the Irish Prison Service should ensure that all prison officer posts are maximised to ensure access to and engagement with purposeful activity for all persons in custody. The CPT (2019) highlighted staffing issues, due in particular to the exponential increase in prison escorts and recommended that measures are required to ensure that prisons operate full regimes with activities and services not being hampered by staff shortages. The CPT also highlighted that further efforts are required to provide a range of purposeful activities and one hour a week of visits to prisoners on protection for more than a short period and to improve the regime for persons segregated for good order.

Other Services

There are a number of multi-disciplinary groups that provide information and support in the area of mental health to prisoners. The Chaplaincy Service play a crucial supporting role in prison life by providing pastoral and spiritual care to any prisoners who wish to avail of the service. Prison Chaplains can offer a support service to prisoners and their family members as they face many personal challenges within a prison environment including a death in custody; when a person in custody is coping with a terminal or life-threatening illness or following a serious cardiac event; and loss and bereavement. Educational services are provided to prisoners by the Education & Training Boards. Teachers are often involved in delivering lessons on Social, Personal and Health Education. The Mental Health Reform report (2024) highlighted the important role of Tier 1 services and supports, encompassing low-level, nonspecialised services available to the whole prison population. They emerged as particularly impactful, with educational services and other resources such as the prison gym frequently cited as beneficial to mental health.
Every year, Mental Health week is held in Irish prisons across the estate. This delivered by the multi-disciplinary team involving teachers, Chaplaincy, Healthcare

and Psychology. This has involved experts by experience and people in custody being deployed as Mental Health ambassadors. Many internal staff and guests from external agencies deliver workshops and lectures on various topics related to Mental Health.

Family Visits

The IPS recognises that prison visits are important to maintain relationships and support the prisoner's mental wellbeing. Stable family relationships and community links have also been recognised as crtical factors in the resettlement and reintegration of prisoners back into society. The rules governing prison visits in Ireland are set out in sections 35-50 of Prison Rules, 2007 [6]. Prisoners are entitled to receive one physical family or virtual visit per week, of not more than 30 minutes for physical visits & 20 minutes for virtual visits. Physical visits are limited to a maximum of five persons with a maximum of three adult visitors. Children may only attend if accompanied by at least one adult. For a prisoner, visits can help them to stay in contact and maintain a healthy relationship. They can also keep in touch by letter and their family member can make contact by telephone. A new National Family Connections Officer has been employed since July 2024 to ensure the overarching goal of tackling intergenerational cycles of disadvantages and imprisonment through supporting family relationships and return from prison to the community. The postholder is responsible for the development and implementation of a highly innovative Family Links Programme, which was piloted in Limerick Prison in 2017. An independent evaluation of the Family Links Programme demonstrated benefits to mothers and fathers as it created opportunities for peer support in groups, and had a positive impact on learning, trust and relationships (Bradshaw & Muldoon, 2017).

Peer to Peer/External services

Further to this, there are a number of initiatives that provide community or peer to peer support available. People in custody in all closed prisons have access to the Samaritans Listeners Scheme. The Listener Scheme is a peer-support scheme within prisons, first established in Irish Prisons in 2002, which aims to reduce suicide and self-harm. Listeners are prisoners who provide confidential emotional support to their peers who are struggling to cope or feeling suicidal. They are specially selected and trained for the role by our volunteers. The Community Based Health and First

[6] https://www.citizensinformation.ie/en/justice/prison-system/visiting-someone-in-prison/

Aid programme (CBHFA) programme, originally designed by the International Federation of the Red Cross and Red Crescent Societies (IFRC), has been implemented in a prison setting in Ireland, with the prisoners themselves as Irish Red Cross volunteers and peer-to-peer educators. Initial evaluations indicate that the initiative benefits the prisoner community, prison staff and families of prisoners, including high impact within the prison environment, significant increase in healthcare awareness and prisoners' personal wellbeing.

Emergency supports for Prisoners

Emergency supports are available, such as ringing the cell bell to call a Prison Officer. A Prison Oficer can make a referral to nursing staff for a healthcare review. Prisoners can directly contact the Samaritans by telephone, and can request in person peer support from Listeners who are trained by the Samaritans. Prisoners can dial a number from any prison phone, either on the landing or from their cell (for those with in cell telephony) to call the Samaritans.

Chapter Summary

This Chapter has provided the wider context within which this PhD research is being undertaken, which includes the broader International Standards for prisoner care, the typical measures used in prisons to manage prisoners at risk of self harm and suicide and the measures in place in prisons in Ireland. It also incorporated commentary from the Inspector of Prisons, the New Connections report (Porporino, 2015) and the Council of Europe's Committee for the Prevention of Torture (CPT). The next Chapter will explore the relevant literature surrounding self injury and suicide in the community and in prisons, and detail the theoretical framework for this thesis.

Chapter 3: Self-Harm, Suicide, and Theoretical Discussion

This Chaper will examine the published empirical research and articles on self-harm and suicidality in prisoners. It will focus on various themes that emerged in the literature, including the prevalence of self-harm and suicide, the role of repetition, the nature of harm, the methods used, risk factors for self-harm and suicide, the motivation for engaging in such behaviours, the impact of the prison environment, the factors that promote desistance from self-harm in prison and the strategies that can be used to prevent or reduce self-harm in custody. It will outline the theoretical framework of this research.

Introduction

People within the criminal justice system present with a higher rate of mental health/substance misuse difficulties and dual diagnosis, which can contribute to both offending behaviour and self-harming behaviours. Prevalence data in the UK on mental health in January 2024 (Davies, 2024) found that 34% of adult male and 46% of female patients in custody had a diagnosis unresolved depression and 7% had a diagnosis of a severe mental health illness in the adult prison estate. The prevalence of Axis 1 mental health diagnosis, alcohol and drug misuse in Irish prisoners is significantly higher than the rate of these vulnerabilities among the general Irish population (Gulati et al., 2018). Adverse health events disproportionately affect individuals in custody, often as a result of trauma, violence, substance use and other risk factors such as self-harming behaviours. Several studies have established that women in custody have often experienced traumatic physical and sexual abuse, as well as mental health difficulties, prior to incarceration (Towl & Crighton, 1998; O'Brien et al., 2003; Jenkins et al., 2005). On entering prison, many have experienced chaotic lifestyles involving substance misuse, mental health problems, homelessness and multiple sources of past trauma (Ministry of Justice, 2018).

Prevalence of self-harm and suicidality in the community and in prison.

This section will explore the prevalence of self-harm and suicidality both in the community and in prisons. The 2019 National Self-harm Registry Ireland annual report (Joyce, et al., 2020) recorded 16,456 presentations to hospital due to self-harm, involving 9705 individuals, which amounted to a rate of 206 per 100,000. This was 2% lower than the 2018 rate, and 8% lower than the peak rate recorded by the

Registry in 2010 (223 per 100,000). The rate equates to approximately 2 per 100 individuals.

Self-harm and suicidality are significant challenges in prison (Harris Review, 2015). A disproportionate number of prisoners engage in self-harm in custody, when compared with the general population (Fazel, Ramesh, & Hawton 2017a). Prevalence rates have been estimated to be five times higher in prison estates when compared with the community. It is widely established that self-harm and suicidality is especially prevalent amongst prisoners (Harris Review, 2015). Internationally, prevalence rates of self-harm were reported between 5-24% in ten small scale studies in the UK, Greece, Spain, Australia and the USA across both young offender and adult prisons (Dixon-Gordon et al., 2012). There are, however, few large-scale epidemiological studies on the prevalence of self-harm in prisons. International rates of suicide and lifetime self-harm are higher in people in custody compared to the general population (Hawton et al., 2016, Fazel et al., 2017). With a prevalence rate for suicide three times higher than the general population (Fazel, 2012), or even higher with a six fold risk of death by suicide for men and an eighteen fold increase in risk for women prisoners (Harris Review, 2015), it is one of the leading causes of death in prison. Higher estimates in the UK have been found by Leibling (1999) who identified that the suicide rate in prisons in England and Wales was four times that of the general population. Towl and Crighton (2017) identified that men were five to six times are likely to die by suicide and women are 15 to 18 more likely to die by suicide for women. This gender disparity will be explained in later chapters.
A national six year study of self-harm in prisons in England and Wales by Fazel et al., (2017) reported a prevalence rate of 6% of prisoners per year between 2004-2009, with a higher rate of self-harm among female (20-24%) than compared with male prisoners. This suggests that self-harm and suicide are a major challenge for the prison population in the UK. In England and Wales, there is growing evidence that the rate of self-harm in prisoners has increased in recent years (e.g. Beard et al., HMCIP, 2017). The person based rates of self-harm in UK prisons (Ministry for Justice, 2023) included 2244 per 1000 women and 467 per 1000 men. According to Safety in Custody Statistics, England and Wales, there was an increase in the number of self inflicted deaths in custody in the 12 months to September 2023 (Ministry for Justice, 2023). However, there was the same number of self-inflicted deaths (85 deaths) in prison custody as in the previous 12 months to March 2024 (Ministry for Justice, 2024). The number of individuals who self-harmed has also increased. There

were 12,914 individuals who self-harmed in the 12 months to December 2023, up 18% from the previous 12 months. The number of self-harm incidents per individual increased from 5.1 in the 12 months to December 2022 to 5.5 in the 12 months to December 2023. Data provided by the Ministry of Justice demonstrated that in 2018 women in prison had higher rates of self-harm (224, 400 per 100, 000 women) compared to men (46,700 per 100, 000 men). A large proportion of incidents are accounted for by a smaller cohort of individuals with a high rate of self-harm. There is limited research contextualising the disproportionate rate of self-harm among incarcerated women.

However, the rate in Irish Prisons remains lower than person based rates of self-harm in UK prisons (Ministry for Justice, 2023). The rate of suicide in Irish prisons from 2011-2014 was 47 per 100,000 prisoners equivalent to 0.047 per 100 prisoners (Fazel et al., 2017). The rate of self-harm in prisons in England and Wales during 2004-2009 was 6.0% (Fazel, 2017). In 2021, the rate in England and Wales was 4.8%. The Irish rate is approximately one third lower than the rate in England and Wales (Fazel, 2017). The National Suicide Research Foundation (NSRF) in Ireland reported that 3.8% of all prisoners engaged in self-harm in Irish prisons in 2004, with a total of 170 self-harm episodes. Reports on self-harm recorded in Irish Prisons arising from the Self-harm Assessment and Data Analysis (SADA) Project have been published annually since 2017 (Griffin, Cully, Kelly, Hume, O'Reilly, & Corcoran, 2018; McTernan, Griffin, Cully, Hume, Kelly et al., 2020 & 2021) and identified that the rate of self-harm amongst prisoners far exceeded those observed in the general population. The annual person-based rate of self-harm (which includes self-harm and suicide) in Irish prisons in 2018 was 400 per 100, 000 prisoners (4%) of people in custody (Griffin et al., 2018). The annual person based rate in Irish prisons has fluctuated from 4% in 2017 & 2018, to 2.9% in 2019, to 3.3% in 2020 and to 2.4% in 2021. In Irish Prisons, there were 4 deaths in custody in 2017 and in 2018, 4 in 2019 and 1 in 2020. This compares to the age-standardised rate of 210 per 100,000 individuals (2%) presenting to hospital following self-harm in 2018 (Griffin, et al., 2019). Table 2 shows the total number of episodes recorded in Irish Prisons.

Table 2

Total Number of Episodes Recorded in Irish Prisons

	Episodes recorded in Irish Prisons	Number of individuals	Rate

2017	223	138	4%
2018	263	147	4%
2019	203	109	2.9%
2020	217	126	3.3%
2021	196	91	2.4%

McTernan et al., (2023) highlighted particularly vulnerable groups in relation to self-harm and suicidal behaviour, such as prisoners on remand, young prisoners and female prisoners. Table 3 shows that particular groups within the prison population in Ireland have a higher risk of harm, such as remand prisoners, young people and women.

Table 3

Breakdown of Number of Incidents by Gender, Age and Sentencing Status.

	2021	2020	2019	2018	2017
Number of incidents per 100 women	10	21	15	30	11
Number of incidents per 100 men	2	3	5	7	3
No of incidents per 100 prisoners on remand	6	6	6	5	7
No of incidents per 100 sentenced prisoners	2	6	2	4	3
No of incidents per 18-29 year olds.	2	5	5	7	/

The prevalence of self-harm has been found in Irish Prisons to be 2.4 times higher among remand prisoners than it was among sentenced prisoners (5.7 versus 2.3 per 100) in 2019. This finding is in line with previous years (1.4 and 2.4 times higher in 2018 and 2017). McTernan et al., (2023) suggested that committal to a prison may be an important time to identify risk among individuals and to implement appropriate prevention measures, such as reception screening for suicide risk (Marzano et al., 2016) and increased training for Prison Officers in the detection and management of mental health difficulties in the custodial population (IPS Strategic Plan 2019; Sousa et al., 2019). The rate of self-harm was highest among prisoners aged 18-29 years, at 5.2 per 100 prisoners in 2019. The rate among prisoners aged 18-29 years was 31% lower in 2019 than it was in 2018 (7.5 versus 5.2). Whilst women only make up a small minority (4% in 2018 & 2019) of the total custody in population (< 5%), the prevalence of self-harm has been found to be between x 4 times higher than men in 2017, 5.7 times higher than men in 2018 and 8.2 times

higher than men in 2019. The rate of self-harm among women prisoners was 3% higher in 2019 than 2018 (19.8 versus 19.3 per 100) with 24 women prisoners engaging in self-harm in 2019 compared to 26 in 2018. The male rate decreased sharply by 31% (2.4 versus 3.5 per 100) between 2018 & 2019. This data shows that a disproportionate number of self-harm incidents by women can be accounted for by a relatively small cohort of women.

However, it is important to understand that calculating the rate and risk of suicide in prisons requires careful consideration as to how the data is collected and interpreted. Rates may fluctuate depending upon the time period under study, and the differing methods used for calculating rates. For example, there were different levels of restrictions being implemented within prisons to limit and control the spread of the virus following the period of Covid-19, changes in population size and age demographic. In the UK, young people have been routinely been retained in the Youth Custody Service (YCS) estate until their 19th birthday due to capacity across the estate in the light of recent increases in the prison population during 2023. In Scotland, the prisoner profile charaterisitics have clearly changed and markedly over the past decade or so, with over 50's men and long term prisoners accounting for a much more sizeable proportions over the overall prisoner population. This weights the population to have an exceptionally high risk of sucide. These changes in population and conditions should be borne in mind when interpreting changes in the numbers of incidents over the past year. There is also a need to consider if study design (cross-sectional vs. longitudinal) might bias these findings. Longitudinal studies might provide a more accurate picture of suicide risk over time compared to cross-sectional studies that only provide a snapshot.

Furthermore, prison population metrics may use different metrics, like the Average Daily Population (ADP) or total annual population, which should be transparently reported and consistently applied to allow for accurate comparisons across studies. For example, the ADP may be weighted differently, or the numbers of prisoners going through the prison over a one year period may vary. The ADP in a busy local prison with an operational capacity for 500 prisoners may well have over a 1000 prisoners going through the prison over the year.

Role of repetition

This section will explore the prevalence of repetition in prisoners. There is an increased risk of repetition amongst individuals who engage in self-cutting. Repetition of non-fatal self-harm is common among prisoners, particularly among females. Larkin (2014) found that while the majority of episodes involving self-cutting were less severe (15.2% required hospital outpatient or accident and emergency department treatment), risk of repetition is elevated among individuals who engage in self-cutting. In England and Wales, the reported average number of episodes per year from 2004 to 2009 among male prisoners was 2 per person compared to an average of 8 episodes per person among females. Consistent with this, a previous Irish study found that, in 2004, 44% of female prisoners and 7% of male prisoners had at least one repeated act of self-harm within one calendar year. Repetition of self-harm in Irish Prisons has been highlighted as problematic (Griffin et al., 2018, McTernan et al., 2020 & 2021), with one third of individuals engaging in non-fatal self-harm more than once during the year 2018 (32.7%). In Irish Prisons in 2019, approx. half (46.3%) of all episodes were incidents of repeat self-ham. Half of all episodes were due to repeat self-harm in 2020 (44.0%) and 2021 (53.6%). The rate of repetition was higher for female prisoners (50.0% vs. 29.4%). A small number of individuals engaged in self-harm more than 10 times engaged in self-harm more than ten times. McTernan et al., (2023) showed that a relatively high proportion of prisoners engaged in self-harm on more than one occasion, particularly among females. This indicates that a small number of individuals may account for a disportionately high number of incidents amongst females, and supports general findings internationally.

Repetition carries its own risk because self-harm is associated with increased risk of suicide in people in custody (Hawton et al., 2014). Risk of suicide has been reported to increase further following self-harm of moderate or high lethality, compared to low lethality, and among prisoners with a history of repetitive self-harm (Fazel et al., 2008, Hawton et al., 2014). It has been suggested that the risk profile of people in custody and factors contributing to repetition and clustering of self-harm should be examined (McTernan et al., 2023).

Nature of harm

There are conflicting viewpoints about whether self-harm should be studied as an aspect of suicide, or a separate conceptual issue. Smith & Kaminski (2010) stated

that attempted and completed suicides are viewed as etiologically distinct to self-injury and therefore deserving of separate investigation (Canadian Centre on Substance Abuse, 2006; Lohner & Konrad, 2006). The longest existing paradigm (Dexter & Towl, 1995, Haycock, 1989, Knoll, 2010, Morgan & Howton, 2004) identifies that self-harm behaviour reflects a range of anger-in behaviours that extends on a continuum of harm to oneself from deliberate self-harm (e.g. self-cutting) to completed suicide. It does not differentiate the aetiology, manifestation and processes that underlie variants of each behaviour. A more recent paradigm makes a distinction between self-harm and suicidal threats, attempts and completions (Crighton & Towl, 2002), which differentiates acts based on their motivation to end life or not, whereby self-harm functions as a desire to feel alive and to retain emotional equilibrium (life affirming), whereas suicide are indicative of exasping life's pains (death affirming). A final paradigm is based on a tripartite schema which features three different groups of self-harming behaviours, with self-harm behaviour, suicidal process and 'mixed group' (e.g. self-harm and suicide) of self-harming prisoners. This paradigm views self injurious events, and suicidal processes as not being equivalent with regard to etiology, manifestation, and policy implication.

The Unified theoretical framework of self-harming behaviour (Liljedahl & Westling, 2014) provides a descriptive model uniting self-harming and suicidal behaviours that have sometimes been formulated separately. Unified theoretical framework of self-harming behaviour is developed with an aim to fully encompass all possible forms of self-harming behavior and their possible interrelatedness, to aid individuals with lived experience and their clinicians to detect, understand, and effectively respond when the form of a self-harm behavior changes. Five self-harm behaviour groupings are derived from the literature on suicide, self-harm, NSSI, and Borderline Personality Disorder (BPD). The five self-harm behaviour groupings within the model are (from lower to higher lethality):

1. Direct: Self-injury (consistent with NSSI).
2. Indirect: Harmful self-neglect; behaviours consistent with very poor selfcare.
3. Indirect: Sexual self-harm or self exploitation; behaviours engaged in without sexual interest or the motivation of pleasure or experience.

4.a. Indirect: Putting oneself in harms' way; exposing oneself to high likelihood of injury or violence such as walking alone at night in neighbourhoods known for violence.

5. Direct: Suicide attempt; Self initiated behaviours undertaken to kill oneself.

They argue that there are common features between NSSI and suicide attempts, and between direct and indirect forms of self-harm, but the behaviours may change form, directness, and lethality.

Methods of self-harm and suicide, including lethality & severity.

This section will explore the methods used by prisoners to hurt themselves. Methods of self-harm are heterogeneous. They can be divided into two broad groups: self-poisoning and self-harm. Cutting is by far the most common method (Hawton et al., 2002a), but other methods include burning, hanging, stabbing, swallowing objects, object insertion, shooting, and jumping from heights or in front of vehicles. In their analysis of prisons in England & Wales between 2004—2009, Hawton et al., (2014) found that the most common methods of self-harm for both women and men were cutting and 'scratching'; for imprisoned women the next most frequent method used is self-strangulation. Other methods of self-harm include impact injury, wound aggravation, ligature, suffocation and biting. It has been identified that hanging is the most commonly used method involved in suicide deaths in prisoners (Leibling, 1991, Lohner et al., 2007, Fazel et al., 2011). The use of ligature among in-prison suicides has been an area of national concern for the UK Prison Service (Marzano, et al., 2016) because it is associated with a high-rate of lethality. Pattison & Kahm (1983) suggest self-injuring prisoners tend to select tools of low lethality (e.g. cutting with an object) and suicidal prisoners typically select highly lethal means (e.g. hanging). Franklin (1998) also found that self-harm prisoners were more likely to engage in low lethality behaviours, particularly superficial cutting to the extremities, when compared to suicidal inmates. However, prisoners were identified as a vulnerable cohort (Walker & Towl, 2018) because they tend to engage in high-risk, often lethal, self-injuring behaviours. Prisoners who cut themselves are most likely to target the limbs or torso (Langbehn & Pfohl, 1993, Virkkunen, 1976).

In a study of prisoners in England and Wales, Hawton et al., (2014) found that the majority of self-harm episodes were categorised as low lethality, defined as not requiring resuscitation or hospital treatment. Just 1% of non-fatal episodes were of high lethality. The most common methods of high lethality self-harm were hanging and strangulation (44%), overdose, poisoning or swallowing objects not intended for

ingestion (25%) and self-cutting (20%). In Ireland, illicit substances, most commonly benzodiazepines, are involved in 68% suicide deaths among those in custody.
In Irish Prisons, the most common method of self-harm recorded in prisoners is cutting or scratching (Griffin et al., 2018, McTernan, et al., 2020, 2021). Self-cutting was involved in 70.5% of self-harm episodes by males and 52.3% of episodes by females. McTernan et al., (2023) identified that no medical treatment was required for almost one-third (32%) of self-harm episodes between 2017 and 2019. Half of all episodes (52%) required minimal medical intervention/minor dressings or local wound management. One in eight required hospital outpatient or accident and emergency department treatment (13%). Fifteen self-harm episodes involved admission to the hospital or intensive care unit (2%). Severity of self-harm was greater for males than females, with a higher proportion of episodes by men requiring outpatient treatment (15% vs 7%) and hospitalisation/ intensive care unit/loss of life (4% vs 1%). One in eight non-fatal episodes (13%) were of high intent. Males were more likely to engage in self-harm of high intent than females (16% vs 6%). Three per cent of episodes were deemed to be associated with high severity (n = 24). The method most commonly involved in suicide deaths in prisoners was hanging. In 2019, 21.1% of episodes in Irish Prisons involved hanging (McTernan, Griffin, Cully, Kelly, Hume, O'Reilly & Corcoran, 2019) in 27.9% of episodes in 2020 and 15.9% of episodes in 2021 (McTernan, Griffin, Cully, Kelly, Hume, & Corcoran, 2022). Female prisoners were more likely to engage in attempted hanging or than males (53.8% vs 15.8% in 2020 and 17.0% versus 15.5% in 2021). This is consistent with previous findings indicating that female prisoners remain significantly more likely to engage in attempted hanging.

When / where do incidents occur?

This section will explore when and where episodes of self-harm occur. The WHO (2015) suggests that incidents tend to occur when prisoners are on their own (even when sharing a cell), and when staffing levels are low such as nights, and weekends. In Irish Prisons, 50% of self-harm episodes involved prisoners in the general population, compared with 34% of prisoners on protection (Rule 62 and Rule 63 of the Prison Rules 2007 restricted regimes), sometimes involving 23-hour lock up and isolation from all other prisoners (McTernan et al., 2020). A minority (7%) were housed

in Close Supervision cells[7], High Support Units[8] (5%) and Safety Observation Cells[9] or Special observation[10] (4%). The highest incidence of self-harm was recorded among prisoners housed in single cell accommodation (74%), followed by those housed in a double cell (26%). A minority (<1%) were housed in triple or more cells.

In Irish Prisons, the number of episodes of self-harm gradually increased throughout the day (McTiernan et al., 2018, 2019). A sharp peak was observed in the afternoon and early evening, with 51.7% of episodes occurring between 2pm and 8pm (McTiernan et al., 2019). The majority (59.1%) of episodes occured while prisoners were unlocked from their cells (McTiernan et al., 2019). The rate of self-harm was two times higher among prisoners on remand than those sentenced (60.5 versus 31.3 per 1,000) between 2017 and 2019. The highest proportion of sentenced prisoners (41%) were serving a sentence of more than three years, with 17% serving a sentence of 5 to 10 years. More than one-third of self-harm episodes occurred in the second trimester of a sentence (37%), however 34% occurred in the third trimester and 29% in the first trimester. By contrast, Baldwin (2022) found that women in prison in England and Wales experienced higher risk periods in the early days in custody, and approaching release, which is linked to the impact of prison on mothers separated from their children.

Risk & Contributory factors for self-harm and suicidality

Many factors contribute to risk of self-harm and suicide. This section will explore the various risk factors (causative factors or variables) and contributory factors (e.g. variables which caused it to happen) which can increase the possibility that a person will engage in self-harm or attempt suicide. The likelihood and extent of self-harm and suicidality are mediated by the interaction of a range of individual, social, environmental and structural factors. The probability of an outcome usually depends on an interplay between multiple associated variables. Such behaviour is rarely caused by a single circumstance or event, and risk can be increased by a range of factors, including individual, relationship, community, and societal. This section will

[7] Isolation for management/discipline reasons often used to manage violent and distressed prisoners
[8] Specialist support in accommodation for prisoners who are in an acute phase of a mental illness, are vulnerable or require detoxification from substances.
[9] Healthcare prescribed seclusion where there is risk of self-harm/harm to others, often limited to 24 hours
[10] 15-minute checks during lock up.

firstly explore the risk factors for self-harm and then explore the risk factors for suicide.

Risk factors for suicide

Many risk factors for suicide have been indentified in the literature. Towl and Crighton (2017) highlighted the risk factors associated with suicide in the community such as marital status, alcohol and drug abuse mental disorder, gender, and age. They indicated that the highest rates of suicide were found in divorced and widowed men over 45 years old, those within social class V, those using drugs and alcohol (Hawton, 1987), and those with a diagnosis of schizophrenia (10-11%) and severe depression (15%). Low educational attainment, homelessness, and being on remand/unsentenced or serving a life sentence are known risk factors for suicidal behaviours in male prisoners (Jenkins et al., 2005). In a systematic review and meta-analysis by Zhong et al., (2020) identified a range of risk factors, including demographic, criminological, clinical, and institutional that were associated with suicide in prisons. The strongest clinical factors associated with suicide were suicidal ideation during the current period in prison, a history of attempted suicide, and current psychiatric diagnosis. Institutional factors associated with suicide included occupation of a single cell and having no social visits. Criminological factors included remand status, serving a life sentence and being convicted of a violent offence, in particular homicide. They suggest that future research should examine the links between childhood adversity, mental illness, substance use and suicide by prisoners.

Similarly, Rivlin, Fazel, Marzano and Hawton (2011) investigated the suicidal process in 60 male prisoners who made near-lethal suicide attempts. The suicide attempts often followed adverse life events (especially broken relationships or bereavement), criminal justice/prison-related factors (e.g. concerns about sentencing) and psychiatric or psychological factors (e.g. drug/alcohol withdrawal, depression/ anxiety and hearing voices). The majority of prisoners said they intended to die (73%), although many acts had been impulsive (40%). Most described visual images about their suicidal acts (82%). Limited access to methods of suicide had clearly influenced method choice (most commonly hanging/ligaturing 67%), along with expectations about the anticipated speed, painfulness and lethality. Half the prisoners believed their acts could have been prevented, often with relatively simple solutions. These findings have implications for the prevention of suicide inmale prisoners. The suicidal process in prisoners is a complex interplay of background

factors, adverse life events, mental health and psychological problems and cognitive processes. Understanding and recognising these various aspects of the process is likely to improve suicide prevention in prisons.

The WHO (2015) reports that "pre-trial inmates who commit suicide in custody are generally male, young (20-25 years), unmarried and first time offenders who have been arrested for minor, usually substance related offences". They identify the highest risk period as the first few hours of committal as a result of isolation, shock, and lack of information and insecurity about their future, with a likelihood of intoxication at the time of arrest. They state that poor social and family support, prior suicidal behaviour, history of psychiatric illness and emotional problems are factors that increase the risk of suicide, which may occur in the context of bullying, peer conflict, disciplinary infractions or adverse information. Factors that increase the risk of suicide (WHO, 2015) include feelings of hopelessness, narrowing or future prospects, lack of connection due to restrictive regime and loss of options for coping.

Older age was a risk factor for suicide identified by the Harris Review (2015) for males when comparing 83 self-inflicted deaths of young adults (2 females) in NOMS custody between April 2007 and December 2013. The average rate of self-inflicted death for males increased with age, whereas the rate for females decreased with age. This may illustrate the importance of having an intersectional understanding of inflated levels of risk of death by suicide. The average rate of self-inflicted deaths between 2002 and 2013 was much higher for female 18-24 year old prisoners (151 per 100,000) than for male prisoners (67 per 100,000). This meant that from 2002 to 2013, a higher proportion of young adult women who were 18-24 took their own lives than older females, and a lower proportion of young adult men who were 18-24 took their own lives than older men. This suggests that whilst young women can be a particularly vulnerable group, young men are at no greater risk of suicide than older men. Indeed they appear to be at a lower level of such risk in prisons when compared with older male prisoners up to the age of 59. This highlighted the reality that young adults in custody are 'young, vulnerable and still developing individuals who need to be nurtured and supported safely to navigate through the complexities of their lives into purposeful, mature adulthood'.

Additional risk factors for suicide in prisoners include previous self-harm incident of high or moderate lethality (Hawton et al., 2014), having a history of violence and several indicators of past or current psychiatric illness, previous psychiatric service contact, history of self-harm, single cell occupation, remand status, and non-white ethnicity (Humber et al., 2013), psychiatric condition, illicit substance use and aggression (Sakelliadis et al., 2010):

Cross-sectional studies continuously show remand status as a marker or driver for increased risk of suicide. However, this needs further investigation. While the cross-sectional design is a good method for determining prevalence, we should not draw a cause and effect association between legal status and suicide risk as it may simply be an artefact of a cross sectional design. It may be more productive to focus on factors such as the number of days spent in prison or mental health supports on commital to prison. Thus, the functional driver may be the number of days spent in the prison, or the lack of supports available on remand, not the legal status of the prisoner. Remand prisoners may be overrepresented in day one experiences, for example, compared with sentenced prisoners.

Risk factors for self-harm

Risk factors for self-harm in prison included static risk factors such as younger age, sentenced status, and violent offending and dynamic risk factors such as psychiatric disorders, distress, and coping strategies (Favril, Baetens & Vander Laenen 2018); suicide-related antecedents, including current or recent suicidal ideation, lifetime history of suicidal ideation, and previous self-harm, any current psychiatric diagnosis, particularly major depression and borderline personality disorder, and prison-specific environmental risk factors such as solitary confinement, disciplinary infractions, and experiencing sexual or physical victimisation while in prison (Favril et al., 2020). A Rapid Evidence Assessment (Pope, 2018) identified a number of empirically supported risk factors for men who self-harm in prison, including socio-demographic factors (age, ethnicity, educational background, relationship status, accommodation), custodial/prison-related factors (early days of prison, on remand or unsentenced and those serving a life sentence, local prisons, high security prisons, and Young Offender Institutes, high number of disciplinary infractions), psychological/ psychiatric factors (history of self-harm, depression/hopelessness, borderline personality disorder, substance misuse).

In a study of the circumstances and psychological processes involved in near lethal self-harm acts of 60 women prisoner, Marzoni, Fazel, Rivlin and Hawton (2012) interviewed prisoners who had been involved in an act which (a) could have been lethal had it not been for intervention or chance and/or (b) involved methods which are associated with a reasonably high chance of death. Hopelessness and images of past trauma were common in the lead-up to the acts. In a systematic review, Favril, Yu, Hawton & Fazel (2020) identified 40 risk factors associated with self-harm in prison and grouped them into five categories: socio-demographic, criminological, custodial, clinical and historical. The strongest associations were found for suicide related antecedents (including current or recent suicidal ideation, lifetime history of suicidal ideation and previous self-harm), and current psychiatric diagnosis and prison specific environmental factors (such as solitary confinement, disciplinary infractions, victimisation and poor social support). This supports findings on the impact of the prison environment on mental health. However, Perry (2020) believes this research is limited because the study did not account for confounding factors or repetition of self-harm.

Whilst findings are consistent across self-harm and suicide, most research on risk factors in prison is focused on specific types of self-harming behaviour, such as superficial cutting with no suicidal intent or episodes that are classified as suicide attempts. It is possible that synthesising this data would generate different findings and the findings may not generalise to all self-harm behaviour when combined.

Combined studies of self-harm and suicide

Poor mental health is a known risk factor for self-harm and suicidal behaviour in male prisoners. However, there are a number of other risk factors that have been identified. In a six year study by Hawton et al., (2013) on suicide and self-harm, rates of self-harm were found to be highest in younger people and those of white ethic origin, with an association with prison type, serving a life sentence or being on remand, and a clustering of self-harm in time and location. Violent offending behaviour increased the rate of self-harm in female prisoners and repeat self-harm was common. Similar risk factors for suicide and self-harm in prison were confirmed, with 109 suicides in prisons in individuals who self-harmed, and more than half within a month of self-harm. Forrester (2014) states that this supports the notion that self-harm and suicide are linked and represent similar entities. He commented that the study makes an important contribution to questions of who self-harms and

how often does it happen, but research is needed to explore why most prisoners do not self-harm and why some who harm themselves are propelled towards suicide whereas others are not. They recommend going beyond studying risk factors and studying groups with enhanced vulnerabilities, such as foreign nationals, or people with neurodevelopmental problems (e.g. learning difficulties).

Recently, our understanding of human behaviour and outcomes has paid due attention on the influence of various lifetime adversities, which originated from a seminal study by Felitti et al (1998) on adverse childhood experiences (ACE). The term ACEs is used to describe a range of stressful and potentially traumatic events that children can be exposed to whilst growing up, such as child maltreatment, witnessing domestic violence, parental substance abuse or having a household member incarcerated. Indeed, a vast body of literature has consistently evidenced clear links between various types of adversity and self-harm and suicide, for example a history of ACE's is a key risk factor for female suicide (Clements-Nolle et al., 2009, Marzano et al., 2011) and that such experiences can impact children's neurobiological, social and emotional development and increase their risks of health and social harms throughout the life course (Berens et al., 2017). Further, risks of poor life course health outcomes increase along with the number of ACE types suffered, and particularly strong relationships are identified between ACEs and mental illness, self-harm and suicide attempt, as well as behaviours conducive to criminal justice involvement such as violence, problematic drug use, and youth and prolific offending (Baglivio and Epps 2016; Baglivio et al., 2014; Hughes et al., 2017). These links have also become more embedded within forensic research and practice (Friestad et al., 2014; Messina and Grella 2006), who found that suicide attempt has been associated with increasing numbers of ACEs in female prison populations. More recent findings from Stagaki et al., (2022) indicated that insecure attachment and impaired mentalising partially explain the association between childhood maltreatment, self-harm and suicidality. This provides clinical support for the potential of mentalisation-based therapy intended to increase understanding of self and other mental states in order to mitigate the risk of self-harm and suicidality among individuals who have experienced childhood maltreatment. However, the Adverse Childhood Experiences Framework has been criticised (Kelly-Irving & Delpierre, 2019) as a probabilistic and population-level tool, which is not adapted to diagnose individual-level vulnerabilities, and is an approach which could ultimately exacerbate inequalities. The ACE's screen has also been criticised as 'a simple

minded score' and is not a validly standardized measure of childhood exposure to the biology of stress (Campbell, 2020). It does not consider the differential impact that experiences will have, depending on the person's response based on their age and sex, the frequency or intensity or chronicity of exposure (Anda, Porter & Brown, 2020), and may omit positive experiences which may have built resilience, as well as many other traumatic factors. Nevertheless, as stated by McDermott & Willmott (2018), the problem of self-harming behaviours (including self-harm and suicide) is both complex and multifaceted. They state that those individuals within society who are at greater risk of entering custody share many of the same features of those who are at an increased risk of self-harm and suicide, such as disrupted family background, family history of suicide, drug and alcohol abuse, failure at school, unemployment. Therefore, it is not surprising that prisoners are at a disproportionately higher risk of self-harm and suicide than individuals within the community.

Prison environment

There are also factors within the risk environment that may increase the risk of self-harm and suicide. Rhodes' theoretical framework (2002) for drug related harm can be usefully applied to understanding the risk environment for self-harm. It describes the 'risk environment' in the context of drug related harm as 'the space – whether social or physical – in which a variety of factors interact to increase the chance of drug-related harm'. This model of risk environment comprises of two key areas: types of environment (physical, social, economic, policy) and levels of environmental influences (micro, macro). Thus, the risk environment comprises risk factors that are external to the individual, such as policies, laws, economic conditions and wider cultural beliefs (Rhodes and Simic 2005). The risk environment in the context of self-harm in prisons may include the physical, policy and social environments within which prisoners find themselves, which may place an individual at risk of harm. Towl & Crighton (2017) highlighted the role of the prison environment in prison suicide, with the highest rates found in local and remand prisons, particularly in prisons with high throughput, in single cell accomodation, by younger prisoners, within three months from reception into a new establishment, and within particular regimes (e.g. staff attitudes towards prisoners). This section explores aspects of the prison environment that may be relevant to self-harm and suicide. The prison environment is an adverse one. This is a result of the consequent disconnection from family,

society, and social support, loss of autonomy, diminished meaning and purpose of life, fear of victimization, increased boredom, the unpredictability of surroundings, overcrowding and punitiveness, experiencing and witnessing violence, negative staff-prisoner interaction, and other aversive experiences (Cunha et al., 2023). This can impact negatively on prisoner's mental health (Cunha et al., 2023). As mentioned previously, Towl & Crighton (2017) highlighted the role of the prison environment in prison suicide (e.g. high throughput, single cell accomodation, reception into a new establishment, and staff attitudes/regimes).

There are two concepts relating to regime – 'time out of cell' (TOOC) and 'time in meaningul activity' (TIPA). These concepts refers to the duraton which an individual spends outside their confinement cell engaging in meaningful or intentional activities. This includes all the occasions when prisoners are unlocked from their cells, for example to associate with their prisoners, have exercise or meals, take showers, or make telephone calls'. It reflects prisoners social engagement with family and wider prison establishment. TIPA includes time in "the formal activities aimed at helping prisoners to gain skills – for example, through education, work, training, and participation in offending behaviour programmes" and reflects prisoner's engagement with rehabilitative activities. This includes education and learning, work, recreation and exercise, counselling and therapy, social interaction, ecotherapy, library access, creative outlets, legal and administrative matters, healthcare appointments, religious and cultural practices and family visits. This time is crucial for various reasons, including mental and physical well being, rehabilitation and maintaining a sense of purpose. Balancing security concerns with the need for purposeful activity is essential. Providing structured and meaningful time out of cell contributes to rehabiliation, reduces recidivism and promotes overall well being for incarcerated individuals. A literature review on the impact of TOOC and TIPA by Leaman, O'Moore, Tran & Plugge (2021) found that poorer mental health and higher suicide rates were consistently associated with lower TOOC and TIPA. Limited evidence suggests a link between TOOC and TIPA and deliberate self-harm. No evidence was found between TIPA and TOOC and violence. However, the limitations included a lack of longitudinal studies, preventing conclusions regardng causality and a lack of heterogeinty of studies preventing comparison. They highlight the importance of considering the impact of TOOC and TIPA on adverse mental health when designing prison regimes, including during periods of adaptation (e.g. Covid-19).

The role of overcrowding was highlighted in a damning report from the HM Inspectorate of Prisons (2018). They focuced on the deaths by suicide of five prisoners at HMP Leeds in less than two years, within the context of a recent decrease in suicides, but an 'all time high' in self-harming and assualts (McDermott & Wilmot, 2018). The over-population, combined with reduced staffing, led to criticism by the Prison Reform Trust of short custodial sentences and raised concerns about risks to the safety of both staff and prisoners arising from over-crowding.

The nature of power in prisons has changed (Crewe, 2009). The prison system of England and Wales (Crewe, 2009) is now characterized by 'soft power', which is exerted through both staff–prisoner relationships and a range of policies that officers assist or implement, such as mandatory drug testing and early release schemes. These policies encourage prisoners to regulate their own behaviour, putting the onus on them to govern their conduct, address their offending behaviour, engage positively with the regime and accept responsibility for any failings to do so. For example, the incentives and earned privileges (IEP) scheme induce prisoners to behave appropriately, rewarding prisoners for 'responsible behaviour and participation in hard work and other constructive activity' (see Liebling et al., 1999). This is in strict contrast with past use of authoritarian strategies which were employed to exert 'hard power', which involved the use of direct command or coercion, where the core requirement was ensuring order and obedience.

The role of trust has also been explored in relation to the prison environment. Prisons are low-trust environments (Liebling, 2004). Prisoners often have a deep-seated mistrust of authority figures (Crewe, 2011), which means that prisons hold people whose experiences of trust tend not to dispose them to put faith in others. Wariness is pervasive (Irwin, 1985), and niceness is often met with scepticism. Indeed, as stated by Morgan et al., (2004), there is already a sense of mistrust between prisoners and anyone who might be considered law enforcement or "cops." Even when prisoners develop some trust in officers, they are often have less trust in the system that officers operate in (Crewe, 2011). Bennett and Dyson (2014), identified trust as a barrier that prevents or interferes with the implementation of policies for reducing self-harm in adults in prisons. They identified that prisoners

show resistance to receiving treatment due to lack of trust and anger towards prison officers about the way they may have been treated.

Procedural Justice has been linked to aggression and self-harm (Howard & Wakeling, 2020). Poorer perceptions of procedural justice in any prison may adversely affect outcomes for mental health, behaviour and re-offending. They are more likely to experience anger, distress and anxiety, which makes them more likely to misbehave (e.g. rule breaking, violence etc.) and/or to engage in self-harm and suicidality. In prisons where there is a strong sense of procedural justice, it may improve prisoner's acceptance of staff authority, improve behaviour and mental health outcomes. The role of procedural justice becomes more important and relevant for people with a history of trauma and mistrust of others. They may respond less favourably to poorer procedural justice. For example, when they do not believe their voice will be taken into consideration by a neutral, caring, trustworthy and principled authority figure, and do not feel respected and treated with fairness and equality, they will be more likely to experience poorer mental health outcomes.

The role of prison culture has also been discussed. Many cultural barriers to care receiving by prisoners have indeed been identified by Jewkes (2005) such as avoiding showing vulnerability to others. These include Jewkes' (2005) reflections that prisons are hypermasculine environments where surviving prison is about having a tough front. There is a culture within prisons of a hierarchy of male power and dominance (Jewkes, 2002), which includes prisoner's initiation into the prison, prisoner-on-prisoner violence and judgements of peer group of authority. Masculine ideology in prisons have a negative effect on the level of care-receiving by prisoners, who may not be able to receive care out of fear for being seen as weak, making themselves vulnerable amongst peers in the social hierarchy, threatening their autonomy and identity. Being asked to lift this front, even temporarily, to reflect on your experiences and identify issues can be a difficult task. The culture of not showing vulnerability may keep prisoners safe from predators who might bully them and appears to be a necessary part of their survival, but it may prevent them from seeking help or support with any difficulties they may have. They may not ask for help from officers or support from MDT services if they are struggling or have mental health difficulties. The care and kindness they are provided with may be at odds with their masculine emotional coping style (Jewkes, 2007). Prisoners may assume that if they tell a staff member that they have suicidal ideation, they will

immediately be placed in an SOC, separated from other prisoners and their belongings (Mims, 2021).

The nature of power in prisons has also been highlighted as an aggravating factor in the prison environment. The nature of power has changed (Crewe, 2009). The prison system of England and Wales is now characterized by 'soft power', which is exerted through both staff and prisoner relationships and a range of policies that officers assist or implement, such as mandatory drug testing and early release schemes (Crewe, 2009). This is in strict contrast with past use of authoritarian strategies which were employed to exert 'hard power', which involved the use of direct command or coercion, where the core requirement was ensuring order and obedience. These 'soft power' policies encourage prisoners to regulate their own behaviour, putting the onus on them to govern their conduct, address their offending behaviour, engage positively with the regime and accept responsibility for any failings to do so. As an example, the Incentives and Earned Privileges (IEP) scheme induce prisoners to behave appropriately, rewarding prisoners for 'responsible behaviour and participation in hard work and other constructive activity' (see Liebling et al., 1999).

The role of Neurodiversity

The role of Neurodiversity in prisons has more recently come to to the fore, which refers to the different ways a person's brain processes information. Neurodiversity is an umbrella term used to describe a variety of of neuro differences including most common types such as Autism, Attention Deficit Hyperactivity Disorder (ADHD), or Attention Deficit Disorder (ADD), other types of neurodiversity such as Foetal Alcohol Syndrome, Dyscalculia, Dyslexia, Dyspraxia, or Developmental Coordination Disorder (DCD), and other examples of how brains can process information differently, which some people like to consider part of the 'neurodiversity' umbrella and others like to keep them separate, such as Cognitive functioning difficulties or executive dysfunction, Dysgraphia, Misophonia, Slow processing speed, Stammering and Tourette's syndrome. Neurodivergent people experience and interact with the world in a different way and may experience more more challenges in a prison environment. The sensory experiences of individuals in prison has more recently explored. In their podcast, Warr & Herrity (2021) explore the impact of sound, touch and smell in the prison environment and the impact it has on people's wellbeing,

particularly for those with neurodivergence or trauma histories. This includes the sound and role of silence and noise, the importance of smell, and the effect of poor ventilation in prisons in shaping the prison environment. It refers to the sensory environment in prison as a communication of power dynamics and punishment, in particular the lack of kind touch and the intrusion of unwanted touch.

This suggests that various risk and contributory factors can increase the possibility that a person will engage in self-harm or attempt suicide, including individual, social, environmental and structural factors. However, it is important to note that not all contributory factors will be negative. Some factors may have mitigated or ameliorated a more serious outcome and some may decrease the likelihood of a person engaging in self-harm or suicide. The same factors may protect against the risk of self-harm and suicide, and are known as 'protective factors'. It is therefore important that these positive factors are drawn out through research, so that this positive learning can be used to support and promote safer custody. The opportunity to provide positive feedback to the people involved in managing prisons also has the power to influence safer custody in the long run.

Self harm data analysis (SADA)

In the SADA project in Irish Prisons, contributory factors were recorded for every incident by the prison multi-disciplinary team. These have been broadly organised into approximately five themes: environmental, relational, procedural, and individual (e.g. medical and mental health). Contributory factors were operationalised based on the three domains of security (environmental, procedural and relational), as described by Kennedy (2002), with the addition of personal and medical/health issues. This was intended to address aspects of the risk environment, such as the environment itself, procedural aspects, relational issues, bereavement/loss, and medical issues. Table 4 highlights the contributory factors identified in Irish Prisons.

Table 4

Contributory Factors Identified in the SADA Project.

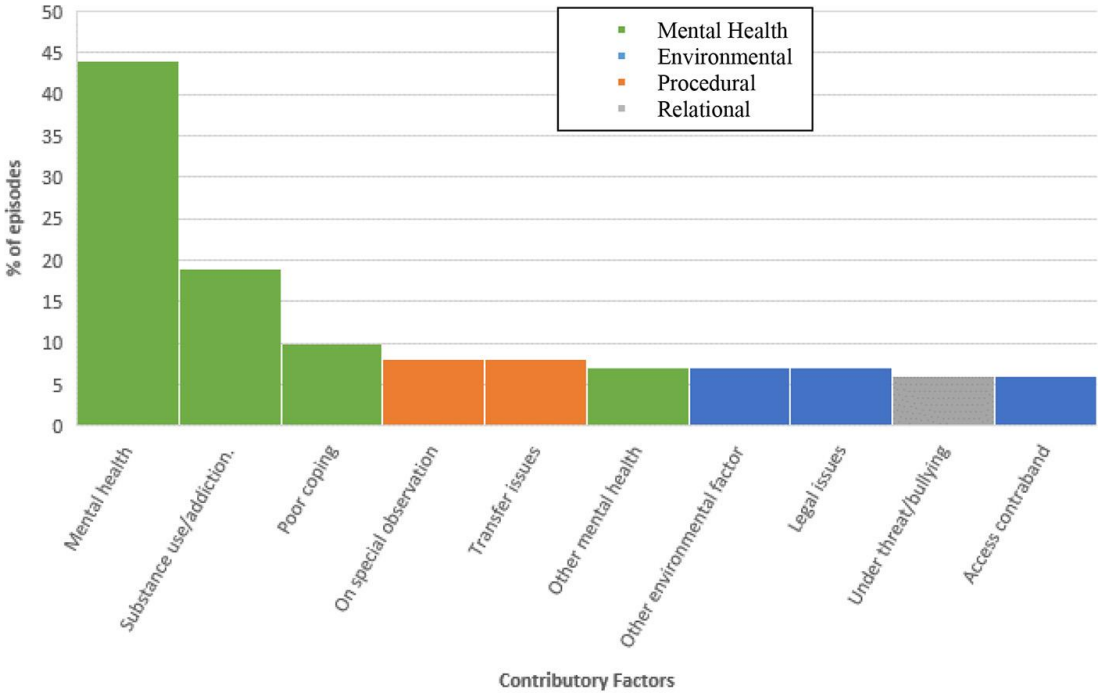
Code		Contributory Factor
ENVIRONMENTAL	**E1**	Legal issues (e.g. pending charges, court case, recently convicted, 1st time in custody, unexpected custody).
	E2	Shortage of staff and/or staffing issues (causing stress/tension/chaos).
	E3	Reduced access to regime (causing isolation/lack of stimulation).

	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 incentivised 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.

The majority of contributory factors recorded in 2019 related to mental health (45.6%), relational issues (22.1%) and environmental issues (32.7%). Figure 1 shows data across all years and shows a consistent pattern of mental health as the predominant contributory factor.

Figure 1

Most Common Contributory Factors 2017-2019



Note: Figure by McTernan *et al.* (2023)

McTernan et al., (2023) highlighted the broad range of contributory factors that have been identified in Irish Prisons, which was argued to demonstrate the need for an all-inclusive, prison-wide approach towards preventing self-harm in Irish prisons. McTiernan et al., (2023) indicated that, as per research by Marzano et al., (2016), this should include both population and specific priority group strategies, with multiagency collaboration between psychological, criminal justice and social care services.

Theories of self harm and suicide

This section will explore theories of suicide and self-harm, which will start by exploring theories of suicide, then theories of self-harm and finally theories that concern both suicide and self-harm. It will draw upon theories that contextualise prisoner's mental health within a Biopsychosocial (BPS) model (Engel, 1977), which considers the biological, psychological and social factors that interact to influence the presence and severity of mental health issues in the population.

Klonsky & May (2015) introduced a new ideation-to-action theory of suicide, known as the Three Step Theory (3ST). The theory posits that '(a) suicidal ideation develops due to a combination of pain and hopelessness, (b) connectedness is a key protective

factor against escalating ideation in those high on both pain and hopelessness and (c) progression from suicide ideation to attempts occurs when dispositional, acquired, and practical factors create sufficiently high capacity to face the pain and fear inherent in attempting to end one's life'. This highlights the importance of connectedness as a protective factor in those with suicidal ideation due to pain and hopelessness. The theory suggests that any efforts to prevent or treat suicidality should specifically target a) pain reduction b) increased hope c) improve connectedness and d) reduced capacity, at both the level of the individual (e.g. psychotherapy), and government policy. This provides an important contributions to understanding why people attempt suicide and what methods work to reduce suicidality. The Three-Step Theory of Suicide was tested in a study among Chinese People Based on the Ideation-to-Action Framework (Yang, Liu, Chen & Li, 2019). It was found that psychological pain and hopelessness interacted to predict suicide ideation, and that connectedness was the most protective against ideation in those high on both pain and hopelessness. Suicide capacity differentiated those who attempt suicide from those with ideation above and beyond current suicide ideation. These findings provide preliminary evidence for the validity of 3ST of suicide within a Chinese context.

There is far less research on developing an understanding of self-harm behaviour and therefore fewer evidence based strategies for managing self-harm in prisons. This has arisen due to conflicting viewpoints about whether self-harm should be studied as an aspect of suicide, or a separate conceptual issue. There are two main theories explaining why individuals engage in self injury in prison. The emotional cascade model (Selby & Joiner, 2009) postulate that many dysregulated behaviours including non-suicidal self-harm, suicide, substance misuse and aggression are the result of intense rumination which occurs during times of emotional distress. Rumination (reflection and brooding which focuses on negative feelings or emotions), can result in emotional cascades, whereby the magnitude of the experience of negative emotion leads to using self-harm to distract from rumination. Their research indicated that the rumination, which is a common feature in in BPD, is the common cause of self-harming among those diagnosed with this disorder.
The Cry of Pain (CoP) model (Williams and Pollock, 2001), which is a biopsychosocial model developed for suicidal behaviour initially, asserts that both suicide and self-harm are the end product of perceiving being trapped in a stressful situation where there is no escape or rescue. The model identifies four key components that

together place an individual at risk of suicide or self-harm, including the presence of stressors (life experience/environmental factors), the perception of defeat (a sense of a failed struggle), the perception of entrapment (a sense of being trapped or unable to escape) and a perceived absence of rescue factors (e.g. support from friends and family). It has been suggested that the prison setting may increase the sense of entrapment, including high external locus of control, ineffective coping and low resilience (Pope, 2018), which warrants further research. Further research is recommended to fully understand the role of the prison environment in self harm, and to better understand the relationship between rumination and self-harm in custody.

These models of self-harm provide plausible explanations for self-harm, and have some empirical support. However, they do have limitations (Pope, 2018) such as lack of consideration of different types of self-harm with different motivations and functions, and differences between single episode and repeat self-harm.
A developmental trauma model (Lewis, 1990) for aggressive, impulsive behaviour has been extended to the use of self-harming behaviours of prisoners. Lanes (2009) provided evidence that significant developmental events, such as abuse or neglect during childhood, central nervous system insult (e.g. head or brain injury/damage) and or lack of formal education, can result in a predisposition to psychological difficulties (e.g. mood disorder, BPD) and can manifest in dangerous behaviour (e.g. suicide attempts, assaults) and may contribute towards poor coping. Such behaviours in prison can lead to environmental instability, by resulting in time in segregation, protective custody or facility transfer, which perpetuates the problem and induces distress. Stanley et al., (2001) stated that self-mutilating suicide attempters gave a history of childhood abuse, show more aggressive behaviour and have more evidence of borderline characteristics relating to affective instability and difficulties with interpersonal relationships.

The Unified theoretical framework of self-harming behaviour (Liljedahl & Westling, 2014) provides a descriptive model uniting self-harming and suicidal behaviours that have sometimes been formulated separately. Unified theoretical framework of self-harming behaviour is developed with an aim to fully encompass all possible forms of self-harming behavior and their possible interrelatedness, to aid individuals with lived experience and their clinicians to detect, understand, and effectively respond when the form of a self-harm behavior changes. Five self-harm behaviour groupings

are derived from the literature on suicide, self-harm, NSSI, and Borderline Personality Disorder (BPD). The five self-harm behaviour groupings within the model are (from lower to higher lethality):

1. Direct: Self-injury (consistent with NSSI).
2. Indirect: Harmful self-neglect; behaviours consistent with very poor selfcare.
3. Indirect: Sexual self-harm or self exploitation; behaviours engaged in without sexual interest or the motivation of pleasure or experience.
4. Indirect: Putting oneself in harms' way; exposing oneself to high likelihood of injury or violence such as walking alone at night in neighbourhoods known for violence.
5. Direct: Suicide attempt; Self initiated behaviours undertaken to kill oneself.

Liljedahl & Westling (2014) argue that there are common features between NSSI and suicide attempts, and between direct and indirect forms of self-harm, but the behaviours may change form, directness, and lethality.

Similarly, the Power Threat Meaning Framework, which published by the British Psychological Society's (BPS) Division of Clinical Psychology (DCP) in January 2018 (Johnstone & Boyle, 2018a, 2019b) has provided a multi-factorial, contextual, service-user informed approach to understanding emotional distress and troubled/troubling behaviour, including self-harm and suicide. The development of the PTMF received contributions from numerous additional authors with diverse professional backgrounds, including experts by experience. The Power Threat Meaning Framework (PTMF) aims to provide both professionals and service-users with an alternative way of understanding the origins, experiences and expressions of emotional distress and troubled/troubling behaviour. It challenges the thinking behind the current classification system as outlined in DSM and ICD of distress and unusual experiences, which is embedded in the psychiatric diagnostic model and has long dominated our understanding of such phenomena and has significant conceptual and empirical limitations. It provides a formulation based, trauma informed approach that views people with problems, rather than labelling patients with illness (medical model). It views symptoms as ways of surviving, rather than individualising the problem by imposing a narrative of individual deficit & illness (e.g., chemical imbalance, maladaptive cognitions), it explains distress as happening from outside inwards (i.e., problems are in the world, your reaction is understandable). By comparison to the medical model, where the external cause is rarely identified, it recognises the causal role of adversity including inequality, social exclusion, etc.

Consequently, there is a need for a paradigm shift in relation to the experiences that these diagnoses refer to, towards a conceptual system not based on a "disease" model'. This offers a wider overall framework to support and enhance current models and practices. Instead of pathologising human experiences and behaviours, the PTMF aims to position these within the biological, social and psychological contexts which surround them (Johnstone & Boyle, 2018a). The holistic structure of the PTMF lends itself to understanding a wide range of phenomena, including self harm and suicidality, hence its applicability to this research. The PTMF contains four core components which can be translated into four core questions: (1) power – what has happened to you? (2) threat – how did it affect you?, (3) meaning – what sense did you make of it?, and (4) threat response – what did you have to do to survive? The PTMF provides numerous examples of each of these components, and further organises them into seven general patterns: (1) identities, (2) surviving rejection, entrapment, and invalidation, (3) surviving disrupted attachments and adversities as a child/young person, (4) surviving separation and identity confusion, (5) surviving defeat, entrapment, disconnection, and loss, (6) surviving social exclusion, shame, and coercive power, and (7) surviving single threats. They maintain that the threat (or operation of power) may be distal and out of conscious memory, but the threat response remains active. They argue that the threat reponse might take the form of self-harm. The person in distress may deny the link of their response to the threat because it may have felt dangerous, stigmatising or shaming. When they encounter a mental health professonal, they may receive a diagnosis that implies deficit and 'illness'. According to the PTMF, threat responses are more usefully understood in terms of the main function(s) they serve. The authors believe that these responses should be linked to the core human need that is being protected by the response. The threat response may serve a multitude of purposes for each individual. Thus, self-harm may be used simultaneously as self-punishment, communication, release of feelings, and a means of eliciting care. Their response—conscious or otherwise—functions as a way to survive the negative impacts of power by using the resources available to them. Rather than being "diagnosed" as passively suffering biological or psychological deficits, the authors suggest that service users (and all of us) can be recognized and validated as using threat reactions for protection and survival. There may be patterns in their responses, but they are not discrete clusters, and they do not replace diagnostic labels or provide universal explanations of symptoms. Various factors may exacerbate or amelorate the power-threat-meaning-reponse process.

Finally, it emphasises the importance of considering individual strengths, particularly when using the PTMF in therapeutic practices (Johnstone & Boyle, 2018a).
The PTMF has received considerable positive feedback from professional and service users both globally and across many different settings. It has received particular interest in forensic contexts, argued to be due mostly to the constraints placed on clinicians of the biomedical model that prevails in such settings (Ramsden, 2019). Positioning troubled/troubling human behaviour as pathological symptoms which necessitate pharmacological and/or psychological treatment may lead to an inappropriate and/or ineffective understanding and thus management of symptoms, which may be frustrating for clinicans. However, the PTMF does not go far enough in providing an understanding of how their current situation, including the barriers to support, and their current stressors and environment, may play a role in maintaining their threat response. This has implications for treatment pathways.

Motivation

This section will explore the motivation behind acts of self-harm and suicidality. Research suggests that the motivation behind suicidal behaviour during incarceration will vary, and that these motivations will be influenced by factors such the number of stays in prison (first time or repeat offenders), length of sentence, and ability to adapt to prison life. (Barczykowska, Muskała, & Kleka, 2023). The most commonly apparent motivation for prison suicide includes the fear of other inmates, fear of the consequences of one's crime, or imprisonment, and the loss of a significant relationship (Leibling, 1999). In their study of near lethal self harm by women prisoners, Marzoni, Fazel, Rivlin and Hawton (2012), most episodes, which involved hanging or ligaturing, and had a high level of suicidal ideation, were motivated by individual and prison-related factors. Therefore, motivations for suicidal behaviour must be considered in the development of management and prevention policies. In a study of the lived experiences of women in custody, Walker et al., (2020) identified complex motivations behind acts of self-harm by women in prison, including past trauma, deteriorating mental health and separation from children or family.

There is significant research into the study of suicide in prisons, however there is fewer research exploring motivation for self-harm. Research exploring the functions

of self-harm in prison is limited, particularly for women. Jeglic et al., (2005) identified four main functions of self-harm in forensic populations including;

- Depression and suicidal intent
- Manipulation of the environment
- Emotion regulation
- A response to psychotic delusions or hallucinations

However, general research on at risk populations has demonstrated a wide range of motivations. Acts of harm may involve various underlying motives, such as loss of control, needing help or self-punishment (Klonsky, 2009). Self-harm may be used as a means to regulate mood (Chapman, Gratz & Brown, 2006), provide relief from intensely negative emotions (Klonsky, 2007), communicate distress (Walker & Towl, 2018) and as a way to dissociate from internal and external environments (Motz, 2001). Past life experiences, such as abuse, victimisation and trauma, may contribute to self-harm being used as a maladaptive coping mechanism to process significant psychosocial stressors (Jeglic, Vanderhoff & Donovick, 2005; Dixon-Gordon, Harrison & Roesch, 2012; Walker & Towl, 2018). The impact of these traumatic events is amplified when people are deprived of liberty (Dear et al., 2001). Research exploring the functions of self-harm for women in prison is limited; however, general research on at risk populations has demonstrated a wide range of motivations. Kenning, et al., (2010) reported that imprisoned women described incidents of self-harm as impulsive and unstoppable acts related to intense feelings of anger, hurt and frustration over which they had little or no control. The impact of these traumatic events is amplified when individuals become deprived of liberty (Dear, et al., 2001). Finally, it is worth noting that prisoners who self-injure have been described as internalising the anger process (Smith & Kaminski (2010) and may display 'anger out' behaviours (e.g. expressions of anger, hostility, and violence directed towards tiers) as well as 'anger in' simultaneously (i.e. self-harm behaviours, suicidal processes, anorexia nervosa, etc.). Smith & Kaminski (2010) identified that self-injuring prisoners receive more disciplinary infraction (37% increase) when compared to non-injuring prisoners. My own clinical observations concurs with this view, whereby often prisoners who desist from violence often display 'anger in' behaviours (e.g. self-harm, hopelessness etc.). This has implications for understanding the function of and treating self-harm behaviours.

Given the range of motivating factors, it is important to consider individual motivation when developing strategies to prevent and manage self-harm and

suicide. As stated by Walker et al., (2017), understanding motivations preceding acts of self-harm is critical in order to ensure we are delivering effective interventions. This is particularly true if acts of self-harm without suicidal intent can indeed be differentiated from acts of suicide. The nosology of self-harm should inform the appropriate institutional response, and treating self-harm as a simple derivative of suicide may not be the most effective for managing self-harm (Smith, Slade & Kaminski, 2019), for example, suicide protocols such as isolation may not be indicated for self-harm. Also, the notion of a 'mixed group' paradigm might require the use of other strategies. If, however, self-harm behaviour reflects a range of anger-in behaviours that extends on a continuum of harm to oneself from deliberate self-harm (e.g. self-cutting) to completed suicide (Dexter & Towl, 1995, Haycock, 1989, Knoll, 2010, Morgan & Howton, 2004), then this may support a 'one size fits all' consistent approach to all self-harm behaviour. It can often be, however, be difficult to fully establish the motivation (and intent) for incidents.

Factors that promote desistance from self-harm in prison.

This review will now consider the factors that promote desistance from self-harm and suicide in prison. This section will explore the factors that may protect against the risk of self-harm and suicide, which are known as 'protective factors'. Similar to risk factors, a range of factors at the individual, relationship, community, and societal levels can reduce the risk of suicide and self-harm. As already mentioned, it is important that these positive factors are identified and shared in order to support and promote safer custody.

A number of reviews have been completed that shed light on the factors that may prevent, or protect against deaths in custody. This includes the Harris Review (Harris, 2015) of all self inflicted deaths in custody of 18-24 year olds, the Lord Farmer Review (2017 & 2019) of the importance of family and other relational ties, and Scottish Centre for Crime & Justice Research (SCCJR, Armstrong & McGhee, 2019) of mental health and well being of young people in custody.

The Harris Review (2015) identified that all (young) people in custody are vulnerable due to a variety of complex bio psycho social factors, which are often further compounded by mental health issues, or by a lack of maturity, associated with the developmental stage in young adults where brain structures and adaptive strategies

are still emerging. Moreover, their experience of being in custody (for example, separation from family, bullying) is likely to exacerbate their vulnerabilities. The review made a number of specific and concrete recommendations about how to mitigate risk of vulnerability of young people. This included strengthening family relationships by facilitating easy & direct contact particularly within two hours of arrival to prison, in cell telephones and video call facilities, a dedicated 24 hour phone line to share information/pass on concerns and ensuring visits and contact with family is not withdrawn as part of punishment, Incentives Earned Privileges (IEP) or because of 'restricted regimes' (the practice of holding a prisoner on 23 hour lock up, which removes access to structured activity, and isolates them from other prisoners. They also suggest developing a strategy to tackle and reduce bullying by providing guidance to staff, and a free, dedicated 24 hour anti-bullying telephone helpline, so that prisoners or their families could report problems in confidence. The review recommend use of safer cells (with reduced ligature points), improving staff prisoner relationships, and providing timely and appropriate provision of the necessary mental health services, including early assessment within 24 hours of arrival (with a more detailed assessment if required within 7 days), a psycho-social assessment, including assessment of maturity and mental health issues, access to mental health treatment (e.g. anxiety, depression etc) with short waiting times, screening and treatment for ADHD in line with NICE guidelines, 24/7 access to psychiatry and equivalent mental health services. The review recommended that self-harm reduction should be a key outcome indicator for prison mental health services and that treatment of emotional instability should be a key focus of the NOMS/DH/NHS England (Specialised Commissioning) 'personality disorder' treatment strategy because of its role as a key driver for self-inflicted deaths.
The review also recommend local authorities have an explicit statutory duty to provide a 'corporate parenting' and should have a mentor for all care leavers who are in custody, in addition to their existing statutory duties. The review maintains that peer relationships are key for young people, and vulnerability can be mediated by ensuring young people are engaged in peer support systems (such as The Listener scheme, Buddy schemes), Peer Mentors (Insiders) and Prisoner Councils. They recommend that Listener Suites are provided within prisons, and that they are a safe and supportive environment. The review suggests that all staff should be committed to the operation of the Listener scheme, and that Listeners feel supported and enabled. It recommended that all young adults should be accommodated in small units with specialist staff and a 'regime' to meet their needs and that, when their

maturity or vulnerability mean it is in their best interests, they should have the facilities to accommodate them in specialised prison wings or block, and a named officer (Custody and Rehabilitation Officer; CARO) to ensure that the prisoner's health, education, social care and rehabilitation needs are met, whilst making sure that their safety and vulnerabilities are addressed.

The Scottish Centre for Crime & Justice Research (SCCJR, Armstrong & McGhee, 2019) identified similar, consistent findings to the Harris review (2015). Family contact and relationships were identified most consistently by young people as helping them to cope with the distress of institutionalisation. The SCCJR (Armstrong & McGhee, 2019) recommended that prisons should never isolate young people, or deny access to family, belongings and support. They found that even short periods of isolation in cell had a negative impact on young people; however, frequent very short periods (an hour or less) was less damaging than less frequent periods (of a day or more), according to one source. They stated that this damage occurs regardless of whether isolation is for disciplinary, protective or regime reasons. The SCCJR recommended maximising time out of cell and availability of stimulating activities and meaningful social relationships to support and allow social development. The SCCJR (Armstrong & McGhee, 2019) also identified frontline prison and health staff as crucial to managing suicide risk but highlighted that their own risk of stress and workload is rarely considered. It also identified that interactions with staff must be meaningful in order to break down a culture of mistrust and miscommunication. They recommended that staff are empowered and supported in understanding mental health issues, and that increasing demands placed on them are addressed and minimised. Whilst the Harris Review (2015) and The SCCJR (Armstrong & McGhee, 2019) address young people in prisons, the above findings may similarly also apply to all prisoners. The Lord Farmer Review (2017) highlighted the following statistics:

- One fifth of male prisoners have attempted suicide, five times the rate in the general male population (Ministry of Justice (2013).
- In the 12 months to December 2016 there were 112 suicides across the whole prison estate (Ministry of Justice, 2016).
- Nearly a third of self-inflicted deaths (in a sample of those they investigated) occurred in the first 30 days and, of these, half died within the first week in prison (Prisons and Probations Ombudsman, 2016).

The review found that strengthening family ties for men in prison are important to prevent reoffending and reduce intergenerational crime. Lord Farmer cited evidence

that the impact of prison on family relationships can lead to an increased risk of self-harm and suicide (Loucks, 2012a). He strongly advocated that the emergence of a rehabilitation culture inside every prison will not happen unless good relationships with families and others on the outside are treated as a much higher priority in many jails. He concluded that family ties and relationships with significant others should be treated as assets by the team that keeps prisoners safe. He referred to family ties as 'a resource that newly empowered governors can, and must, deploy in the interest not just of reducing reoffending rates, but also of creating a more settled regime'. Following his 2017 review, Lord Farmer's second review looks at strengthening family and other relational ties across both custody and the community through the lens of female offenders. The new report found that healthy relationships are a 'must have' when it comes to preventing women from reoffending. Lord Farmer points to Ministry of Justice statistics which show that prisoners who receive family visits are 39% less likely to reoffend, and research suggests that these relationships are even more important for women than they are for men. Around 30% of all female offenders have dependent children and maintaining these relationships can also reduce the issue of intergenerational offending. Female offenders are frequently among the most vulnerable individuals in society, often suffering from abuse, substance misuse and mental health problems which can profoundly impact their ability to develop and sustain healthy, trusting relationships.

Given the existence of strong family ties being so crucial to rehabilitation and to ensuring the safety of prisoners, he recommended that families should be regarded as a central component of support from the earliest point of coming into custody – before they leave the court to be transported to prison, on their first night and during the induction period and processes. He believed that, as well as laying a good foundation to help them cope with the difficult adjustment to the prison regime and settle into their sentence, it also helps them in the immediate present when vulnerabilities can be fatal. He also refers to the importance of hope and a sense of the outside world in protecting prisoners' mental wellbeing. One family member told him 'Prisoners live for visits and letters' and one prisoner the researcher met said, 'If I don't maintain my family life I'll lose it, if I lose it what happens then?' and referred to their family ties as 'the bond you're scared of losing…it's my biggest fear.'
In a study by Howard & Pope (2019), they explored men's experience who have desisted from self-harm in prison. Features identified as critical to their desistance included feeling important, encouraging hope for the future and promoting change,

trusting relationships with genuine care, understanding the motivation for self-harm, developing strategies to cope and critical turning points for change such as persons, situations or units that enable people to feel safe, believed in and supported. However, there are limitations in this study because it appears to be restricted to self-harm and does not explore suicidal processes. It is unclear, however, how self-harm was defined in the study (e.g. what type of self-harm participants had engaged in). It also could involve people in the 'mixed group' paradigm who have also engaged in suicidal processes as it did not check with participant's their history of self-harm before they came to prison.

Liebling (2022) found that trust does actually exist in prisons, and is vital to their functionning during periodic crises. In a study of two high security prisons in the UK (Williams & Leibling, 2023), they found that different patterns of control and authority lead to varying 'inmate social systems', with rigid, domineering styles of control leading to 'covert, secret and defensive' formations among prisoners. The institutional climates, including the patterns of control and levels of trust confirgured and directed the degrees and types of violence. There were strong correlations between respect, humanity, staff-prisoner relationships, staff professionalism and intelligent trust.

Procedural justice has been linked to aggression and to mental health outcomes in custody. Procedural justice (PJ) theory suggests that if incarcerated people perceive their treatment to be fair and just, greater acceptance of staff authority, less misconduct, better mental health, and improved recidivism outcomes will follow. There are four key principles of procedural justice:

- treating people with respect and dignity
- making unbiased decisions and interpreting and applying rules consistently and transparently
- giving people a voice and hearing their concerns and experiences
- showing and encouraging trust by being sincere, caring and authentic, and trying to do what is right for everyone.

People in prison who feel treated unfairly and disrespectfully are more depressed, distressed, and anxious (e.g., Gover et al., 2000; Liebling et al., 2005). The Dutch Prison Project (Beijersbergen et al., 2014) demonstrated a causal relationship between procedural justice and mental health. When people in prison perceived their treatment by the prison to be procedurally just, fewer mental health problems

were reported after three months, and improved reoffending outcomes 18 months following release (Beijersbergen et al., 2016). Poorer procedural justice perceptions were weakly associated with self-harm and attempted suicide, and negatively associated with misbehavior/incidents in custody in UK prisons (Howard & Wakeling, 2020), although procedural justice perceptions were not a significant predictor of incidents.

People who believe they are being treated unjustly are more likely to experience anger, distress and anxiety, which makes them more likely to misbehave (e.g. rule breaking, violence etc.) and/or to engage in self-harm and suicidality. In prisons where there is a strong sense of procedural justice, it may improve prisoner's acceptance of staff authority, improve behaviour and mental health, whilst poorer perceptions of procedural justice in any prison may adversely affect outcomes for mental health, behaviour and re-offending. People who believe their voice will be taken into consideration by a neutral, caring, trustworthy and principled authority figure, and feel respected and treatment with fairness and equality will be more likely to experience positive mental health outcomes. This suggests that procedural justice may be a protective factor against self-harm or suicide.

Peer support is increasingly recognised as a key asset to protecting and improving health in prison/detention settings. There is evidence that becoming a peer supporter can have a positive effect on prisoners by enhancing confidence and self esteem, improving communication and organisational skills and behaviour, generating positive self image, increasing levels of independence and gaining trust (Hunter & Boyce, 2009). To date, there has been no evaluation of peer support relating to self-harm specifically, delivered by people who formerly struggled with this (Howard & Pope, 2019). Following a review of 12 studies, Deering & Williams (2018) highlighted the potential recovery benefits to bringing together people for support for those who continue to self-harm in the community, such as developing connections with others, feeling understood and not judged which enabled the development of trust and combatted stigma, increasing access to support and transitioning over time to becoming the support provider, catharsis of emotions through talking/writing, developing hope and empowerment through inspirational relationships, learning techniques to cope and take control, fostering positive identities as people who help others and are not defined by their self-harming behaviour, and gaining a better understanding of why they harm themselves.

However, as stated by Howard & Pope (2019) these findings should be considered preliminary as this was drawn from secondary analysis, rather than directly from the participants, and no primary evaluation of this type of activity in prisons has yet been conducted.

Strategies to prevent or reduce self-harm and suicide in custody.

This section will explore interventions for self-harm and suicide, which have been identified (formal and informal, prevention and treatment) in the literature, ranging from individual treatment, whole system approaches, and protocols for managing self-harm and suicide. Suicide protocols are typically employed to address both suicide and self-harm behaviour equally (Smith & Kaminski, 2011) without any theoretical rationale. This is consistent with DeHart (2009) who documented use of crisis intervention cell, 15 minute observation and provision of an anti-suicide smock and blanket – which is tear resistant - for self-harm. Further research is needed to explore the implications of the tripartite schema (self-harm, suicide, and a mixed group) for informing treatment and management strategies to support staff dealing with these behaviours on a daily basis. To combat the increased risk and limit the loss of human life, organisations such as the World Health Organisation (WHO), the Council of Europe's Committee for the Prevention of Torture (CPT) and the United Nations have made recommendations about the management of suicide risk in prisons.

The WHO (2015) suggest that subtle changes such as the level of care, induction process and routine procedures in the prison can increase risk. They recommend at a minimum the development of a suicide prevention programme, with prevention training on suicide that addresses why correctional environments are conducive to suicidal behaviour, staff attitudes about suicide, potential predisposing factors to suicide, high risk periods, warning signs and symptoms, recent suicides and/or serous suicide attempts with the agency. The WHO advocates practical training such as first aid training, use of emergency equipment, with practice drills incorporated into training. The WHO highlights that the prevention of suicide includes effective communication between arresting officer and prison staff, communication between prison staff and communication between prison staff and prisoners. They also caution against the risks of using isolation cells because the "majority of suicides in correctional settings occur when an individual is isolated from staff and fellow

inmates" and recommend use of shared accommodation. The WHO also recommend use of specially trained listeners, family visits for social support and use of psycho-pharmacological treatment. Mental health and medical staff within prisons are unlikely to be the people managing or recognising suicide risk on a day-to-day basis (Konrad et al., 2007). Therefore, a number of fundamental recommendations centre around training of general prison staff to develop an environment which aids in preventing death by suicide. Key recommendations include staff developing a working relationship with vulnerable prisoners, enabling them to monitor well-being via conversation at key times e.g. pre- and post-sentencing (Tomaszewska et al., 2019). All staff are recommended to receive training on recognising signs of suicidal ideation and planning (WHO, 2007), and staff are also recommended to utilise these skills with the entire prison population, not solely those in high-risk groups (Favril et al., 2021).

A number of research projects have also highlighted ways to prevent self-harm and suicide in prisons. The Revolving Doors Agency (Bennett, 2020) explored views and experiences of people with lived experience of the criminal justice system to consider what actions could support the mental health of prisoners and reduce the occurrence of suicide in prison. It was found that mental health support in prison was viewed as inadequate due to staff not being able to recognise deteriorating mental health, especially as prisoners did not disclose details about their physical and mental health, and not being caring. They also found that the behaviour of other prisoners and not being able to access pharmacological and psychological support, including experiencing delays to access, had a negative impact on well being. It was suggested that family contact, improve processes by which prisoners access medication and therapeutic support, provision of support before sentencing by specialist mental health staff, staff training on mental health first aid, peer support with people who have lived experience to provide support because they may be trusted (with training and ongoing supervision and support), thorough assessment, early intervention and diversionary activity at point of entry into the criminal justice system, and an increase in community sentences.

A rapid evidence assessment by Pope (2018) to identify what works in reducing or managing self-harm in men found that only two studies met the inclusion criteria. This suggested that there is very little research exploring what works to reduce or manage self-harm in prison settings (Pope, 2018). The first, a literature review by

Bennett and Dyson (2014), identified the following key themes as barriers that prevent or interfere with the implementation of policies for reducing self-harm in adults in prisons: knowledge; attitudes; emotion; staff skills; environment; and resisting treatment. They suggest that a lack of knowledge by staff in the context of poor support, training, motivation, and confidence, can lead to negative attitudes towards self-harm. Emotions can become heightened due to building tensions, and resentment, in the context of managing self-harm. Staff may not have the skills to respond effectively including listening, communication, and the ability to identify risk behaviour. The environment, including staffing levels, occupational activity, and multi-disciplinary working, also contribute towards barriers to the prevention of harm. They also identified lack of trust and anger as towards prison officers as a barrier to receiving treatment (Bennett and Dyson, 2014).

The second, a meta-analysis of RCT studies, Hawton et al., (1998) reported promising (but not significant) results for problem solving therapy, provision of a card to allow people to make emergency contact with services, drug treatment for recurrent self-harm, and DBT for female patients with BPD. Pope (2018), however, identified limitations to this meta-analysis due to small sample size, mostly representative of patients treated in the community and only focusing on women (Pope, 2018), which means that no firm, generalizable conclusions can be drawn. Pope (2018) concluded that interventions should be developed, piloted and evaluated to improve emotion regulation, problem solving and rumination, supporting the improvement of knowledge and attitudes of staff, developing relationships between staff and between staff and prisoners are important and conducting further research to explore risk and protective factors and the link between violence and self-harm.

This supports findings on the impact of the prison environment on mental health and suggests that interventions should include a comprehensive, prison wide approach towards preventing self-harm in prison including both population and targeted strategies, in prison and maintaining these approaches on release, such as diverting people before prison, improvements to mental health care in prison, purposeful activities and social support, with multiagency collaboration between the services for mental health, social care and criminal justice. This could include culture, attitudes and relationships between staff and prisoners and procedural change such as the prisons process for behavioural punishments (Howard, 2017). Perry (2020)

recommends further research to identify how tailored interventions can support people who self-harm in prison by considering cultural and environmental differences across prison systems and examine the cultural and environmental risk factors in relation to people who go on to experience suicidal ideation in prison or self-harm in the community.

Zhong et al., (2020) suggest that preventative measures should target the modifiable risk factors, such as suicidal ideation, during the current period in prison, single cell occupancy, and current psychiatric diagnosis and access to evidence based mental health care should be improved. This concurs with Jacobs et al., (2003) who argue that during elicitation of risk factors, the clinician should take note of modifiable risk factors so that these can be addressed. These include alcohol and abuse of other substances, recent stressful life events (especially financial/relational loss), access to lethal means, hopelessness/ despair anhedonia, impulsivity, and recent discharge from a psychiatric facility.

Research has explored the role of specific psychological interventions in addressing self-harm and suicide. Dialectical Behavioural Therapy (DBT) can be effective at reducing self-harm behaviour in prison environments, by developing prisoners' skills around mindfulness, distress tolerance, emotional regulation and interpersonal effectiveness (Berzins & Trestman, 2004). A recent meta-analysis by Hawton et al., (2016) reported effectiveness of CBT in reducing the proportion of people who harm themselves, and effectiveness of DBT in reducing frequency of self-harm. In a review of interventions designed to reduce or prevent self-harm and suicidal behaviour in prisons, including DBT, Peer prevention programs, Winikov (2019) found CBT and uniquely tailored interventions offered promising results. However, there are several limitations in the research including general absence of comparison groups, few evaluation studies, and inconsistent definition of self-harm and behavioural measurements. As Winikov (2019) suggests, this makes it difficult to synthesise the results.

Various authors have offered their reflections on how to prevent self-harm and suicide in custody based on the factors that contribute towards those behaviours. Jeglic (2005) makes a number of recommendations for psychological treatment depending on the motivation. For those experiencing depression/suicide intent, he recommends using psychotherapy, CBT and pharmacotherapy. For those using self-

harm as a way of having needs met, he recommends to use a behavioural plan such as minimising secondary gain i.e. reducing emotional responses to the behaviour, altering the environment, etc. For self-harm that is associated with emotional regulation, a DBT approach may be useful, involving a behavioural chain analysis for incidents of self-harm and working to build emotional regulation and distress tolerance skills.

Forrester (2014) emphasised the value of more recent focus on self-harm management, including addressing causal factors. He highlighted the role of multi-agency collaboration within and between organisations, with an emphasis on 'suicide being everyone's concern' and effective joined up care with a broad reach of specialist training and supervision for prison staff to support identification and management of risk by prison officers. He also advocated for the need to understand the link between suicidal ideation and completed suicide.
Leibling (1995) argued that the focus should be on developing and strengthening protective factors, rather than preventing suicide. This includes both the development of a comprehensive plan for each prisoner, which assesses their needs, recognises their vulnerabilities, provides the opportunity to address their offending behaviour, and the development of appropriate programmes. This may include family support and visits, constructive activity within the prison, support from prisoners, prison staff, prison visitors and other services, having hopes and plans for the future, effective multi-disciplinary working, with trained staff who are valued by the system. Liebling (1999) argued that programmes that equip prisoners with skills and capabilities would not only protect them from self-harming behaviour but would also protect the wider community. The researcher concurs with the the focus expressed by Liebling (1995) on developing and strengthening protective factors, rather than preventing suicide or self-harm. This may include equipping prisoners with skills and capabilities to show their vulnerability and communicate their needs in healthy ways, and trusting staff-prisoner relationships that enable people to feel safe, believed in and supported.

Given the range of contributory factors that lead to self-harm and suicide, there is reason to believe that an all-inclusive, prison wide approach towards preventing harm in Irish Prisons should be used (McTiernan et al., 22). It should target demographic, criminological, clinical (e.g. reduced pain, increased hope), and institutional risk factors (e.g. lack of connectedness) at both the level of the

individual, and government policy level. This suggests that interventions should not specifically target self-harm or suicidal behaviour, but should target the culture of prisons, and the way in which prisoners tend to interface with their environment based on their experiences to date, which will indirectly positively impact on self-harm.

There is growing support for the development of a trauma informed service model suitable for implementation into a male prison environment (Donley et al., 2012). There is a strong association between experiencing trauma and being involved in the criminal justice system (Donley et al., 2012). Trauma is linked to child abuse, physical trauma and sexual trauma, but is also associated with experiencing trauma linked to witnessing harm to others. There is a significantly higher prevalence of ACEs in justice-involved populations than general populations (Skarupski et al., 2016). For incarcerated adult males, trauma exposure rates range from 62.4 to 87%. Despite high levels of ACEs in offender populations, relatively few studies have explored the relationships between ACEs and prisoners' mental health and wellbeing (Ford et al., 2020). Ford et al., (2020) found that adverse childhood experiences (ACEs) such as child maltreatment are strong predictors of poor mental health and wellbeing. Prisoners with ACEs have been found to have poorer mental health and greater suicidality (Godet-Mardirossian et al., 2011) Self-destructive and suicidal behaviours, anger and aggression towards others are linked to interpersonal trauma (Van der Kolket al., 1996).

There have been a number of trauma informed interventions developed in prisons. This includes developing and implementing therapeutically-informed in-cell activities. Female prisoners who have survived self-inflicted death attempts identified that activities to reduce anxiety and distract from intrusive thoughts would have been beneficial in the lead up to their self-inflicted death attempt (Borrill, et al., 2005). The introduction of relaxation and mindfulness activities within prisons improved sleep and lowered anxiety (Lutz, 1990). Developing a better understanding of the association between ACEs and, self-harm or suicide in the prison population can help to identify where preventative work can be directed. In October 2018, HMPPS initiated the Trauma Informed Prisons Project (TIPP) in Wales, which aimed to develop a sustainable trauma informed approach across prisons and address vulnerabilitues linked to ACE's within the prison population. This includes ACE's awareness for all staff, trauma informed casework approach. It aims

to improve stability for incarcerated individuals during their time in prison and beyond, and positively impact families, local communities and partners like the Police. Public Health Wales will evaluate the project to identify areas of success and areas for improvement.

The Wellness Recovery Action Plan (WRAP) was created by mental health recovery advocate Mary Ellen Copeland and is now integrated into various services offered by the Department of Health in the UK. The WRAP programme is intended to foster a combination of personal agency and support so that those suffering with mental health problems can inform their own recovery while at the same time feel held on their journey. The five essentials of recovery are (Copeland, 2024):

- Hope
- Personal responsibility
- Education
- Self-advocacy
- Support

There are few studies exploring interventions for self-harm and suicide. From the limited number of studies that exist, there is potential for the use of formal and informal interventions, to support prevention and treatment, ranging from specific, individual treatment, whole system approaches and protocols for managing self-harm and suicide. There are no studies of desistance that explore both suicide and self-harm in male prisoners, and none that included questions designed to delineate participants self-harming behaviours across community and prison environments. Interestingly, few studies were found that evaluated intervention that is aimed towards recovery from substance use and none were males. Given the role of substance abuse as a risk factor in all studies that explore self-harm and suicide, it is surprising that there is not more extensive research on the role of promoting desistance of substance use in preventing self-harm and suicide.

Theoretical Framework of the Thesis

This section will now describe the theoretical frameworks which the study will draw upon in order to meet the aims and objectives of this study, including:

- The risk and contributory factors for self-harm and suicide.
- The facilitators and barriers to desistance.

- What works to reduce and/or manage self-harm among people in custody in order to inform effective ways for prison managers and staff to respond to incidents of self-harm and provide safer custody.

The theoretical framework used by this research to understand the factors that put people at risk of engaging in self-harm, the factors that contribute towards a person engaging in self harm in prison and the factors that protect people against harm or support desistance can be found in Table 5 below.

Table 5

Relevant Theories drawn upon by this Research

Nature of Harm	Risk and contributory factors	Protective factors and strategies that support desistance
Tripartite Schema (Smith et al, 2019) Creighton & Towl (2002) Unified theoretical framework of self-harming behaviour (Liljedahl & Westling, 2014)	Developmental trauma model (Lewis, 1990) Power Threat Meaning Framework (Johnstone & Boyle, 2018a).	Power Threat Meaning Framework (Johnstone & Boyle, 2018a).

1. Nature of self harm

This research drew upon the tripartite schema (Smith et al., 2019), which features three different groups of self-harming behaviours (self-harm behaviour, suicidal process and 'mixed group' of self-harm and suicide). It views self injurious events, and suicidal processes as nosologically distinct with regard to etiology, manifestation, and policy implications, and thus warrant specific institutional responses. This paradigm is in contrast to other paradigms such as the Unified theoretical framework of self-harming behaviour (Liljedahl & Westling, 2014) which provides a descriptive model uniting self-harming and suicidal behaviours. Another paradigm (Crighton & Towl, 2002) makes a distinction between self-harm and suicidal threats, attempts and completions based on their motivation to end life or not.

2. Risk and contributory factors for self-harm in prison

This research drew upon the developmental trauma model (Lewis, 1990) and the Power Threat Meaning Framework (Johnstone & Boyle, 2018a) to understand why some people engage in self-harm and suicide in prison. The developmental trauma model argues that that significant developmental events, such as abuse or neglect during childhood, central nervous system insult (e.g. head or brain injury/damage) and or lack of formal education, can result in a predisposition to psychological difficulties (e.g. mood disorder, BPD) and can manifest in dangerous behaviour (e.g. suicide attempts, assaults) and may contribute towards poor coping. Such behaviours in prison can lead to environmental instability, by resulting in time in segregation, protective custody or facility transfer, which perpetuates the problem and induces distress.

The PTMF considers self harm and suicide in relation to four core components, which can be translated into four core questions: (1) power – what has happened to you? (2) threat – how did it affect you?, (3) meaning – what sense did you make of it?, and (4) threat response – what did you have to do to survive? The PTMF provides numerous examples of each of these components, and further organises them into seven general patterns: (1) identities, (2) surviving rejection, entrapment, and invalidation, (3) surviving disrupted attachments and adversities as a child/young person, (4) surviving separation and identity confusion, (5) surviving defeat, entrapment, disconnection, and loss, (6) surviving social exclusion, shame, and coercive power, and (7) surviving single threats. The PTMF views self-harm and suicide as a threat response for protection and survival and may vary in terms of the main functions they serve. Thus, self-harm may be used simultaneously as self-punishment, communication, release of feelings, and a means of eliciting care. All of these strategies represent people's attempts—conscious or otherwise—to survive the negative impacts of power by using the resources available to them.

3. Factors that protect against self-harm and strategies to promote desistance.

The PTMF (Johnstone & Boyle, 2018a) states that factors may exacerbate or amelorate the power-threat-meaning-reponse process. It emphasises the importance of considering individual strengths, particularly when using the PTMF in therapeutic practices. Use of the PTMF has led to a gradual shift in forensic settings towards towards trauma informed practices (Willmot & Jones, 2022). The PTMF shows great promise as a trauma informed approach that is compassionate about the origins of

self harm and suicide, and translates these 'symptoms' and 'illnesses' into understandable responses to life circumstances.

Reflections

Before undertaking this research, the researcher believed that self-harm and suicide were distinct entities and should be treated and managed differently, consistent with the Tripartite Schema (Smith et al., 2019). The researcher hypothesised that different strategies should be employed to manage self-harm and suicide. The researcher also supported Crighton & Towl (2002). It was believed that self-harm may be a form of communication that they have needs that are not being met or are being frustrated concurs with the view that self-harm may be life affirming and is designed to retain emotional equilibrium. Sometimes, it may be used as a more manipulative way of forcing the system to respond more favourably towards them. Suicide may be more indicative of exasping life's pains (death affirming) and functions as a statement of despair and hopelessness that has reached the point where they believe their needs cannot be met. The 'mixed group' (e.g. self-harm and suicide) of self-harming prisoners may consist of those who oscillate between communicating their needs using self-harm and those who have given up hope that their needs can be met. When reviewing the literature, the researcher began to reflect on the core components identified in the PTMF in the aetiology of self-harm and suicide in prisoners:

(1) power – what has happened to you?

Prisoners have often experienced Adverse Childhood Experiences (ACE'S).

(2) threat – how did it affect you?

These experiences may have negatively impacted on their attachment style, self-esteem, emotional coping style and interpersonal style. People who have been physically, or indeed sexually, abused may experience high levels of mistrust and paranoia. They might expect others to harm them, either physically or psychologically. They will likely have difficulties with mentalising others and may attribute hostile intent to other's behaviour. This may include a fixed perspective or rigid representation of others as dangerous or bad (e.g. humiliating or criticising them). People who have been emotionally neglected may be inclined to feel uncared for or seen as insignificant by others. People who have experienced abandonment, such as bereavement/loss or interrupted caregiving (e.g. death of a caregiver, periods of abandonment as a child by a caregiver due to mental ill health, or parental

separation) may be sensitive around fears of abandonment. People may be susceptible to a form of adult 'sibling rivalry', whereby they are sensitive to differential treatment of others, whether it is real or imagined. These adverse experiences may also lead to enduring patterns of inner experience and behaviour that deviates markedly from the expectations of the individual's culture (e.g. Personality Disorder), or mental health issues, including Axis-1 disorders.

(3) meaning – what sense did you make of it?,

People who have have adverse childhood experiences often blame themselves, or feel defective and ashamed as a result. These early life experiences, which have shaped their attachment style, their interpersonal relationships and their coping responses, will inevitably impact how they experience imprisonment. Early life experiences may also impact on how a person in custody experiences imprisonment, and the way in which prisoners interface with their environment. The culture of the prison playing a critical role in how a person's experience is shaped. These factors make them more or less susceptible to being triggered by the prison environment, situations or individual experiences and the culture of the prison will either mitigate or exacerbate their experience of custody. Prison is likely to heighten the threat, and their subsequent threat response. By their very nature, prisons are an austere environment, with a constant and pervasive threat of violence, which may contribute towards a lack of psychological and physical safety and keep the threat alive. There are also a number of challenges to being imprisoned, especially for those with a history of trauma. Imprisonment in itself asks those in custody to trust those in authority who may either have abused them in the past, or have been pivotal in their imprisonment. Prisons are low-trust environments (Liebling, 2004). Prisoners often have a deep-seated mistrust of authority figures (Crewe, 2011), which means that prisons hold people whose experiences of trust tend not to dispose them to put faith in others. Wariness is pervasive (Irwin, 1985), and niceness is often met with scepticism. Indeed, as stated by Morgan et al., (2004), there is already a sense of mistrust between prisoners and anyone who might be considered law enforcement or "cops." Even when prisoners develop some trust in officers, they are often have less trust in the system that officers operate in (Crewe, 2011).

Some of the protocols in custody, such as searching, may in addition be re-traumatising due to the perception of humiliation involved. This may trigger memories of traumatic experiences in their life (e.g. feeling powerless) and they may

have difficulty with use of power and feeling they have to submit to authority. They may have been socialised to adopt an 'inmate code' that, in the past, was highly suspicious of prisoners who were friendly with officers. The rules of engagement are such that developing close relationships with officers would likely breach some aspect of personal or criminal identity.

(4) threat response – what did you have to do to survive?

People will respond to their experience of threat with various coping mechanisms to survive and protect themselves, many of which will be unhelpful if they persist into adulthood.

These factors all combine to increase or decrease the risk of incidents of harm to self (or indeed to others if anger-in is turned outwards). Self-harm may function as self-punishment, communication that they have needs (e.g. need for care or support that are being frustrated), release of feelings, and a means of eliciting care. This may have implications for how we address prevention of self-harm and suicidal processes in custody. It also highlights the importance of care needs being individualised and understood through the voice of the prisoner, as stated by Neave (2021).

Some aspects of the Emotional Cascade model (Selby & Joiner, 2009), and the Cry of Pain (CoP) model (Williams and Pollock, 2001) are also addressed in the reflections above. In particular, the role of emotional cascades, whereby the magnitude of the experience of negative emotion leads to using self-harm to distract from rumination, and the presence of stressors, the perception of defeat, the perception of entrapment, and a perceived absence of rescue factors (e.g. support from friends and family), which are all exacerbated by the prison setting. However, neither of thee theories account for the origins of poor emotional self management in terms of their trauma history.

Simply by being placed in custody, prisoners are being punished for their actions through imprisonment. Prisoners often have difficulty taking responsibility for their behaviour. They can often blame others for their behaviour, or minimise what they have done. This may be the result of an external locus of control, or a response to shame as a result of their actions (e.g. their offence) or past experiences (e.g. sexual, physical or emotional abuse). They may place responsibility on those around them to change, in order to avoid them being triggered by their environment or by others. This tends to lead to frustration and disappointment in the system when it requires

them to change and does not meet their needs. When their behaviour steps out of line, they are managed under the P19 adjudication system or the criminal justice system depending on the severity of the indiscretion, and their behaviour is incentivised by the use of incentivised regime. This is consistent with Crewe (2009) who characterised the nature of power prisons as 'soft power', which is exerted through both staff–prisoner relationships and a range of policies that officers assist or implement, such as mandatory drug testing, early release schemes, and the incentives and earned privileges (IEP).

When applying Crewe's model, those with significant adverse experiences (e.g. abuse) as a child should find a high care environment a positive experience. However, those with anti-social attitudes or higher levels of mistrust may experience this as adverse and reject any caregiving attempts, and sometimes they may reject positive care, even though they find it beneficial because they cannot trust it. Those who have been neglected emotionally may be triggered by low care environment and react negatively to feeling uncared for. This is consistent with the cultural barriers to care receiving by prisoners identified by Jewkes (2005), such as avoiding showing vulnerability to others. Adverse childhood experiences can have an impact on the capability of the prisoner to receive care. People in custody with adverse childhood experiences may have developed coping strategies as a child that serve them well in terms of survival, but become less helpful as an adult. Some coping strategies may involve manipulating the system in order to get their needs met. Their coping strategies may also include shutting down their emotional needs, and avoiding showing vulnerability to others. In order to cope with early inconsistent/abusive caregiving experiences and personality disorder, prisoners often see things as good or bad – in what we describe as a split way. They might see staff as either good or bad, and this can translate into seeing one side of the roster as bad, and the other side as good. It can be difficult for prisoners and staff to believe that management/the system could care about both at the same time. It's perceived as an either/or - so if you show care to the prisoner, it automatically means that you don't care about staff at all, and vice versa. This makes it difficult for those in custody to fully maximise the level of support that is available to them. They may also develop loyal peer relations with other anti-social peers regardless of whether they have their best interests at heart. This can lead to a particular culture or mind set amongst prisoners, where there is often a tendency for prisoners to

engage in group think/pack mentality. There are a number of unwritten or informal rules endorsed (publicly, but not always privately) by prisoners, which include:

- You do not 'rat' on each other.
- You do not show vulnerability, because it is a sign of weakness, and may be seen by others as an opportunity to exploit or take advantage of you.
- You should not step out of line with the expectations of a prisoner (e.g. engage with Psychology/officers/goal setting) because you may be given a hard time by other prisoners.

Group think/pack mentality may also lead to tolerance of unacceptable behaviour, such as bullying or intimidation by others, which may be difficult to cope with without challenge, or indeed support. This is consistent with the culture within prisons of masculine ideology in prisons (Jewkes, 2002) which have a negative effect on the level of care-receiving by prisoners.

Before undertaking this research, the researcher believed that interventions should not specifically target self-harm behaviour, but should target the culture of prisons, and address the way in which prisoners tend to interface with their environment based on their experiences to date, and the broader prison culture, which will indirectly impact on the level of self-harm. The role of prison culture (both prisoner and staff-prisoner) may be critical in encouraging desistance from harm. Howard & Pope's (2019) research on factors that promote desistance is consistent with the researcher's observations. It is believed by the researcher that the level of mistrust, poor mentalisation, and sensitivity to perceived differential treatment, in the context of a strong prisoner culture, may lead to increased risk of harm and may need particular strategies to manage this. This supports Howard & Pope's (2019) view on the role of strategies through the staff-prisoner relationship using genuine care, showing understanding, support and creating safety and belief.

The researcher's experience of trying to manage self-harm and suicide in prisons is that there can be a diffusion of responsibility. Due to the risks and high stakes nature of self-harm and suicide, people can often run away from the risk responsibility. This is consistent with a number of studies (Ramluggan, 2013; Ireland and Quinn, 2007; Bennett and Dyson, 2014) who found that interdisciplinary conflict between staff, particularly health and custodial staff, was evident, with each discipline viewing the other as best placed to deal with self-harm, leading to an absence of shared responsibility or effective multidisciplinary working. In particular,

reported conflicts that arise for prison staff included conflict with other disciplines including health care staff and senior management.

Chapter Summary

Self-harm and suicidality poses a significant problem in prison. A range of clinical, risk factors have been explored in relation to self-harm and suicidality in prison, including socio-demographic, criminological, custodial, clinical and historical factors. A wide range of motivations have been identified for self-harm and suicidal acts by prisoners. There is a growing literature on strategies and interventions to prevent risk of harm in custody. There are some positive findings about the potential role of preventative strategies based on providing individual treatment and an appropriate institutional response to self-harm depending on their motivation in order to reduce self-harm and suicidality amongst people in custody. Understanding the motivation for self-harm is critical for informing the prevention and management of self-harm. Prison provides a unique opportunity to address the factors that lead to self-harm and suicide. Identifying people in custody at high-risk of negative health outcomes and delivery of appropriate care may also provide an important step in reducing wider health disparities in this population (Borschmann et al., 2018).

There is a paucity of research undertaken on the lived experience of people in custody which might help inform the management and prevention of self-harm in prisons. There are no studies that explore the nature of self-harm that people in custody engage in (including the prevalence, patterns, methods, functions, triggers, risk factors, intended lethality of self-harm and suicidality) as well as the factors that support desistance, together in one study. Most studies explore the nature of harm such as risk factors, or motivations, or evaluate factors that support desistance or prevention. Many studies also explore either suicide or self-harm but not both self-harm and suicide together.

The aim of this PhD research is to investigate the experiences of male prisoners of the risk and protective factors that contribute to both self-harm and/or suicidality amongst people in custody. This PhD will contribute towards new research by providing the first qualitative study in Ireland of prisoner's experience of self harm and suicide in prisons. Relatively little is known about managing self-harm in individuals in this specific context so by drawing on the perspective of people in custody and their lived experiences, this can provide a useful - and much needed –

insight into their experiences and challenges of being in custody, whilst considering potential environmental, psycho-social factors and implications. This PhD research will provide innovative research that combines both an in depth understanding of the nature of both self-harm and suicide from the perspective of people in custody, and the factors that promote desistance. It will provide new data by directly exploring participant experiences and perspectives, rather than a broader overview achieved through data analysis, inspectorial or evaluation and by exploring multiple dimensions together.

This PhD will add to the debate on the aetiology of self-harm and suicide, and provide a new theoretical framework contributing to the debate about whether self-harm and suicide are similar entities. This will enable a clearer picture of both the aetiology of self-harm and suicide and how this influences preventative or treatment approaches. It will contribute to a better understanding of desistance, persistence and resilience against self-harm in custody. It will contribute to new methods by enabling a reliable, simultaneous analysis of the drivers for both self-harm and suicide in the same study. It will help to identify what works to reduce and/or manage self-harm among people in custody and help inform effective ways for clinicians, prison managers and staff to respond to incidents of self-harm and provide appropriate, helpful care.

The next Chapter will outline the methodology used in the research, including the design and methods, data analysis and any ethical issues raised by the PhD research. It will also discuss the limitations of this research and the challenges and opportunities of conducting the research as ‘an insider’ (an employee of the Irish Prison Service).

Chapter 4: Research Methodology

Introduction

This chapter will introduce the methodology used in this PhD research to achieve the aims of the study and to answer the research questions. This will discuss the design and methods, data analysis and any ethical issues raised by the PhD research. The limitations of this research and the challenges and opportunities of conducting the research as 'an insider' (an employee of the Irish Prison Service) will be considered. To recap, the PhD research had the following objectives (see Table 4):

- To explore the risk and contributory factors for self-harm and suicide for men in custody.
- To explore the facilitators and barriers to desistance.
- To identify what works to reduce and/or manage self-harm among men in custody in order to help inform effective ways for prison managers and staff to respond to incidents of self-harm and provide safer custody.

Methodology

Design and Methods.

The current PhD research employed a cross-sectional multi-site design. It collected and analysed qualitative data from a group of male participants at a single point in time in 2023 within eight closed adult male prisons in Ireland.

Qualitative methods were used to explore the perspectives of men in custody about their experience of prison. Quantitative data on the sample demographics and characteristics were used to underscore and augment the in depth qualitative research. This included using prisoner record files (PIMS), data collected by the Self-Harm and Data Analysis (SADA) project, psychometric testing and Prisoner Healthcare Management System (PHMS) data in order to obtain demographic (e.g. age, gender, nationality, offence, sentence length, P19 history), characteristics of the participant at the time of self-harm and severity /intent /contributory factors/etc. of the episode of the self-harm, committal screen information, past history of suicide and self-harm, contact with healthcare and psychological processes (e.g. depression, anxiety, function of self-harm, suicide ideation, self-concept, self-esteem, health, psychological distress and ways of coping). Use of quantitative data allowed for

analysis to be situated in a wider context of complex psycho-social background factors about the selected group.

Qualitative studies typically involves observing the population and conducting in-depth interviews or focus group discussions (Corner et al., 2019). Qualitative research has the advantage of understanding people's experiences in a simple, easy and analytical way and seeks answers to research questions using a systematically pre-defined set of procedures (Cleland, 2017), obtaining information about behaviour, opinions and social contexts of a particular population, providing textual and complex descriptions of why and how people experience certain phenomena, providing deeper insights into real-world problems without having to quantify data and gathers participants' perceptions, experiences and behaviour by answering answers "why" and "how" instead of "how much" or "how many" (Moser & Korstjens, 2017). Qualitative studies also have the advantage of flexibility and spontaneity, a smaller study sample, offers the opportunity to meet participants, encourages discussion with the participants, allows for the collection and interpretation of non-verbal cues (smiles, frowns, tears) and offers the opportunity to seek clarification and gain deeper understanding of phenomena under study. Notably, the direct involvement of the researcher provides them the opportunity to get insightful and relevant responses from the participants (Oranga & Matere, 2023). The use of qualitative interviews allowed the researcher to get insights into people's experiences, behaviour, beliefs, attitudes and motivation and played a key role in deconstructing individual experiences.

However, there are some disadvantages to qualitative methods, including concerns that a smaller sample size limits generalizability to the whole population of the research (Harry & Lipsky, 2014; Thompson, 2011) or to other contexts (Lam, 2015), interpretation and analysis of data may be more difficult or complex (Richards & Richards, 1994) and take a considerable amount of time (Flick, 2011), and data analysis and refining of the research question (Darlington and Scott (2003) may be a continuous process.

Participants

This PhD research involved men (n=15) in custody in Ireland. This section will consider the decisions to select male participants only and the number of men

interviewed. Firstly, the research only involved men due to the relative persistence over time between 2017 and 2021 in the number of men engaging in self-harm (3.6 per 100 in 2017, 2.4 per 100 in 2018, 2.4 per 100 in 2019, 3.3 per 100 in 2020, 2.7 per 100 in 2021) and the increased severity associated with episodes of self-harm amongst men (McTiernan et al., 2021). 87.4% of males who self-harmed required treatment compared with 30.8% of women prisoners in 2018 (McTernan et al., 2021). Rates of self harm and suicide are however higher amongst women, and the rate of self-harm in 2017-2019 was six times higher among females. This might suggest the research should focus on women. The decision to focus on men also took into account a number of factors which will be outlined now.

There were only 214 women in custody in Ireland in May 2023. Prevalence rates for women fluctuate significantly, with the number of females engaging in self-harm varying between 19 (16 per 100) in 2017, 26 (19.3 per 100) in 2018, 24 (19.8 per 100) in 2019, 31 (4.9 per 100) in 2020 and 14 (2.1 per 100) in 2021 (see table 6 below). This reflects the high turnover of women in custody. There is also a significant reduction in the number of women and girls engaging in self-harm (McTiernan et al., 2023). A number of episodes can be accounted for a small number of women in custody. A considerably smaller gender difference was recorded in 2020 (3.3 for males versus 4.9 per 100 for females) and 2021 (2.7 for males versus 2.1 per 100 for females) compared to 2017 (16 for females vs 3.6 males per 100), 2018 (19.3 for females vs 2.4 for males per 100), 2019 (19.8 for females vs 2.4 for males per 100). To establish a sufficient sample size, the majority of women in custody who have self-harmed or engaged in suicide would have to agree to participate in the research, and they may not provide representation across all groups (repeat self harm, suicide and mixed). These factors would make it difficult to identify a sufficient sample size, particularly the 'suicide' group, and a small sample size might breach anonymity because it might identify women in custody. Focusing on both men and women would involve two populations and thus a higher sample size, and may not be feasible or possble to be achieved within the timeframes provided.

Secondly, the number of participants required for qualitative research to get an in depth picture of participant's experiences of self-harm and suicide in Irish Prisons was explored. Sampling procedures in qualitative research are primarily driven by the concept of saturation, whereby data is collected until new data is not thought to

contribute anything new to the research (Glaser & Strauss, 1967). There have been many attempts to quantify the point of saturation. For example, Bertaux (1981) recommends a minimum of 15 participants, Charmaz (2006) an average of 25, and Ritchie et al (2003) a maximum of 50. In a review of the sample sizes featured in the qualitative studies of PhD students in Ireland and the UK, Mason (2010) reported that the modal sample size for studies using thematic analysis was 30. Early research indicated that the mean sample size and saturation for PhD studies using qualitative interviews is 31 (Mason, 2010). A large sample size has been deemed necessary (Malterud et al., 2016) to ensure what some researchers have referred to as a 'higher information power'. A more recent review found that qualitative research can reach saturation at relatively small sample sizes, with research showing 9 – 17 interviews or 4-8 focus groups reaching saturation (Hennink & Kaiser, 2022).

Most studies reviewed by Hennick & Kaiser (2022) involved a "homogenous study population", and "narrowly defined objectives". They also indicated that "multi-country research" may require a larger sample for saturation (Hennink & Kaiser, 2022). It is also stated that sample sizes of 20-40 interviews are necessary to reach data saturation of meta-themes (Hagaman and Wutich, 2017). This PhD project involved one homogenous population within a single country (people in custody in Ireland), however, it did involve meta themes.

The proportion of people in custody who engaged in self-harm in the cohort is very small relative to the proportion of people in custody in the Irish Prison Service. The research considered the percentage of people in custody who self harm or engage in suicide. This should be approx. 20-25% of the sample size in order to ensure representative percentage based on the prevalence rates of self-harm and suicide in Irish prisons. The prevalence rate is recorded as between 2.9 and 4 per 100 prisoners per year (Griffin et al., 2018, McTernan et al., 2020/2021). The prevalence rate was 4 per 100 prisoners in 2017 & 2018, 2.9 per 100 in 2019, 3 per 100 in 2020 and 3.6 in 2021. Between 01 January 2017 and 31 December 2019, there were 696 episodes of self-harm recorded in Irish Prisons, involving 397 individuals by 328 males and 69 females (McTernan et al., 2023), as shown in Table 6 below.

Table 6

Number of Individuals who Engaged In Self Injury and/or Suicide In 2020/2021.

	Individuals	Episodes	Rate per 100 (95% CI)

	2020	2021	2020	2021	2020	2021
Total	126	91	225	196	3.6 (2.4-3.5)	2.6 (2.4-3.5)
Male	95	77	132	144	3.3 (1.9-2.9)	2.7 (1.9-2.9)
Female	31	14	93	52	20.9 (3.4-6.9)	9.7 (1.2-3.5)

There were approximately 4649 people in prison in Ireland (Irish Prison Service, 2023). Based on the known prevalence rates, there are between approximately 91 and 147 people in custody each year who engage in self-harm and suicidality (Griffin et al., 2018, McTernan et al., 2020 & 2021). As shown below, there are between 77 and 121 males who engage in self-harm and/or suicidality each year. It is therefore expected that 15 participants (approx. 20% of males who self injured in 2021) would a representative number for the population of people who engage in self-harm and suicidality in prisons in Ireland.

However, qualitative methods are notably time-consuming. Smaller sample sizes are not only normative, but often most effective, for example in allowing for greater familiarization with the data (Braun & Clarke, 2006). Sample adequacy and data quality is often more important than the number of participants (Malterud et al., 2016). Therefore, the adequacy of the final sample size was iteratively reviewed during the research process. The quality of the dialogue in the interviews was considered, with regard to breadth and depth. After conducting 12 interviews, similar themes/material was observed to be emerging during interviews with participants and the only benefit to continuing further interviews was that another participant would articulate a particular issue more clearly. It was deemed that sample adequacy had been reached, with sufficient breadth and depth of information observed during data collection after 12 interviews, and it was deemed not necessary to conduct further interviews to ensure data quality.
Therefore, based on these points, 15 interviews were deemed sufficient in this research. The PhD research initially aimed to recruit 16 participants in four groups, each with a sample size of in each group of approximately four participants. 15 interviews were completed, lasting between approximately 60 and 120 minutes. The four initial proposed groups included:

- People in custody who self-injured since 2017 and desisted after one episode of self-harm.
- People in custody who engaged in self-harm since 2017 and persisted in self-harm by engaging in repeat self-harm.

- People in custody who attempted suicide (non-completers).
- A random control group of people in custody who have not engaged in self-harm and/or suicidal processes in custody. This included all people in custody since 2017.

Inclusion criteria comprised of men in custody between 18 and 65 years, who have at least a conversational level of the English language, are not experiencing acute mental health difficulties (e.g. an episode of psychosis) at the time of recruitment and did not pose a serious & significant risk of harm to the researcher. The PhD research excluded those on the 'Red and Blue list', and those assessed as having a high level of psychopathic traits.

A database is held in the Irish Prison Service to record all incidents where an individual in custody has engaged in self-harm since 2017. Groups i-v were identified using the excel spreadsheet containing all data from the SADA project. The list included all people in custody who have engaged in self-harm and/or suicidality since 2017. This includes all incidents that meet the NICE guidelines (National Clinical Practice Guidelines Number 16, 2004) which the Irish Prison Service adopted as the definition of self-harm: "Self-harm is (non-accidental) self-poisoning or self-harm, irrespective of the apparent purpose of the act." This definition will be used throughout this thesis. The definition includes acts involving varying degrees of suicidal intent, from low intent to high intent and various underlying motives such as loss of control, cry for help or self-punishment.

Inclusion/Exclusion Criteria:
The following inclusion/exclusion criteria were used to decide whether to include the incident in the data returns.
Inclusion criteria
The following were considered to be self-harm cases:

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

- Alcohol overdose (e.g. hooch) where the intention was to self-harm.

Food refusal was included primarily because there were no other forums to discuss this issue. However, it can often be motivated by very different drivers, and has different aetiology.

Exclusion criteria

In the Irish Prison Service, the following were NOT considered to be self-harm cases:

- Behaviour where there is no intent to self-harm.
- Accidental overdoses e.g. an individual who takes additional medication in the case of illness, without any intention to self-harm.
- Alcohol overdoses alone where the intention was not to self-harm.
- Accidental overdoses of illicit substances used for recreational purposes, without the intention to self-harm.
- Acts of self-harm by individuals with a profound learning disability. One of the reasons for exclusion is that self-harm is a behavioural outcome of some learning disabilities.

All incidents in the database were reviewed and categorised into three separate databases, as follows:

- People in custody in custody who have self-injured in custody and have desisted after one episode of self-harm (no suicidal intent).
- People in custody in custody who have engaged in self-harm in custody and have persisted in self-harm by engaging in repeat self-harm (no suicidal intent).
- People in custody in custody who have engaged in attempted suicide in custody.

This was completed by reviewing the description of the incident, scoring of intent, and the number of times an individual appears in the database. Those who appeared to have engaged in self-harm once since 2017 (e.g. no intent) were placed in Group 1, and those who appeared more than once in the database for different incidents, where there was no obvious intent to die, were placed in Group 2. Those who appeared to have attempted suicide & survived (e.g. high intent score, method of hanging etc.) were placed in Group 3. Some individuals who attempted suicide had also engaged in single or repeat incidents of self-harm and appeared in both groups.

A random generator tool (https://www.randomizer.org/) was used to randomly select a minimum of four individuals who remained in custody from each list.

However, most individuals in custody in 2017 and 2018 had been released and as a result, many of the sample randomly selected had been released, which unintentionally left only those on longer sentences, providing a systematic bias against those on a shorter sentence.

Individuals on the database who self-injured in 2017 and 2018 were removed in order to prevent a skewed sample. The database only included those who had self-injured in custody since 2019. Those who had been released from custody since 2019 were removed. Individuals in custody who engaged in food refusal were also excluded. Individuals in custody who were on remand were excluded for practical reasons because they could be released at any time. A sample of four individuals for each group was again randomly generated.

The final sample for groups 1-3 included individual's in custody who had engaged in self-harm since 2019 who remained in custody/had not been released from custody. The sample was then reviewed by prison management to exclude those without at least a conversational level of the English language, those who are experiencing acute mental health difficulties (e.g. an episode of psychosis) at the time of recruitment and those who pose a serious & significant risk of harm to the researcher. Letters were sent out to a total of 28 people to invite them to participate in the research. Eight people did not respond to the invitation to participate. This led to additional people in the sample being randomly generated until there were four in each group that verbally agreed to participate. One agreed to be participate and declined when called for interview. One was transferred either before the letter was received. 15 responded with their participation form signed.

During the early stages of conducting interviews, it became apparent early on that some participants had been assigned to the wrong group.

- Participants in the suicide group had engaged in self-harm in 2014, which occurred before data was collected.
- Participants in the repeaters group had desisted from self-harm and therefore did not fit into any group.
- A participant in both the self-harm and suicide group had only engaged in one episode of suicide (he reported he lied about having swallowed a battery).

- None of those assigned to the single incident group had only engaged in a single episode – they had either engaged in self-harm previously in prison before data was collected or in the community.
- Participants had engaged in self-harm in prison, and had attempted suicide in the community.

In fact, it was only possible to fully confirm which group individuals should be placed in until they were interviewed. This led to having too many participants in Group 2, insufficient numbers of participants in Group 1 due to the repeat nature of self-harm and some participants not neatly fitting into any Group because they had engaged in self-harm and suicide, or had desisted from repeat self-harm.

The decision was taken after interviewing 12 people in custody to change the groups to the following:

1. People in custody who have engaged in self-harm in prison (and in the community).
2. People in custody who have engaged in attempted suicide in prison.
3. People in custody who have either engaged in self-harm and/or suicide in prison (and in the community).

This seemed to be the most obvious grouping emerging from the research interviews based on the above observations. It was also decided not to proceed with a random control group of 4 people in custody who had never injured themselves (Group 4). The rationale was that after interviewing some participants, it no longer felt meaningful to speak to a small group of people who had not self-injured in custody as a comparison group. To be able to make meaningful comparisons with any confidence, a representative sample would have included at least the same number of people in the control group as the total number in the other groups (1-3), which equals approx. 12. This would also have significantly inflated the total number in the sample and became too expansive. It felt more valuable to increase the number people in the sample who had engaged in self-injury and/or suicidal behaviour. Instead it was agreed to increase the total sample in Groups 1-3 to 15.

The people in custody who responded to the invitation to participate typically included those who have desisted from self-harm and/or suicide. This enabled a better understanding of the factors that led to desistance and can therefore help to identify what prevents people in custody from harming themselves. There was also the potential for finding people in Group 4 who had a previous history of suicide and

self-harm in the community, which would confuse things further. After completing 12 interviews, similar material was emerging from interviews with participants and the only benefit to continuing further interviews was that another participant would articulate a particular issue more clearly. This is consistent with Hennink & Kaisier's (2022) finding that saturation is reached within a narrow range of interviews.

A total of 15 men participated in the research, as shown in Table 7:

Table 7

Number of Participants in each Group

Cohort	Total number of participants
People in custody who have engaged in repeat self-harm in prison (and in the community).	4
People in custody who have engaged in attempted suicide in custody or in the community.	3
People in custody who have either engaged in self-harm and have attempted suicide, both in prison and/or in the community.	8
Total number of participants in sample	15

Data collection

Measures

The interview consisted of several semi-structured, open-ended questions. Interviewing is a very common qualitative method which can be used 'to understand the meaning people make of their experience (Seidman, 2012), is flexible (Bryman, 2016), and can provide contextual meaning (Denzin, 2001) and insight into social issues by exploring individuals experiences (Seidman, 2012), with the benefit of non-verbal cues being used to help understand the message being given (Robson, 2011), However, interviews are time consuming (Seidman, 2012) and responses are co-constructed by interviewer and interviewee (Hosifi, 2014), and may be influenced by the authority (Nunkoosing, 2005), race, gender and the theoretical views (Hofisi, et al., 2014) of the interviewer. Whilst interview data cannot be generalised, it can be rich and deep.

The semi-structured interview was initially based around the Deliberate Self-Harm Inventory (DSHI) by Gratz (2001) and the semi structured interview used by a small scale qualitative study (Howard & Pope, 2019). The interview guide (see Appendix C) facilitated the semi-structured interviews for each group. There was a different format for each sample group, in which some of the questions varied for each group

based on their past use of self-harm (e.g. self-harm, suicide, attempted suicide). The interview schedule focused on the following key areas:

- Background information, socio-economic factors, early years, and criminogenic history, history of self-harm and suicidality, and involvement in treatment.
- History of self-harm behaviour and/or suicidality in prison and in the community.
- The function/motivation/contributory factors of their behaviour and the intentions behind their actions.
- The perceived risks of their self-harm and their strategies to reduce use of harm.
- Their experience of being in custody.
- Perceived barriers to their attempts to seeking support/reducing the risk of harm and their aspirations for the future.
- Understanding of facilitators of, and protective factors against risk of harm.
- Understanding of strategies/resources used by people in custody that produce or mediate risk.
- Their experience of moving to a period of not self-harming (what prompted this, length of time taken, process and awareness of change), how self-harm had been managed (triggers or pressures, activities and support, skill development), coping strategies used, the effect of managing self-harm (on thoughts and feelings, relationships with others).
- What helped or hindered the change process (such as people, places, activities, life events), reflection on progress made (learning, views of the past and future) and advice for others (for individuals and prisons).
- Their experience of existing policies, practices and intervention used in the management of self-harm and suicidality in custody in Ireland.

The topics covered by the interview were asked in a different order depending on the participant's dialogue and was much more responsive to the clinical needs of the individual than planned. This was in response to evidencing a need for participants to tell their story, particularly for those who had not received support when they needed it, or since their episode of self-harm. Better quality answers were provided when participants were allowed space to talk freely, whilst asking follow up questions that guided them towards covering all topics. Interviews were audio-recorded and transcribed verbatim manually and transferred onto a secure database.

The audio-tapes were erased once this was completed. Interview transcripts were thematically analyzed, and findings written up in report format.

Prisoner file records (PIMS) in the Irish Prison Service were accessed in order to obtain demographic (e.g. age, gender, nationality, offence, sentence length, P19 history). Committal screen information, past history of suicide and self-harm, contact with healthcare was accessed on PHMS in order to obtain historical data on self-harm and data collected by the SADA project on SADA forms, specifically the demographic, characteristics of the participant group at the time of self-harm and severity/intent/contributory factors/etc. of the episode of the self-harm. This information is necessary to accurately describe the sample in the current PhD research via descriptive statistics and accurately interpret findings. These records are the official property of the Irish Prison Service and not the person in custody, and so consent is not required to access and use this information. However, participants were informed in advance (via information sheets) that this information will be accessed and used. Participants were also assured that this information will not be used to describe single participants, but will be aggregated to describe the characteristics of the sample as a whole and to interpret findings.

Each participant also completed psychometric measures, which were selected following the interviews. Psychometrics measures were completed by the participant after the structured interview. These included:

- Beck Hopelessness Scale (HS; Beck et al, 1974); 20-item is designed to reflect respondents' negative expectancies.
- Beck Depression Inventory (BDI, Beck, Ward, Mendelson, Mock & Erbaugh, 1961) 21-item questionnaire that evaluates behavioral aspects of depression and correlates with its clinical severity.
- Beck Anxiety Inventory (Beck et al., 1988): 21 self-reported items (four-point scale) used to assess the intensity of physical and cognitive anxiety symptoms during the past week.
- Robson Self Esteem questionnaire (Rosenberg, 1989): a 20 item measure of self esteem.
- Difficulties in Emotion Regulation Scale (DERS) (Gratz & Roemer, 2004): This scale a 6-item self-report measure of six facets of emotion regulation.
- Dialectical Behaviour Therapy (DBT) Ways of Coping Scale (Neacsui, 2010): This checklist was developed to assess DBT skills use in difficult situations.

- Adverse Childhood Experiences (ACE) Survey (California Surgeon General's Clinical Advisory Committee): 10-item that measures the number of Adverse Childhood Experiences for adults.
- UCLA Loneliness (UCLA) V3 (Russell, Peplau, & Ferguson, 1978); A 20-item measure that assesses how often a person feels disconnected from others.
- State-Trait Anxiety Inventory (STAI) (Spielberger, C. D, 1989): a psychological inventory consisting of 40 self-report items that measures two types of anxiety – state anxiety and trait anxiety. Trait Anxiety is how participants typically feel on a daily basis and State anxiety is feelings that occur in response to situations perceived as dangerous.

Informed consent

Participants were aware in advance of consenting to participation of the nature of the research and discussions. A letter was sent to prospective participants inviting them to take part in the PhD research in an envelope which contained an information sheet, agreement to participate form and consent form. Simplified language was used to reduce the barriers to those with literacy difficulties and where no response was received, The multi-disciplinary team were asked by the researcher if there were any potential barriers such as literacy. Men in custody who agreed to participate were met face-to-face by the researcher, who introduced themselves and verbally re-iterated the information contained in the information sheets and consent forms. If the person in custody consented to participate in the PhD research based on the information outlined in the information sheet and consent form, they provided their written consent by signing the consent form. Participants were advised that they were free to skip any questions that they wished during the interview.

The interviews were then held, which were audio-recorded and lasted between approximately one to two hours. All interviews were conducted face-to-face, in a private setting within the prison (e.g. psychology clinic room). If participants were happy to continue, audio-recording began. At the end of the interview, participants were thanked for their participation and asked how they were doing. Participants were monitored for signs of distress through the interview, and the line of questionning was responsive to the needs of each participant. Participants were debriefed, and provided with a de-briefing sheet following interviews, which outlines

ways in which participants can seek further support in the prison if they wished to do so.

Confidentiality/Anonymity

The current study could assure a level of anonymity and confidentiality of participants. The officer escorting the participants to meet the researcher were not informed about the nature of the interview. Any instances where a participant indicated a risk of harm to others or a risk of harm to themselves would have had to be reported to prison management. Participants were assured confidentiality, except in circumstances where there was a significant risk to their life. Where serious suicide risk was identified, it was explained to the participant that these risks would be disclosed to prison healthcare staff who will formulate an immediate care plan. These scenarios were managed using Safety Protocol 2 and Safety Protocol 3 respectively, which can be found in the Appendix. The researcher would also have informed the relevant authorities in instances where a participant disclosed any undocumented criminal activity or informs the researcher that a child is being harmed in the community. Participants were made aware of the limits to confidentiality in advance by participant information sheets and consent forms. However, some measures were implemented to assure the confidentiality and anonymity of participants as much as possible. Firstly, the researcher will not openly disclose the identity of participants or raw content of interviews. Project supervisors will only have access to de-identified data.

Secondly, the data was de-identified as much as possible. Once audio tapes had been transcribed by the researcher, they were erased. Identifiable information (e.g. names, locations) were removed from typed interview transcripts. Written consent forms are securely stored in a locked filing cabinet at the Irish Prison Service Psychology Headquarters in Arbour Hill. All other data (e.g. transcripts, descriptive statistics) was stored securely on a secure laptop provided to the researcher by the Irish Prison Service until the PhD has been examined and awarded. After this period, these materials were archived by the Irish Prison Service and deleted or shredded after 2 years. These measures to assure anonymity are outlined in participant information sheets and consent forms. This information will only be used to contribute to future research in the area which is being conducted by the researcher involved with the project.

Thirdly, quantitative data, including the demographic and characteristics of the sample, was not used to describe single participants, but was aggregated to describe the characteristics of the sample as a whole. Data extracted from PIMS was stored in Microsoft Excel and SPSS files in a designated folder on the researcher's personal H drive on the Irish Prison Service IT network. The researcher accessed this H drive via a laptop provided by the Irish Prison Service and the researchers PC in their office in the Irish Prison Service Psychology Service Headquarters (Arbour Hill). It is acknowledged that this information is highly sensitive, and as such, a number of protective measures are in place. The IT department must be able to access H drives, where necessary to fulfil their support role and function. Any access by IT to personal H drives is in line with the Irish Prison Service IT Security Policy. For this reason, the researcher is unable to encrypt files/folders on their personal H drive. However, where possible (e.g. with Microsoft files) the researcher password protected all files containing sensitive information, including PIMS data. With the exception of the IT department (in the circumstances outlined above only), no other individual in the Irish Prison Service or otherwise was able to access the researcher's personal H drive. Both the researchers PC and laptop are secured in the first instance with a personal username and password. The PC and laptop are then secured with Citrix security software, which require another personal username and password. The laptop is further secured with MobilePASS+ software. This requires the researcher to access an app on their phone, where they enter a personal password to obtain a unique code, which must then be entered into the laptop to gain access. Given the protective measures in place, the data from this study (including PIMS data) will be managed with the highest level of security possible. These measures of assuring confidentiality and anonymity as much as possible are conveyed to participants in the information sheets and consent forms, which can be found in the supporting documents.

Post-interview support

Participants were offered support during and after the interview. Participants were assured confidentiality except in circumstances where there was a significant risk to their life. Where serious suicide risk was identified, it was explained to the participant that these risks would be disclosed to prison healthcare staff in order to formulate an immediate care plan.

Data analysis

Demographics (e.g. age, gender, sentencing status), historical factors (e.g. history of violence, history of trauma, history of self-harm or suicide), psychometric measures and data on episodes of self-harm were collated. Qualitative data from interviews were assessed using a reflexive approach to thematic analysis (TA), which is defined as “a method for identifying, analysing and reporting patterns (themes) within data (Braun & Clarke, 2006). Thematic Analysis was used because of its many benefits, including being a highly flexible approach which provides rich and detailed, yet complex account of data and its ability to examine the perspectives of different research participants, highlighting similarities and differences and generating different research participants (Braun & Clarke, 2006; King, 2004). It does not require the detailed theoretical and technological knowledge of other qualitative approaches, there are few prescriptions and procedures which makes it easy to grasp and can be relatively quick to learn, and is therefore a more accessible form of analysis, particularly for those early in their research career (Braun & Clarke, 2006). It also allows a large data set to be analysed to identify key features, and provide a clear and organised final report (King, 2004).

Despite its many advantages, it is important to also acknowledge the disadvantages of this method. There is a lack of substantial literature to advise researchers on how to conduct a rigorous thematic analysis by comparison to other qualitative research methods. A simple thematic analysis is disadvantaged when compared to other methods, as it does not allow researcher to make claims about language use (Braun & Clarke, 2006). The flexibility provided by thematic analysis is flexible can lead to inconsistency and a lack of coherence when developing themes derived from the research data (Holloway & Todres, 2003).

This research has ensured that the chosen analytic practice is theoretically coherent and all methodological procedures and concepts cohere with the research values and TA approach Braune & Clarke (2006, 2022). (Any divergence will be justified). The current PhD research primarily adopted an essentialist method (Braun & Clarke, 2022), which aimed to capture the experiences, meanings and reality of participants. Braune & Clarke (2022) distinguish between descriptive and interpretative TA. The chosen TA approach is located in the artfully interpretive (Big Q) spectrum, rather than the scientifically descriptive (small q). The research used an inductive approach, whereby themes emerge from the data. Whilst the data set may be understood in

the context of a theories, the researcher's interest in the experiences, perspectives and meaning of the participants warranted the use of interpretative TA. The Big Q qualitative involves the use of techniques of qualitative data generation and analysis within a non-positivist framework informed by qualitative research values.

Six phase process:

TA involved an iterative six-phase process, which was completed manually using Microsoft Word. This took into consideration the rich, overall description of the entire dataset, and patterned responses which were identified and summarised. In phase 1 (familiarisation), the audio files were manually transcribed verbatim and interview transcripts were read in-depth. Initial impressions of the data were noted during interviews, and through continuous reading. Phase 2 (coding) involved identifying and labelling segments of data relevant to the research questions. Initial codes were created, which are defined as 'any features of the data which appear to be of interest to the research'. All responses were coded individually in a Microsoft Word (2016) document, before manually collating all data extracts for each code in seperate MS Word (2016) documents. Responses were coded inductively at the semantic level (i.e. focusing exclusively on the surface-level meanings expressed by participants). In phase 3 (searching for themes), main themes and sub-themes were identified, by combining different codes. Similar codes were placed into broad categories, using themes and sub-themes to structure the data. Themes were conceptualised as summaries of topics or categories. The topic was what is shared and unites the observations in the theme. It captured a core idea or meaning (what is shared and unites the observations in the theme is meaning), and the telling of an interpretative story about it. In phase 4 (reviewing themes), themes were reviewed in terms of the codes they contained and how they related to the entire dataset. These themes were then reviewed, for example, deciding if they are too broad or too specific. In phase 5 (naming and defining themes), themes are then defined and named were created for themes and sub-themes, accompanied by definitions specifying their focus and scope. In phase 6 (producing the thesis), an illustrative narrative was produced around the thematic results, using data extracts to evidence and emphasise important findings. The final stage involves reporting the results of the TA, by presenting and analysing themes, illustrated by participant quotes. A table/thematic map/list was used to provide a clear overview of themes. Credibility and consistency was gained by the researcher's prolonged engagement with the data

(Kitto, et al., 2008). Transferability (neutrality) was supported by using supervision to discuss reflexivity.

Reflexivity

In qualitative research, it is important to link the researcher's personal positioning to their analytic process (Trainor & Bundon, 2021). Personal reflexivity was linked to analytic practice. In reflexive TA, themes are generated, created or constructed (for example), they are not identified, found or discovered, and they definitely don't just "emerge" from data like a fully-grown Venus arising from the sea and arriving at the shore in Botticelli's famous painting (see Braun & Clarke, 2006, 2016). The decision to use reflexive TA views researcher subjectivity as a resource for research, rather than a threat to be contained, and meaning and knowledge as contextually situated, partial and provisional. Big Q researchers typically conceptualize mind-*dependent* truths, rather than a mind-*independent* truth (Tebes, 2005).

The chosen reflexive TA approach embraced researcher subjectivity as a resource for research (rejecting positivist notions of researcher bias, see Varpio et al., 2021), view the practice of TA as inherently subjective, emphasize researcher reflexivity, and reject the notion that coding can ever be accurate—as it is an inherently interpretative practice, and meaning is not fixed within data. In interpretivist research, there is an assumption that the researcher takes a central role in the interpretation – in the discovery of situated knowledge (Cohen et al., 2007). As such, there is no pretence of dispassionate objectivity (Bukamal, 2022) and the researcher is an active, central part of the research process. Researchers are assumed to have a positon, influenced by their beliefs, their likes and dislikes, their backgrounds, life history and their pastimes, their vested interests and expectations (Bukamal, 2022). Their position affects the nature of the observations and the interpretations they make (Bryman, 2016).

'Insider research' is the term used to describe research in which the researcher has a direct involvement or connection with the research setting. This might be where the researcher is a member (Brannick & Coghlan, 2007; Hellawell, 2006; Mercer, 2007; Trowler, 2011) or has 'a priori' intimate or familiar knowledge (Hellawell, 2006) of the organization or group in which the research is being conducted. It was once considered that research conducted by an outsider was the only form of 'objective' research (Chavez, 2008; Hellawell, 2006). Bukamal (2022) highlights the need to

make explicit the researcher's background – including class, gender, ethnicity, sexuality, age, ideas, commitments and national identity – due to the importance of the nature of the relation between the researcher and research participants. Firstly, the researcher is a white, middle class, middle aged female, which may be in contrast to participants and may influence the subjective bias. Secondly, the researcher is an employee of the Irish Prison Service, and has significant work related forensic and clinical experience of prisons having worked as a Psychologist in HMPPS between 1998 & 2005, and with the Irish Prison Service since 2005. The researcher is currently the Acting Head of Psychological Services in the Irish Prison Service. Since 2016, the researcher has been very involved in implementing Ireland's national strategy 'Connecting for Life' in order to reduce suicide. As an active member of the National Suicide and Harm Prevention Steering Group (NSHPG), the researcher has pioneered the design, and implementation of data collection methods for monitoring every episode of self-harm and suicide in Irish prisons under the 'SADA' project.

As an employee and senior manager in the Irish Prison Service, the researcher has a privileged level of access to the Irish Prison Service and Irish Prison Service information and data, which offers a unique posiiton as a researcher. Most researchers have limited access to the 'inside' and do not have the full picture of what happens in a prison. Roberts & Indermaur (2008) highlight difficulties with access to prisons and recruitment of prisoners. They highlight that access to prisons is tightly controlled, including layers of bureacracy for research approval, delays to each step of the process, and problems with cooperation at the level of the prison and prison officers. However, positionality will have affected the way that the findings of the research were seen and understood. This will have inevitably shaped the analysis produced. The researcher was expected to complete independent research on the management of self-harm and suicide in prison, and remained informed of developments within the Irish Prison Service.

The research included inherent controls that mitigate the opportunity for bias to affect the research. This included being clear on what the obligations are for each role, being confident that the organisation is clear about what the obligations are for a researcher, and being alert for situations where the interests of the two roles might conflict, even if they generally do not. However, there will be some inevitability to the researcher's subjective bias which has been the subject of reflection. Whilst

listening to participants and analysing themes, the potential for bias was considered and reflected upon due to the dual role of the researcher as a clinician. Careful consideration was given to the validity of the themes identified, and ensuring that themes truly represented the participants responses (and not the researcher's own reflections). Consideration was also given to the impact of the research findings on the organisation and on relationships with colleagues. As an IPS employee and senior manager, the researcher had to maintain ongoing professional relationships with staff. Some of the participants reported negative experiences of being in prison, including with staff, and reporting this as a researcher may cause reuptational damage for the organisation and relational damage with colleagues. This may have led to a bias in reporting the findings of the PhD.

Personnel:

The researcher was solely responsible for the current PhD research, including securing the necessary approval and access, participant recruitment, planning and scheduling interviews, conducting interviews, and analysing and reporting data. The researcher was the Principal Psychologist for the Irish Prison Service during the preparation and data collection phase, and is currently the Acting Head of Psychological Services).

Conflicts of Interest

An individual conflict of interest may arise when an individual has a professional interest, which may affect or appear to affect the design, conduct, or reporting of the research. There may be a potential conflict of roles in this research.

The researcher was studying and carrying out research whilst being employed in a professional role, which can be considered to be a dual role. Consideration was given to whether the interests of the two roles may conflict. For example, can you fulfil a duty to one's organisation as an employee and maintain some sort of duty of loyalty to the role of a neutral researcher. Potential research participants may have known the researcher in their professional role, and may even be or have been in their professional care. This may inadvertently put pressure on people who are known to the researcher to participate as they may find it difficult to decline a request to participate in the research. This is particularly true if potential research participants are in their professional care. In some cases initial recruitment by a third party or recruitment by poster or email could be the best option – this allows participants to take a positive step if they wish to participate rather than having to decline an

invitation. However, this was not possible in this PhD research due to the sample constraints. It was made clear to potential participants that there was no pressure to participate and that they can choose to withdraw from the project entirely at any time, including once their participation is complete (before the research report has been written up). This was communicated to participants in the information sheet. When the researcher was already known to participants, participants were given the option of asking to withdraw data via communication with a third party (such as another member of the department or a prison officer) in case they should feel reluctant to ask the researcher face-to-face. It was also ensured that participation could not have any detrimental effect on the professional care provided to the participants (and that the participants were aware of this).

The research used workplace information. It was important to keep the researcher role separate from the employee role. The researcher's workplace is responsible for ensuring compliance with law (e.g. the Data Protection Act 1998) and good conduct (e.g. that research with human participants is conducted ethically) for work undertaken within its remit. This research included the provision of data by the workplace to use in the capacity as a researcher, which was only be done with the full permission from the workplace to do this, and the data was anonymised, and de-identified.

The role of psychologist and researcher may have also come into conflict. Firstly, the researcher's professional obligations were tested during the course of the research because the professional role obliged the researcher to take action following a disclosure made by a participant, which falls outside the obligations for disclosure as a researcher. The potential for such a conflict was identified early in the research, including the duty to disclose when a participant indicates that a) they may cause harm to themselves or others, (b) that they were the perpetrator or victim of an undocumented crime, (c) that they were the victim of serious harm from someone else and/or d) that a child is being harmed in the community, then the researcher was required to report this information to the relevant authority (e.g. prison management, healthcare, TUSLA, Gardaí) and discussed in supervision. In the information sheet, participants are informed exactly what the obligations for disclosure were for the researcher. Secondly, there were occasions when unmet clinical need was identified (e.g. lack of psychological support, clinical distress) and projection, and/or counter transference was experienced. Probing questions were

asked to elicit a better understanding of their presentation, their current mental state was checked, and the researcher provided low level clinical intervention, making onward referrals where appropriate. Positive encouragement was given to people who are on a journey of desistance and/or recovery.

It was very evident that most participants had experienced difficulties with accessing psychological therapies, either before, at the time of the episode of self-harm, or since the episode. This led to feelings of responsibility for the lack of care provided, particularly when it was clear that participants had not received any support, and had been placed on a waiting list and were not seen at a time when they needed support. This was mitigated by providing intervention simultaneously during the interview, and providing onward referral where appropriate.

Ethical approval

Formal ethical approval was obtained from the Research Advisory Board of the Organisation (including access to databases such as PIMS/PCTS/PHMS). Ethical approval was obtained from the Department of Sociology /Durham University. There are several ethical challenges of doing research in prisons (Dalen and Jones, 2010) This is largely due to the complexity of the correctional settings and the power differential between criminal justice agents and the potential research participants (Gostin & Pope, 2007) which arise in the context of limitations on personal choice and control. This may be exagerated by the researcher's role as a practitioner within the prison context.

Ethical considerations for any human population requires serious consideration. However, research with prisoners require particular attention because they are especially vulnerable as research participants. Historically, they have been exploited by researchers because they are cheap and available (Hornblum, 1997). Gostin & Pope (2007) describe prisoners as the classic "captive population" and have identified three specific problems: informed consent, privacy and ensuring prisoners have a meaningful choice between the existing standard of medical prison health care and the experimental intervention. They highlight the difficulties with ensuring privacy within a prison because everyone sees who moves where and may often speculate for what purpose. They state that researchers must ensure that the setting permits the processes of informed consent and refusal. In this research, the only person who knew that they were participating in research was the person in custody

themselves, no medical intervention was offered and measures were taken (see above) to ensure informed consent.

The research involved participants who are potentially vulnerable. Potentially vulnerable groups can include, for example: children and young people; those with a learning disability or cognitive impairment; those unable to give informed consent or individuals in a dependent or unequal relationship. The prison population was recognized as a vulnerable population, to be protected from potentially harmful interventions (Hornblum, 1997). People confined to institutions have an unequal positioning in the prison service, which means it is possible that they may feel coerced into completing the study. This might be more likely where the participant knows the researcher in their professional role, and may even be or have been in their professional care. However, Dalen & Jones (2010) also raise concern that if prisoners are systematically excluded from many human subject studies, it may prevent research for the benefit of this population. Mitigations in the research included emphasising the completely voluntary nature of participation, the lack of detrimental effect on the professional care provided and the option to withdrawn at any time.

Participants may also have language difficulties or have a recognised or diagnosed intellectual or mental impairment, which must be considered when obtaining informed consent. Literacy rates amongst people in custody are often observed to be lower than the general population. All documents, including information sheets and consent forms, were created using simple English language free from jargon. Information sheets and consent forms were verbally re-iterated with people in custody at the beginning of all interviews, to ensure anyone with these difficulties fully understood the research.

The research addresses a potentially sensitive topic. Sensitive topics can include participants' sexual behaviour, their illegal or political behaviour, their experience of violence, their abuse or exploitation, their mental health, or their gender or ethnic status. During interviews, people in custody discussed their experiences of self-harm and/or suicidality, their mental health and their history of trauma. They may find discussion of sensitive issues distressing. Such discussions may evoke emotional responses in participants. A number of measures will be used to minimise and appropriately manage any potential harm or distress to participants. Firstly,

participants will be aware in advance of the nature and purpose of the research, and the content to be discussed during interviews. Secondly, participants will be aware that during the interviews they are free to skip any questions they do not wish to answer. Participants will be made aware of this information in the information sheets and consent forms, and this information will be re-iterated verbally by the researcher at the beginning of each interview. Thirdly, the researcher will provide participants with a de-brief sheet after completion of the survey, which will outline ways of receiving further support should they feel they need it, such as referral to primary care and/or secondary care, and/or referral to the Irish Prison Service Psychology Service.

Initially before the interviews, potential concerns were identified about the negative impact on participants of recounting. However, there were surprisingly some positive benefits of allowing people to tell their story. This was particularly true of those who have desisted. Partipants willingly and openly shared their story. When debriefed at the end of interviews, participants spoke about the benefits of participation in the research:

> *"I know I need help, I've asked for help every jail I've been in on commital. I am still getting nothing, this is the first chat I've had, I feel like it's helping a bit, genuinely, im not balling, id love to be balling. It takes a man to cry. In places like this, you're really sending it down to the bottom, you're in jail with a lot of men"* (John, May, 2023).

During the interview, when a participant appeared to be affected by the interview questions, he was asked how he was doing, and he replied:

> *"First time I've ever went on about it. It is hard. Just trying my best here now. I am obviously upset"* (Jamie, May, 2023).

By the end of the interview, he stated:

> *"It felt better talking to you. Yeah because I've never got to explain my thinking on my story before, I have only ever explained what they wanted to hear, today I've told you what I wanted you to hear, that felt great"* (Jamie, May, 2023).

This is consistent with Biddle et al., (2012) who found involving vulnerable individuals in research into self-harm and suicide was an overall positive experience, with 50-70% reporting improved mood, and 18-27% reporting lowered mood, with most anticipating it would only be transient and was outweighed by their desire to contribute to research.

Many of those in the sample were on a waiting list to be seen by the IPS Psychology Service. This led to feelings of discomfort about offering them an interview with a psychologist when they could not meet a psychologist. Concern was also experienced in relation to those who had declined to participate, particularly when they appeared to be experiencing significant distress. Inviting them to participate in the research could have been experienced by them as not necessarily in their best interest.

There were also potential risks to the health, safety and well being of the researcher in conducting the research (although not necessarily beyond those experienced in their everyday life). Firstly, this study involved interviewing people in custody who have engaged in self-harm and/or suicidality. This involved emotional distress from listening to distressing content. The researcher received regular clinical supervision with a supervisor, in order to confidentially talk through any difficult thoughts or feelings following interviews.

Secondly, this study involved interviewing men in custody who may have engaged in violence in the past and/or may continue to engage in violence. The risk of physical harm is unlikely, but cannot be ruled out. The local Psychology team was notified before and after each interview with a person in custody. The project supervisor and some Irish Prison Service staff were also aware of the time and location interviews. The researcher had previously received training in breakaway techniques from HMPS and personal protection training from the Irish Prison Service. For interviews with people in custody, a Prison Officer remained outside the interview room for the duration of the interview, except when they were collecting another people in custody. The researcher had a personal alarm and/or the interview room had a panic alarm on the wall. Based on advice from prison management, interviews could have taken place in a screened interview room which would separate the researcher and people in custody with a Perspex screen, although this was not necessary. Finally, the researcher is a very experienced psychologist and whilst the interview is for research purposes, the researcher has significant experience in the management and containment of distress during interviews.

Reflections

Reviewing the SADA data in more detail for this research offered a unique opportunity to gain insight into the nature of self-harm in Irish Prisons. The researcher was struck by the sheer volume of self-harm. Analysing the details provided a grim reality of what individuals resort to for various reasons, and how difficult this must be for healthcare and prison staff to manage on a daily basis. It gave a sad insight into the potential trauma for individuals who engage in self-harm and the potential for vicarious trauma for staff involved in their care.

Some trends were observed in the data, for example in specific prisons, there appeared to be a propensity towards self-harm for young prisoners in Wheatfield, and remand prisoners in Castlerea, a pattern of increased single incident in Mountjoy, and a significant number of repeat incidents in the Midlands prison. For incidents in the low severity, low intent category, the typical contributory factors tended to relate to poor coping. Whilst not quantifiable, it proved an interesting and thought provoking experience. This led to the submission (& approval) of a business case for the employment of research assistant to help analyse the data on a larger scale.

Chapter Summary

This chapter introduced the methodology used in this PhD research to achieve the aims of the study and to answer the research questions. This discussed the design and methods, data analysis and any ethical issues raised by the PhD research. The limitations of this research and the challenges and opportunities of conducting the research as 'an insider' (an employee of the Irish Prison Service) were considered. The following four Chapters (5, 6, 7 & 8) will present the findings from this PhD research.

The next Chapter (Chapter 5) will report on the quantitative findings, such as the demographics and characteristics of those who harm themselves in custody, before discussing the qualitative findings.

Chapter 5: Quantitative data

This Chapter will present the quantitative data of this PhD research. This will review the demographics and characteristics of the sample (age, history of offending, P19's, substance use, and social factors), results of the psychometric measures, and data from the SADA forms (sentence length, trimester, intent and severity, and contributory factors for their self harm). suicide. This chapters will present the raw data, and compare findings to the academic literature.

Participant characteristics

The demographic of the sample included 15 men who had engaged in a total of 19 episodes of self-harm or attempted suicide between them whilst in custody between the ages of 20 and 48 years old.

Number of epsiodes of self-harm and/or suicide

Two participants had engaged in repeat episodes in custody since 2016. Four participants had engaged in repeat self-harm either in the community and/or in prison. Eight had engaged in both self-harm and suicidal behaviour either in the community and/or in prison. Three had engaged in suicidal behaviour. This was shown in Table 7 above. Participants described cutting arms and wrists, self-strangulation, attempted hanging, and swallowing blades, either in prison and/or in the community.

This suggests that most incidents occurred in the context of longer-term suicidality and/or multiple, repeat attempts in prison or in the community prior to imprisonment. These findings provide some support for the tripartite schema paradigm (Smith et al., 2019), which features three different groups of self-harming behaviours, with self-harm behaviour, suicidal process and 'mixed group' (e.g. self-harm and suicide) of self-harming prisoners. The majority of participants in the sample who had self-harmed repeatedly reported or had a documented history of prior suicidality, and those had engaged in suicidality in the sample had a previous history of self-harm. This is consistent with research by Marzoni et al., (2012) on female prisoner and with studies that demonstrate that suicidal prisoners are more likely to have histories of self-harm than non-suicidal prisoners (e.g. Jones, 1986) and that previous self-harm predicts future suicide attempts (Matsumoto et al., 2005; Penn, Esposito, Schaeffer, Fritz, & Spirito, 2003).

Demographics of the sample:

The majority of participants (63%) were aged between 20 and 30 years old at the time of the episode of self-harm or suicide attempt. All participants were of Irish nationality. Two participants identified as a white traveller.

Relationships:

Only 3 participants were currently in a relationship. The majority were single, or separated.

Children:

12 participants had at least one child (with a maximum of 2 children).

Education:

Six participants reported leaving school with no formal qualifications. Seven participants reported completing their Junior Certificate. Two reported that they completed the Leaving Certificate. This can be found in Table 8 below.

Table 8

Level of Education of Participants

	Repeat	Suicide	Mixed	Total
None	1	1	5	7
Junior cert	2	2	2	6
Leaving cert	0	1	1	2

- Employment

Five participants reported being unemployed before they came to prison. Four reported working before they came to prison. It is worth noting that this topic did not appear in participants narratives about the contributory factors for self injury or suicide.

- Homelessness

Three participants reported being homeless before they came to prison, however as above this factor did not appear in their narratives.

Offence history

Participants were convicted of a range of offences which can be found in Table 9 below.

Table 9

Number of Offences by category

	Repeat	Suicide	Mixed	Total
Acquisitive offending	15	7	96	**182**
Violence	4	21	40	**65**
Sexual Offence	23	0	21	**44**
Failure to comply	5	6	6	**17**
Drugs and alcohol	0	6	8	**14**
Driving	8	1	5	**14**
Prostitution	0	0	3	**3**
Other	0	3	1	**4**
Prison offending (e.g. Possession of mobile)	1	1	0	**2**
Harassment / Stalking	0	0	2	**2**
Trespass	0	1	1	**2**
Breach of barring order	1	0	0	**1**
False imprisonment	1	0	0	**1**
Total by group	58	110	183	**351**

The most serious offence for participants was listed as theft (5), criminal damage (3), robbery (2), murder (2), rape (2), unauthorised interference with MPV (1), false imprisonment (1), possession (1), attempted murder (1), and burglary (1). The highest prevalance rates for all groups was acquisitive offending, violence and sexual offending. The 'mixed' group (e.g. those who engaged in self-harm and suicide) had the highest prevalence of offending history, primarily for acquisitive offending and violent offending.

Sentencing

Participants were serving a range of sentence lengths between two years and a life sentence. This can be found in Table 10 below.

Table 10

Number of Episodes of Self-Harm and Suicide in Custody Based on Sentence Length.

	Repeat	Suicide	Mixed	Total
Remand	2	2	4	8
3mths – 1 year	0	0	1	4
2-3 years	0	0	0	0
3-5 years	0	1	0	1
5 – 10 years	2	0	0	2
+10 years	1	0	1	2
Life	0	0	2	2

Almost half (8) of all episodes (42%) occurred whilst on remand. This highlights that being on remand is a period of increased risk, similar to other research (McTernan, 2023).

Trimester

Episodes occurred at different stages in their sentence, which can be found in Table 11.

Table 11

Number of Episodes During Each Trimester of Sentence (Including Remand).

	Repeat	Suicide	Mixed	Total
Trimester 1	2	0	3	5
Trimester 2	0	0	0	0
Trimester 3	1	1	2	4

*excludes lifers/those on remand (no trimester)

Five episodes occurred during the 1st trimester of the sentence and four episodes during the 3rd trimester. No episodes occurred during the 2nd trimester. This highlights the significant vulnerability faced by individuals during the early stages and final stages of imprisonment.

Prison behaviour

All males in the sample had a history of at least one P19 report (disciplinary process that can result in sanctions). This can be found in Table 12 below.

Table 12

Number of P19's by participant

No of P19's	Repeat	Suicide	Mixed	Total no. of people
1-10	1	2	2	1
10-20	2	1	3	1
30+	1	/	3	1
Total	63	24	119	15

The maximum number of P19's recorded for an individual was 37. The P19's included possession of a prohibited article (e.g. phone, hooch, blade, improvised weapon, tablets), throwing at nets, misuse of phone system, refusing an order to move/to give a sample, failing a mandatory drug test, being abusive and threatening towards staff, property damage, and fighting. The 'mixed group' had the most incidents of behavior that led to a disciplinary process, and the number for repeat self-harm was higher than those who engaged in attempted suicide. This suggests that people who engage in self-harm and attempt suicide in prisons also engage in behaviour that leads to a disciplinary process, particularly those in the 'repeat' and 'mixed' group. This may concur with Smith & Kaminski (2010), who identified that self-injuring prisoners receive more disciplinary infraction when compared to non-injuring prisoners, however this would require further comparison to non-self injuring prisoners.

Substance use:

All participants disclosed a history of substance use, which can be found in Table 13.

Table 13

Number of Participants with a History of Substance Use

	Repeat	Suicide	Mixed	Total
Drugs	2	4	3	9
Alcohol	0	0	3	3
Both	1	0	2	2

This indicates that all participants (100%) have a history of substance use. Drug use appeared to be more prevalent than alcohol use in those who have engaged in suicidal behaviour. Some individuals reported having a dual diagnosis, with co-morbidities including personality disorder, or ADHD.

History of violence:

The number of offences for participants, including violent offences, can be found in Table 14.

Table 14

Number of Violent Offences Committed by Participants.

	Repeat	Suicide	Mixed	Total
Total no of violence offences	31	21	64	116
Total no. of offences	58	110	183	351
Percentage of violent offences	53%	19%	35%	33%

Fourteen of the 15 participants had committed an offence / multiple offences that were classified as violent, based on the definition; 'Violence includes any actual, attempted, or threatened, physical harm of another person that constitutes a violation of explicit social norms. Serious problems include violence that results in severe (potential) physical or psychological harm to victims or the imposition of severe legal or other consequences on one or two occasions; or a clear pattern of violence that results in at least moderate harm to victims or in the imposition of at least moderate legal or other consequences'. Indicators include:

- Explicit threats of physical harm
- Use of or threats with weapon
- Included acts, attempts or threats motivated by financial gain
- Included acts, attempts, or threats motivated by sexual gratification
- Threats include statements (written or oral) that explicitly communicate intent to cause physical harm as well as statements or other intimidating behaviour that implicitly communicate an intent to cause physical harm
- Attempts include plans or conspiracies

The accumulated data in Table 15 included 116 violent offences (approx. 33.05% of the 351 total offences from all 15 participants). This suggests that one in three offences committed by participants who engaged in self injury and/or suicidality in prison are violent offences. The 'repeat' grouping had 31 violent offences, while the 'suicide' group had 21 and the 'mixed' group had the highest with 64. This suggests that self-harm may be linked to use of violence. Table 15 demonstrates the number of violent offences for participants.

Table 15

Breakdown of Violent Offending by Participants.

Violent offence	Repeat	Suicide	Mixed	Total
Rape	20	O	13	33
Criminal damage	3	6	15	24
Assault	0	4	8	12
Assault causing harm	0	1	7	8
Threatening/abusive/insulting behaviour in a public place	1	4	3	8
Sexual assault on male/female	2	0	4	6
Defilement of a child under 15 years	0	0	4	4
Possession of knives and other articles	0	2	1	3
Aggravated burglary	0	0	1	3
Production of article in course of dispute/fight	0	2	0	2
Possession of article with intent to cause injury etc	0	1	1	2
Murder	0	0	2	2
Harrassment/stalking	0	0	2	2
Causing serious harm	0	0	1	1
Threatening to kill or cause serious harm	0	1	0	1
Threatening to damage property	0	0	1	1
Attempted rape	1	0	0	1
Breach of barring order	1	0	0	1
False imprisonment	1	0	0	1

These findings suggest that the majority of participants (n=14/93%) had a history of violent offending.

Psychometric measures:
Only eight participants returned the completed Psychometric measures and some were not completed fully. This included all four who engaged in repeat self-harm, one who engaged in suicide and two in the mixed group (e.g. who engaged in self-harm and suicide.

Data from the ACE Survey indicates that all participants had at least one Adverse Childhood experience, one participant had four ACE's, one had five, one had six or and two had ten. This suggests that all participants had experienced adverse childhood experiences. Table 16 shows the number of adverse childhood experiences reported by participants.

Table 16

Adverse Childhood Experiences

Number of ACE's	1-3	3-5	5-7	8+
No. of participants	1	3	1	2

All six participants who completed the Hopelessness scale showed some level of hopelessness. The level of hopelessness among participants can be found in Table 17.

Table 17

Hopelessness

Score	Mild (-9)	Moderate (9-14)	Severe (14)
No. of Participants	1	3	2

All six participants who completed the Rosenberg Self Esteem Scale reported above average self-esteem. The levels of self-esteem reported by participants can be found in Table 18.

Table 18

Rosenberg Self-Esteem

Average = 22.62	Above Average	Below Average
No. of Participants	6	0

On the Beck Depression inventory, three out of six participants reported depression with clinical severity that is mild (3) or severe (1). Participant's scores on the Beck Depression Inventory can be found in Table 19.

Table 19

Beck Depression Inventory

Score	Normal (0-13)	Mild (14-19)	Moderate (20-29)	Severe (30-63)
No. of Participants	3	2	0	1

Scores on the Beck Anxiety Scale are shown in Table 20. It identified that all participants who completed the measure had mild, moderate or severe intensity of physical and cognitive anxiety symptoms during the past week.

Table 20

Beck Anxiety Scale

Score	Mild (-15)	Moderate (16-25)	Severe (26-63)
No. of Participants	2	2	3

Scores on the State Trait Anxiety Inventory (STAI) show that all participants reported high 'State-Trait' anxiety. All participants reported mild or moderate state anxiety. Higher scores are positively correlated with higher levels of anxiety. This suggests that participants typically feel anxiety on a daily basis and have some anxiety in response to situations perceived as dangerous. Scoring of participants on the measure of State/Trait Anxiety are shown in Table 21.

Table 21

State/Trait Anxiety

STAI	No/Low (20-37)	Moderate (38-44)	High (45-80)
No. of Participants (state)	2	2	0
No of Participants (trait)	0	0	4

Participant's scores on a 20-item measure that assesses how often a person feels disconnected from others can be found in Table 22. The three participants who completed the UCLA Loneliness Scale reported a low or high degree of loneliness.

Table 22

UCLA Loneliness Scale

Score	Low	High
No. of Participants	2	1

Participant's responses to the DBT Ways of Coping Checklist (DBT- WCCL) can be found in Table 23. Two participants who completed the DBT Ways of Coping scored as having difficulties with emotion regulation, which reflected poor coping skills, dysfunctional coping and a tendency toward blaming others.

Table 23

DBT Ways of Coping

	Above Average	Below Average

No. Participants	Skills scale	2	0
	General Dysfunctional coping	2	0
	Blaming Others	1	1

Participant's scoring on the Difficulties in Emotion Regulation Scale (DERS) can be found in Table 24.

Table 24

Difficulties in Emotion Regulation Scale

Average = 80	Above Average	Below Average
No. of Participants	4	1

This is broken down based on the six facets of emotion regulation below in Table 25.

Table 25

Six Facets of Emotions

		Average/Max scores	Above average	Below average
No of Participants	Limited emotional awareness	Average score = 16 Max score = 30	4	1
	Difficulty engaging in goal directed behaviour	Average score = 14 Max score = 25	3	2
	Non acceptance of emotional responses	Average score = 12 Max score = 30	4	1
	Impulse control difficulties	Average score = 12 Max score = 30	5	0
	Limited access to emotion regulation strategies	Average score = 16 Max score = 40	4	1
	Lack of emotional clarity	Average score = 11 Max score = 25	4	1

Four out of five participants who completed the measure scored above average on the Difficulties in Emotion Regulation Scale (DERS), which indicates increased difficulties with emotion regulation on the six facets, including limited emotional awareness, difficulty engaging in goal directed behaviour, non acceptance of emotional responses, impulse control difficulties, limited access to emotion regulation strategies and lack of emotional clarity.

Whilst completion rate for all psychometric measures was low, data indicated that the majority of participants have experienced ACE's, have difficulties with emotion regulation, and some have poor coping skills, dysfunctional coping and a tendency towards blaming others. The data also suggests that participants were likely to present with anxiety, and hopelessness and low levels of depression.

Data from the Self-Harm Data analysis (SADA) project

Severity & Intent

The severity and intent for each episiode can be found in Table 26 below.

Table 26

Severity & Intent for each episode

Severity	No treatment needed	Minimal intervention/ minor dressing.	Local wound management	Outpatient/A &E treatment.	Hospital/ Intensive Care
High	0	1	0	0	0
Medium	2	4	1	1	1
Low	3	4	2	0	0

Cell Type/Location:

One episode occurred when the individual was on special observations and one was in a Special Observation Cell. The majority of incidents (14) occurred whilst the individual was in a single cell (74%). Three episodes occurred whilst the individual was in a double cell, and two in a triple cell. Table 27 shows the level of regime that participants were on when they engaged in self-injury or suicide. This indicates that twelve episodes occurred when the individual was on standard, three episodes occurred when the individual was on basic regime, and three when on enhanced.

Table 27

Level of Regime for Participants when they Self Injured or Engaged in Suicide

Regime level at time of episode	Repeat	Suicide	Mixed	Total
Basic	1	1	1	3
Standard	2	2	8	12
Enhanced	1	0	2	3

Contributory factors

As part of the SADA data collection, primary and secondary contributory factors were rated by the multi-disciplinary team (MDT) for each episode of self-harm and/or suicidality on the SADA form, which are listed in Table 28 & 29 below.

Table 28

Primary Contributory Factors

Primary Contributory factor	Repeat	Suicide	Mixed	Total
Substance use/addiction			5	5
Mental health	3			3
Poor coping/difficulties managing emotions		6	1	3
Relationship issues with significant others	1		1	2
Medication issues			1	1
Death or anniversary of death of someone close.			1	1
Recent P19, reduction in incentivized regime			1	1
Reduced access to regime			1	1
Type of accommodation or cell type		1		1
Adjustment issues	1		1	1

Additional commentary was added to some forms about the primary contibutory factors, which included “addiction history, requesting zimovane, being a recent commital, Covid restrictions, relationship issues with significant others, awaiting P19 for receipt of contraband, states looking for head space, finding life in custody difficult acting out on thoughts of DSH/new committal withdrawing from polysubstance abuse impulsive behaviour, had bad call with partner, was stress relief”. This research indicates that mental health, substance use, poor coping, relationship difficulties, were rated by the MDT as primary contributory factors in self-harm and suicide.

Table 29

Secondary Contributory Factors

Secondary Contributory factor	Repeat	Suicide	Mixed	Total
Impulsivity	0	0	4	4
Relationship difficulties with other prisoners	1	1	1	3
Relationship issues with significant others	1	0	1	2

Poor coping/difficulties managing emotions	1	1	1	2
Substance use/addiction	2	0	1	3

Additional commentary on the secondary contributory factors included “Impulsivity/ on C2h5Oh detox at time of incident, ongoing addiction issues, maybe carrying contraband internally, peer pressure, under threat, time of the year, may have been threatened by other inmates”. This research indicates that impulsivity, mental health, substance use, relationship difficulties with significant others and other prisoners, were rated by the MDT as a secondary contributory factors in self-harm and suicide.

Chapter Summary

In summary, this chapter has set out the quantatitive elements of the study including the demographics and characteristics of the sample (age, history of offending, P19’s, substance use, and social factors), results of the psychometric measures, and data from the SADA forms (sentence length, trimester, intent and severity, and contributory factors for their self harm). The following Chapters (Chapters 6, 7, 8 & 9) will turn to describing the themes derived from the qualitative interviews with men in custody.

Chapter 6: Qualitative Findings

Introduction

The following Chapters (Chapters 6, 7, 8 & 9) will turn to describing the themes derived from the qualitative interviews with men in custody. The following Chapters (Chapters 6, 7, 8 & 9) will turn to describing the themes derived from the qualitative interviews with men in custody. Chapter 6 will describe the qualitative findings on the nature of harm. Chapter 7 will describe the qualitative findings on the risk & contributory factors leading to suicide and self harm. Chapter 8 will describe the qualitative findings on the barriers to support in Irish Prisons. Chapter 9 will describe the qualitative findings on the protective factors and intervention. These chapters will highlight the nature of self-harm and/or suicide engaged in by participants, the risk factors that predisposed participants to self-harm and/or suicide, and the contributory factors that played a role in their self-harm and/or suicide. It will also explore the link to violence. Finally, it will explore factors involved in desistance, including barriers to support and protective factors for self harm and/or suicide. It will explain the data, and offer an analysis and synthesis of the data within the contect of the academic literature. It will discuss the implications of these findings both in terms of the theoretical framework. At the end of Chapter 9, it will explore the wider context and implications for prison practice. The findings from each theme will now be discussed in detail. Quotes are provided to give context and meaning to the themes.

Themes identified by participants

The analysis derived six higher order themes for all cohorts of prisoners (Self Injury, Suicide, Mixed), presented in Table 30, each comprising a cluster of subordinate themes. Themes did not differ significantly between groupings, with similar themes emerging across all groupings. These themes were interrelated to some degree, but still emerged as separate and distinct. They are of equal importance; the ordering of their presentation below does not imply differential significance. It is worth noting that when discussing self harm and/or suicide, participants often circled back to addiction and its subsequent link to offending. A Thematic Map of Prisoner's Qualitative Results can be found in Appendix F (Figure 2).

Table 30

Themes identified during interviews

Theme 1	Sub Theme	Code
Nature of harm	Type	Self-harm Suicide No harm
	Function	Release of feelings To gain feeling Coping strategies To punish self Intent to die To hurt others Instrumental gain Cry for help

Theme 2	Sub Theme	Code
Risk Factors	Social factors	Social Supports
	Custodial sentences	First time Multiple
	Biological / Neurodiversity	ADHD Impulsivity Risky behaviour P19's
	ACE's	Physical and emotional Neglect Parental separation/divorce Household physical violence Household substance abuse Emotional, physical sexual abuse Household mental illness, mental health challenges or suicide attempt Incarcerated household member Discrimination Witnessing violence
	Substance use	Illegal drugs Prescription drugs Alcohol Both

Theme	Sub Theme	Code
Link to Violence	Externalisation	Inward directed harm To hurt others Highly controlled violence
	Alternative behaviour	Longer solution

Theme 3	Sub Theme	Code
Factors contributing to self-harm and suicide	Mental Health	Managing emotions Axis 1 Disorders Mental illness
	Substance use	Alcohol Drugs Both

	Medical	Access to detox Continuity of medication
	Neurodiversity	Boredom Getting into trouble Access to medication
	Bereavement/loss	Death or anniversary of death of someone Loss of family or intimate relationships Family members becoming unwell Transfer or release of supportive person Child custody/access issues Loneliness Losing everything/hopelessness Covid-19
	Relational	Prisoners Staff Staff characteristics and approaches
	Environmental	Prison Culture Large prisons Staff shortages Lack of regime
	Procedural	SOC Non trauma informed approaches

Theme 4	**Sub Theme**	**Code**
Barriers to Support	Lack of Support	Waiting lists No support available Unwilling to receive support
	Trust	Preference for friends/family Mistrust of others Mistrust of authority
	Emotions	Shame Worthless
	Prison response to self-harm	Consequences Aftermath
	Culture	Not showing vulnerability Self-doubt/comparison to others

Theme 5	**Sub Theme**	**Code**
Protective Factors	Addiction recovery	Abstinence from drugs and Opioid substitutes
	Family connection	Family matters
	Motivation	Personal Responsibility Willpower Agency Family To prove others wrong Seeing the Consequences Believing in myself

	Structured regime	Distraction Incentives
	Prison environment	More staff Staff training Specialist units Support for specific cohorts Increased family contact Peer to peer support Single cell Access to medical care TV Channels
	Strategies to Cope	Gym/music/school Finding ways to cope with emotions Hope Other strategies
	Help from others	Support Compassion Engaging with Psychology

Nature of Harm

This Chapter will present the first theme of the nature of self-harm derived from the qualitative interviews with men in Irish prison in custody. Table 31 provides an understanding of male prisoner's experience of the nature of harm. This Chapter will explain the data, offer a critical analysis and synthesis of the data, compare findings to the academic literature, and review the findings within the context of the theoretical framework of the research.

Table 31

Participants Understanding of the Nature of Harm

Theme	Sub Theme	Code
Nature of harm	Type	Self-harm Suicide No harm
	Function	Release of feelings To gain feeling Coping strategies To punish self Intent to die To hurt others Instrumental gain Cry for help

Type

Participants described a number of repeat episodes in prison and/or in the community of self-cutting to varying degrees of severity (throat, chest, arms/wrists),

swallowing blades, swallowing batteries, overdose, shotgun, attempted hanging and attempted drowning.

> *"I cut my wrists. I cut myself with blades, plastics. I cut my arms so deep I could see the veins in my arms".*
>
> *"When I cut myself in (a prison), I went out of the way, breaking window, sharpening knife. They weren't deep. Just enough to bleed"* (Peter, May, 2023).
>
> *"The only thing I could find was the plastic knife and fork, I tried to slice my throat, and I tried to slice my arms' (Patrick, May 2023).*

This suggests that participants reported that they used the typical range of methods such as hanging, cutting, and swallowing objects. This is consistent with Hawton et al., (2014), and Griffin et al., (2018) that the most common method of self-injury is cutting and 'scratching'.

Function

Participants were asked to describe their motivations for their self-harm and suicidal behaviour. A range of motivations were described by the men interviewed about their self-harm.

- Release of feelings

The most prominent motivation for self-harm being cited was a release of feelings:

> *"You feel release. Feelings are gone, you feel numb. It's (self-harm is) always a release. I can compare it now to smoking hash. When you cut yourself it's like a release, boom! It's gone. 30 seconds later, you say shit!" (Aidan, May, 2023).*
>
> *"(I cut myself) to reduce tension, express emotion. When I do it, the feeling is gone"* (Dan, June, 2023).

These findings suggest that self-harm is used to release emotions. This is consistent with Gordon et al., (2010) which found that people with more numerous past DSH episodes felt more soothed, more relieved, and calmer following their most recent episode of DSH. This suggest thats the emotion regulation functions of DSH may become more reinforcing with repetition. The findings about repetition, alongside these findings, concur with Joiner's (2005) interpersonal theory of suicide, which proposes that deliberate self-harm (DSH) becomes increasingly more reinforcing with repetition.

- To gain feeling

Some participants described self-harm as a way of gaining feeling, or a combination of gaining feeling, alongside it being a release. When asked why they self-harmed, some men described that they used self-harm:

"To gain sensation – to feel something in the moment, to get release…instead of building up and exploding, it's like a quiet release" (Eoin, May, 2023).

"To get a feeling, or sensation or something, you become numb after a while, and pain is the only outlet, and the only feeling that makes you feel real. It's weird sensation, it's a weird way of thinking, most people don't understand it" (Eoin, May, 2023).

This suggests that self-harm may be motivated by a desire to gain feeling.

- <u>Coping Strategies</u>

Some of the men described using self harm as a coping mechanism for managing their emotions:

"Just hurt myself, it was a 'go to' reaction, instead of dealing with the hard emotion or dealing with what I am feeling, I would lash out by hurting myself because if I wouldn't think I'd be worth anything" (Eoin, May, 2023).

Self-harm was reported as an alternative, preferred solution to other coping mechanisms, like substance use, in managing difficult feelings or as a way of getting relief.

"It becomes a coping mechanism, it's like the way some people deal with anxiety by laughter or comedy, my way is use self-harming or self-medication with drugs or drink. It would be one or the other" (Eoin, May, 2023).

Some participants described using self-injury for the adrenaline rush. Men reported that there was a feeling of relief from self-harm which can be repeated without significant effort by re-opening the wound.

"*The relief I got was like pain from sport….I took every drug bar crack cocaine. That was still nothing like the adrenaline you got from self-harm. The drugs numb your brain and remove reality…Even the next morning, a packet of salt on it (the wound) and the pain was gone. Even music or drugs it didn't compare to self-harm"* (Peter, May, 2023).

This suggests that self-harm might be a way of regulating emotions.

- <u>To punish self</u>

Some described self-harm as a way of punishing themselves;

"Despair. Black emptiness of my life, of coming to terms with what I did, what I did in my past, what happened to my future with my father committing suicide. It's basically when you hit rock bottom… If there's despair and there's nothing left under it, that's where self-harm comes in. With self-harm it felt like I'd dropped 1 level to where I should be. It's a long road back from up there and sometimes

when you get to the top. It's scary when you get there. I used to self-harm again to where I think I should be. I never felt I deserved it, that I should be doing as well as I was" (Peter, May, 2023).

This suggests that self-harm may be used to punish yourself.

- Intent to die

Some participants who attempted suicide stated that their intention was indeed to end their life.

"To end life" (David, May, 2023);

"I tried several times to kill myself. Three months before came to prison….it was planned. I started ticking off list, I said it will happen in a few weeks, I know it will happen, it happens in the exact same time frame" (Darren, Aug, 2023).

However, some apparent suicide attempts were not driven by an intent to die. Some men who attempted suicide described having no intent:

"*I wasn't trying to kill myself. It was to get rid of feelings, my thoughts. I bite my nails down low, it's a kind of self-harm in itself. It's to take away the feelings. The relief I got was something similar to pain from sport"* (Peter, May, 2023).

"It was more a cry for help. I used a sheet to try hang myself, I knew it could (kill me). Once or twice I hurt myself, I also tried to take my own life. In prison, it was a moment of madness. Having a bad day. That's the only way to sum it up. I was having a bad day and I said I want to get out of here. I just wanted to cut myself. I cut myself. I just got sick of it that day, and I just threw a tantrum. My mood just got the better of me. It's hard to hold it together all the time" (Aaron, June, 2023).

Some participants described using suicide as a way of managing emotions:

"A moment of weakness. I don't do it to kill myself. I was feeling all these emotions, anger, full of energy, feeling sorry. Thinking of things I put away for ages, thinking of me Ma. Then I'm thinking 'where's that blade?' (Liam, Aug, 2023).

One man who had taken an overdose reported that he was experiencing a variety of stressors (being on high court bail, no longer able to stay with his girlfriend and child), and he coped with this by meeting up with friends and taking

cocaine/prescription drugs. When asked about intent, he stated that he had no intent to die;

> *"I was getting it from all angles…Intent – there was none of that. I was so intoxicated I didn't realise"* (Mark, July, 20023).

This suggests that some participants who appeared to attempt suicide had no intention to die. However, some participants described using self-injury, such as cutting, as a means of trying to die.

> *"I cut my arms, slicing down my arms, if I slit this way, I will slit the artery. The doctor said it was attention seeking. I couldn't get the nerve to put it around my neck, I thought it might be quicker"* (Darren, August 2023).

This suggests that the nature of the act itself may not reflect the motivations identified by the person who engaged in it.

- <u>To hurt others</u>

Some participants described using self-harm and/or suicide to hurt others:

> *"There was a sense of I knew what I was doing, more to give these a fright, just how many I had taken. I need my child and my best friend. In a way it worked, it was effective"* (Aaron, June, 2023).

Another participant described using self-harm to get revenge against his ex-girlfriend (he was suspicious that she was seeing someone else);

> *"I was on phone to my ex, we had been together 9 yrs. I was desperately trying to get my family back together. I needed that support, I couldn't get through it without her, I was desperately trying to get her back. I got angry what she was doing to me, what she was feeling inside, she didn't realise what she was doing to me. She told me 'kill yourself, kill yourself', I took a knife and cut myself. It was more revenge, I felt really angry, I was hurting, I wanted her to see how serious I was, I thought she thought it was funny, she wasn't taking it seriously"* (Mark, July, 2023).

Another participant reported using self-harm as a way of trying to communicate his pain to others;

"It's not that I wanted to feel pain. I wanted them to be able to feel the way I felt. But they didn't know what I was feeling, cos I didn't tell them" (Aidan, May, 2023).

- Instrumental gain

Some described self-harm and/or suicide as being more instrumental acts in order to get their needs met. One participant admitted that he told staff he swallowed batteries in order to go to hospital. Other examples included to get away from a situation, to get someone to listen, or to get access to medication;

"I thought they would listen if I hurt myself. (Q Who?) The prison. Just come to your door, lock down your hatch, they didn't care….I was hoping to go to the hospital, at least I would have a couple of hours with them. They wouldn't bring me, they knew I wanted to go to hospital. I was going through a hard time, the hospital would have given me medication and my family would have been able to come in to see me" (Jason, June, 2023).

"To get medication. I couldn't get it at the time. I was using" (Jamie, June, 2023)

One participant who tended to speak in the 3rd person about himself spoke about his understanding of other's behaviour;

"There are people who are genuine in their self-harm and some who are in trouble on the landing. People use self-harm as a way of getting away from situation" (Colm, May, 2023).

- Cry for help

Some participants also spoke of self-harm or suicide as cry for help or attention.

"It was a cry for attention more than anything else" (Eoin, May, 2023).

Some participants described their motivation as changeable. This varied greatly from an intention to die to a release of emotions for one person:

"It can go from wanting to kill myself to a release. It can change from time to time. I could have flashbacks to when I was younger, to a bad thought or a memory, and then I try to block it away. All I know is I ended up with a SOC. I was starting to lose the head, get wound up. I find it hard sometimes to try and keep it in. Just battling through day to day. I was trying to end my life, to draw blood to relieve stress. It was both. Sometimes you just lose it I suppose, day to day" (Aaron, June, 2023).

In summary, this suggests that participants engaged in acts of self-harm, attempted suicide, or both suicide and self-harm in prison which varied in terms of motivation. It varied from a release of emotions, a way of trying to feel or manage emotions or to hurt others, or to an intention to die, which can vary from one situation to another within the same individual. This is consistent with the four main functions of self-harm in forensic populations; depression and suicidal intent, manipulation of the environment, emotion regulation, or a response to psychotic delusions or hallucinations (Jeglic et al., 2005). For the majority of participants, episodes appeared to be in response to (a) pain and hopelessness, (b) loss of connection and (c) access to means, which are included in Klonsky & May's (2015) ideation-to-action theory of suicide, known as the Three Step Theory (3ST). Both suicide and self-harm also appeared to have the presence of stressors (life experience/environmental factors), the perception of defeat (a sense of a failed struggle), the perception of entrapment (a sense of being trapped or unable to escape), and a perceived absence of rescue factors (e.g. support from friends and family). These elements were identified and discussed in the Cry of Pain (CoP) model (Williams and Pollock, 2001). It is worth noting that the function of the episode of self injury or suicide was not always accurately recorded by the MDT and their motivation to engage in self injury or suicide may have been determined by the nature of the act. For example, whilst self cutting may have been seen by the MDT as motivated by a release of emotions, it may have reflected a desire to die. Similarly, an apparent attempted suicide (e.g. attempted hanging) may have been an attempt to release emotions. However, participants gave a different account of their intent behind the act, which was not always based on the nature of the act.

It appears that it is not possible to determine motivation from the nature of the act itself (e.g. self harm, or suicide). Some participants who had engaged in self-harm had wished to, or intended to die. Some participants described using self-harm to relieve their distress, but not caring if they died in the process. Some of those who engaged in apparent suicidal behaviour similarly did not wish to die. This suggests that some episodes of self-harm were motivated by a desire to 'feel alive' and to retain emotional equilibrium (life affirming), whereas others were indicative of exasping life's pains (death affirming). Some episodes of suicide functioned as a desire to feel alive and to retain emotional equilibrium (life affirming), whereas others were indicative of exasping life's pains (death affirming). These findings suggest that it is

important to only consider individual intent when developing strategies to prevent and manage self-harm and suicide. It could be argued that incidents should solely be differentiated by their intention to end life or not, rather than the nature of the act itself (self-harm, suicidal threats, attempts and completions). This research supports a new paradigm of self-harm and suicidal behaviour as a continuum of self-harming behaviour that should only be differentiated by an analysis of the intent behind the episode. This suggests that all self-injurious behaviour reflects a continuum of 'acting out' behaviours that reflect different degrees of disturbance of the mind, which carries a different consequence or outcome (e.g. death, or injury) depending on their intentions (e.g. to die, to live).

Findings on the theoretical framework

This research provided interesting insight into the aetiology of self injury and suicide, and the conceptualisation of self injury and suicide. Most incidents occurred in the context of longer-term suicidality and/or multiple repeated attempts in prison or in the community prior to imprisonment. This supports the notion that self-harm and suicide are linked and represent similar entities (Forrester, 2014), rather than as separate conceptual issues, which should only be differentiated by the intentions behind the act and the function(s) they serve. This challenged the researcher's prior clinical understanding of self-harm and suicide as distinct entities, which required different treatment approaches to manage each distinct set of behaviours. The further the research progressed, the more it became apparent that self-harm and suicidal behaviour should be viewed on more of a continuum of intentionality and referred to under an umbrella term such as 'self-harming behaviour'. This identifies the need for an individualised approach that is based on their own story, rather than an approach based on different typology. Every individual has their own story, each with their own different or unique needs and intentions, regardless of the act they engage in.

This was consistent with Smith et al., (2019) who believes that self injurious events, and suicidal processes are not equivalent with regard to etiology, manifestation, and policy implication. The findings may provide support for the longest existing paradigm (Dexter & Towl, 1995; Haycock, 1989; Knoll, 2010; Morgan & Howton, 2004) that views self-harm behaviour as a range of anger-in behaviours that extends on a continuum of harm to oneself from deliberate self-harm (e.g. self-cutting) to

completed suicide and does not differentiate the aetiology, manifestation and processes that underlie variants of each behaviour. It does not appear to support a more recent dichotomous paradigm (Crighton & Towl, 2002), which differentiates acts (self-harm and suicidal threats, attempts and completions) based on their motivation to end life or not. This perspective is based on the premise that self-harm functions as a desire to feel alive via the retention of one's emotional equilibrium; whereas attempts at suicide are indicative of escaping from life's pains. This paradigm highlights the concept of motivation, that is, whether the individual committed the act with the intent to end life or not.

The findings are consistent with the PTMF, which argues that threat responses are more usefully understood in terms of the main function(s) they serve. This research found that these responses are linked to the core human need that is being protected by the response. The threat response appeared to serve a multitude of purposes for each individual. Primary motivations for self-harm and suicide expressed by participants are also consistent with the PTMF, where self-harm may be used simultaneously as self-punishment, communication, release of feelings, and a means of eliciting care.

Chapter Summary

This chapter has provided an understanding of the nature of harm. This highlights that participants engaged in self-injury, attempted suicide, and/or self-injury and attempted suicide. Various functions were identified by the participants, including a release of feelings, a way of gaining feeling, hurting others or punishing self, a coping strategy, a cry for help, or instrumental gain, or as an intention to die. The next Chapter will explore participants understanding of the factors that put people at risk of self-harm and suicide in prison.

Chapter 7: Risk & Contributory Factors

Introduction

This Chapter will explore the qualitative findings of participants understanding of the factors that put them at risk of self-harm and suicide in custody and the factors that contribute towards their self-harm and suicide, and the link to violence. Each theme will be explored in three sections. The first section will explore the factors that put them at risk of self-harm and suicide in custody, the second section will explore the

factors that contribute towards their self-harm and suicide, and third section will explore the link to violence. During interviews, participants were asked what they thought put them at risk of hurting themselves and what contributed towards ther self-harm and suicide. Various risk factors (causative factors or variables) were identified by participants. Table 32 provides an understanding of male prisoner's experience of the factors that put them at risk of injuring themselves, or attempting suicide. The first section will now explore the risk factors for self-harm and suicide.

Table 32

Participants Understanding of the Risk Factors

Theme	Sub Theme	Code
Risk Factors	Social factors	Social supports
	Custodial sentences	Single Multiple
	ACE's	Physical and emotional Neglect Parental separation/divorce Household physical violence Household substance abuse Emotional, physical sexual abuse Household mental illness, mental health challenges or suicide attempt Incarcerated household member Discrimination Witnessing violence
	Substance use	Illegal Drugs Prescription drugs Alcohol Both
	Biological / Neurodiversity	ADHD Impulsivity Risky behaviour P19's

Risk Factors

Social Factors

While social factors such as unemployment, homelessness and education level were identified in the quantitative data (see page 135), these factors did not appear in the participants narratives about the risk factors for self-harm or suicide.

Social support

Participants identified a range of social supports as relevant factors that put them at risk of self-harm and suicide. This included not being in a relationship, or the loss of a

relationship. Lack of visits was also reported as a risk factor that played a central role.

> *"No visits. No outside help. I'm on my own"* (John, May, 2023);
>
> *"I've had no visits in 2yrs, phone calls with friends occasionally, no contact from my family"* (Eoin, May, 2023);
>
> *"I don't speak to my family. No visits, my friends call. My family has left the country"* (Darren, Aug, 2023);
>
> *"We don't speak. They done stuff to me. I got through last 25 years, I can get through the next 25 years on my own*" (Darren, Aug, 2023).

The majority of participants reported having one or more children. They identified the lack of contact, or limited contact with their children, mostly due to their offending history & imprisonment, as a relevant factor in their risk of self-harm or suicide:

> *"Their mum is minding them. I can't go near them. There are people who want to hurt me"* (Patrick, May, 2023);
>
> *"They're safe with their mam. I don't see them that much anymore, I've been in and out of prison, the best thing I can do is to take a step back being in here"* (Aaron, June, 2023);
>
> *"She (my daughter) kept asking 'me dad, can I go see him?' I really want to see her, more than life itself. But I don't want her to see me in this environment. I don't want my daughter to be afraid of me. I still have all the gangsters. I have enemies. If anything happened to her, they would come at her to get at me"* (Patrick, May 2023).

This highlights the importance of social supports in prisoner's lives.

Custodial sentences

Repeat custodial sentences was identified by participants as a risk factor in their self-harm and suicide. The challenges of facing further time in custody for a repeat offence was often cited as a primary factor in their self-harm and/or suicide:

> *"On my first sentence, I sailed through it, no partner, no child, my mother was there for me. It just went a lot easier….This is a repeat sentence, with my first child. I did time before but not like that. I found it much harder locked in my cell"* (Jamie, May, 2023);
>
> *"The first time, I had no child, no partner. It was a lot easier than this sentence"* (Jason, June, 2023).

Substance Use

A history of substance use (e.g. drug use, alcohol use, or a combination of both alcohol and drug use) was a leading factor identified by men in their risk of self-harm and/or suicide. Participants described the chronic nature of their addiction;

> *"I used drugs from when I was old to hang out in town"* (Aaron, June, 2023);
>
> *"There was only one love, go to sleep, get more drugs"* (John, May, 2023);
>
> *"Being sick, pale. Chasing drugs"* (John, May, 2023).

This research indicates there is a significant link between substance use (e.g., alcohol, drugs) and both self-harm and suicide. It also highlights the high prevalence of people in prison with dual diagnosis and it's association with the incidence of self-injury. This is consistent with Sakelliadis et al (2010) that substance use is a known risk factor for suicide. This research indicates that efforts should be made to support recovery from substance use. Specific supports should be provided for those on remand, particularly those on repeat sentences. This should including access to both medication, and psychological therapies.

Adverse Childhood Experiences (ACE's)

The role of Adverse Childhood Experiences (ACE's) in their self-harm and/or suicide was evident. All fifteen participants who have engaged in self harm or suicide spoke about their lives having been affected by a history of adverse childhood experiences, and many described having experienced several ACE's in their life. This included physical and emotional neglect, lack of parental boundary, loss of parent through separation, divorce, abandonment, death, household substance abuse emotional, physical, sexual abuse, household mental illness, mental health challenges or suicide attempt, witnessing violence, trauma/household challenges. Some participants were able to link their self-harm and/or suicide to their history of abuse;

> *"Abuse explains worthlessness. I didn't have happiest childhood…abuse and neglect"* (Eoin, May, 2023).

Others identified specific traumatic events that were relevant;

> *"Being molested when I was a child"* (Liam. Aug, 2023);
>
> *"Caravan fire. My life has been hectic"* (Patrick, May, 2023).

Some participants highlighted adverse experiences;

"I felt despair. I can't explain it. I can still remember the day we were taken away. I had a hatred towards my mother. She put us in foster care because she didn't want my dad to have us. When I turned 18, social services made them send me on. You're your own problem now" (Darren, Aug, 2023);

"My dad died then, it slowly wrecked my life. He (my dad) was a recovered alcoholic, I was told 'your father is dead' just like that. Only way I knew how to deal with it was drink and drugs, other than play a couple of tunes… I found my mum on the toilet, she had bled to death" (John, May, 2023);

"I still have crosses to bear from when my father committed suicide. I feel guilty and responsible. He committed suicide 3 days after I was sentenced for this. My father never believed in suicide. I've spent ten years thinking of it. He had it in his head a year and a half before he killed himself that he was going to kill himself if I was found guilty" (Peter, May, 2023);

"My old fella got shot when I was a kid; only 18 months old" (Patrick, May, 2023).

Some participants linked their adverse experiences to their substance use which was a driver for their self-harm and/or suicide. Growing up with alcohol or drugs in the household was cited as critical risk factor;

"Both my parents were an alcoholic" (Peter, May, 2023);

"*There was a lot of alcohol involved"* (Patrick, May, 2023);

"I seen drugs at a young age, I was allowed to smoke joints at 14 yrs. old, I used to go to fathers at weekend & he used to let me smoke joints but only after 7pm, I could do what I liked with my mum, we would go off and score drugs together. My dad was a recovering alcoholic. I could go to youthreach and get home – hear EastEnders, now I can smoke weed'" (John, May, 2023).

This suggests that from the perspective of participants, a history of adverse childhood experiences may have been a risk factor for their self-harm and suicide. This includes exposure to physical and emotional neglect or abuse, household violence, challenges, and substance use, loss of a parent, poor parental boundaries, and bullying. These findings support the growing body of evidence that supports a history of adverse childhood experiences (ACE's) as a key risk factor for self-harm and suicide (Baglivio and Epps 2016; Baglivio et al., 2014; Hughes et al., 2017). These findings support a developmental trauma model (Lewis, 1990) for self-harming behaviours. As suggested by Lanes (2009), significant developmental events

can predispose individuals to psychological difficulties, and can manifest in dangerous behaviour (such as suicide attempts, assualts), and may lead to poor coping and environmental instability, which perpetuates the problem and creates further distress. However, it may be that the inflated risk is not just simply associated with risk factors such as ACEs, but rather the person's experience of ACEs (e.g. intensity, severity, meaning) albeit both. As stated previously, individuals within society who are at greater risk of entering custody share many of the same features of those who are at an increased risk of self-harm and suicide, including disrupted family background (McDermott & Willmott, 2018). It may be that the inflated risk is not just simply associated with risk factors such as ACEs, but rather the person's experience of ACEs (e.g. intensity, severity, meaning) albeit both. It is therefore important that research should explore the intensity, severity or meaning attributed to their adverse childhood experiences, and not just the frequency.

The findings support the view expressed by the PTMF (Johnstone & Boyle, 2018a) that people with problems have experienced trauma in their lives and that substance use, self-harm and suicide are a possible response to trauma. It identifies the potential external causes, and recognises the causal role of adversity in it's origins. This was similar for violence, where participants linked their adverse experiences to their violence;

> *"I come from a traveller background, I'm expected to fight. I was fighting grown men aged 15/16 years old - not normal fights, with weapons. Gave me a hiding for crying, especially at a funeral. You don't show emotion. A traveller man is not supposed to feel emotion. Use violence*" (Patrick, May, 2023);
>
> "*My family were involved in a feud, there was a lot going on, a lot of liability, family rows"* (Mark, July, 2023).

Neurodiversity

Three participants reported being neurodivergent, either having received a diagnoses or having self-reported symptoms of ADHD (impulsivity, hyperactivity and risky behaviour):

> *"I was driving bikes on roads at 15/16, I was banned off road for six and a half years; I should have been in the grave long ago. I fell through a window, flipped car, quad accident, head on collisions, hit bridges"* (Liam, Aug, 2023);

"I got 19 P19's in one year, I was in a lot of trouble. 3 P19's since in this prison. I can't do this anymore. I had to do it for myself. If judge saw the P19s and he's in for this…!!" (John, May, 2023);

"I've been through a fair share of jobs, don't tend to stay for more than a few weeks, not offices, sleeves rolled up, physical" (Darren, Aug, 2023):

"I didn't know how to cope with pressure. I never used to come home, I used to run away. I was running away from home" (Darren, Aug, 2023).

Neurodiversity was highlighted by some participants in relation to their self-harm and/or suicide, particularly impulsivity.

"Sometimes it will be just be an impulsive…be an impulse, a thought in my head and I won't even realise" (Colm, May, 2023).

"I was out of the yard 5/6 years ago, playing tin whistle, then boof ! I snapped the tin whistle, there was no thinking, even looking back there was no thinking. But there was a lot building up to it before it" (Peter, May, 2023).

The above symptoms have presented significant difficulties for participants with neurodiversity in custody, which will be discussed later in this chapter. Efforts should also be made to provide specialist support to those presenting with neurodiversity issues.

The first section of the Chapter on the qualitative findings has presented the participants understanding of the factors that put them at risk of self-harm and suicide. This included a history of substance use, the presence of ACE's, lack of social supports, history of repeat custodial sentences, and neurodiversity. This research supports the five categories of risk factors identified by Favril, Yu, Hawton & Fazel (2020) including socio-demographic, criminological, custodial, clinical and historical. This is consistent with research on suicide that supports the role of a history of childhood abuse (Stanley et al., 2001), having no social visits (Zhong, et al., 2020), illicit substance use (Sakelliadis et al., 2010). Similar risk factors for suicide and self-harm in prison were identified. There were many similarities in the responses for different groups (e.g. self-harm, suicide, mixed), and no themes that were unique to each group This is consistent with Hawton et al., (2013) who also confirmed similar risk factors for suicide and self-harm. These findings support the ideas by Zhong et al., (2020) that preventative measures should target the modifiable risk factors.

The next section of this Chapter will now explore participants perspectives on the contributory factors in their self-harm and suicide.

Contributory Factors

The next section will now explore participants understanding of the factors that contributed towards their self-harm and suicide in prison. During interviews, men were asked what factors led them to engage in self-harm and/or suicide. Table 33 provides an understanding of men's experience of the factors that contribute towards self-harm and suicide. This included substance use, stress and anxiety, arising in the context of recent committal to prison, mental health difficulties (e.g. emotion regulation difficulties & Axis 1 disorders), adjustment issues, neurodiversity, loss of relationships through bereavement or loss, and relational difficulties with staff and other prisoners. These all contributed to feelings of loneliness, isolation, hopelessness and despair. This also identified five key factors that underlie the level of risk posed by the environment included lack of structured activity, staffing shortages /overcrowding, large prisons, prison culture that does not support showing vulnerability, and lack of procedural justice. They also identified the use of an Special Observation Cell and lack of trauma informed practice.

Table 33

Participants Understanding of the Contributory Factors

Factors contributing to self-harm and suicide	Mental Health	Managing emotions Axis 1 Disorders Mental illness
	Substance use	Alcohol Drugs Both
	Medical	Access to detox Continuity of medication
	Neurodiversity	Boredom Getting into trouble Access to medication
	Adjustment issues	
	Bereavement/loss	Death or anniversary of death of someone Loss of family or intimate relationships Family members becoming unwell Transfer or release of supportive person Child custody/access issues

		Loneliness Losing everything/hopelessness Covid-19
	Relational	Prisoners Staff characteristics and approaches
	Environmental	Prison Culture Large prisons Staff shortages Lack of regime
	Procedural	SOC Non trauma informed approaches

Mental Health

The level of mental health difficulties and their relevance as a contributory factor for self harming behaviour was evident during interviews with men in prison.

- Managing emotions

Difficulties with managing emotions, particularly with recognising and dealing with their emotions, was identified by participants as a contributory factor for self-harming behaviour (and substance use):

> *"I don't understand much about emotions, (Q do you recognise your emotions?) Not really no, I block it out… No strategies, just get high and take drugs to block it out. I don't have any (emotions), nobody taught me how to manage emotions. No exercises, just have to sit there and think about it"* (John, May, 2023).
>
> *"I never knew how to handle emotions, I never knew how to open up. It's survival"* (Mark, May, 2023).

- Axis 1 Disorders

Participants also reported experiencing Axis 1 disorders and other symptoms that contributed to their self-harming behaviour. They reported having symptoms of depression, anxiety, PTSD, and OCD which were relevant to their self-harm.

> *"I had depression and suicide when I was a teenager. I went to my GP, got an anti-depressant"* (Darren, Aug, 2023).
>
> *"I suffer from a bit of anxiety, sometimes I feel the walls pulsing, a couple of things don't feel real, I'd be going in and out of a trance, I dread that door opening, I'd rather it stay closed"* (Mark, July, 2023).
>
> *"I read about PTSD. I used to carry weapon, up at 3 or 4am. I can't cope at night time sleeping, I get really bad flashbacks, I get glass shattering in my head"* (Patrick, May, 2023).

"I have PTSD. I have very strong OCD as well, I have stuff a certain way. I get that feeling of anxiety" (Colm, May, 2023).

"I sometimes don't know what I'm feeling. I could have a feeling or a sense of what's going on, you could have a different view of what's going on" (Colm, May, 2023).

- Mental illness

One participant reported a history of mental illness in the community, which was relevant to his use of self-harming behaviour:

"I have been linked with psychiatry in community since 16 yrs. of age. I suffered a little bit up here (pointing to head). Mentally paranoid. Little bit of psychosis. I'm well now. I found it helpful; talking and medication…I keep an eye out, I'd be watching" (Aaron, June, 2023).

This suggests that mental health difficulties (especially how participants think, feel and behave, interact with other people, look after themselves and others and take part in and enjoy their lives) play a contribtory role in their self-harm and suicide. The role of mental health (Axis 1 disorders, mental illness) is consistent with Favril et al., (2020), who suggested risk factors include any current psychiatric diagnosis, particularly major depression and borderline personality disorder (Favril et al., 2020).

Substance use

The most prevalent contributory factor to self-harm and suicide identified by the men who were interviewed was substance use. They typically described using substances, such as alcohol or drugs, as a coping mechanism for stress and to manage feelings. This included:

"I was all over the place. I had an addiction, I can't see my child. I was drinking vodka/southern comfort" (Aidan, May, 2023).

"I used drugs as a coping mechanism" (Colm, May, 2023).

"Only way I knew how to deal with it (my dad's death) was drink and drugs, other than play a couple of tunes" (John, May, 2023).

"I was using drugs to cope with stresses of everything" (Dan, June, 2023).

"Blocking it out with drugs. Being sick, pale. Chasing drugs…I turned to my one best friend; drugs. That's how I cope with feelings. I want to get linked in with bereavement counselling. I don't want to get out with no support" (John, *May, 2023).*

"I'd wake up in the morning with a full bottle of whiskey, I wouldn't even pour a glass, I'd just open bottle and pour bottle just so my brain would stop thinking" (Patrick, May, 2023).

"I was addicted to drugs, couldn't get off them. I was walking around like a zombie. I didn't want to live like that anymore. I was on heroin" (Dan, June, 2023).

This highlights the use of substances as the most significant contributory factor to their self harm and suicide from their perspective, which was often present with a dual diagnosis or co-morbidity. It found that individuals who engage in self-harm and suicide often use substances as a coping mechanism to deal with emotional distress. These findings highlights the need to provide support to address both substance use and mental health and to support people in custody to develop healthier coping mechanisms. This supports Hawton et al (1998) finding that reported promising (but not significant) results for drug treatment for recurrent self-harm with female prisoners. Whilst the role of substance use has consistently been linked to self-harm and suicide, this research indicates that it should be prioritised as a critical contributory factor and a specific target for direct intervention in its own right, or as part of a dual diagnosis, in efforts to support desistance.

Medical

The challenges of coming to prison with an active addiction was often cited when discussing the factors that led to their self-harm and suicidality.

- Coping without substances

Men interviewed for this study talked about the challenges of not having access to substances when they come to prison which played a role in their self-harming behaviour:

"I was using drugs to cope with stresses of everything. When that was gone, I didn't have anything" (Dan, June, 2023).

- Access to methadone

Participants reported using self-harm and suicide at a time when they were struggling with their detox from substance use without access to methadone:

"I think it was coming off all the drugs…I didn't want to go through the sickness from the drugs and I was sick of this place. I didn't get methadone. It's the doctors here. They won't give it to me. Gave me all different stupid tablets. Just left with tablets, that's it. If you're on medication for 3 or 4 years, your body is used to it. It's not just the body, it's hard on the mind. They just tell you you're not suitable or we don't do it here. Even if they wouldn't give me maintenance they could have given me detox. I'm happy that they didn't give in in a way cos I'd still be on it and I'd never get off it….I wanted to get on methadone…When I came in here, they cut me off it (methadone." (Dan, June, 2023).

"Getting the right support on committal, people coming in with a heavy addiction and people who need a substitute I'd be prioritising that, like you come in, particularly when injecting, it's a different sickness. It's a very easy fix, they just wouldn't do it. Even on this sentence, I was very sick and I got put to (a prison), I got the support. No suicidal thoughts going through your head, they had me on methadone the very next day. You might have to wait the extra day, but you wouldn't have to be sick for a week. Prioritise. Doctor makes a phone call to get you accepted. Fax the prison a prescription. It's not like you are getting out for the day and need an escort. Just a phone call. Took me 2 weeks, remotely prescribed me 1 zimo for 7 nights. I had the medic at my door every night, I'd never be smashing up the place. They knew I was sick" (John, May, 2023).

"*You need medication to help you until you get help. Medication doesn't work on its own"* (Eoin, May, 2023).

Another participant explained that he had attempted suicide in order to get access to methadone:

"If they don't come, they don't come. I wasn't getting the support I needed. I wanted to get on maintenance. No help at all, it's crazy it is. If they had given me methadone on committal I wouldn't have hung myself. It was a major cry for help, they put me in pad for 3 days. In the pad, they came the very next day with methadone. Before they were saying no, you weren't on methadone before came to this prison so we are not giving it to you, that attitude. It made no bit of sense. It wouldn't have happened if they had put me on maintenance to me, I could have got two clinics on the outside that would have accepted me for maintenance" (John, May, 2023).

"It was a cry for help, I needed help, I'm willing to do anything to get help. I couldn't even do laps of yard, I was just lying down, very sick over methadone. Lucky enough I got bail on that, I was on remand for 2 weeks, able to walk out of court, first thing I did was go for bag of heroin" (John, May, 2023).

- Continuity of access to medication

Challenges with accessing medication was a factor identified by participants. This included not being being able to see a GP in prison in order to access medication, or not being able to access medication that has been prescribed by the GP:

"I'm entitled to a bed, pillow, and the same access to a doctor as in the community. You just get used to it, you're not going to see a doctors….It's down to the doctors, the doctors not in" (John, May, 2023).

"Medication is often taken away under governors orders. Sometimes they have a suspicion that someone is selling their medication and they will stop everyone accessing it. The medics come around and they say you won't be getting it… (Q what was the purpose?) *To get medication. I couldn't get it at the time. I was using"* (Jamie, June, 2023)

"Sometimes I do get the feeling I don't want to be in this life anymore. Cutting my throat. Trying to cut my Adams apple. That night they refused my medication, I got panicky, my chest was boom boom boom. I said will I hit him or him. I was just paranoid to close the doors out. Then I'd be sitting on the chair afraid to go to bed, I can't go to sleep, I get al.,l panicky, I do more damage when I don't have them going into my cell, I start cutting myself, when they look in they see you cutting yourself and then they give them to you. Maybe they were going to bring them up later, I don't know, but it drives me mad" (Liam, Aug, 2023).

"I got zimovane from the GP for 2 weeks. Nurse told me you're not allowed them, they were on the trolley, they wouldn't give them to me. The medics overrule the doctor. I know you need this meds, but my hands are tied. I had to get the drugs out there, that's when I fell off, ending up sitting in the yard" (Patrick, May, 2023).

"In (a prison) they gave me a D5, I thought I was on it then, because of something traumatic like that, they gave it to me, then the next day they wouldn't give it to me" (Jason, June, 2023).

"Zimovane Tablets – sleep like a baby. They're the only thing that keeps me feeling like I wanna be on the planet. I'm out cold" (Liam, Aug, 2023).

> *"Concerta - tablets kept me calm. When I was 16, I was in the marines, I came off, they put me back on them. Doing wonders. When I didn't take them I knew, I'd wreck place around me* (Darren, Aug, 2023).
>
> *"Medication should be separated from the prison side of things. The prison have too much say over people's medication.. …Everyone is given antipsychotics, they use antipsychotics to try to quieten you…. I don't ask for any addictive medications. They have no history of me taking tablets. You should be on same medication as you came in, they're not doing that. I was on pregablin for nerve damage, prisons don't like putting you on that, they tried putting me on methadone. You get the drugs you need on the landing quicker than you would from the medics…They wouldn't be in that situation (having to self-medicate) if they did not have any say, let the doctors decide what medication they should have"* (Colm, May, 2023).

This suggests that participants reported that they faced difficulties in accessing medication that they believe they needed, were prescribed in the prison, or were precribed in the community prior to committal. It is worth noting, however, that people who have desisted from self-harm or suicide reported that they are now happy that the past decision not to prescribe some types of medication. For example:

> *"I'm happy that they didn't give in in a way cos I'd still be on it (methadone) and I'd never get off it*" (Dan, June, 2023).

They reported that at the time that they believed they depended heavily on a particular medication, which contributed towards distress when it was not prescribed and they felt they would be unable to cope without it. These findings highlight the challenges faced by prisoners upon commital who perceive that they will not cope without continued access to medication they were prescribed in the community. They reported that it was not the clinical decision not to prescribe a medication, but their perception at the time that they depended heavily on a particular medication, and cannot get off drugs, and/or face another sentence, which they reported led to hopelessness and significant distress and likely contributed to their decision to engage in self-harm or suicide. This suggests that it is the perception, not necessarily the clinical decision making, that makes people more susceptive to choosing suicide or self-harm as a way of managing the adjustment to custody. This has implications for how clinical decisions are clearly and

collaboratively communicated at the time to help them to understand and to accept the decisions.

- Self-medication

Prisoners spoke about the risk posed by difficulties accessing medication;

> *"People self-medicate. That's an issue in the prison, people are not getting their medication, so they self-medicate to substitute that medication. That's where the blame on drug use comes into play. I use cannabis…I would love to get the help I need to come off medication. Until then I do need the medication, the right ones, so I don't have to take the contraband"* (Colm, May, 2023).

This suggests that the difficulties described by participants of accessing methadone, or prescribed medication that they were prescribed in prison or in the community may be a contributory factor in self-harm and suicide. These difficulties may lead to self-medicating, taking substances to cope, or poor coping, which all contribute towards self-harm and suicide.

Neurodiversity

Having a diagnosis of, or symptoms of ADHD (e.g. hyperactivity, impulsivity) led to problems with boredom, getting into trouble and difficulties accessing medication, which some participants felt played a role in their use of self-harm and suicide.

- Boredom

Those who reported ADHD symptoms spoke about the particular challenges of being in prison as a person with neurodiversity and how it led to them hurting themselves. When speaking about the factors that contributed towards self-harm and/or suicide, one man spoke about the impact of being detained in a prison with symptoms of hyperactivity:

> *"It's having those bars, everything is bars and wire. That fucks my head, I feel like a trapped animal in a cage. I can't do the yard, I see barbed wire and cages"* (Darren, Aug, 2023).

- Getting into trouble

This participant also described the challenges of being surrounded by people in prison, including staff and prisoners, that can lead to distress and self-harm and/or suicide:

"Then you have officers in the hub watching you, it's like show and tell for them. I had to stop this, I'm not doing this. I went to the gym. I'm used to waking up and screaming at top of my lungs and no one hearing me, I'm not from the city, it's not my cup of tea, I like to be on my own miles away from anywhere. Too many people around me. My personality clashes, with my personality, I clash with everybody. I clash too much with people on my landing, I get too over aggressive and hyper, I'm told to calm down, I can't keep my mouth shut, I'm too loud" (Darren, Aug, 2023).

- Access to medication

This man also reported the negative impact on his behaviour, including self-harm, without access to ADHD medication:

"I've told the doctor several times I'm going to get into trouble, I'm going to get myself seriously hurt if I don't get back on the medication. They said they would and that was two years ago. Even the teachers are catching up with me, here comes (name), he talks too much" (Darren, Aug, 2023).

This highlights the challenges faced by people in prison with neurodiversity that may be relevant to their self-harm and suicidality. This includes boredom in the context of hyperactivity, getting into trouble due to impuslvity, and the challenges of not being able to access medication.

Adjustment issues

Difficulties adjusting to their conviction and/or coming into custody, especially when facing into a repeat sentence, were reported by participants around the time of their use of self-harm and/or suicide. Participants reported a sense of hopelessness when they faced similar situations (e.g. further sentence, perceived inability to cope with their current circumstances, lack of confidence in their ability to desist from substance use, and loss of connection (e.g. no access to children in custody).

"When I came in (to prison) them times, I was all over the place" (Jason, June, 2023).

"The day after I got committed. I knew I was going to get the sentence again. I was thinking I'm not doing this again. I was only just out after 8 months after finishing 3 years" (Dan, June, 2023).

"It was a repeat sentence, with my first child. I did time before but not like that. I found it much harder locked in my cell. I had to deal with Covid in prison, one

phone call per day. I couldn't deal with it. We had no visits at all, we only had video calls. It was worse cos you could see everything you left behind, it was torture. They were the things I couldn't deal with, when I first came in. I was thinking I'd never get through it, I did get through it thank god. I had a lot going on. It was hurting me that I didn't know what was going on outside…..I was just in prison, I had no contact with my daughter, only 6 min calls. I had to choose between my girlfriend and my mother. When I came off cannabis, I wasn't on anything for mental health. I was begging them, I was crying for at least 12 hours a day. I wouldn't mix, wasn't going to yard….I just couldn't deal with what was going on outside, not seeing my mother, my partner, and my mother was feeling left out as I wasn't ringing her" (Jason, June, 20023).

"I think it was just the way everything came on top of me; the sickness from drugs, being back here, and it was Xmas. My son is five, and I haven't been out for Christmas yet" (Dan, June, 2023).

One participant spoke about the challenges of going through the courts system:

"Sitting in court on a murder charge, family members giving me evidence against you, loneliest place in the world, everyone is judging you and having to hold your tongue" (Patrick, May, 2023).

This highlights the difficulties adjusting to prison for participants that are relevant to their use of self-harm or suicide.

Bereavement/loss

Recent loss of someone close was identified by the majority of participants as a contributory factor in their use of self-harm and/or suicide.

- Death or anniversary of death of someone

When asked what factors contributed to their attempt to hurt or kill themselves, many participants described experiencing the death of a person (a friend or family) in their life as relevant factors.

"I've had a few losses in my life, hanging around with people and I'd notice they were gone. Lost contact, friendship is never the same. Miss them. My dad died then….I was only after losing my father a few months. If I die, I'll see both of them. Which is hard for me, as I don't believe in God/heaven and hell. I'm after losing so much" (John, May, 2023).

"My friends (who died) I grew up with them, they were the ones I trusted. When they died, and I lost my appeal, I just couldn't hack it. I was going straight back to the beginning, to fight" (Patrick, May, 2023).

"Sometimes I just wish I'd died. Why did they take my friends, and why am I still here?" (Patrick, May, 2023).

"My brother died that year, cousins, aunt passed away that year. I went from playing music to cutting myself" (Peter, May, 2023).

Some spoke about the effect of losing family or friends, particularly in the context of adjustment issues;

"I wanted to die. I didn't see no way out of this life sentence. My friends were gone. My ma had cancer. I lost my appeal. I didn't want to be a burden on anyone anymore. I just wanted to end it. It's all the hurt and the harm and the damage I've done. I didn't know how to deal with it. If I'm not there, my ma can focus on my two brothers, and getting better. I was reaching, screaming for help" (Patrick, May, 2023).

- Loss of family or intimate relationships

In the build up to their self-harm or suicide, many participants reported experiencing loss of contact, or reduced contact with their family, or the breakdown of a relationship following imprisonment;

"I am on my own, I felt lonely" (John, May, 2023).

"Sometimes I cut my wrists cos I miss my ma and my brother, my da" (Liam, Aug, 2023).

"When I came to custody, I lost her (my girlfriend), I was full of anger…She was my left hand man, my best friend. From staying around with the baby and being with each other, I never considered that I would lose her in here. When solicitor told her 8/10 years, she got cold feet" (Mark, July, 2023).

"I went back to drugs after my father (died), she didn't want drugs around" (John, May, 2023).

- Family members becoming unwell

Men described the distress of finding out a family member had been diagnosed with cancer as a relevant factor that contributed towards their self-harm and/or suicide;

"The second incident happened when I just found out my ma had cancer, I'd taken tablets as I couldn't handle it. My ma is all I have, she means more to me than

anything. The thoughts of losing her after losing all my best friends, after losing everyone I trusted, I was over on (a landing), the only thing I could find was the plastic knife and fork, I tried to slice my throat, and I tried to slice my arms" (Patrick, May, 2023).

"When I came back to jail, her cancer came back, she had to have double mastectomy, I'd hate to think it was the jail and everything else that was going on. It's just a vicious circle, a snowball effect" (Mark, July, 2023).

- Transfer or release of supportive person

Recent loss of the support of a close friend in custody was identified by participants when describing the factors that led to them hurting themselves;

"I was on my own most of the time. I was in a double cell, on my own as my cell mate was in hospital for 6 weeks, I was isolated and on my own with no one to talk to, I didn't have anyone, no support. Just feeling lost, alone, isolated" (Eoin, May, 2023).

"There was a fella on my landing, we hit it off straight away, we were extremely close. We kept in contact. He's the only one who will keep me on the straight and narrow. My family are gone. He tells me to keep your head down. He's the only friend I have in this whole world. I have so called friends, and they are gone. It was heart-breaking when he left. I did go into myself for a while. I'm lonely" (Darren, Aug, 2023).

- Child custody/access issues

Problems with contact with their children and/or losing access to their children was cited as a factor that is relevant to their self-harm and suicide;

"I lost contact with my son, only video calls"…"I was all over the place. I had an addiction, I can't see my child. Pain..can't get out of that, I was disappointing my son" (Dan, June, 2023).

"My first child, there were issues between mother and daughter, I lost contact with mother, she was playing games, I had access issues. I've done prison time before, but never done it in that way, much harder. It was different. It was out of my control. I only had one phone call a day. I was up the walls. I couldn't deal with that" (Eoin, May, 2023).

Loneliness

A participant described feeling lonely and isolated in prison when he self-harmed;

"The place, people around me. Loneliness and isolation….The isolation, loneliness and no one listening to you, you're just a number in most places….Just even one person to talk to" (Eoin, May, 2023).

This highlights the role played by the loss of a person in their self-harm and suicide. It suggests that losing contact with family or friends, losing someone close to them, finding out that someone close to them is sick, losing access to their children, or the transfer of a close friend in prison to another prison plays a contributory role in self-harm and suicide.These factors also appeared to be confounded by feelings of loneliness and isolation.

Losing everything, hopelessness:

Participants spoke about losing everything and feeling hopeless, which was cited as a factor contributing to their self-harm and suicidality;

"I lost everything I built up. That was our place, Had family home, had cars had best of clothes, had bunch of friends, everything I ever worked so hard for was gone, I couldn't see me starting again, couldn't see me getting better, it took me very long time, with numerous occasions in the block, throwing stuff at officers, naked in cell, no TV, no cigarettes, losing track of time, I had to sit myself down and find myself again" (Mark, May, 2023).

"Despair. Black emptiness of my life, of coming to terms with what I did, what I did in my past, what happened to my future with my father committing suicide. It's basically when you hit rock bottom. You can't go any further but you want to go further and that pain is putting you further than you should be going. If there's despair and there's nothing left under it, that's where self-harm comes in. You can only torture yourself so much before it starts feeling like torture so if you torture yourself mentally and torture yourself through drugs, which I've done before. And I've used both on occasions, and I can only still get to there, and with self-harm it felt like id dropped 1 level to where I should be. It's a long road back from up there and sometimes when you get to the top it's scary when you get there. I used to self-harm again to where I think I should be. I never felt I deserved it, that I should be doing as well as I was" (Peter, May, 2023).

Covid – 19

Covid-19 restrictions were highlighted by some participants in their use of self-harm;

"I had to deal with Covid in prison, 1 phone call per day. I couldn't deal with it. They were telling us stuff I couldn't deal with. I thought they (the prison) would listen if I hurt myself. Just come to your door, lock down your hatch, they didn't care. We had no visits at all, we only had video calls. It was worse cos you could see everything you left behind, it was torture. They were the things I couldn't deal with, when I first came in. I was thinking I'd never get through it, I did get through it thank god. I had a lot going on" (Jason June, 2023).

Relational

- Prisoners

Relationship difficulties with other prisoners was identified by participants as a relevant contributory factor in their self-harm and/or suicide. One participant spoke about how the way in which he mentalised others intentions has led to self-harm;

"My biggest problem is I'm a deep thinker. If someone passes me on the landing to say something it will resonate with me for days going to bed and waking up 'what did that cunt say it for?'... I'd have to look at it lots of different ways before I can forget about it, it keeps you awake. It can be dangerous, when I say I look at it 100 hundred ways, that cunt is trying to put me down, or he's' going to make a move, I can do something stupid and it can be bad or it can be right" (Mark, July, 2023).

Other examples of relational factors with prisoners that contributed to self harm, included being intolerant of other's behaviour such as others making allegations, asking stupid questions, 'getting away with stuff', and others having homophobic beliefs.

- Staff characteristcs and approaches

Participants were asked what prison factors make them more likely to hurt themselves, or what prison factors they find unhelpful. Participants spoke about their negative experiences with staff. When reading the following quotes, it is first worth noting that participants spoke highly of staff when asked what were the things that they found helped them most. This is reflected in the following quote:

"I'm not going to paint them with the same brush, there are a couple of officers who have helped me. (Patrick, May, 2023).

Some participants described having relationship difficulties with staff which contribited towards their self-harm and suicide and/or suicide.

> *"The screws set me off. The medics set me off. I was feeling all these emotions, anger, full of energy, feeling sorry for myself. Thinking of things I put away for ages, thinking of me ma. Then I'm thinking 'where's that blade?'* (Liam, Aug, 2023).

When asked what kind of things contribute to this kind of behaviour happening, participants spoke about their perceptions about staff's interest and their level of care. Some men described feeling that staff do not listen;

> *"In the (closed prison) it's hard to get an officer to listen to you. You go to the medics, they tell you you're on the list for psychology or psychiatry or something, it takes a while to get medication or anyone. Up here (new closed prison), it's different, you get the medics straight away, go 3 times a week. In the (previous closed prison) I'd still be hurting myself. This place has changed me"* (Eoin, May, 2023).
>
> *"I thought the only way they (staff) would listen is to hurt myself. I wouldn't say it was the officers, they just come to your door and lock down your hatch, they didn't care…that was more annoying than anything else"* (Jason, June, 2023).
>
> *"They don't even listen to you when you're pouring your heart and soul out"* (Aidan, May, 2023).

Some participants spoke about not getting care when they asked for it:

> *"I went to medics and told them I was not coping. I understand, it's hard as there's so many people, there's 800 people. Not getting care frustrated me more, it got me more into a deeper cycle" (Eoin, May, 2023)*

Men described feeling like they do not matter to staff;

> *"Multiple times I looked for help. You're just a statistic as a prisoner 'here, how much do we spend on that lot?'"* (John, May, 2023).
>
> *"The isolation, loneliness and no one listening to you, you're just a number in most places… Officers can be very blunt about it, they don't care…An officer could guide you in the right direction, most officers say its above their pay grade, it's a lot of that strike activity, work to rule, getting nowhere"* (Eoin, May, 2023).
>
> *"I was sick of asking for help, they were getting abusive about the situation. Like 'I really don't care', 'you're just another statistic here', 'you came to jail', that's the*

feeling I got, you're just a statistic, how much money do we spend of the tax payers money on these people in jail" (John, May, 2023).

"See your friend hanging. Nobody comes in and asks you 'do you need to talk to a psychologist?', 'do yous need this, do you need that'? I've seen people take loads of tablets. If the prison system had more courtesy, people would come out with different attitude". (Eoin, May, 2023).

Some participants described feeling judged by staff and treated in a demeaning way as a contributory factor in their self-harm and suicide;

"Some of them have a foul attitude, everyone is the same scumbag, painted with the same brush, it annoys me. Like, I was on the same wage as they are, I was thinking who do you think you are, do you know what I mean, put me down, you have to just take it. The attitude is always there, they have their bad days and their good days. If they have a bad day it can be disastrous. I understand they have a job to do, there's different levels, there's anti-system people, they hate the system, people have been in the system all their life, young offenders institutions, they're the ones who are anti prisoner, fuck off away from me, or I'll smash you up. That falls back on us, everyone gets the brunt end of it. It's a human trait, if I was there treating like shit you're not going to take it, you have an ego" (Mark, May, 2023).

"It doesn't help when you have officers giving you attitude, painting you as a scumbag, you build that anger up again, I was on the same wages as you last week" (David, May 2023).

The perceived lack of rehabilitation in IrIsh Prisons was cited as a contributory factor;

"There's no rehabilitation in Ireland.....People say this is place is about rehab its not. Its either cell or yard, people say there's gym or school. There's never officers there…Like, Irish jails, they are not build for rehabilitation yet. We are probably 40 or 50 years behind most prison system in terms of rehabilitation" (John, May, 2023).

"All they care about is 'what's the numbers?', that's it… there's barely any rehabilitation in the prison, there's barely any rehab in any Irish jail, unless you look for it, you can't rehabilitate a person and make them better, you can't do nothing" (Peter, May, 2023).

> *"You come to prison to get rehabilitated, there's no rehabilitation in prison. There's one drug counsellor for 600 prisoners…Come in, do your time, come back in, there's no help, no rehabilitation. I've learned the first ten years I was like a zombie, taking tablets, I'd be paranoid. I know my triggers my warning signs, I'm surrounded, I'm attacking because I don't know any better, my legs are going, my head will be gone….You're screaming at someone to pull you out of that situation"* (Patrick, May, 2023).
>
> *"In (a prison), I don't know what it was, they didn't want to help me, they wanted me to cold turkey it. In your cell, no support, you keep putting on the light, and they only come and tell you to 'stop putting on the light, I'm watching the match' not 'do you need help, what do you want'?. "Yeah no bother, Thanks very much for that, I was just trying to hang myself, and I'll stop putting the light on, no problem". Whatever they're doing - drinking their Cappuccinos or Nespressos, they have to come out of their box to help you".* (John, May, 2023).
>
> *"There's no help. Staff are standing at gate looking to see if there's any drugs coming over the yard. The Irish Prison Service has slipped off, they don't care".* (Patrick, May, 2023).

This suggests that mattering was a contributory factor. Participants reported that feeling as though they mattered was critical for them in their desistance, as was knowing that their rehabilitation mattered and that staff cared about them as a person. Participants reported that in order to prevent single or repeat episodes of self-harm and suicide, there should be a focus on staff making them feel like they matter, conveying that they care about their rehabilitation, and ensuring that staff act as positive role models. This is consistent with Mann, Fitzalan Howard and Tew (2018) which suggested that developing the rehabilitative culture of prisons includes providing a safe and decent environment, where hope and change are supported, where everyone treats each other with respect, and where people's needs are understood and met.

Staff training was identified by participants as essential in managing self-harm and suicide, and that staff should try to understand incidents of self-harm and suicide;

> *"I was talking to a few officers about this; 'we had no formal training, when we joined this job we literally had a 10 minute training, mainly on aggressive behaviour, rather than suicidal behaviour', so they're not equipped. They're set in their ways, you can't really blame them in their own way. I was cutting myself,*

banging myself….You're a man, or you're not, they are not used to seeing a man hurting themselves, they don't know how to deal with that either…If they do a training every year, a refresher and highlight of new changes. New recruits are younger, give it 10 years and we would see a big change. You can't blame staff for how they are told to do their job" (Colm, May, 2023).

"They need to be taught to sit back and think about the behaviours. Find out what's happening, do your job, what's the meaning behind those behaviours" (Patrick, May, 2023).

This impressed that it is important for staff understand why people hurt themselves in custody and what helps them to manage it. These findings are consistent with Pope (2018), who recommended the improvement of knowledge and attitudes of staff, and highlighted the importance of developing relationships between staff and between staff and prisoners. Participants explained that they do not feel that staff fully understand their use of self-harm and/or suicide, and that the subsequent responses to self-harming was perceived in some instances as punitive. This suggests that there is a gap in staff knowledge, skills and attitudes that would benefit from being addressed. It would be helpful to understand better how staff view self harm and whether this has a negative impact on how staff respond. While some self harm can be instrumental, it is worthwhile helping staff to understand that this is an unhelpful way of managing problems, or getting their needs met, rather than any deliberate intention to manupulate others. These findings are, however, already a key, critical message of existing training for Recruit Prison Officers RPO's. As part of the core curriculum, New Recruit Prison Officers are taught that 'every contact counts'. Yet it is apparent in this research that from their perspective, participants did not feel that this training always translates into the response to self-harm and/or suicide by staff.

This highlights the importance of understanding the barriers to staff applying their training, knowledge and skills in their day to day practice. This may need to take into consideration the complexities of the impact of the job and the often complex task of being carer and custodian of those in prison. This is consistent with those who maintain that conflict within themselves is evident in their dual role as custodian versus carer (Ramluggan, 2013; Ireland and Quinn, 2007; Bennett and Dyson, 2014). It would be useful to interview staff to explore their attitudes towards self-harm in order to explore this conflict further. This is also consistent with findings of the

SCCJR (Armstrong & McGhee, 2019), who identified frontline prison and health staff as crucial to managing suicide risk but highlighted that their own risk of stress and workload is rarely considered. The SCCJR also identified that interactions with staff must be meaningful in order to break down a culture of mistrust and miscommunication. They recommended that staff are empowered and supported in understanding mental health issues, and that increasing demands placed on them are addressed and minimised. This may help to increase the likelihood of staff supporting prisoners, and to provide critical turning points for those who are struggling. There may be a need to be some exploration of 'what's in it for me?' in order to improve staff prisoner outcomes.

- Impact of the job

Some participants were able to try to understand the impact of the job on staff behaviour;

> *"I suppose it's the job, they're stressed, the job brings a lot of stress, when you try to do good, and it gets throw back in your face I suppose you lose time for people…The attitude is always there, they have their bad days and their good days. If they have a bad day it can be disastrous. I understand they have a job to do, there's different levels, there's anti-system people, they hate the system, people have been in the system all their life, young offenders institutions, they're the ones who are anti prisoner, fuck off away from me, or I'll smash you up. That falls back on us, everyone gets the brunt end of it. It's a human trait, if I was there treating like shit you're not going to take it, you have an ego"* (Mark, July, 2023).

This suggests that relationships with other prisoners and staff play a role in contributing towards promoting self-harm and suicide. Participants reported that feeling listened to, cared about, not feeling judged and being supported in their rehabilitation are helpful responses. Some participants were able to reflect on how the challenges of the job impact on staff and suggested staff training should be provoded, particularly on understanding the function of self-harm and suicide.

Environmental

- Prison Culture

Prison culture was highlighted as a factor that makes them more likely to hurt themselves in prison;

> *"I dread that door opening, I'd rather it stay closed, It's tyring putting on another brave face. You don't show weakness… of course you do to people close…it's only*

half the landing you get on with, the rest you don't, you have to keep the façade up, it gets tiring, sometimes you feel physically and emotionally drained. It's peace behind the door. (Mark, July, 2023).

*"It's not one of the things you do in prison (talk about feelings), coming to prison is a tough hard pace, you have to be a tough hard man" (*Eoin, May, 2023).

"*Stigma in jail, what's he talking to an officer for. That's why you need to get them in reception, start working with him, someone to assess him"* (Patrick, May, 2023).

"I won't show it to anyone else. If you show it it's a sign of weakness….The only way you survive prison is not only you have to act hard you have to show you are" (Liam, Aug, 2023).

"It's exhausting to put on an act. The days you feel like shit and are tired and all, it's like ugh" (Mark, July, 2023).

"Prison is a horrible environment, in here you're either a sheep or a wolf. If you want to be a victim then you're a victim" (Patrick, May, 2023).

"I had two different lives, one with criminals and gangsters, and one with movie stars. It's exhausting to put on an act. The days you feel like shit and are tired and all, it's like ugh"; (John, May, 2023).

"(Q what did you need?) "Just even one person to talk to. Emotion, bull headed, stubborn, showing the face, hard to deal with all the bravado. It's in spades out there" (Eoin, May, 2023).

This suggests that participants believe that prison culture is a factor that make them more likely to hurt themselves, which includes not being able to show vulnerability in prison because it is a sign of weakness, and having to put up a façade in order to survive. This is consistent with Jewkes' (2005) reflections that prisons are hypermasculine environments where surviving prison is about having a tough front, which may have a negative effect on the level of care-receiving by prisoners, who may not be able to receive care out of fear for being seen as weak, making themselves vulnerable amongst peers in the social hierarchy, threatening their autonomy and identity.

- Large prisons

When asked about the factors in prison that make them more likely to hurt themselves, some participants mentioned that bigger prisons make them feel lost;

"Just feeling lost, alone, isolated; In a big prison, you get lost" (Eoin, May, 2023).

- Staff shortages

Reduced staffing levels was identified by participants as a factor in prison that makes them more likely to hurt themselves:

"There's not enough staff, there is no school. Sit here all day twiddling our thumbs" (Mark, May, 2023).

"In (a prison), no officer, so no school…I wouldn't have stopped self-harm in (a prison)" (Eoin, May, 2023).

Long waiting times was reported by participants as having a detrimental impact of on their use of self-harm and/or suicide:

"Psychology has gone off the map" (Patrick, May, 2023).

"Before I came up, I was starting to see psychology, it didn't come quick enough." (Eoin, May, 2023).

"Help, help help, I had to take a high court case about Psychology. I came back from hospital when this case was done (I had to get blades removed from me) 'OK you've got 1-1 psychology sessions, every Tuesday morning" (Colm, May, 2023).

This demonstrates the detrimental impact of reduced staffing (Prison officers and Psychologists) and overcrowding in prisons, It also highlights the subsequent difficulties supporting prisoner's access to regime activities (e.g. school and Psychology) in the context of staff shortages, which will be covered now in more detail.

- Lack of regime

A lack of regime and having nothing to do was cited by participants when asked what contributed towards their self-harm and suicide, or what factors make them more likely to hurt yourself.

"*Lack of regime…In the (closed) prison, I did do the engraving shop - it was something, sitting around, as they say 'idle hands - devils play thing'. Your head goes to darker places" (John, May, 2023).*

"You don't really get to do that (keep busy) here, you just get to push the thought to one side for a bit then it stays up. There's no structure or regime. Sit here all day twiddling our thumbs" (Mark, May, 2023).

"I used to go to work in the servery, keep busy, there's nothing to do here" (David, May, 2023).

Participants explained that their negative thoughts increase when they have nothing to do;

"If there's nothing else to do, there's stuff going around your head" (Colm, May, 2023).

"If you keep busy, you have less time to think about it. It's the time you have in the cell that's the problem." (Peter, May, 2023).

"The bad thing is you have too much time to think in prison" (Peter, May, 2023).

"You need structure in prison. Without structure you fall victim to gangs, and all sorts" (Patrick, May, 2023).

"There is nothing to do in that place (remand prison where self-harmed). You go out for 10 and you have nothing to do. You have a tiny gym. You don't leave the landing. No sports hall. No going over and learning maths or English. People can be on years for remand" (Darren, Aug, 2023).

This suggests that environmental conditions, such as prisoner culture, prison size, staffing shortages, overcrowding, and the level of structured regime play a contributory role in self-harm and suicide from the perspective of participants.

Procedural

- Special Observation Cell (SOC)

When discussing factors that make them more likely to hurt themselves, participants identified being placed in an Special Observation Cell (SOC);

"Throw me into a padded call and leave me in there for days and think that's helping me. I bring blades with me and have a shit on the floor, write my name on the wall with my shit, and the same thing on the other side with my blood. Then I sit down and starting cutting myself…That's just rubber walls. It's pretty claustrophobic. In a poncho you do be freezing. They should just leave me in my cell. It's horrible" (Liam, Aug, 2023).

"You cut yourself here, and they put you in a pad for 24/48 hrs, you have more time, you have no books, sitting in a poncho with no clothes on you, no blanket then you're thinking of how you got there. I think it's a load of bollock" (Peter, May, 2023).

> *"If it's done to you out of someone's concern, their concern will only last until the doctor comes in the next morning, and you still have to go back to the same environment you came out of the night before, you still have your television but that's still the same. The pad, it's basically a plaster. They use that to frighten someone"* (Peter, May, 2023).
>
> *"When they're in the pad instead of an officer saying here's a cup of tea, the door is banging, they're shouting 'shut up before we send a team in', they're sending in shields and battering the young fella and all he wants is someone to talk to, a cup of tea and a roll up. There's a television on, you can't turn it down or up, it's on or off, so youre getting no sleep. You're there with a scruffy poncho over you and that's not helping, that's amplifying the situation. All he has then is time to think and that's where the mind starts to run"* (Patrick, May, 2023).

This highlights that aggravating role of SOC use in managing risk of self-harm and suicide. However, participants spoke about the importance of having the option to request a transfer to an SOC in order to protect against causing harm to yourself.

> *"Sometimes it useful, don't get me wrong. I've felt like snapping, I have gone to an officer and said do me a favour, put me in a pad. It's grand to go in there, its grand to stops you self-harming in that moment. The pad for me is a safe place. They're going to look after me, I'd be happy, I'll sleep like a baby. It's me telling me I need to stop. It's me knowing myself, before doing something to myself. I didn't go to the pad in 6 months" (Peter, May, 2023).*

This is consistent with Mims (2021) that prisoners may assume that if they tell a staff member that they have suicidal ideation, they will immediately be placed in an SOC, separated from other prisoners and their belongings. This suggests that from the perspective of participants placing a prisoner in an SOC, whilst benefical to prevent immediate risk of harm to self, can intensify overthinking and anxiety, which may increase the risk of self-harm and suicide in the medium to long term. It also highlights the detrimental role of an SOC in aggravating mental health issues, such as rumination, isolation and hopelessness. This supports the Developmental Trauma Risk Model (Lanes 2009) that states that dangerous behaviour (e.g. suicide attempts, assaults) in prison can lead to environmental instability, by resulting in time in segregation, protective custody or facility transfer, which perpetuates the problem and induces distress.

- Non-trauma Informed practices

When talking about the factors that contribute towards their self harm and/or suicide, participants referred to some of the practices used by prison staff that were not trauma informed. The most cited non trauma informed practice was cell searches;

> "*Everything was took, other stuff was left on ground and stood on. I knew who it was. He laughed in my face the week after. I said 'you think you're funny don't you?' I didn't get my stuff back. I don't care about that, it's the fucking point do not touch my stuff. You can search me all you like, do what you want"* (Darren, Aug, 2023).

This suggests that from the perspective of participants, the use of an SOC and lack of trauma informed practice may be contributory factors in the use of self-harm and suicide. It was found that participants believed that prisons are not trauma informed, or using formulation based practices. They want staff to recognise that cell searches can trigger trauma memories and feel invasive, and to be respectful of property during cell searches. Participants reported that culture in Irish prisons does not support the underpinning values of the PTMF. Whilst there may have been a gradual shift in forensic settings towards towards trauma informed practices (Willmot & Jones, 2022), there is little clarity about what trauma informed practice means in prison.

This section has explored the contributory factors that lead to self-harm and suicide. This highlighted the challenges of adjustment to imprisonment can contribute towards self-harm and/or suicide, particularly for repeat sentences, and at difficult times such as Christmas or during Covid. Participants reported stress and anxiety in relation to continuity of medical care from community to prison, mental health issues (such as emotion regulation difficulties, Axis 1 disorders, psychosis) neurodiversity, loss of relationships through bereavement or loss, difficulties with adjustment to prison, relational issues with staff and prisoners. These all contributed to feelings of loneliness, isolation, hopelessness and despair. This also identified five key factors that underlie the level of risk posed by the environment included lack of structured activity, staffing shortages /overcrowding, large prisons, prison culture that does not support showing vulnerability, and lack of procedural justice. They also identified the use of an Special Observation Cell and lack of trauma informed practice. These findings are consistent with Rivlin, Fazel, Marzano and Hawton (2011) who found

that suicide attempts often followed adverse life events (especially broken relationships or bereavement), criminal justice/prison-related factors (e.g. concerns about sentencing) and psychiatric or psychological factors (e.g. drug/alcohol withdrawal, depression/anxiety and hearing voices). This supports their view that suicidal process in prisoners is a complex interplay of background factors, adverse life events, mental health and psychological problems and cognitive processes.

Finally, this Chapter will explore the link to violence from the perspective of prisoners in the next section.

Link to violence

A link between self-harm and violence was made by some participants in relation to it's function. However, many denied using violence or believed that it was not relevant to their self-harm and/or suicide, even though there was a high prevalance rate for violence in the sample. Table 34 provides an understanding of men's experience of using violence and self-harm.

Table 34

Participants understanding of the Link to Violence

Theme	Sub Theme	Code
Link to Violence	Externalisation	Inward directed harm To hurt others Highly controlled violence

Externalisation

Firstly, self-harm was reported as a means of externalising feelings onto others instead of using outward directed violence. For example;

> *"I came close to beating the system, I had the system on its knees. I stopped eating. Sending in six men teams with riot shields, I'd be in the cell looking forward to them coming in, to inflict as much pain as I could on them. It's 'if I'm hurting, you're hurting'. That's the way it was"* (Patrick, May, 2023).

Secondly, men spoke about using self-harm as an alternative to using violence for a variety of reasons (inward directed harm). Some men made a conscious decision to self-injure due to there being fewer consequences to self-injury than violence;

> *"I cut myself. It was an attempt to stop myself from hurting anyone else at the time. I was having an argument one night, and I cut my wrist, with my family, I*

don't talk to them anymore. Out in a field drinking, I picked up a knife as they kept at it, shouting at me, I told them I'll fucking cut you up. Instead of using the knife, I cut myself. I had had enough with the person I was around. I didn't touch him. I'd do it again under any circumstances if I had to. If someone was threatening my life. More of a family dispute kind of a thing" (Aaron, June, 2023).

Others described self-harm as an alternative way of getting rid of anger when it is not possible to use violence;

> *"When I get angry, someone sets me off, and cos I can't get to do anything outside the cell I have to take it out on myself. The anger has to be released. Most of the time it has to be released, and there has to be blood drawn from it. That's what I got so used to, I put all that into my head" (Jack, July, 2023)*

Some men described self-harm as a way of making the other person feel their pain through their actions (i.e. inward directed harm, which was outward directed). For example, inward directed harm to self can be used to hurt others, for example to make a partner in an intimate relationship pay for their behaviour, or indeed when they are angry with staff. For example, the previous quote cited by Mark (July, 2023) who described using self-harm to get revenge against his ex-girlfriend because he was suspicious that she was seeing someone else. It has been observed in clinical practice instances where people have used inward directed harm to cause outward directed harm, either when the person is unable to use violence to express their feelings because it is tightly controlled using risk management strategies, or due to their lack of physical access to the potential victim.

This suggests that from the perspective of participants, there may be a link between self-harm and violence. This may reflect externalisation of self-harm and suicide onto others, use of inward directed harm rather than outward directed harm, using self-harm to hurt others psychologically rather than physically, or using self-harm or suicide when options for violence may be limited. The research extends the relevance of the PTMF to self-harm, suicide, violence and as such offending behaviour. The link between violence, addiction and self-harming behaviours demonstrates that improving measures in prison would not only protect them from self-harming behaviour but would also protect the wider community, which is consistent with Liebling (1999).

Chapter Summary

This Chapter has explored the factors that put men in custody at risk of self-harm and suicide, and what factors contribute to self-harm and suicide. It also explored the link to violence. included substance use, stress and anxiety, arising in the context of recent committal to prison, mental health difficulties (e.g. emotion regulation difficulties & Axis 1 disorders), adjustment issues, neurodiversity, loss of relationships through bereavement or loss, and relational difficulties with staff and other prisoners. These all contributed to feelings of loneliness, isolation, hopelessness and despair. This also identified five key factors that underlie the level of risk posed by the environment included lack of structured activity, staffing shortages /overcrowding, large prisons, prison culture that does not support showing vulnerability, and lack of procedural justice. They also identified the use of an Special Observation Cell and lack of trauma informed practice.

The findings provide some initial support for the Power Threat Meaning Framework (Johnstone & Boyle, 2018a; 2019b). Participants shared that they had experienced the following challenges: 1) identities, (2) surviving rejection, entrapment, and invalidation, (3) surviving disrupted attachments and adversities as a child/young person, (4) surviving separation and identity confusion, (5) surviving defeat, entrapment, disconnection, and loss, (6) surviving social exclusion, shame, and coercive power, and (7) surviving single threats. The findings support the view that people with problems have experienced trauma in their lives and highlight the potential role of substance use, self-harm and suicide as a response to trauma. It identifies the potential external causes, and recognises the causal role of adversity in it's origins. It also highlights the high prevalence of people in prison with dual diagnosis and it's association with the incidence of injury (including self-harm).

The next Chapter will explore the barriers to support from the perspectives of men in custody.

Chapter 8: Barriers to Support

Introduction

This Chapter will explore participant's perspectives of the barriers to support in prison. Participants spoke about the many barriers that exist to seeking and receiving support in prison. Table 35 provides an understanding of men's experience of seeking support. It will explain the data, offer an analysis and synthesis of the data

within the contect of the academic literature and discuss the implications of these findings both in terms of the theoretical framework and in the wider context and implications for prison practice.

Table 35

Participants Understanding of the Barriers to Support

Barriers to Support	Lack of support	No support available Waiting list Unwilling to receive support
	Trust	Preference for friends/family Mistrust of others Mistrust of authority
	Emotions	Shame Worthless
	Prison response to self-harm	Consequences Aftermath
	Culture	Not showing vulnerability Self-doubt/comparison to others

Lack of support

- No support available

The lack of support or help available to people in prison was highlighted when asked about the things they find unhelpful or caused them difficulty in stopping them from self-harming;

> *"I know I need help, I've asked for help in every jail I've been in on commital. I am still getting nothing, this is the first chat I've had… know I need help, need help regular. I don't feel nice but it's the truth…It's very hard to get help in here. The only help you get is signing a cheque" (John, May, 2023).*
>
> *"No, it wasn't (cry for help). That was it. There was nobody to help me" (Aidan, May, 2023).*

This suggests that the perceived lack of help available was unhelpful or caused participants difficulty in stopping them from self-harming.

- Waiting list

One participant described the frustrations of waiting times to engage with services, for example, accessing drug treatment, methadone programmes, or psychology.

> *"They told me I was on the waiting list and couldn't give me anything until I'd seen psychology"* (Eoin, May, 2023).
>
> *"I've seen psychologist a few times, it took a long time"* (Mark, May, 2023)

Some men described having similar problems accessing help in the community;

"I was on heroin, there was a 6 month waiting list for the methadone programme, they're telling you 'you're on the waiting list"' (Dan, June, 2023).

- Unwilling to receive support

Partcipants reported a lack of readiness or ability to engage in support was a barrier to receiving support when they were engaging in self-harm and/or suicide. Some participants who had desisted from self-harm and suicide advised that they did not seek support when they were engaging in self-harm and suicide.

"I only linked in with psychology when I came to (a prison), they found it hard to keep track of me, I wouldn't want to see them the next week, then I'd get into a humour that you's are useless" (Mark, July, 2023)

"I didn't want to (go to Psychology). The only time I wanted to was when I was upset, when I was upset, there was nobody there" (Aidan, May, 2023).

"If I'd got the help back then that I needed I wouldn't be here. But back then I didn't ask for help because I didn't want it. I've done it all by myself" (Aidan, May, 2023).

Some participants who have desisted from self-harm were asked what helped them and would have stopped them from self-harming at the time and they responded':

"I can't really say much helped…Nothing". (Colm, May, 2023).

"No, if I didn't do it that day, I would have done it somewhere else, the following day, following week, the following month" (Peter, May, 2023).

These findings have identified possible barriers to seeking and receiving support. This includes support not being available and not being ready to seek support when they were engaging in self-harm and suicide. This was consistent with the level of engagement in this research. Those who are continuing to engage in or had recently engaged in self injury or suicidal processes consistently did not agree to participate in the research. They did not respond to the invitation to participate. By contrast, those who have desisted presented as eager to participate and very responded quickly. Those who have since desisted spoke of the lack of support at the time of their episode, and their lack of readiness to engage. They often talked about preferring to use substances to cope in the immediate aftermath, especially in the community, but regretting it later. Those who participated stated that they would not previously have participated in this research when they were actively engaging in self-harm. They spoke about their interest in getting the support now that they

did not receive before and they appeared to benefit from the support provided by the interview. This suggests that the timing of support is important and their readiness to accept help is a critical success factor in accessing support to desist. It is important to provide support at the right time and this appears to be at a time when they have made a commitment to change and are not in crisis.

Trust

- Preference for family/friends

Trust was a topic that was mentioned many times as a critical issue during interviews. Participants expressed a strong preference for family contact, rather than being offered the chance to talk to prison based staff. They reported a lack of trust in prison-based relationships;

> *"I don't feel a benefit from talking to a stranger. If I started getting an extra phone call from my family it would be better. You'd soak things in more easily from people you look up to. You trust your mother or father more than a stranger, that's not saying anything bad, it's just trust, my mother and father haven't steered me wrong before, they won't steer me wrong again, they know the situation too they know your background, what's going on* (Mark, May, 2023).
>
> *"I could ring the Samaritans every day for hours, and the ones who could help me most in a crisis are my family. They would talk me out of doing something, rather than someone who doesn't know me*" (Jason, June, 2023)

- Mistrust in others

Participants talked about their lack of trust in the psychologist, especially in the early stages of contact;

> *"I found it extremely difficult to open up to a stranger; even when I did, it didn't help at all"* (Mark, July, 2023),
>
> *"I went down once (to psychology). I just didn't click with the person. It didn't feel right, it was like she was standing there with a rope. I didn't tell anyone at that stage. So it was like she was trying to force it out of me, I was like 'I don't know you'. People at home, it was easier to get it out*" (Aidan, May, 2023).
>
> "*Psychology, yes, did chair work, we fell out, they wanted me to talk to someone"* (Peter, May, 2023).
>
> *"For the first 4 months (in psychology), I didn't talk, that went on for 6 months until I knew I could trust her. I only trust you because I see what these fellas are going through*" (Patrick, May, 2023).

- Mistrust of authority

Some men described some of the barriers to trust, including a mistrust of authority figures;

> "*You're programmed from a young age, 'the law is out to get you', 'they're always out to get you', 'don't say this to the psychologist, they'll report this to the prison'…Paranoid that it will be used against you, to punish you…You need to show them trust in order to gain trust, with the likes of self-harm they need intensive therapy*" (Patrick, May, 2023).

This highlights that trust is the most significant barrier to seeking and accessing support. These findings suggest that developing relationships based on trust are vehicles to seeking out and accepting support. This is consistent with Leibling (2004) who found that prisons are low-trust environments and that prisoners often have a deep-seated mistrust of authority figures (Crewe, 2011), even when prisoners develop some trust in officers. The findings indicate that trusted resources should be used and maximised to support prisoners (e.g. family, peer support). Any services engaging with prisoners should seek to find ways to avail of the trusted support in the community and the Irish Prison Service should seek to increase direct contact with their family. This might also include increased contact by the Irish Prison Service Psychology Service with members of their family to help garner motivation to change, or to help inform intervention. It should also consider enhancing use of peer to peer facilitators, which may increase trust. This indicates the need for a particular focus on the role of procedural justice in the day to day management of prisons. These findings also provide support for the potential of mentalisation-based therapy to reduce the risk of self-harm and suicidality among individuals who have experienced childhood experiences via increasing understanding of self and other mental states. These interventions would likely support greater acceptance of staff authority, less misconduct, better mental health, and improved recidivism outcomes.

Emotions

Participants described a range of emotions that demonstrated their feelings about their past experiences or behaviour.

- Shame

Men highlighted the level of shame they, or others, feel about their past, including their history of trauma, their offences, their self-harm/suicide and drug use.

When talking about his overdose, one man stated:

> *"I am now so embarrassed* (Patrick, May, 2023).
>
> *"I have compassion for others, not myself. I'm the worst of the worst in Irish law…What has happened to me doesn't excuse what I've done. Lots of fellas have been through what I have and they didn't end up in prison for murder"* (Peter, May, 2023).
>
> *"I was ashamed of my abuse when people found out, being the hard man, knocking on people's doors, I've dealt with it in my own head, I'm not ashamed, sort yourself out. I don't look at myself like that, I see myself as moving on. Now with dealing with it and having it all out there, I'm looking forward to seeing the future"* (David, May, 2023).
>
> *"I call this place a cess pit. I see people coming off the streets with a cannabis addiction, they can't get their cannabis so they take cocaine, they can't admit it to nurses"* (Mark, July, 2023).

- Worthlessness

Men described how they often become self destructive when they do well in life;

> *"Whatever I do in life, I always try to drop myself back down again. That's how I learnt to cope all my life….It has seen me being destructive in the past, but I always held back from the brink and it worked out better for me. The fact that I want I want to better myself, or the fact that this world owes me too much. I don't think it should be 'why me?'…I've tried to teach myself what kind of person I am. I know I'm a nice guy, I just can't believe it. When I believe it. I start to love myself to become it. When I get to there (high), I drop back down again"* (Peter, May, 2023).

They also reported that their low sense of self worth was a barrier to support seeking;

> *"I can't hold myself that high…I'll come to terms with that, what I think about myself, I had to bring myself down so I can jump up on the ladder. When I get out, I won't look back. When I'm in here, I need it to stop myself going back there"* (Peter, May, 2023).

This suggests that shame, worthlessness and embarrassment about their behavior are barriers to seeking support.

Prison response to self harm

Participants described the challenges they faced with the prison response to their self-harm and/or suicide.

- Consequences

Some participants spoke about their experiences of receiving a punitive response from prison staff when they self-harm or attempt suicide;

> *"Support, yeah….I swallowed blades in Mjoy, I got punishment, I got dropped from enhanced to basic because I hurt myself. 3 calls a week because I hurt myself, 3 calls a week, I hurt myself and you limit my support, conversations with my family. That's what happened to me. It says 'I don't give a fuck'. You be a problem, I'll give you a problem too. Self-harm is not seen as a medical problem, it's seen as a disciplinary problem. 3 months it took. From that day the incident happened, I got put down to basic for 3 months. That's what you're dealing with. What do you expect me to do? I'll find another way of coping, to help me get through"* (Colm, May, 2023).
>
> *"I was in (a closed prison), I was cutting myself, banging my head, they gave me a kicking, they were basically doing what I wanted to do to myself anyways "* (Colm, May, 2023).
>
> *"They see it as a behavioural issue, they don't see it as someone being ill or having a bad time. They see that as you causing them an issue with paperwork"* (Colm, May, 2023).

The response they received from staff was identified by participants as central to supporting prisoners. This often involves not being punitive towards those who have harmed themselves, showing more compassion, and improving the support to other prisoners in the aftermath of a suicide. This is consistent with (Marzano et al., 2012) who found that prisoners reported being negatively affected by hostile reactions to their self-harm. This is also consistent with Bennett and Dyson (2014) who identified knowledge; attitudes; emotion; staff skills; environment; and resisting treatment as barriers that prevent or interfere with the implementation of policies for reducing self-harm in adults in prisons.

- Aftermath

One man spoke about the need to improve measures that are put in place in the aftermath of an incident;

> *"I've seen my friends hang themselves covered in a sheet the next morning. It's wrong, someone needs to do something. They do like….Do you know what it's like*

to see your friend covered in a sheet, cutting himself, coming out of cell, his cell card has gone. Who do you talk to? You go get drugs to numb the pain" (Patrick, May, 2023).

This is also consistent with research highlighting the importance of preventing a so-called contagion effect (Konrad et al., 2007).

Culture

Prison culture is a barrier identified by participants to seeking and receiving support.

- Not showing vulnerability

Participants spoke some of the cultural barriers in a prison environment to seeking and receiving support. This includes a prison culture of not showing vulnerability, as discussed previously. The following quotes provide excerpts from the interviews with men about why you can't talk to others about feelings of vulnerability;

"I come from a rough estate, my family were bold, two uncles been in jail, I've seen it all, it's water off a ducks back, it's still traumatic. You wouldn't go crying to someone. Especially when you're going through emotions. I lost my grandmother, why are they coming after me?, am I giving them a bad vibe or something that's making them want to approach you, put it up to you. You're screaming out inside, fuck off away from me. You just want to go home to your child" (Mark, July, 2023).

"I won't show it to anyone else. If you show it it's a sign of weakness" (Liam, Aug, 2023).

Some men also described how it is not safe to talk to staff;

"There's stigma in jail, what's he talking to an officer for. That's why you need to get them in reception, start working with him, someone to assess him" (Patrick, May, 2023).

This suggests that prison culture (e.g. not showing vulnerability) is seen by participants as a factor which increases the barriers to support, and may prevent help seeking behaviour. Men cannot seek support because of the potential stigma, the fear of being seen by others as weak and the need for survival. This is consistent with a culture of a hierarchy of male power and dominance (Jewkes, 2002) and their use of masculine emotional coping styles (Jewkes, 2007), which is not conducive to care-receiving by prisoners.

- Self-doubt

Some men talked about how it affects your thinking when you see others putting on a brave face. One participant spoke about how you start to question yourself if you are not coping;

> *"It's not one of the things you do in prison (talk about feelings), coming to prison is a tough hard pace, you have to be a tough hard man. If you're not OK you think something is wrong with you because you're not fitting into the norm of everybody bravado, putting on a facade. It's a shock when you first come in, seeing everyone giving it loads, being the big men, then when they're behind the door they could be crying your heart out. Christmas is the hardest time of year"* (Eoin, May, 2023).

This perception of others is likely to make someone even less likely to seek support, and cause further distress.

These findings about the barriers to support suggest that response remains active in their current environment, and can be re-activated in the context of their current stressors, which may present barriers to support. This suggests that the PTMF should be expanded to include two additional core components: current stressors, and barriers to support. This suggests that the PTMF should contain seven core components, which can be translated into seven core questions: (1) power – what has happened to you? (2) threat – how did it affect you?, (3) meaning – what sense did you make of it?, and (4) threat response – what did you have to do to survive? (6) how does their current stressors and/or environment maintain or reactivate the threat response and (7) how does the threat response provide barriers to support? A Thematic Map of Prisoner's Qualitative Results based on the PTMF can be found in Appendix F (Figure 3).

Chapter Summary

This Chapter has explored participant's perspectives of the barriers to support in prison. It explained the data, offered an analysis and synthesis of the data within the contect of the academic literature and discussed the implications of these findings both in terms of the theoretical framework and in the wider context and implications for prison practice. The next Chapter will describe the factors and interventions that participants identified that may protect them against self-harm and suicide by men in custody.

Chapter 9: Protective factors and Interventions

This Chapter will describe the factors and interventions that participants identified that may protect them against self-harm and suicide. As stated previously, the majority of participants had desisted from hurting themselves. Participants described a number of factors that they believe protected them against self-harm and suicide, or factors that would have helped them to stop hurting themselves. Table 36 gives a breakdown of participants understanding of the protective factors against self-harm and suicide. It will explain the data, offer an analysis and synthesis of the data within the contect of the academic literature, and discuss the implications of these findings both in terms of the theoretical framework. At the end of this chapter, it will highlight the implications of this research in the wider context and implications for prison practice.

Table 36

Participants Understanding of the Protective Factors Against Self-Harm and Suicide in Prison

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Protective Factors	Addiction recovery	Abstinence from drugs and Opioid substitutes
	Family connection	Family matters
	Motivation	Personal Responsibility Willpower Agency Family To prove others wrong Seeing the Consequences Believing in myself
	Structured regime	Distraction Incentives
	Prison environment	More staff Staff training Specialist units Support for specific cohorts Increased family contact Peer to peer support Single cell Access to medical care TV Channels
	Strategies to Cope	Gym/music/school Finding ways to cope with emotions Hope Other strategies
	Help from others	Support Compassion Engaging with Psychology

Addiction Recovery

The single most protective factor against self-harm and suicide identified by participants was recovery from addiction.

Abstinence from drugs and Opioid substitutes

The majority of participants who have desisted spoke about having stopped using drugs and/or Opiod substitutes or alcohol.

> *"I done the hardest thing, I got off heroin, and methadone. Off now"* (John, May, 2023).
>
> *"I'm off (drugs) now"* (Eoin, May, 2023).
>
> *"I smoked hash for a very long time. I haven't touched anything for over a year. I can sit with the emotion now. It's much better to talk…Off drugs. Detoxed off methadone"* (Aidan, May, 2023).
>
> *"I stopped drink"* (Eoin, May, 2023)

When asked how he is managing feelings now, one man who is no longer self-harming stated;

> *"I'm not on drugs"* (Dan, June, 2023).
>
> *"I used drugs and drinks in past, now finally learnt to deal with things, accept things, I went onto better myself"* (Eoin, May, 2023).

Some men offered their strategies for not using drugs;

> *"I need to avoid certain people, hang out with friends who don't use. Certain people and places, apply what doing inside outside. Mates still, easier without. Only end up back here. I have not used in prison"* (Dan, June, 2023).
>
> *"I just try to stay away from it, if you stay around it, the want gets stronger. Try and focus a small few things. A bit of luck & I'll get out and, keep my head together* (John, May, 2023).

Some men described the benefits of stopping using drugs/substitutes;

> *"When I gave up the methadone they were all praising me, 'I've seen a change in you since you gave up the Phi'. They can see a change in me. I always worried after, now I start to worry before. Now I stop and think"* (Jack, July, 2023).

This suggests that the single most critical factor in desistance is recovery from substance use. Given the significance placed by participants on the role of substance

use in their self-harm and/or suicide, it is remarkable that there is a lack of research in the literature focusing on how to address substance use in the context of reducing self-harm and suicide. While emotional instability has been identified as a key focus for treatment, it also highlighted the importance of directly targeting substance use in the prevention of harm.

Family Connection

- Family Matters

Another significant protective factor identified by participants was the importance of family support, or friends. This appeared more significant than any other relationship in custody (for those who had family support, of course), including prison officers and psychologists. One man explained that he is not self-harming because he is back in a relationship with his ex-girlfriend. Most participants spoke about how support from a family member, partner and/or child could have helped to prevent an incident:

> *"The ones that could help me in crisis the most are my family, they would talk me out of doing something rather than someone that doesn't know me….I had to deal with Covid in prison, one phone call per day. I couldn't deal with it. I could ring the Samaritans every day for hours, and the ones who could help me most in a crisis are my family. They would talk me out of doing something, rather than someone who doesn't know me. We had no visits at all, we only had video calls. It was worse cos you could see everything you left behind, it was torture"* (Jason, June, 2023).

When participants who are now desisting from suicide and self-harm were asked about what has changed, some spoke about how family and friends have played a protective role;

> *"I talk to my ma. My brothers keep me grounded. Family";*
>
> *"Good support from family, I've got good friends"* (Patrick, May, 2023).
>
> *"The only good thing here is you have a phone in your cell, you can get 2 calls a day, I can make calls in my cell when im shut up from 7 o'clock at night. Even if I wake up having a bad night I can make calls, I have access throughout the night. Being able to buy your own credit would make it better"* (Colm, May, 2023).
>
> *"I think the family, if you have that support at home, I think that's vital. Otherwise, if I had been left to rot in hell, it would have destroyed everyone.*

Because I had a team at home, you want to do them proud and repay them for sticking by you, it keeps you ticking away" (Mark, May, 2023).

This research identified the importance of family contact in promoting rehabilitation and ensuring prisoner safety. Most participants identified that it would be helpful to their desistance from self-harm and/or suicide to have more contact with family, including extra visits or additional phone calls. This suggests that role of family support is viewed by participants as critical to desistance. This is consistent with the findings about the need to strengthen family relationships identified by the Scottish Centre for Crime & Justice Research (SCCJR, Armstrong & McGhee, 2019) the Harris Review report (Harris, 2015) and Lord Famer (2017, 2019) who found that families are not sufficiently involved or considered in the processes. This is consistent with Lord Farmer (2017) who stated that 'family should be seen as resource that newly empowered governors can, and must, deploy in the interest not just of reducing reoffending rates, but also of creating a more settled regime'. This supports recommendations made by Lord Famer (2017, 2019), which would support family contact from the earliest point of coming into custody in order to lay a good foundation to help them cope with the difficult adjustment to the prison regime and settle into their sentence, help reduce their vulnerabilities which can be fatal, and provide hope and a sense of the outside world in order to protect prisoners' mental wellbeing.

Motivation

- Personal Responsibility

Taking personal responsibility was identified by participants as part of the change process for desistance from self-harm and suicide;

"In a single cell, every gets their raw days, their depressed days, I'm still sitting in the cell it still hits you, depressed. You have no choice but to get on with it, think of your family…You're asking for help and nobody is giving it. I'm putting that on them, how the hell is that an excuse for me to run off and take drugs. I had done everything I could. Get your head down, you've got two years just get on with it" (Darren, Aug, 2023).

"Stubborn love. He (my brother) had to wash his hands of me. Got to own up to yourself. I'm 30 years of age, spent my 30th in prison. I want to life live, I need to sort out issues in my head" (John, May, 2023).

"I'm just here to keep the right mind-set. Stop hanging around with the people. If you're around drugs all day, you'll take it" (John, May, 2023).

"I was thinking I want to get out of here, and see what it's like to live outside. If I don't, I'll do something to come back in, I'll open the gate myself". (Jack, July, 2023).

- Willpower

Some men made clear statements that demonstrated their commitment to changing their self-harming behaviours:

"*It's not going to happen to me. I am that determined. I ain't going to be found dead in a prison cell*" (Peter, May, 2023).

"*I'm definitely not thinking I'll hurt myself again*" (Colm, May, 2023).

"I will never try and hurt myself again" (Jason, June, 2023).

This also applied to their substance use.

"I was lucky now anyway because I have overcome my challenges. I've a lot of tools when I get out, I know the path I am going to take. (Q How did you stop taking drugs?) I don't see a point in it, sick of it, it's stupid. I see people on drugs now and I don't want to behave like them (Dan, June, 2023).

"You have to be strong. It's like a movie, the strong survive…I was often talking to my father. My father said you have to be strong. You have to be strong. You have to be strong and all this shit. I don't think it's a catch. You just have to be strong in life as things happen….I am older now and a little bit more ready for the world…I've done my time well. Being in the right headspace most of the time. Not to say some days weren't worse than others….Life is what life is…No incidents. I'm mentally more stronger in myself in the prison, and the people around me have been very strong" (Aaron, June, 2023).

"There was power in my brain to stop me. A lot of willpower involved, I had to think of repercussions, I think it is selfish…you leave people behind you" (Darren, Aug, 2023).

- Agency

Participants spoke about the need to become the *agent* of your change, and take control of your life in order to desist from self-harm and/or suicide (and substance use);

"If I did it for someone else, or thought someone else wanted me to do it, I wouldn't do it. I gotta do it for me. If you are going to change you've got to change for you. Everything I've done is for me" (Peter, May, 2023).

"I make these choices very easily. I had plans, 3 months where I was talking about going on hunger strike. One day I woke up and said what are you up to, let's just get on with it, I am only getting myself into a state" (David, May, 2023).

"I had to stop this, I'm not doing this" (Darren, Aug, 2023).

"The major things I have overcame in here I've done myself. Even coming off methadone they wouldn't drop me down. I've done it all on my own" (John, May, 2023).

"I worked so hard to better myself" (Mark, July, 2023).

"I like the song 'Something inside you so strong''. No matter how much they keep me down I'll get….Up until 12 months ago, I took my life into my own hands. I said fuck the world it owes me too much. I never felt worthy" (Peter, May, 2023).

"Some people know when to stop, some people don't. I count myself lucky I had that moment, where I told myself I wanted to stop, some people don't want to stop the circus, I was just lucky I had that moment" (Mark, July 2023).

Many participants talked about being on their own in this world and making changes on their own to desist from self-harm and/or suicide (and substance use):

"I have no outside help. I'm on my own.. I've done it all on my own. I'm just here to keep the right mind-set. Stop hanging around with the people. If you're around drugs all day, you'll take it" (John, May, 2023).

"I've done it all by myself (Aidan, May, 2023).

"If I see something I don't want to do, I tend to put my head down and get around it. If it keeps following you, like anyone, I can keep going back to it, and I'm used to being around what I'm used to being around" (Aaron, June, 2023).

"A few of them (staff) have helped me, been around. I find it easier to control myself and stuff like that. I found my way, figured it out, what the story is. I get by day to day" (Aaron, June, 2023).

One man who came off methadone by himself stated:

"I was sick of it. I really wanted to get off all addictions/substitutes six weeks before getting out, to really overcome that addict mind of thinking" (John, May, 2023).

This demonstrates the participants emphasis on individual motivation, including personal responsibility, willpower and consequences, and agency, which appear to be critical for the change process. This reminded me of the words of singer-songwriter Robbie Willliams (2023):

> *"If you don't start the process, the process seldom finds you".*

These findings found that the bottom line to desistance was recovery from substance use, which is supported by increasing hope for the future (e.g. having something to live for), and promoting a sense of personal responsibility and agency. This suggests that having hope for the future, agency, and personal responsibility may be a protective factor in their desistance from self-harm and/or suicide. This was particularly the case when timely access to services was not forthcoming. This is also consistent with Howard & Pope's (2019) critical features to desistance, which included feeling important, encouraging hope for the future and promoting change, trusting relationships with genuine care, understanding the motivation for self-harm, developing strategies to cope and critical turning points for change, such as persons, situations or units that enable people to feel safe, believed in and supported. Participants spoke of the benefits of 'digging deep' to take control of their own lives and finding determination. This is consistent with Copeland's (2024) five essentials of recovery, particularly personal responsibility.

- Family

Family, or children were identified as a significant motivation to changing their substance use, and therefore self-harming behaviours;

> *"Whatever I do have left, I'm not going back to drugs again, I want to get back in my brother's life. Stubborn love. He had to wash his hands of me"* (John, May, 2023).
>
> *"I need to start reconnecting with my daughter. She's 12 now, 3.5 when I started taking cocaine"* (Aidan, May, 2023).
>
> *"The thoughts of coming out of jail I've to get my son back, I knew, I told myself I have to get myself a place. How am I going to raise my son, guide my son through this if I can't deal with myself. What's the point of me back into this life if I don't bring in any quality? If I can't guide him, or help him that's like, a lot of things that played a factor"* (Mark, July, 2023).
>
> *"I ring my sister and brother most days. I've made a few promises about changing"* (David, May, 2023).

"I need to start reconnecting with my daughter. She is 12 now, she was 3.5 when was taking cocaine. It was completely all my fault. It wasn't my choice but it was the right choice. I couldn't look after myself, let al.,one a child" (Aidan, May, 2023).

"The thoughts of coming out of jail I've to get my son back, I knew, I told myself I have to get myself a place. How am I going to raise my son, guide my son through this if I can't deal with myself. What's the point of me back into this life if I don't bring in any quality? If I can't guide him, or help him that's like, a lot of things that played a factor" (Mark, July, 2023).

One man spoke about the not wanting to let his parents down after they have supported him during his sentence;

"I think it was down to my mother and father being so supportive that I didn't want to let them down, I didn't want to throw it back in their face, if I threw it back in their face I'd be some bollocks. I was some proper boy, my friends ditched me, I used to have 15 young fellas around me, smoking weed every day. I came to jail and the only people that was there for me was my parents. Do your mates put money into your account? You have no friends, it's only the years go by, I'm telling you from my experience" (Mark, May, 2023).

One man spoke about how enjoying spending time with his brothers who are doing well in school helped him to desist from self-harm;

"I didn't think I deserved to be happy. They made me long for that life even more. Now when I ring home, they talk to me about their homework. Now when I get out, want to settle in a house in Wexford, explain to them where I went wrong. They visit me, ask me 'Will you be home for this birthday, my debs? Half the times I don't want to be on this planet anymore. I've been in that cell at night thinking 'Will I just end it?', then I think of my family and that sees me through. The only worry about me committing suicide is my two brothers, do they idolise me & start going down that road" (Patrick, May, 2023)

- To prove others wrong

Motivation to change their behaviour was driven for some participants by the need to prove other people wrong;

"I want to get out and prove a lot of people wrong, and help addicts. If they saw me now. I'll be proving a lot of people wrong. I don't know how I did it. If I didn't come in on this sentence, I'd be dead" (John, May, 2023).

"I'm going to be alone getting out of here, I'd better get a grip, better myself, want to get out of here, be a better person, say fuck you, I'm not going to get out of here riddled with a drug addiction and skin and bone, I'm going to kill her (his ex-girlfriend) with kindness, make her regret it" (Mark, July. 2023).

Some described being back in people's lives being a driver for change:

"Whatever I do have left, I'm not going back to drugs again, I want to get back in my brother's life" (John, May, 2023).

One man described how he is motivated by his father who committed suicide after he was convicted;

"I am not doing it for him, I am doing it because of him, because my actions made him take his life, I will make sure everything I do will make him proud" (Peter, May, 2023).

- Seeing the consequences

Some of the men described how seeing the impact on others of their behaviour made them desist. Participants talked about how they made a decision to stop using self-harm because they saw the shock reaction from the officer;

"If you can tell yourself you're not going to do jail, if you tell yourself you want to climb Mount Everest, you have to be able to tell yourself self-harm isn't for you no more. I told myself two years ago never again, that I wasn't going to harm myself again and I haven't, I haven't done it since. I told myself 2 years ago, never again, I was never going to do it again because that day when I walked out of the cell, I seen the shock on that officers face. It was the shock on that officer's face, the fright he got. Do you know what, I felt sorry for him. This is a very hard officer, used to locking 40 or 50 up inside of his cell, and there no way (inaudible) at the sight of blood. It could have been the fact that I cut myself up on his watch, that he knew he had to write out 20 forms for me doing it, it could have been that, but I seen the shock on his face when the door opened with the medic, he said I didn't know he was going to do that, I didn't know he was going to do that, I said nobody knew I was going to do it. It was me feeling sorry for him….I keep telling myself I'm not going to put anyone in the position that I put that officer in that

day. He got the fright for his life, seeing someone self-harming. It's me trying to be a better person, but a better person to them as well" (Peter, May, 2023).

"Even the thoughts of going over to your mother with a big scar on your face, that would cause sleepless nights and stress. My mother had cancer, she beat breast cancer…All the stuff I got away with, I wouldn't be doing it again, I wouldn't be able to handle a longer sentence" (Mark, July, 2023).

"A fella said to me 'Jesus you look like Rambo, all the scars on you'. I'd never thought about it, and never cared. Around then I started caring, if a 40 year old thinks that, how is a child going to feel when I go swimming, go out walking" (Peter, May, 2023).

"On arms on the side, I go to the yard and get a tan, they're all snow white. My shoulders, my chest. You can see all my scars., you can see all the scratch marks I have to get out of jail, I like wearing vest tops, t shirts, I have to do that around other people. I ain't putting any more marks on my body that I doesn't need to be there, this is me actually thinking of myself for once, if I want to go down that road, there's tattoos for that" (Peter, May, 2023).

"There are times when I have thought about it, and thought it's not worth it. It's not worth the pain, the blood, the cleaning up" (Eoin, May, 2023).

"Different agendas…priorities" (Mark, May, 2023).

"Lockdown helped me. 2 week period in cell, drinking nearly every day, got to point where I was blacking out, I needed to get a handle on it, I got caught for the final time, threatening with being sent back to Midlands. There was talk of moving me somewhere more secure. CMH, god knows what happens when you go there" (Eoin, May, 2023).

One man described using strategies such as looking at himself in the mirror or doing push ups as a disinsentive to hurt himself;

"I'd often be sitting in the cell, and I'd look, and you call it the urge, I get up and look in the mirror and say look don't be that stupid again, by the time I sit back down, I've forgotten about it again, it works for me don't be that stupid again, sit back down, make a roll up, do 100 push ups and its gone. Even when I get in bad form, yesterday my visit was stopped, I banged out my door at 11o clock, I do 1000 push ups, and I kept going until 5 o clock, had a shower and a cup of tea, then it stopped. 10 year ago, I would have went out and broke up the wing battered bins, smashed a window" (Peter, May, 2023).

Similarly, participants reflected on the consequences of using violence:

> *"Now I think of consequences, walk away, think, if they were wrong, say if you were in wrong. Ask myself if I was in wrong, think about how argument started, apologise if needed (Dan, June, 2023).*

- Believing in myself

One man described how believing in himself is a driving force in change;

> *"I'm thinking of me now, the world owes me too much, I deserve to go out and make a life for myself, I didn't always believe that, but I believe it, I still doubt it, but I believe it, that's my motivation"* (Peter, May, 2023).

Structured regime

- Distraction

The importance of having a structured regime was a critical factor identified by participants in order to support their desistance from self-harm and suicide. They clearly associated a reduction in incidents when they are busy or have a structured regime;

> *"Keeping busy, having structure, it keeps your mind away what you're thinking, if you have a negative thought about hurting yourself, distracting yourself. You get into that structure of a regime, keep yourself busy, that's stops any boredom"* (Colm, May, 2023).
>
> *"Here you're stuck to a stricter regime, all year, it's great, you get up at 9am, go to workshops, 2pm you're back at work until 4. You don't have time, you're kept busy"; "School really helped me in this place. If I didn't have the school I wouldn't be here, I swear I wouldn't be sitting here. Even psychology done a lot. I had no school in Cloverhill and that's when I got P19's. Psychology was who I was dealing with. When I came here, I knew there was school, lovely, I was up there every day I was busy, the weekends drag"* (Darren, Aug, 2023).
>
> *"They have engineering up here. I was doing something I liked, I had a chance to get a single cell and a job, I said it myself I can sit here in this two man cell and act the bollocks, stop school, nights, or keep the head down"* (Darren, Aug, 2023).
>
> *"I have a lot more structure here. I do more. It helps me more than, do you know what I mean. The school, as well"* (Colm, May, 2023).
>
> *"There's not much to focus on in here, you feel a lot better for going to the gym for an hour"* (John, May, 2023).

"People need to get into school, into psychology whatever, something to get them off the landing even for 20 mins a day" (Darren, Aug, 2023).

"Go to work in the servery, keep busy….I am making a little plaque for my mum's grave" (John, May, 2023).

"Regime. Structure, keeping busy - workshops or school" (Eoin, May, 2023).

The importance of being engaged in a structured regime was highlighted by this research. Consistent with the SCCJR (2019), the findings acknowledge the negative impact of periods of isolation in cell and recommend maximising time out of cell and availability of stimulating activities and meaningful social relationships to support and allow social development. This is consistent with the International Guiding Statement on Alternatives to Solitary Confinement (Physicians for Human Rights & Antigone, 2023) emphasis on activities/maximising time out of cell. This concurs with the researcher's clinical experience of working in prisons. Major disturbances like a riot typically happen on the wing or in the exercise yard, which tells its own story.

- Incentives

One man spoke about how an officer got him onto the enhanced landing and he got a job six months later;

"I had no choice, I had to stop the acting the bollocks, and stop the fighting" (Darren, Aug, 2023)

"Turn the wing out, get them off drugs, If you do this, this this and this…we will get you time out for a communion" (Patrick, May, 2023).

Prison environment

- More staff

Men often spoke about the need for more staff to protect against suicide and/or self harm;

"More team…dedication…increasing numbers of staff. More nurses, doctors, access to psychology, therapy. Being isolated leads to me cutting myself" (Eoin, May, 2023).

- Staff Training

Men in this research explained that in order to support desistance, staff training is needed to help prison officers to understand their behaviour;

"You need someone who knows about PTSD, that's what they're going through, you need to school the officers as well to recognise the signs, when a young fella is quiet he's too quiet, watching everything, that's when he's most dangerous, that's when the gangs say use him" (Patrick, May, 2023).

"Officers should be regularly trained. A safer custody unit with regular training to help them assess a situation, for example, highlight when someone is being genuine or is attention seeking trying to get something" (Colm, May, 2023).

"All their argument is we need more staff, what's the point of bringing in new staff that don't know anything, they need to be educated about the warning signs for suicide. It's not helping what they're doing, it's not. They need to sit back and think about the behaviours….at least stop and ask a fella, how are you doing, do you need to talk to someone?" (Patrick, May, 2023).

- Specialist Units

Men in this research spoke about the importance of specialist units and how the calm, relaxed atmosphere helped;

"I was in the (specialist unit), I went to address my drug addiction, there's a skinny landing with 8 cells, tele and kitchen, with a little hub, officers come out at 9.30am to open up and sit in their hub all day, they don't bother us, we don't bother them. Everyone just gets along great. We bang our own doors out, the officers leave in great form, if you bought that environment to the main jail, everyone would like that more. The environment is better, the officers enjoy it, we are not acting the bollocks, getting an earful, they don't have to be on their toes making sure we don't escape, it's so much easier, everyone just gets on great, it's 'how are you today?' Some of the officers are great, banter and humour, we used to have the chats, he helped me, not stuck behind the door all day, he took small steps, on hot days he would bring back an ice cream, keeps the morale up, it goes along way. Every time he came on as class officer, I wouldn't bother him, even if I wanted to fight, I'd move onto the others. He scratch my back, I'll scratch his" (Mark, July, 2023).

Some men spoke about the need to make it easier to access the High Support Unit (HSU);

"I had to beg for 5 years to go to the (specialist unit), I begged and begged and begged, because the ACO had an argument with the main ACO who wouldn't take me. I had to chase them around the cell, I got caught with a blade, I refused

to move, and refused to go anywhere else. 'Why are you not there already'? 'They won't take me'" (Mark, July, 2023).

These findings suggest that participants welcomed better access to specialist units, especially for young people. This is consistent with the Harris Review (2015) who recommended that all young people should be accommodated in small units that have the specialist staff and 'regime' to meet their needs and that, when their maturity or vulnerability mean it is in their best interests, they should have the facilities to accommodate them in specialist prison wings or blocks.

- Support for specific cohorts:

Participants identified the need for support for specific cohorts, such as young people and people on remand, in order to prevent self-harm and/or suicide:

"I was on remand until 2022, my opportunities were limited, I just kept getting told I had to wait until I was sentenced, I got nothing. By the time I was sentenced, I was after falling off that track, it was too late, I was back on basic or standard, I was full of anger, saying I'm after doing this already and I've got nothing for it, so why, I might as well, I started swaying towards 'right I'll be a bastard, I may as well try out a few quid in my pocket if I'm not going to get anything here to help my situation' (Mark, May, 2023).

"Listen, you's need, the Irish Prison Service, Psychology need to start helping these young fellas. What should happen is that when that prisoner is in reception, he should be bought straight to see a psychologist, and an officer who will just sit and listen and not judge 'he's one of them'….Please please please help these young fellas" (Patrick, May, 2023).

"There should be different categories of prisoners, young fellas should be separated. Because they already have a cannabis addiction, you're vulnerable, it's so easy to try it, and then you're on that gravy train" (Mark, May, 2023).

The need to provide specialist support for young prisoners and remand prisoners was highlighted by the men in this study. This is consistent with McTernan et al., (2023) who found the highest rates of self-harm in young prisoners and among those on remand and identified a need to ensure access to timely and appropriate mental health services, including both appropriate referral and provision of evidence-based mental health interventions to address the needs of these cohorts.

- Increased family contact

Many men spoke of their desire to have more family contact. They made suggestions about how the prison could support this;

> *"Being able to buy your own credit would make it better"* (Colm, May, 2023).
>
> *"Every prisoner should have voicemail, where a family member can say give us a ring today, cos otherwise they've no way of contacting. My mother and father are doing the jail with me….More contact with family, extra visits or something like that. I think the family, if you have that support at home, I think that's vital. Otherwise, if I had been left to rot in hell, it would have destroyed everyone. Because I had a team at home, you want to do them proud and repay them for sticking by them, it keeps you ticking away. I found it extremely difficult to open up to a stranger, even when I did, it didn't help at all"* (Mark, May, 2023).
>
> *"More family support. Phone in: It didn't work, other peoples calls going through to the wrong cell. Email photographs in, that would make a difference. You could send it through the censors. It makes a lot of sense"* (Colm, May, 202).

- Peer to peer support

Men in this research spoke about the value of helping others in their recovery from self-harm and suicide.

> *"I like to help people. My way of coping and to deal with my issues is to help people"* (Colm, May, 2023).
>
> *"I was asking for a listener's course. Addiction…self-harm…I tried to hang myself a couple of times….what more do you do need? I can listen to someone. Just someone to listen to. I asked to be put down for listener"* (Aidan, May, 2023).

This highlights the critical value of helping others in their desistance from self-harm and suicide. Participants also described how helping others is a protective factor in their own desistance. The findings suggest there is potential value in promoting peer to peer activities. This is consistent with Hazlett et al., (2022) on the effectiveness of peer support schemes in the prevention of suicide and self-harm in prisons. The use of peer to peer interventions is growing in Irish Prisons (e.g. Listener Scheme, Red Cross) and was viewed as a potential aid in their own journey of desistance. These findings have implications for the use of peer to peer initiatives in the prevention of self-harm and suicide in male prisoners.

- More TV Channels

"More TV channels….They should give us a wireless station. All repeats, same shitty films from 20 years ago. All we have to look forward to is EastEnders…Little things that would change the whole way of thinking. We got a menu change. We got kebab last night. Doors should be left open. Replace broken cues for snooker table…Everyone loves the wreck. They won't allow us to have wreck" (Liam, Aug, 2023).

- Single cells

One participant spoke about benefits of having a single cell.

"I haven't hurt myself since I came here, I can't say I haven't had thoughts. The shower helps, for as long as I like. I'm on my own in the cell. One of two officers didn't like that. No, don't prefer double cell. My anxiety goes through the roof. Outside, my room I lock my door at night-time. Even if my door was unlocked, it would upset my sleep, goes back to trauma as a child. So I don't put myself in that situation" (Colm, May, 2023).

- Access to medical care

Another participant spoke about the benefits of consistent access to medical care.

"Up here (Arbour Hill), it's different, you get the medics straight away, go 3 times a week. In the Midlands I'd still be hurting myself. This place has changed me" (John, May, 2023).

Strategies to cope

The majority of participants in this research had desisted from using self-harm and suicide. A number of effective strategies were identified by participants who have desisted from hurting themselves. The primary strategy is mentioned above (recovery from substance use), and others are described here.

- Gym/music/school

Participants identified engagement in structured activity, such as school, the gym, and music, as a critical strategy for desistance. They spoke about how such activities have helped them not to self-harm or to act on suicidal thoughts;

"Playing Xbox, listening to music that's what I do, it works for me" (Liam, Aug, 2023).

"I listen to music. School and music helps me…School. Got me a course. If you ask someone, they will do it for you. I picked up banjo"" (Darren, Aug, 2023).

"I play music. Since I got into music, I haven't self-harmed once, I used the tin whistle. It's the pain and adrenaline you get off it, it gives me a different perspective on what I should be thinking about. If I'm focusing on pain I'm not focusing on what I was thinking about beforehand…Computer game, poetry or music, whatever" (Peter, May, 2023).

"At Christmas I turned to music, it helps me. It's concentrating on the one thing. It's a distraction, it helps, anyone who is depressed" (Darren, Aug, 2023).

"Music saved me. I could focus on learning a song rather than self-harm. The thoughts I had when I wanted to self-harm…. Like I was in the cell and I had a handful of drugs in my hand, it was a night when I was not going to wake up tomorrow, and I picked up my guitar and ended up learning a new song. That saved me. Now I get that relief from training" (Peter, May, 2023).

"I find the gym a great coping mechanism, I suffer from a bit of anxiety, sometimes I feel the walls pulsing, a couple of things don't feel real, I'd be going in and out of a trance. Gym/ Music is my therapy. The gym is the only place you can get forget everything, you're just thinking of what you're doing next, you're not thinking what happened last night, or what happened last year. My biggest problem is I'm a deep thinker" (Mark, July, 2023).

"I am just keeping busy, doing my own poetry, playing games, workshops, school. Keeping busy, even in cell not sitting doing nothing…distraction" (Eoin, May, 2023).

These findings highlight the importance of engaging in structured regime as a strategy to cope, including access to education, gym and psychological therapy. They also spoke about strategies that they had developed such as abstinence from substances, using the gym/music and attending school, helping others, and talking to others/support. These findings were consistent with the important role of 'Time out of cell' (TOOC) and 'Time in purposeful activity' (TIPA) (Leaman, O'Moore, Tran & Plugge, 2021) on mental health. It highlights the particular importance of engaging in meaningful and intentional activities. This is consistent with findings by Howlard & Pope (2019) that developing strategies to cope were critical to their desistance.

- Finding ways to cope with emotions

Many of the men interviewed who have desisted talked about how they now cope better with emotions;

"Talk to someone, have a conversation with myself. Talk my way around it" (Aaron, June, 2023).

"Someone to talk to and thrash it out. What I've took from all I've learnt, if you don't thrash it out, and you let it, things turn nasty for me. That was the first time I asked for help. I was told that if you need help, don't be afraid to ask for help. I came out laughing, I am getting nowhere. I had done everything I could" (David, May, 2023).

"I stopped drink, learned to deal with my emotions, and then went on a course, learnt a few skills" (Eoin, May, 2023).

"I've been talking so I don't have that build up" (Aidan, May, 2023).

"Only on this sentence I've learnt to deal with my emotions. I just had to sit myself down, after plenty of times in the block, bottling things up and losing the head, I had to sit myself down. You tell yourself to do something and you still make that same mistake. I just had to cop myself on, I think maturity plays a part. I learnt to open up to people in fond of. I've a girl who I knew the last 2 year, we were never been in a relationship, we were close, she was a stranger at the start, she ended up being someone who I opened up to" (Mark, July, 2023).

"What's changed is now I know how to deal with things better. I will never try and hurt myself again. I was listening to men. I had a lot going on, it was hurting me that I didn't know what was going on outside" (Jason, June, 2023).

"The place I'm in now is good in my own head" (David, May, 2023).

- Hope

The importance of hope was identified as critical in their desistance from self-harm and suicide. When asked what has stopped you from self-harming, participants stated;

"Something to live for" (David, May, 2023).

"Starting to speak to nieces and nephews, they are getting older, saying they are looking forward to go out and get something to eat. Back then I couldn't be around them. They're adults now, they're not babies anymore" (David, May, 2023).

- Other strategies

Some men talked about other strategies, for example removing all access to means, or going outside to stop them self-harming or acting on suicidal thoughts:

"I took all blades and put them down toilet. I'm a danger to myself when there's a blade in my cell. I found 6 of them hidden behind poster. Now I have a packet of biscuits instead" (Liam, Aug, 2023).

"Having a history of depression, there were days when I didn't want to leave cell. Even in evenings. Just do it. What's the worst that can happen, you get fresh air" (Eoin, May, 2023).

One man recognises that his thinking is problematic;

"I need to relax a bit more. Think I'm being made a fool of. Too much time to think" (Peter, May, 2023).

This suggests that participants who have desisted have used various strategies to cope such as talking, and finding new ways to manage emotions.

Help from others

Participants described a variety of sources of support that helped with their desistance.

- Support

Participants in this research spoke about the positive support they received from prison staff;

*"Medical staff in (small closed prison) were very good. The ACO was brilliant. They know how to deal with me alright. Theres some banter with officers, I have the crack with them. I've no problem with officers…If you ask for something, you either get yes or no, you don't get pawned off…I went to the chief when all this was going on with the complaint and told them I couldn't put up with it anymore, my head wasn't right. Went to doctor, same thing and they kind of passed it off. I knew I was getting bad, that was about two weeks before it. One of officers knew there was something up, they knew me so well up there, they noticed something wasn't right, and came into cell to me and seen all the wrapping of the papers. I didn't expect anything" (*David, May, 2023).

"There was one officer, he came in, he said 'Look, give me the plastic knife', I said 'as soon as you step foot inside here I'll cut your throat', he knew me a while, he said 'Listen, I'm not here to hurt you, I'm here to help you. Please give me the blade, I'll make you a cup of tea, me and you will go outside and chat'. But I said to him 'half the time that's only an act you get you outside and put you in a figure

of 8'. I said 'go on outside, I have another one these cheeked, so if you bring me outside yous try do this then I'm going for an officer'. But he didn't He bought me in, sat down, talked to me, gave me a roll up, 'Sorry to hear about your ma, the chaplain told us, you shouldn't be here, I'll try and get you back down this evening'. Stuff like that, it's the little thing that means so much, to that person who that lost. Mr X on (a landing), he's been here since I was 17. He knows me, he knows I'm not one for kicking doors or anything, they can put me in a pad, sit there with my own thoughts, he will come down are you alright, give me a cigarette, throw an arm around you, how's your ma. He came in with a cup of tea and roll up, he said 'listen you've to be strong, for your ma, it's not helping, you've to be strong'" (Patrick, May, 2023).

"I've had officers come to me who say I lost a friend to suicide, they have an understanding, they have more emphasis towards the situation" (Colm, May, 2023).

Participants described the critical role of staff in providing care and rehabilitation. The message from participants was simple and was summed up nicely:

"*Don't underestimate the small stuff'* (Jamie, May, 2023).

"It's the little thing that means so much, to that person who is that lost" (Patrick, May, 2023).

A critical moment that helped them to change was often described when talking about their desistance from self-harm and/or suicide.

"They do be begging me, ah (name) don't be doing that to yourself. They do mind me, they are very good to me. There's a few I did have run ins with, but in last few weeks they're actually being nice to me. It does count. They have the hardest job in here" (Liam, Aug, 2023).

"Officers on the medical staff were very concerned. They would turn around and say "OK, how are you keeping, do you need to talk?'. They would notice there's something wrong, they would ask you, try to tease it out of you. They would be doing it to help" (Eoin, May, 2023).

Participants also mentioned the value of support from others in prison and having someone to talk to in preventing their self-harm and/or suicide;

"I got a lot of help. One or two inmates, my own little community got me to where I wanted to be. You could go into talk to someone around" (David, May, 2023).

"There's a person I go to, sit and chat, keep each other company. There is support here, support in dark places, you will find it if you look for it. Now I've no interest, or plans (to hurt myself). I keep talking now. Thank god there's nothing bad happening at the moment. There's nothing down there to be sad about.I am happy with current environment, I have a few people to talk to here" (Eoin, May, 2023).

"*Being around people. When you're on your own you just adapt to what's going on around you"* (Aaron, June, 2023).

"I've seen fellas in a bad mood, going around, you know they are. You nearly know they're coming over because they know you're doing a bit of time, and just to see if see if you are alright, you're around each other all the time anyway. What are you going to do, walk around and not say anything? I think it would be hard to do that for everyone. Most of the people I have been in with, I talk away to them. They tell me what's the story with them, what they're into, not too much into it. We try to be there for each other. Some of the things in life are a little bit private to some people, and even hard to deal with" (Aaron, June, 2023).

"I go to people with it, I don't try to hide it. It doesn't always work, it's taking very small doses" (Aidan, May, 2023).

(Q any critical moments?) "Normal people that are around from day to day I have beneficially taken strength from" (Aaron, June, 2023).

Family was identified as a source of comfort and support which helps them to not self-harm and/or attempt suicide:

"I talk to my ma. My brothers keep me grounded" (Patrick, May, 2023).

Men described how being able to ask for help now is critical to their recovery;

"Be more able to ask more help, go to GP, more likely to do something now to ask for help" (Eoin, May, 2023).

"If I'd got the help back then that I needed I wouldn't be here. But back then I didn't ask for help because I didn't want it….Before – out to nothing, back to drink and drugs. It gives an instant feel of happiness, grace, then guilt is always two steps behind it" (Adan, May, 2023).

Others talked about the value of talking to services in desitance from self-harm and/or suicide:

"Talk to psychology team, go to medic, friend I talk to, instead of just bottling it up, it'll all explode suddenly. It took a while to get used to. It was a 6 week cycle, push it away, cope with it" (Eoin, May, 2023).

These findings highlight the positive impact that an individual staff member can have in their day to day interactions with prisoners, and the critical support that staff provide in supporting their desistance from self-harm and suicide. These findings highlight the value of support from psychologists, family and friends in desistance from self-harm and suicide. This is consistent with findings by Howard & Pope (2019) that feeling important, trusting relationships with genuine care, critical turning points for change such as persons, situations or units that enable people to feel safe, believed in and supported were critical to their desistance.

- Compassion

Compassion towards them as another human being was highlighted a critical factor in their desistance. Many participants felt staff could improve the level of care and support they provide as a way of helping to prevent suicide and self-harm;

"Be a bit more humane. More compassion and more understanding towards you, I suppose be treated more like a human in a sense, if someone is treated like a human they are more easy to talk to, maybe talk to the person, it may help the situation there and then and not escalate into self-harming. I suppose it could calm the situation down, I suppose in your head, maybe I shouldn't have to do this, maybe I have to do that. You're not going to go to an officer and say I'm thinking I'm going to do this, by the time you get back to your cell, you'll be in the pad. The governor will come around in the morning with a doctor. It doesn't make any sense" (Colm, May, 2023).

(Q-What is needed?) "It's hard, not a lot that you're not doing already. Nothing spectacular. I think there should be more compassion" (Mark, July, 2024).

"All it takes is for an officer to say 'he's sitting in his cell all day, a red flag or a warning flag or something'. It's all very simple. A lot of that it cuts out because it's so massive"; *"So many voices shouting, the loudest ones get seen eventually"* (Eoin, May, 2023).

"Simple things, just show a bit of human emotion, and compassion and understanding, he's made his mistakes, he's doing his time, let's try help him. These young fellas, ah grab him, handcuff him, give him a hiding. I've tried to grab an officer by his neck" (Patrick, May, 2023).

When asked what advice would you give staff about how to respond to an incident, one man said;

> *'Be nice and generous. 'Nothing is going to happen, we won't punish you. If it happens again, let us know'. Reassure. Show them that help is there. Accepted it bit by bit versus 'You're on the list', youll see them eventually" (Eoin, May, 2023).*

The benefits of compassion were reported to be exemplified when the 'tougher' prison officers showed concern and compassion.

> *"Lots of people were helpful along the way. They have a certain understanding, but there's a point where enough is enough. I wasn't getting punished, but I wasn't get rewarded either. What got me was one of the female medics, she is known as a hard nose medic, her kindness and concern got to me. She's the hardest bull face medic, no one likes her but she showed concern and compassion. It got through to me, if she is willing if she is there changing her attitude then I have a problem. It was a shock, there's something wrong here if she's paying attention. Compassion and understanding is a way in. Her approach was shock – if you keep going the way you're going you could do serious harm, damage, risk, infection. She helped with medications, she helped calm me down, relax me…Softly softly appeal to their human nature, keep trying"* (Eoin, May, 2023).

These findings identified the need for compassion and for prisoners to be consistently treated as human beings. Interestingly, the role of prison based staff featured more heavily in their narrative when discussing support when desisting and seemed to be more effective due to the 'shock value'.

- Engaging with Psychology

The benefits of engaging with Psychology was cited in helping them to desist from self-harm and/or suicide, whilst, inevitably, criticising the delays in accessing Psychology;

> *"If it wasn't for (named Psychologist) I wouldn't be here today. If it wasn't for (named Psychologist), I'd have killed myself. She seen I wasn't acting out, I wasn't seeking drugs, Ruth seen it with me. She knew. Taking hundreds of tablets and smoking heroin. I trusted her more than my own family. She was like a mother figure. When she left I fell off, started cutting people, doing things for drugs"* (Patrick, May, 2023).

"Group support is nice to have. People talked, we all opened up" (Eoin, May, 2023).

"I've seen psych a few times, obviously got a few tips, I had to, it took a long time" (Mark, May, 2023)

"You need a psychologist. Psychology has gone off the map" (Patrick, May, 2023).

"Before I came up, I was starting to see psychology, it didn't come quick enough. I did 1-1, and DBT skills" (Eoin, May, 2023).

"Even when you get sentenced, or remanded, you should get counselling, some sort of introduction, or meeting to help you acclimatize, an assessment at the beginning of their state of mind" (Eoin, 2023, May).

"I found when I was going to psychology, they should want to listen, they want to help, be a listening ear, sit there listen, listen, listen, you need more feedback. I was going back to the cell saying 'what's the point, I don't feel any better', I think you could give them more, more ways to deal with coping. When I was handed breathing exercises, I found it stupid, I did try them once, tried PMR (progressive muscle relaxation) and I fell asleep, I did try it, it helped a small bit. The amount of trauma. I suppose to a degree Sleeping pills did help me escape, it gets you to work" (Callum, 2023, May).

"You're not talking to us about the basic things. Coming down and talking about feelings. They're leaving with their feelings. What you need to do is psychology, drug counsellor, drug rebab landing, therapy, structure. Turn the wing out, get them off drugs, If you do this, this this and this…we will get you time out for a communion. With the likes of self-harm they need intensive therapy" (Patrick, May, 2023).

"You'd need to explain to them that it's OK to suffer from PTSD and you need to decriminalise them. If you're a young fella bouncing off the wall on West 2 (Mark, May, 2023)

'You need to be assessed by a psychologist. Just sit down. Look its OK, you're allowed to feel angry. Youre allowed to feel sad. Youre allowed to feel used. But if you want to break the cycle and get out, this is what you need to do. Not if you do this you will get a P19, if you don't do this, this is happening" (Patrick, May, 2023).

This highlights the benefits of Psychology (despite the delays to access) and the need for early access to psychological therapies. Participant's spoke of the benefits

from engaging in psychological therapies, including DBT skills, Mentalisation based therapy and work to address their coping strategies for managing their emotions. They stated that they need help to understand their own behaviour in order to develop effective coping strategies. This is consistent with Hawton et al., (2016) on the effectiveness of DBT in reducing frequency of self-harm (Jeglic, 2005; Berzins & Trestman, 2004) on the usefulness of a DBT approach. This supports the view that Dialectical Behavioural Therapy (DBT) can be effective at reducing self-harm behaviour in prison environments, by developing prisoners' skills around mindfulness, distress tolerance, emotional regulation and interpersonal effectiveness. Their preference for timely and appropriate provision of the necessary mental health services is also consistent with the Harris Review (2015). However, there was reluctance to engage in support during heightened distress, with a greater level of willingness, and eagerness to talk/seek support when they have desisted. This suggests that the stage of recovery should dictate the response or approach to management. For those in early stages (e.g. pre contemplation) the response should be focused on whole system prevention, and the later stages of recovery, the response should be more focused on active management (e.g. building resilience, preventing relapse, skills development). It is argued that prevention should expedite people's journey to recovery and enable quicker access to support.

Chapter Summary

This Chapter has explored the protective factors and interventions for self-harm and suicide. The findings suggest that from the perspective of prisoners, the protective factors for self-harm and suicide include individual motivation, abstinence from substances, coping strategies like structured activities, talking, managing emotions, and other strategies. This needs to take place within the context of support, compassion, hope, access to Psychology, availability of a structured regime, more staff, specific supports for young prisoners and remand prisoners, increased visits with family and other suggestions. The presence of protective factors identified by participants in this research is consistent with the PTMF (Johnstone & Boyle, 2018a), which states that factors may exacerbate or amelorate the power-threat-meaning-reponse process, and emphasises the importance of considering individual strengths, particularly when using the PTMF in therapeutic practices. The next Chapter will explore the qualitative findings in the wider context and implications for prison practice.

Chapter 10: Findings in the Wider Context and Implications for Prison Practice

Introduction

This section will explore the qualitative findings in the wider context and implications for prison practice. The aim of this research was to better inform the effective management of self-harm and provide safer custody. It was very striking how preventable suicides are, and how simple it is from the prisoner's perspectives to prevent episodes of both self-harm and suicide. This is consistent with Rivlin, Fazel, Marzano and Hawton (2011) that half the prisoners believed their acts could have been prevented, often with relatively simple solutions. An interesting finding was that prisoners who had survived a suicide attempt were now glad that they did not die:

> "I am happy I survived, think it was just the way everything came on top of me, sickness of drugs, being back here, it was Xmas, my son is 5, and I haven't been out for Christmas yet" (Dan, June, 2023).

This is consistent with Dombrovski & Hallquist (2017) that suicide attempts are usually regretted by people who survive them.

This research explored the nature of harm, the risk and contributory factors for self-harming behaviours, the barriers to seeking support, and the protective factors and interventions that may prevent self injury and suicide in Irish Prisons. Importantly, it gave voice to prisoners in custody, acknowledging the value of their perspective in facilitating the understandings of their self-harming behaviour. User-led evidence in research provided a unique contribution to the management of both self-injury and/or suicide, which may provide a foundation from which safer custody efforts can be built. This insight will be used to benefit others. The findings have important implications for policy and practise in prisons to make them safer.

The IPS could use the findings to implement a recovery based model for substance use and mental health. The role of dual diagnosis gives rise to consideration of a dual diagnosis model of care for people with mental disorder and co-existing substance use disorder, or other comorbidities. Recovery College is designed to support people with mental health problems to recover through recovery based education from professionals and those with lived experience. It is based on the belief that people can and do recover from mental health problems to build meaningful and satisfying

lives. Recovery is supported by a willingness to try new things, good relationships, personal growth, a supportive environment, being believed in, being listened to, and understanding past experiences. These are all critical aspects described by participants in their own desistance. The inclusion of those with lived experience might increase their trust in the process, and their hope for recovery. Each person in custody with an addiction or mental health issue should have a roadmap for recovery, which addresses the essential elements of recovery, and be based on their stage of change, and may include reference to aspects of 'Bridges out of poverty (Payne, Devol & Smith, 2009). This also supports the continued implementation and wider roll out of the Wellness Recovery Action Plan (WRAP). Efforts should provide early intervention and focus on improved connections between people in custody with an addiction and healthcare professionals, which place the client at the centre of communication about clinical decisions about medication. The high prevalence of people who engage in self-harm and suicide that have an active addiction suggests that the IPS should consider implementing an pro-active engagement with people on commital.

Access to structured in the day to day management of prisons to alleviate boredom and rumination is essential. At an organisational level, the findings could be used to argue for more frontline prison staff, more prisoner accommodation to ease overcrowding, and more funding to support structured activities for prisoners and early access to psychological therapies.

Targeted policies and interventions could reduce the risks presented by people in custody by highlighting the complex interplay of individual, social and environmental or prison specific factors. These findings support the ideas by Zhong et al., (2020)) that preventative measures should target the modifiable risk factors, such as suicidal ideation during the current period in prison, and current psychiatric diagnosis and access to evidence based mental health care should be improved. When exploring what might be helpful approach to people who appeared to be beyond reach, their answer was simple; Prevention, not crisis management. This is consistent with Liebling (1995) who argued that the focus should be on developing and strengthening protective factors, rather than preventing suicide. This research supports findings on the impact of the prison environment on mental health and suggests that interventions should include a comprehensive, prison wide approach to preventing self-harm in prison. This includes both population and targeted

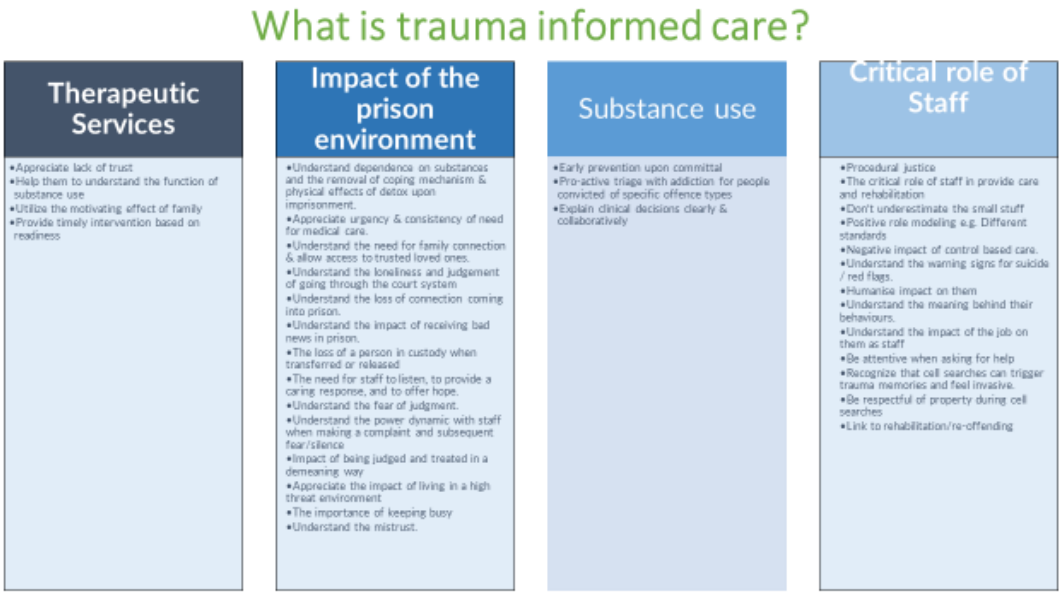
strategies in prison and maintaining these approaches on release. This also includes diverting people before prison, improvements to mental health care in prison, purposeful activities and social support, with multiagency collaboration between the services for mental health, social care and criminal justice (Favril, Yu, Hawton & Fazel (2020).

The positive impact an individual staff member can have in their day to day interactions with prisoners highlighted that efforts should be made to develop a more rehabilitative culture. This should include a shift from control based care to contact based care. Contact based care should promote a reduction in aggression, improve the quality of care and reduce use of seclusion, which promotes safety. Staff training should ensure staff understand the meaning behind their behaviours, know the warning signs for suicide/red flags and be attentive to people who ask for help, to recognise that cell searches can trigger trauma memories and feel invasive, to be respectful of property during cell searches, and become more sophisticated at translating 'symptoms' and 'illnesses' into understandable responses to life circumstances. Positioning troubled/troubling human behaviour as a threat response to adversity may lead to an appropriate and/or effective understanding and thus management of symptoms.

The broader themes identified in this research are consistent with the wider literature around prisons and rehabilitation, such as the need for a trauma informed model (Donley et al., 2012). These findings add further support to the development of a trauma informed service model suitable for implementation into a male prison environment (Donley et al., 2012). Use of the PTMF may lead to a shift towards towards trauma informed practices, as recommended by Willmot & Jones (2022). Whilst there may have been a gradual shift in forensic settings towards towards trauma informed practices (Willmot & Jones, 2022), there is little clarity about what trauma informed practice means in prison. Table 37 provides a summary of what may constitute trauma informed care from the perspective of participants.

Table 37

Trauma informed care from the perspective of prisoners



These findings have implications for the restrictive and invasive act of isolating and observing individuals, even if for the purposes of their own safety (Gaglione, 2021). This suggests that those deemed to be at acute risk of suicide should not be isolated – even if this is done for practical safeguarding reasons e.g. observation – and it is recommended that such individuals are provided with companionship and support (WHO, 2007; Favril, 2021). This is also consistent with Garrihy, Marder, & Gilheaney (2023) who highlighted the pronounced negative impact of isolation on prisoner mental health, sense of self, and social engagement. It is recommended that individuals who are at acute risk of suicide should be housed in the least restrictive setting which allows for adequate supervision. Whilst measures should be taken to make the environment 'suicide safe' (e.g. limiting ligature points), it is noted that physical restraint does not prevent suicide in the medium or long-term, nor does it change the individuals' thoughts of suicide. Alternatives that support people in custody that support connection and minimise social isolation should be considered in light of the widely-reported negative impacts of isolation.

It is recommended that the organisation explores creative ways to engage prisoners who typically have difficulties with trust and authority. This should promote the positive impact of family connections in order to alleviate isolation and loneliness of being in prison and to motivate prisoners to engage with rehabilitation efforts, use of high quality peer support initiatives, and positive staff-prisoner relationships in order

to improve rehabilitation efforts. The findings also suggest that trusted resources should be used and maximised to support prisoners (e.g. family, peer support). Any services engaging with prisoners should seek to find ways to avail of the trusted support in the community and the Irish Prison Service should seek to increase direct contact with their family. This might also include increased contact by the Irish Prison Service Psychology Service with members of their family to help garner motivation to change, or to help inform intervention.

Findings highlight the role of culture, attitudes and relationships between staff and prisoners and procedural change such as the prisons process for behavioural punishments (Howard, 2017). The organisation should address perceptions of procedural justice (Howard & Wakeling, 2020) by:

- treating people with respect and dignity
- making unbiased decisions and interpreting and applying rules consistently and transparently (e.g. P19 hearings) and improving communication and providing transparency in decision making (e.g. transfers, overcrowding).
- giving people a voice and hearing their concerns and experiences (such as new policies and procedures)
- showing and encouraging trust by being sincere, caring and authentic, and trying to do what is right for everyone.

These findings have implications for the use of peer to peer initiatives in the prevention of self-harm and suicide in male prisoners. There should also be efforts to ensure that peer support schemes are of good quality and that peer support volunteers are supported. This includes;

- Screening and selection processes for peer supporters
- Training for peers (including training to be trauma informed)
- An appropriately defined role and use of a job description.
- Information provided to prisoners about available peer support at reception, induction and on residential units, including the use of presentations and other advertising materials.
- Risk assessments taking into account both peer supporters and the prisoners they support.
- Appropriate freedom of movement for peer supporters to be available to prisoners
- Supervision by staff and/or supporting organisation e.g. NGO.

- Opportunities for peer supporters to feed back to prison staff.

This research also lends support to better provision of care and changed practices for those presenting with neurodiversity issues. Special consideration should be given to how best to support those with neurodiversity. Findings suggest that people who self-harm would benefit from the formulation related practice of the PTMF, which would help them to view their distress as happening from outside inwards (i.e., problems are in the world, their reaction is understandable). In view of the barriers to support, it is recommended that efforts should focus on provision of whole population approaches, particularly those which can be accessed privately (e.g. TV channel). It is suggested that the Irish Prison Service develop a series of workshops online that can be viewed in cell on the TV channel by prisoners. Whilst cell sharing may be a further limiting factor to the choice of viewing material, this limits some of the barriers to accessing therapies and psych-education by removing the need to overcome the barriers to trust, such as physically going to a clinic room or classroom and/or asking someone for help.

The findings of this research have, however, provided valuable insights into safer custody. It also provides some reassurance that the Irish Prison Service are on the right path for the practices being developed and implemented. For example, a business case has been submitted and approved to the IPS for the introduction of recovery based model of mental health and substance use. This research has made a positive impact in terms of improving practice and has led to informal discussions with colleagues, formal discussions at national forums, some immediate changes to practice and some new plans under development. The SADA form has been changed to include an assessment by the MDT of the intentionality for each episode of self-harm and/or suicide. Contact has been made with the Chief Pharmacist to discuss prescribing practices for ADHD. A steering group is currently exploring alternatives to use of an SOC when a person in custody is in distress. The final Chapter will explore the conclusions of this PhD research and make recommendations for the management of self-harm and suicide in Irish Prisons.

Chapter 11: Conclusions and Recommendations

This chapter will summarise the key findings of this novel research on prisoner's perspectives and experiences of self-harm and suicide in Irish Prisons. This section will highlight the importance of this PhD, both in terms of new theoretical advances, new data, new approach combining the study of both self harm and suicide, and achieving meaningful impact on policy and practice. This is the first qualitative study of it's kind in Ireland. It will present key arguments about the aetiology of self harm and suicide. It will present the new theoretical implications of this research that arises from exploring both dimensions of self harm and suicide together in one study. It will present new data by directly exploring prisoner's experiences and perspective of the relevant risk and protective factors for self injury and suicide in Irish prisons. It will make recommendations about what might help or support desistance from self-harm and suicide. It will specify what contribution this PhD research makes to the literature, and to policy and practice. It will consider the implications for the management of suicide and self-harm and consider strengths and limitations of this PhD research.

Introduction

Self-harm and suicide in prisons and its subsequent negative impact on individuals (psychological, physiological, and social), clients and organizations, is a concern that requires immediate attention. Whilst there have been significant mult-agency efforts to improve the monitoring of the incidence and profile of self-harm in Irish prisons since 2017, there have been no qualitative studies completed in Ireland on self-harm and suicide in Irish Prisons. It is unclear why most prisoners do not self-harm and why some who harm themselves are propelled towards suicide whereas others are not (Forrestor et al,. 2014) and why some desist and others persist with their self harm.

This PhD research aimed to explore from the perspective of prisoners who have engaged in self-harm and/or suicide in prison what the risk factors and contributory factors are for their behaviour, and works to prevent and support desistance from self-harm and suicide. People with lived experience of the criminal justice system are a valuable resource for suicide prevention in the Criminal Justice System worldwide (Walker, Wainwright, Dunlop, Forrester, Senior & Shaw, 2022). The engagement of service user's experiences in exploring appropriate interventions for self-harm has

been relatively neglected in comparison with clinical studies focusing on the management and prevention of self-harm (Hume & Platt, 2007). There are no studies in the literature that have collected and shared evidence about individuals' experiences of prison in Ireland. This research directly explores the experiences and perspectives of people in custody with lived experience of engaging in self-harm and/or suicide in prison.

Some studies have shown potential benefits of prevention measures used to reduce self-harm and suicide. For example, Howard & Pope (2019) identified that the development of staff-prisoner relationships using (genuine) care, showing understanding, support and creating safety and belief may improve desistance of self-harm in male prisoners. Walker et al., (2022) suggested that 'knowing my history, being treated as an individual and being able to express vulnerability' are relevant to the process of assessment and prevention of suicide and self-harm risk. There is a need to understand the individual and environmental drivers of risk of harm in Irish prisoners, and the protective factors help prisoners to desist from self-harm and suicide. This is the first Irish study which seeks to explore and understand the factors that place prisoners at risk of both self-harm and suicide, and the factors that protect against both self-harm and suicide. This will help inform effective ways for prison managers and staff to respond to incidents of self-harm and provide appropriate, helpful care. Improving strategies to promote desistance is important to reduce the potential for harm. Relatively little is known about managing self-harm in individuals in this specific context so by drawing on the perspective of prisoners and their experiences, this can provide a useful - and much needed – insight into their experiences and challenges of being in custody, whilst considering potential environmental, psycho-social factors and implications.

Summary of findings

This section will summarise key findings for each of the six themes identified by participants. In the qualitative analysis, the research identified six themes relevant to self-harm and suicide risk, including 1. Nature of harm, 2. Risk Factors, 3. Link to Violence, 4. Factors contributing to self-harm and suicide, 5. Barriers to Support and 6. Protective Factors. This PhD has provided new data by directly exploring participant experiences and perspectives in the area of self-harm and/or suicide amongst the prison population. By exploring multiple dimensions together (e.g. self-harm and suicide) in the same study, it has provided new data that confirms there

are similar risk factors for both suicide and self-harm. These findings highlight the commonalities of individuals' motivations for hurting themselves, regardless of whether the incident is an act of self-harm or suicide. These findings have added to the debate on the aetiology of self-harm and suicide. This sheds light on the theoretical framework that can be used to conceptualise the nature of self-harm and suicide, and adds further weight to the idea that self-harm and suicide are similar entities that should be understood and managed in terms of their motivation and main function(s) that they serve.. It suggests that self harm and suicide may not require different interventions. This research provides support for the Power Threat Meaning Framework about why individuals engage in self harm in prison and indicates that treatment should vary according to the functions they serve. It also offers some suggestions about practices that can be used to support safer custody.

The research has shed some light on the role of repetition in self injury and the interchangeable use of self-harm and suicide by prisoners. This research indicates that there may be three different groups of behaviours, with self-harm, suicidal processes and a 'mixed group' (e.g. self-harm and suicide), and whilst they can have different motivations and intentions (incl. apparently similar acts), they can each require similar responses. This suggests that there is a little distinction between self-harm and suicidal behaviour and does not view self-harm as a distinct entity, which is delineated from suicidal behaviours. Findings indicate that self-harm and suicide should not be seen as separate conceptual issues, and should solely be differentiated by their intention to end life or not, or the motivation or function of the behaviour (e.g. emotion regulation, instrumental gain), rather than the nature of the act itself (self-harm, suicidal 'threats', attempts and completions).

The key risk factors identified by male participants in custody in Ireland for self-harm and/or suicide included a history of substance use, the presence of Adverse Childhood Experiences (ACEs)'s, being on remand, previous history of custodial sentences, limited social support, history of P19's and neurodiversity. ACEs, but rather the person's experience of ACEs (e.g. intensity, severity, meaning) albeit both. As stated previously, however, individuals within society who are at greater risk of entering custody share many of the same features of those who are at an increased risk of self-harm and suicide, including disrupted family background (McDermott & Willmott, 2018). It is therefore important that research should explore the intensity, severity or meaning attributed to their adverse childhood experiences, and not just

the frequency. Future research may wish to explore further the factors that are associated with increased risk.

This research provided support for the Power Threat Meaning Framework (Johnstone & Boyle, 2018a, 2019b) as an approach to understanding emotional distress and troubled/troubling behaviour such as self-harm and suicide. It demonstrates that self harm and suicide should be understood within the framework of power (e.g. what has happened to you?), threat (e.g. how did it affect you?), meaning (e.g. what sense did you make of it?), and threat response (e.g. What did you have to do to survive?). This supports the PTMF, whereby the external cause was identifiable in the research (e.g. ACE's, being imprisoned, neurodiversity). The findings recognised the causal role of adversity including social exclusion, discrimination, devalued identities. The research positioned these human experiences and behaviours, within the biological, social and psychological contexts which surround them (Johnstone & Boyle, 2018a). A Thematic Map of Prisoner's Qualitative Results can be found in Appendix F: Thematic Map (Figure 2).

The research demonstrates that the threat reponse might take the form of self-harm and/or suicide. Participants use of self harm and suicide were clearly ways of surviving, rather than individual deficits & illness. The external cause was identifiable from the risk factors identified in the research. The research recognises the causal role of adversity including social exclusion, discrimination, devalued identities etc. The research positioned these human experiences and behaviours, within the biological, social and psychological contexts which surround them (Johnstone & Boyle, 2018a). There was also evidence that the threat or power may be distal and out of conscious memory, but based on their self-harm and suicidal behaviour, and their distress, the threat response appears to remain active. The research also attested to the idea that shame and stigma experienced in relation to the adverse events may mean the link of their threat response is unconcious, which is heightened further when they receive a diagnosis from a mental health professional that implies deficit and 'illness'. Therefore, these findings concur with the view of the PMTF that the threat responses such as self-harm or suicide are more usefully understood in terms of the main function(s) they serve, or the core human need that is being protected by the response. It supports the view that the threat response of self harm may serve a multitude of purposes for each individual, including self-punishment, communication, release of feelings, and a means of eliciting care. Their

self harm and/or suicide response—conscious or otherwise—appears to function as a way to survive or to protect themselves.

This research indicates there is a significant link between substance use (e.g., alcohol, drugs) and both self-harm and suicide, which places substance use as the most significant contributory factor. Individuals who struggle with substance use may experience intense emotional pain, distress, may be neurodiverse, and/or may have mental health issues (such as emotion regulation difficulties, Axis 1 disorders). They may experience stress or anxiety upon commital to prison about the continuity of healthcare from community to prison. This may be aggravated further in prison by a loss of connection, loss of relationships through bereavement or loss, adjustment issues, and relational issues with staff and other prisoners. These may contribute towards feelings of loneliness, isolation, hopelessness and despair, which increases their risk for self-harm and suicide. Participants reported a sense of hopelessness when they faced 'repeat' situations (e.g. repeat sentence). They may experience a perceived inability to cope with their current circumstances, lack confidence in their ability to desist from substance use, and may be experiencing a new loss of connection (e.g. no access to children in custody for first time since becoming a father). Substances can also impair judgement, increase impulsivity and lower inhibitions, which can increase the likelihood of impulsive suicidal behaviour.
Five key factors were identified in the research that underlie the level of risk posed by the environment: Lack of structured activity; large prisons; a prison culture that does not support prisoner's showing or expressing their vulnerability; and lack of procedural justice. An increase in the prison population and a decrease in staffing in Irish prisons has no doubt further decreased the Time Out Of Cell, and the opportunities for Time in Purposeful Activity, such as visits from family or access to intervention programmes. Environmental conditions such as smaller, or specialist units in prisons with meaningful and purposeful structured activity and/or timely access to therapies may reduce the risk of harm. Prison factors that may increase risk of harm were identified in the research, which includes the use of an Special Observation Cell and lack of trauma informed practice.

Research also supported some links between self-harm, suicide and/or violence. Some individuals who engage in self injury may also engage in outward directed harmful behaviour towards others. Some individuals who engage in violence may also engage in inward directed harm. This is often the case when violence is

prevented. Some studies have shown that there is an increased risk of suicidal behaviour among individuals who have a history of violent behaviour. It is likely that substance use and violence should be viewed similarly to self-harm and suicide as a threat response to ensure survival and protection. This highlights the need to support individuals with adversity by helping them to formulate their human behaviour using the PTMF and using a trauma informed approach in order to help them to develop healthier coping mechanisms. However, as highlighted already, these variables are all typical prisoner population characteristics, and not everybody in custody engages in self-harm or suicidal behaviour. The findings below sheds further light on what differentiates those in custody with similar risk factors who do engage in self-harm from those who do not, but further exploration may be required. Barriers to support were identified including mistrust, lack of available support, shame, punitive response and prison culture. These barriers to support need to be taken into consideration in approaches to self-harm and suicide, including the use of whole population approaches that do not require prisoners to trust others, efforts to break down cultural barriers to support seeking behaviour, to acknowledge the destructive role of shame in help seeking behaviour and provide helpful staff responses to self-harm and suicide and to develop trust between staff and prisoners. Trusting in the availability of genuine help and developing relationships based on trust were vehicles to seeking out and accepting support.

This research has identified factors that promoted desistance from self-harm and suicide. This includes recovery from substance use, family connections, involvement in structured activities and psychological therapies, taking personal responsibility for recovery, intervention focusing on prevention (not crisis management), continuity of medical care (including effective communication about any changes to their prescriptions), contact based care involving trusting relationships with staff in which they feel they are treated as individuals, that their rehabilitation matters, and a culture that makes it safe for them to reveal their vulnerabilities and seek support. It is also evident, as highlighted by McDermott (2018) that staffing shortages and over-crowding have had a significant negative impact on the supportive staff relationships that are needed by vulnerable prisoners.

The protective factors identified in this research further supports the PTMF, which maintains that various factors may exacerbate or amelorate the power-threat-meaning-reponse process. This research also emphasises the importance of

considering individual strengths, particularly when using the PTMF in therapeutic practices (Johnstone & Boyle, 2018a).

The PhD research demonstrates that improvements can be made to the management of self-harm and suicidality. Using the broad framework of the risk, contributory and protective factors as a guiding principle, the following key findings that emerged from the research can be summarised below:

The primary focus of individual harm prevention should be on recovery from substance use and/or mental health issues. People coming into custody with an active addiction should be supported in the transition from prison to community with good communication and consistency of approach. A recovery based model for those with a dual diagnosis of substance use and mental health issues should be implemented.

Prisoners need access to structured activities in prisons to alleviate boredom and rumination. Prisoners need increased family contact due to their impact on isolation, and their trusted capacity to motivate them towards desistance and rehabilitation. Involvement in peer support is also a factor that promotes desistance. The timing of intervention is important, and should be preventative in nature (i.e. not crisis intervention). Specific cohorts, such as young prisoners, prisoners with neurodiversity and remand prisoners, anyone with an active addiction have specific needs and need more specialist support, particularly on early commital to prison. A PTMF could support individuals who have harmed themselves to develop a good understanding of their own behaviour in order to develop effective coping strategies. This may help individuals to replace the threat response (including self-harm, substance use and violence) with healthier alternatives. Use of the PTMF may also lead to a shift towards towards trauma informed practices, as recommended by Willmot & Jones (2022).

Overcrowding and decreases in staffing is having a detrimental effect on the safety of prisoners and staff. Prisoners need support to find hope for the future, to help them make sense of their self-harm in a way that promotes change or commitment to change, to help them to take personal responsibility and to recognise & realise their potential for helping others. Prisoners need to be treated as individuals by staff who they feel care about their rehabilitation, and be provided with safe spaces in

which they can reveal their vulnerabilities. With a history of ACE's, prisoners need to be supported using principles of trauma informed care and a high level of procedural justice. A shift from control based care to contact based care, which should foster connection and safety. This should use a relational approach. This necessitates staff having a good understanding of the varied reasons for self-harm and how to respond in a helpful way and should ensure prisoners feel as though they matter, and that their rehabilitation matters. The use of an SOC may provide short term reduction in risk, but may heighten the longer term risks.

Implications and future directions

a. Usefulness of the study.

A notable strength of this research is the inclusion of men in custody who have engaged in self-harm and/or suicide. This included the breakdown analysis of those who have engaged in repeat incidents of self-harm, those who have engaged in self-harm and/or suicidal behaviour, and those who have engaged in suicide. Most research in the literature tends to focus exclusively on one type of behaviour, and not both. This research provides snapshot insights from across the male prison population from all three groups. This research has helped to contribute to a better understanding of improved methods for managing risk of harm within prisons. This should help to reduce prevalence rates for self-harm and suicide by prisoners. If it is indeed correct that self-harm and violence may actually serve the same function and could potentially be tackled using similar interventions (McDermott, 2017), the above recommendations might further reduce the risks to the safety of both staff and prisoners and contribute towards safer custody

b. Sustainability

A positive outcome of the research is that it has moved the IPS strategy for harm prevention beyond data collection and analysis to the next steps of progressing best practices for preventing and reducing self-harm and suicide. It provides new data by directly exploring participant experiences and perspectives, rather than a broader overview achieved through data analysis, inspectorial or evaluation. The data should be used to drive changes to policy and practice. Further research should continue to explore the positive benefits of changes made and to keep improving strategy for the prevention of harm.

c. Potential for spread to other contexts

These findings could be used to inform management of women in custody, remand prisoners and community based approaches to the management of self-harm and/or suicide.

d. Implications for practice and for further study in the field

Applications: This PhD sheds light on the preventative interventions prisons should implement to reduce risk of harm in male prisoners. Further research is required in this area to better understand the prevalence of substance use, neurological issues and mental health issues in a larger sample of prisoners who engage in self-harm and suicide. It would be interesting to explore further what differentiates those in custody with similar risk factors who do engage in self-harm from those who do not. Further research should focus on exploring further the relationship between self-harm and suicide and behaviour that initiates disciplinary processes. This data could be analysed on a larger scale for all episodes of self-injury and suicide in Irish prisons. Further research should also focus on dual use of inward and inward and externally directed harm, perhaps by reviewing the timing of self-harm, suicide and P19's in order to identify whether prisoners engage in both self-harm, suicidality and/or challenging behaviour during periods of instability, or whether they engage in either self-harm, suicidality or challenging behaviour at such times. The prevalence rates for specific offences amongst those who engage in self-harm and/or suicide should be compared to the general population. The prevalence rates for P19's for those who engage in self-harm and/or suicide compared to those who do not engage in self-harm and/or suicide should be reviewed. The needs of young prisoners should be further explored. The benefits of peer to peer initiatives for self-harm and suicide should be evaluated. Further research should explore the link to concurrent or consecutive use of violence and the timing of self injury and suicide in the mixed group. Further research should explore the role of procedural justice in mental health and re-offending. It would be interesting to explore staff perceptions of self-harm and suicide, and the training they have received. Future research should explore the experiences of women in custody, those on remand, and those who are still engaging in self-harm and/or suicide to ascertain if what appears to help these men learn to cope without self-harm and suicide are similar for these groups too. Future research could explore staff perspectives, as well as prisoners experiences, with the integration of these sources to understand the same phenomenon (i.e.

triangulation) increasing the dependability of findings. Further research is required to evaluate the benefits of peer to peer intervention on self-harm and suicide.

e. Suggested next steps

Use of evaluation of peer to peer initiatives to understand better the role of helping others in desistance, and the role they might play in instilling hope for others would also be beneficial. Quality control is also recommended.

Recommendations

Arising from this research, seven core recommendations are made. The first recommendation is to take a risk environment approach to self-harm and/or suicide, which focuses on prevention strategies that emphasises environmental change. This should include improving access to structured activities and psychological therapies and developing specialist units that provide a trauma informed care & formulation based approach.

The second recommendation is to directly maximise the positive impact of family connections as early as possible in order to alleviate isolation and loneliness of being in prison and to motivate prisoners towards change. Family links could be used to build trust and to support interventions with the person in custody.

The third recommendation is to move from control based care to contact based carem, which will foster connection and safety. This may need to be underpinned by an emphasis on a shared, common goal of reducing future re-offending, use of specialist, psychologically informed units and/ or individual efforts by staff, efforts to mitigate the impact of the job (e.g. institutional depersonalisation), provision of individual formulations for individual's self-harm and suicide and therefore more likely to consider each prisoner as an individual with a story to tell and promotion of trauma informed practices in order to enable institutions to become more psychologically minded and trauma informed in their overall approach.

The fourth recommendation is that intervention should be provided at the right time using the principle of readiness (i.e. not necessarily during a crisis). Specific cohorts such as remand prisoners, people with neurodiversity and young prisoners should receive specialist support, particularly on early commital to prison and anyone with an active addiction should receive timely access to appropriate care, with clear

explanations for clinical decisions made to the person in custody. This could include commital units that are supported by trained prison staff, addiction nurses, addiction counsellors, psychologists, occupational therapists and chaplaincy.

The fifth recommendation is that a PTMF should be adopted to support individuals who have harmed themselves to develop a good understanding of their own behaviour in order to develop effective coping strategies. This may help individuals to replace the threat response (including self-harm, substance use and violence) with healthier alternatives.

The sixth is the direct referral to the addiction nurse for anyone with active or historic substance use, and referred onto Addiction Counsellors, or the inclusion of those convicted of acquisitive offending in the categories of offences that are included in the pro-active referral to the to the Psychology Service.

The seventh is that alternatives to using an SOC (unless the person is requesting it) should be sought in order to reduce the detrimental effects of use of the SOC.

The eighth recommendation is to employ peer to peer initiatives across all areas to break down the barriers of trust and to ensure they are of of good quality.

Finally, the ninth recommendation is that a recovery based model of mental health and substance use should be fully implemented for those with a dual diagnosis of substance use and mental health issues, with trained professionals and those with lived experience available to support this.

The above recommendations will clearly need to be supported by a reduction in the prison population and an increase in staffing to ensure the safety of prisoners and staff can be addressed.

Strengths and limitations

Strengths

These findings should be contextualised within the strengths of this research. Empirical research enabled an in-depth exploration of participant experiences and perspectives. It provided new data by directly exploring participant experiences and perspectives, rather than a broader overview achieved through data analysis,

inspectorial or evaluation and by exploring multiple dimensions together. This research is groundbreaking in that it has contributed towards new research by providing the first qualitative study of male prisoner's experiences in Ireland of self harm and suicide in prisons. It has developed new methods by analysing the risk, contributory and protective factors for both self-harm and suicide in the same study. This unique research allowed an exploration of both self-harm and suicide by people in prison across multiple dimensions in one study. The research further provided innovative findings by combining an in depth exploration of both self-harm and suicide, with the exploration of the nature of harm (type, intended outcomes, motivations, functions, etc.), risk and contributory factors, and the factors that protect people against harm or support desistance. This contributes to developing a better understanding of self-harm behaviour, including suicide. It added to the debate on the aetiology of self-harm and suicide, and provided a new theoretical framework to understand whether self-harm and suicide are similar entities. As the first study to examine self-harm and suicide in Irish Prisons, broad research questions and interpretative TA ensured that detailed descriptions of the factors that contributed to self-harm and suicide and lead to desistance could be generated, and that these were appropriately grounded in the experiences of prisoners. The categorisation of people into the repeat, suicide, and mixed groupings during/post interview provided a more reliable analysis of the motivation for, and factors involved in, different types of self injurious behaviour, such as risk factors, contributory factors and protective factors. This research has addressed gaps in the literature on strategies or interventions for managing self-harm in prisons. Detailed description of the participants, setting and circumstances of the research allow the reader to assess the transferability of findings to other contexts (Lincoln & Guba, 1985). It also enabled user-led evidence in research and for the first time, it explored the experiences and perspectives of prisoners in Ireland. This research offers new and interesting insight into interventions that should be used to address self-harm and suicide. The findings will have a significant impact on policy and practice. This study made recommendations for positive changes to policy and practice that will have a meaningful impact on prisoner's lives.

Limitations

a. Limits to the generalizability of the work

This research only explored self-harm and suicide among male prisoners. The findings may not generalise beyond male prisoners. The findings have been gathered

from a small sample size (between 12-19.5% of males who self injure or attempt suicide in prison based on the annual prevalence rate). Findings about participants demographics such as offence history, number of P19's etc may be representative of the wider population. Prisoner participation was appropriately voluntary. The study sample mostly consisted of sentenced prisoners who had desisted from self-harm and suicide. This is likely to be the result of the identified barriers to support, including shame, difficulties showing vulnerability and low trust. It is not possible to fully establish what findings could generalise to female prisoners, to those who are actively in distress/and or self-injuring/engaging in suicidal processes, or to those on remand. Some participants were on remand when they were engaging in self-harm and/or suicide.

b. Factors that might have limited internal validity such as confounding, bias, or imprecision in the design, methods, measurement, or analysis

Limitations of the PhD research (e.g. sample profile) must also be considered. The sampling strategy used in the PhD research excluded prisoners on the 'Red and Blue list', those assessed as having a high level of psychopathic traits and those experiencing acute mental health difficulties (e.g. an episode of psychosis), whose contributions might have been valuable. This might skew the findings of the research, which may not be representative of prisoner's experiences of self-harm and suicide in prison. There were difficulties in recruiting a sample of prisoners who were currently active in their use of self-harm, with many declining to take part (n = 8). It relied mostly on the narratives of those who have desisted based on their perspective of the contributory and protective factors for their past behaviour. Their notable absence could have influenced the themes that emerged and may have skewed the findings. The research also relied on self-report which may limit the validity of the findings. The unfortunate poor response rate to psychometric measures should also be considered. Psychometric measures should have been completed with the person in custody around the time of the interview. This would have helped to avoid any literacy difficulties which may have affected the quality of completion of the measures, and may have improved the response rate, and thus their contribution to a quantitative element to the research. Given the role of personal responsibility identified for recovery from mental health and/or substance use, a measure of locus of control would have been helpful.

Chapter Summary

This research has contributed towards a better understanding of the risk factors that predispose prisoners towards self-harm and suicide, the factors that contribute to prisoners engaging in self–harm and suicide, the barriers to seeking support, and the factors that promote desistance from self injury and suicide. User-led evidence in research, which explored both self injury and suicidal behaviour, provided a unique contribution to the management of self injury and/or suicide. It provided interesting insight into the aetiology of self injury and suicide, the role of repetition, and the conceptualisation of self injury and suicide as linked, similar entities which should only be differentiated by intent to die and the function(s) they serve.

These findings have important implications for policy and practice in prisons to make them safer. It provided insight into the role of preventative interventions directly addressing both mental health issues and substance use. Prisons should become more trauma informed, and adopt a recovery based model for mental health issues and substance use.

Prisons should support prisoners in their own recovery by instilling hope and promoting personal responsibility. Prisons can promote prevention by enabling greater access to families, by providing better access to structured activities, peer support opportunities and psychological therapies, by treating people with respect, courtesy and as individuals, making sure they feel that they matter and that we care about their rehabilitation and promoting a culture that embraces vulnerability.

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Appendices:

Appendix A: Information Sheets

Information Sheet (single incident)

"Addressing Self-Injury & Suicide: the lived experience of prisoners in Ireland and the factors that contribute towards resilience, desistance and persistence."

My name is Sarah Hume and I am a Principal Psychologist Manager doing some research (a PhD) with Durham University and the Irish Prison Service (IPS). The research is supervised by two project supervisors at Durham University and one project supervisor at the IPS. The research will look at the experiences that prisoners have in relation to imprisonment and very specifically in relation to self-harm (cutting, burning, for example) and suicidal behaviour in prison. I am interested in talking to prisoners who:

- have self-harmed once,
- those who have self-harmed or engaged in suicidal behaviour more than once, and
- Those who have not been involved in any self-harm suicidal behaviour.

If you think you might be interested in sharing your experience of this, please make sure you understand this information sheet and consent form.

What is this research about?

The IPS has been collecting information when people hut themselves in order to help us better understand self-injury and suicidal behaviour. The IPS is exploring ways to better manage situations where people self-injure or engage in suicidal behaviour in the service. It is also exploring ways to reduce the number of times people want to self-injure and engage in suicidal behaviour. This research aims to explore the experiences of both prisoners in Irish Prisons to understand why some people harm themselves and why others do not.

Why am I doing this research?

The IPS want to make prisons safer and reduce the number of incidents of self-injury and deaths in custody. Therefore, it is important that we understand prisoner's experiences of the risk environment. By exploring these experiences from the perspective of those who hurt themselves and those who do not, we can better

understand what is working well in the IPS and what needs to be improved. This will help the IPS further develop its' policies and practices over the next few years.

Why have you been invited to take part?

You have been invited to take part in the research because you have previously hurt yourself in custody.

How will your data be used?

Your data will be combined with that of other people in custody to describe overall experiences of being in custody. These findings will also be included in reports, which will be used for the researcher's PhD thesis, and to update the prison service on how the research is going. The researcher may also publish or present the research in academic journals or conferences.

What will happen if you decide to take part?

You will be asked to take part in an interview. When you are interviewed for the research, you will be asked to provide your written consent to take part. This information sheet, and the consent form, refer to the interview you are being asked to take part in.

If you understand this information sheet and the consent form and would like to take part in the research, please sign the consent form and return to your class officer in a sealed envelope. The staff member will return your consent form to the researcher. The researcher will then work with prison staff to schedule a meeting with you. Please know that some meetings may take place in a psychology consultation room, and that an officer may be outside the door.

During this meeting, the researcher will conduct an interview, asking you some questions about your experience in prison. The interview will be audio-recorded and will take approximately one hour. The researcher will then provide you with a de-brief sheet, which outlines ways in which both people in custody can seek further support if they wish to do so.

With your consent, the researcher will also be collecting some demographic (e.g. your age, nationality) and offending (e.g. offence history, incidents in prison) information about you from the prison service's official records. You will be asked to complete some psychometric questionnaires, and then your involvement in the

research will be complete. This information will be used for the purpose of this research only.

How will your privacy be protected?

During the meetings you are free to skip any questions that you do not wish to answer. The researcher will protect your identity as much as possible. Any data that could identify you (e.g. your audio file and signed consent form) will be securely stored by the researcher in a locked filing cabinet and secure laptop. Only the researcher will have access to this identifiable data. Any information that might identify you (e.g. names, locations) will also be removed from your typed interview responses and demographic and offending information. Your audio file and your signed consent form will be retained until the researcher's thesis has been examined and PhD awarded.

This information will be stored by the researcher on a secure laptop. After this, it will be archived confidentially by the IPS and deleted or shredded after two years. Information will only be used to contribute to future research in the area which is being conducted by the researchers involved with the project.

Please know that if you indicate to the researcher (a) that you may cause harm to yourself or others, (b) that you were the perpetrator or victim of an undocumented crime, (c) that you were the victim of serious harm from someone else and/or d) that a child is being harmed in the community, then the researcher will be required to report this information to the relevant authority (e.g. prison management, healthcare, TUSLA, Gardaí).

What are the benefits of taking part in this research study?

This research is an opportunity for you to share your experience of being in custody and may help the IPS to better support people who self-harm or engage in suicidal behaviour in the future. However, participation is completely voluntary, and you do not have to take part if you do not wish. No incentives or rewards will be offered for taking part in the research. Similarly, there will be no negative consequences if you choose not to take part in the research.

What are the risks of taking part in this research study?

During the interview, you may talk about some sensitive issues (e.g. recalling incidents of self-injury/suicidality) which you may find distressing. Please know you are free to

skip any questions you do not wish to answer. The de-brief sheet provided to you after the meeting will have information on how you can seek further support if you wish, such as talking a Psychologist or Class Officer, a Chaplain, or a GP.

Can you change your mind at any stage and withdraw from the study?

If you wish, you can withdraw your consent to take part in the study. If while meeting the researcher you no longer want to take part in the research, please let the researcher know and they will finish the meeting early. If after the meeting you no longer wish to participate in the research, please let a member of staff know and they will contact the researcher. This will be possible up until your audio file has been deleted. You can also request to access and/or remove any of your data from the study, up until your audio file has been deleted.

How will you find out what happens with this project?

If you would like to receive an update on the research, please let a member of staff know and they will contact the researcher on your behalf. The researcher will provide a staff member with a written research update for you. Once the final results of the study are ready, the researcher will share these with all participants.

How to receive more information

You may have questions before deciding if you would like to take part in the research. If this is the case, please let the staff member assisting you know what you would like to find out. They will ask the researcher on your behalf, and the researcher will provide you with an answer.

If you would like to write a letter to the researcher with your questions, please give this to the member of staff assisting you and they will pass it on to the researcher. The researcher will provide a letter with some answers to your questions in return.

You can also meet with the researcher more informally to discuss your questions, before deciding if you would like to take part in the research. If you would like to do this, please let the member of staff assisting you know, and they will liaise with the researcher to arrange a meeting with you.

Information Sheet (repeat)

"Addressing Self-injury & Suicide: the lived experience of people in custody in Ireland and the factors that contribute towards resilience, desistance and persistence."

My name is Sarah Hume and I am a Principal Psychologist doing some research (a PhD) at Durham University and the Irish Prison Service (IPS). The research is supervised by two project supervisors at Durham University and one project supervisor at the IPS. The research will look at the experiences of person in custody's of the risk of self-injury and suicidality and the risk environment in prison. I am interested in talking to people in custody who either have engaged in a single, or repeat episode of self-injury and suicidal behaviour and people who have not engaged in self-injury or suicidal behaviour. If you think you might be interested in sharing your experience of this, please make sure you understand this information sheet and consent form.

What is this research about?

The IPS has been collecting data on incidents where a person in custody has hurt themselves in order to help us better understand self-injury and suicidality, and is exploring ways to improve the management of self-injury and suicidality in the service. This research aims to explore the experiences of people in custody in Irish Prisons to understand why some people harm themselves and why others do not.

Why am I doing this research?

As we are looking to make prisons safer and reduce the number of incidents of self-injury and deaths in custody, it is important that we understand people in custody's experiences of the risk environment. By exploring these experiences from the perspective of those who do hurt themselves and those who do not, we can better understand what is working well in the IPS and what needs to be improved. This will help the IPS further develop its' policies and practices over the next few years.

Why have you been invited to take part?

You have been invited to take part in the research because you have previously hurt yourself in custody on one or more occasions.

How will your data be used?

Your data will be combined with that of other people in custody to describe person in custody's experiences of being in custody. These findings will also be included in reports which will be used for the researcher's PhD thesis and to update the prison service on how the research is going. The researcher may also publish or present the research in academic journals or conferences.

What will happen if you decide to take part?

You will be asked to take part in an interview. When you are interviewed for the research, you will be asked to provide your written consent to take part. This information sheet, and the consent form, refer to the interview you are being asked to take part in.

If you understand this information sheet and the consent form and would like to take part in the research, please sign the consent form and return to your class officer in a sealed envelope. The staff member will return your consent form to the researcher. The researcher will then work with prison staff to schedule a meeting with you.

Please know that some meetings may take place in a psychology consultation room, and that an officer may be outside the door.

During this meeting, the researcher will conduct an interview, asking you some questions about your experience in prison. The interview will be audio-recorded and will take approximately one hour. The researcher will then provide you with a de-brief sheet, which outlines ways in which both people in custody can seek further support if they wish to do so.

With your consent, the researcher will also be collecting some demographic (e.g. your age, nationality) and offending (e.g. offence history, incidents in prison) information about you from the prison service's official records. You will be asked to complete some psychometric questionnaires, and then your involvement in the research will be complete. This information will be used for the purpose of this research only.

How will your privacy be protected?

During the meetings you are free to skip any questions that you do not wish to answer. The researcher will protect your identity as much as possible. Any data that could identify you (e.g. your audio file and signed consent form) will be securely stored by the researcher in a locked filing cabinet and secure laptop. Only the researcher will have access to this identifiable data. Your signed consent form will be shredded by the researcher once the researcher's thesis has been examined and PhD awarded. Any information that might identify you (e.g. names, locations) will also be removed from your typed interview responses and demographic and offending information. All other data (e.g. transcripts, descriptive statistics) will be stored by the researcher on a secure laptop until the PhD has been examined and awarded. After this, it will be archived confidentially by the IPS and deleted after 2 years. This information will only be used to contribute to future research in the area which is being conducted by the researchers involved with the project.

However, please know that if you indicate to the researcher (a) that you may cause harm to yourself or others, (b) that you were the perpetrator or victim of an undocumented crime, and/or (c) that you were the victim of serious harm from someone else, then the researcher will be required to report this information.

What are the benefits of taking part in this research study?

This research is an opportunity for you to share your experience of being in custody. However, participation is completely voluntary, and you do not have to take part if you do not wish. No incentives or rewards will be offered for taking part in the research. Similarly, there will be no negative consequences if you choose not to take part in the research.

What are the risks of taking part in this research study?

During the interview you may talk about some sensitive issues (e.g. recalling incidents of self-injury/suicidality) which you may find distressing. Please know you are free to skip any questions you do not wish to answer. The de-brief sheet provided to you after the meeting will have information on how you can seek further support if you wish, such as talking your Psychologist or Personal Officer, a Chaplain, or a GP.

Can you change your mind at any stage and withdraw from the study?

If you wish, you can withdraw your consent to take part in the study. If while meeting the researcher you no longer want to take part in the research, please let the

researcher know and they will finish the meeting early. If after the meeting you no longer wish to participate in the research, please let a member of staff know and they will contact the researcher. This will be possible up until your audio file has been deleted. You can also request to access and/or remove any of your data from the study, up until your audio file has been deleted.

How will you find out what happens with this project?

If you would like to receive an update on the research, please let a member of staff know and they will contact the researcher on your behalf. The researcher will provide a staff member with a written research update for you. Once the final results of the study are ready, the researcher will share these with all participants.

How to receive more information

You may have questions before deciding if you would like to take part in the research. If this is the case, please let the staff member assisting you know what you would like to find out. They will ask the researcher on your behalf, and the researcher will provide you with an answer.

If you would like to write a letter to the researcher with your questions, please give this to the member of staff assisting you and they will pass it on to the researcher. The researcher will provide a letter with some answers to your questions in return.

You can also meet with the researcher more informally to discuss your questions, before deciding if you would like to take part in the research. If you would like to do this, please let the member of staff assisting you know, and they will liaise with the researcher to arrange a meeting with you.

Information Sheet (suicide)

"Addressing Self-injury & Suicide: the lived experience of people in custody in Ireland and the factors that contribute towards resilience, desistance and persistence."

My name is Sarah Hume and I am a Principal Psychologist doing some research (a PhD) at Durham University and the Irish Prison Service (IPS). The research is supervised by two project supervisors at Durham University and one project supervisor at the IPS. The research will look at the experiences of person in custody's of the risk of self-injury and suicidality and the risk environment in prison. I am interested in talking to people in custody who either have engaged in a single, or repeat episode of self-injury and suicidal behaviour and people who have not engaged in self-injury or suicidal behaviour. If you think you might be interested in sharing your experience of this, please make sure you understand this information sheet and consent form.

What is this research about?

The IPS has been collecting data on incidents where a person in custody has hurt themselves in order to help us better understand self-injury and suicidality, and is exploring ways to improve the management of self-injury and suicidality in the service. This research aims to explore the experiences of people in custody in Irish Prisons to understand why some people harm themselves and why others do not.

Why am I doing this research?

As we are looking to make prisons safer and reduce the number of incidents of self-injury and deaths in custody, it is important that we understand people in custody's experiences of the risk environment. By exploring these experiences from the perspective of those who do hurt themselves and those who do not, we can better understand what is working well in the IPS and what needs to be improved. This will help the IPS further develop its' policies and practices over the next few years.

Why have you been invited to take part?

You have been invited to take part in the research because you have previously hurt yourself or tried to commit suicide in custody.

How will your data be used?

Your data will be combined with that of other to describe person in custody's experiences of being in custody. These findings will also be included in reports which will be used for the researcher's PhD thesis and to update the prison service on how the research is going. The researcher may also publish or present the research in academic journals or conferences.

What will happen if you decide to take part?

You will be asked to take part in an interview. When you are interviewed for the research, you will be asked to provide your written consent to take part. This information sheet, and the consent form, refer to the interview you are being asked to take part in.

If you understand this information sheet and the consent form and would like to take part in the research, please sign the consent form and return to your class officer in a sealed envelope. The staff member will return your consent form to the researcher. The researcher will then work with prison staff to schedule a meeting with you. Please know that some meetings may take place in a psychology consultation room, and that an officer may be outside the door.

During this meeting, the researcher will conduct an interview, asking you some questions about your experience in prison. The interview will be audio-recorded and will take approximately one hour. The researcher will then provide you with a de-brief sheet, which outlines ways in which both people in custody can seek further support if they wish to do so.

With your consent, the researcher will also be collecting some demographic (e.g. your age, nationality) and offending (e.g. offence history, incidents in prison) information about you from the prison service's official records. You will be asked to complete some psychometric questionnaires, and then your involvement in the research will be complete. This information will be used for the purpose of this research only.

How will your privacy be protected?

During the meetings you are free to skip any questions that you do not wish to answer. The researcher will protect your identity as much as possible. Any data that could

identify you (e.g. your audio file and signed consent form) will be securely stored by the researcher in a locked filing cabinet and secure laptop. Only the researcher will have access to this identifiable data. Your signed consent form will be shredded by the researcher once the researcher's thesis has been examined and PhD awarded. Any information that might identify you (e.g. names, locations) will also be removed from your typed interview responses and demographic and offending information. All other data (e.g. transcripts, descriptive statistics) will be stored by the researcher on a secure laptop until the PhD has been examined and awarded. After this, it will be archived confidentially by the IPS and deleted after 2 years. This information will only be used to contribute to future research in the area which is being conducted by the researchers involved with the project.

However, please know that if you indicate to the researcher (a) that you may cause harm to yourself or others, (b) that you were the perpetrator or victim of an undocumented crime, and/or (c) that you were the victim of serious harm from someone else, then the researcher will be required to report this information.

What are the benefits of taking part in this research study?

This research is an opportunity for you to share your experience of being in custody. However, participation is completely voluntary, and you do not have to take part if you do not wish. No incentives or rewards will be offered for taking part in the research. Similarly, there will be no negative consequences if you choose not to take part in the research.

What are the risks of taking part in this research study?

During the interview you may talk about some sensitive issues (e.g. recalling incidents of self-injury/suicidality) which you may find distressing. Please know you are free to skip any questions you do not wish to answer. The de-brief sheet provided to you after the meeting will have information on how you can seek further support if you wish, such as talking your Psychologist or Personal Officer, a Chaplain, or a GP.

Can you change your mind at any stage and withdraw from the study?

If you wish, you can withdraw your consent to take part in the study. If while meeting the researcher you no longer want to take part in the research, please let the researcher know and they will finish the meeting early. If after the meeting you no longer wish to participate in the research, please let a member of staff know and they

will contact the researcher. This will be possible up until your audio file has been deleted. You can also request to access and/or remove any of your data from the study, up until your audio file has been deleted.

How will you find out what happens with this project?

If you would like to receive an update on the research, please let a member of staff know and they will contact the researcher on your behalf. The researcher will provide a staff member with a written research update for you. Once the final results of the study are ready, the researcher will share these with all participants.

How to receive more information

You may have questions before deciding if you would like to take part in the research. If this is the case, please let the staff member assisting you know what you would like to find out. They will ask the researcher on your behalf, and the researcher will provide you with an answer.

If you would like to write a letter to the researcher with your questions, please give this to the member of staff assisting you and they will pass it on to the researcher. The researcher will provide a letter with some answers to your questions in return.

You can also meet with the researcher more informally to discuss your questions, before deciding if you would like to take part in the research. If you would like to do this, please let the member of staff assisting you know, and they will liaise with the researcher to arrange a meeting with you.

Information Sheet (no incidents)

"**Addressing Self-Injury & Suicide: the lived experience of people in custody in Ireland and the factors that contribute towards resilience, desistance and persistence."**

My name is Sarah Hume and I am a Principal Psychologist doing some research (a PhD) at Durham University and the Irish Prison Service (IPS). The research is supervised by two project supervisors at Durham University and one project supervisor at the IPS. The research will look at the experiences of people in custody of the risk of self-injury and suicidality and the risk environment in prison. I am interested in talking to people in custody who either have engaged in a single, or repeat episode of self-injury and suicidal behaviour and people who have not engaged in self-injury or suicidal behaviour in custody. If you think you might be interested in sharing your experience of this, please make sure you understand this information sheet and consent form.

What is this research about?

The IPS has been collecting data on incidents where a person in custody has hurt themselves in order to help us better understand self-injury and suicidality, and is exploring ways to improve the management of self-injury and suicidality in the service. This research aims to explore the experiences of people in custody in Irish Prisons to understand why some people harm themselves and why others do not.

Why am I doing this research?

As we are looking to make prisons safer and reduce the number of incidents of self-injury and deaths in custody, it is important that we understand people in custody's experiences of the risk environment. By exploring these experiences from the perspective of those who do hurt themselves and those who do not, we can better understand what is working well in the IPS and what needs to be improved. This will help the IPS further develop its' policies and practices over the next few years.

Why have you been invited to take part?

You have been invited to take part in the research because you have <u>not</u> been involved in an incident of harm to self in custody.

How will your data be used?

Your data will be combined with that of other people in custody to describe people in custody's experiences of being in custody. These findings will also be included in reports which will be used for the researcher's PhD thesis and to update the prison service on how the research is going. The researcher may also publish or present the research in academic journals or conferences.

What will happen if you decide to take part?

You will be asked to take part in an interview. When you are interviewed for the research, you will be asked to provide your written consent to take part. This information sheet, and the consent form, refer to the interview you are being asked to take part in.

If you understand this information sheet and the consent form and would like to take part in the research, please sign the consent form and return to your class officer in a sealed envelope. The staff member will return your consent form to the researcher. The researcher will then work with prison staff to schedule a meeting with you. Please know that some meetings may take place in a psychology consultation room, and that an officer may be outside the door.

During this meeting, the researcher will conduct an interview, asking you some questions about your experience in prison. The interview will be audio-recorded and will take approximately one hour. The researcher will then provide you with a de-brief sheet, which outlines ways in which both people in custody can seek further support if they wish to do so.

With your consent, the researcher will also be collecting some demographic (e.g. your age, nationality) and offending (e.g. offence history, incidents in prison) information about you from the prison service's official records. You will be asked to complete some psychometric questionnaires, and then your involvement in the research will be complete. This information will be used for the purpose of this research only.

How will your privacy be protected?

During the meetings you are free to skip any questions that you do not wish to answer. The researcher will protect your identity as much as possible. Any data that could

identify you (e.g. your audio file and signed consent form) will be securely stored by the researcher in a locked filing cabinet and secure laptop. Only the researcher will have access to this identifiable data. Your audio file will be deleted once the researcher's thesis has been examined and PhD awarded, and your signed consent form will be destroyed one year after the study has been published. Any information that might identify you (e.g. names, locations) will also be removed from your typed interview responses and demographic and offending information. This information will be stored by the researcher on a secure laptop, until one year after the study is published. After this, it will be archived by the IPS indefinitely. This information will only be used to contribute to future research in the area, being conducted by one or more of the researchers involved with the project.

However, please know that if you indicate to the researcher (a) that you may cause harm to yourself or others, (b) that you were the perpetrator or victim of an undocumented crime, and/or (c) that you were the victim of serious harm from someone else, then the researcher will be required to report this information.

What are the benefits of taking part in this research study?

This research is an opportunity for you to share your experience of being in custody. However, participation is completely voluntary, and you do not have to take part if you do not wish. No incentives or rewards will be offered for taking part in the research. Similarly, there will be no negative consequences if you choose not to take part in the research.

What are the risks of taking part in this research study?

During the interview you may talk about some sensitive issues (e.g. recalling incidents of self-injury/suicidality) which you may find distressing. Please know you are free to skip any questions you do not wish to answer. The de-brief sheet provided to you after the meeting will have information on how you can seek further support if you wish, such as talking your Psychologist or Personal Officer, a Chaplain, or a GP.

Can you change your mind at any stage and withdraw from the study?

If you wish, you can withdraw your consent to take part in the study. If while meeting the researcher you no longer want to take part in the research, please let the researcher know and they will finish the meeting early. If after the meeting you no longer wish to participate in the research, please let a member of staff know and they

will contact the researcher. This will be possible up until your audio file has been deleted. You can also request to access and/or remove any of your data from the study, up until your audio file has been deleted.

How will you find out what happens with this project?

If you would like to receive an update on the research, please let a member of staff know and they will contact the researcher on your behalf. The researcher will provide a staff member with a written research update for you. Once the final results of the study are ready, the researcher will share these with all participants.

How to receive more information

You may have questions before deciding if you would like to take part in the research. If this is the case, please let the staff member assisting you know what you would like to find out. They will ask the researcher on your behalf, and the researcher will provide you with an answer.

If you would like to write a letter to the researcher with your questions, please give this to the member of staff assisting you and they will pass it on to the researcher. The researcher will provide a letter with some answers to your questions in return.

You can also meet with the researcher more informally to discuss your questions, before deciding if you would like to take part in the research. If you would like to do this, please let the member of staff assisting you know, and they will liaise with the researcher to arrange a meeting with you.

Appendix B: Consent forms

Consent Form

"Addressing Self-injury & Suicide: the lived experience of people in custody in Ireland and the factors that contribute towards resilience, desistance and persistence."

If you would like to take part in this research, please make sure you understand and agree to the following points before providing your written consent:

- I understand why the research is being done
- I understand why I have been invited to take part in the research
- I understand how my information will be used in the research
- I understand what will happen if I take part in the research
- I understand that taking part in the research involves meeting with the researcher at various different time-points, and that I will be contacted about the research in advance of each time-point
- I understand that the research will also access some demographic and offending information from my official prison service record, for the purpose of this research only
- I understand that my identity will be protected as much as possible, by the researcher:
  - securely storing my audio file and consent form
  - deleting my audio file once the researcher's PhD has been examined and awarded
  - destroying my consent form one year after the study has been published
  - removing some information (e.g. names, locations) from my typed interview responses
  - securely storing my typed interview responses up until one year after the study has been published, and after this point they will be archived indefinitely by the IPS to contribute to future research being conducted on this topic, by one or more of the researchers involved with this project
- I understand that the interview will be audio recorded
- I understand that if I indicate that (a) I may cause harm to myself or others, (b) I was the perpetrator or victim of an undocumented crime, (c) I was the victim of serious harm from someone else, and/or d) a child is being harmed in the community, the researcher will report this information

- I understand that taking part in the research is completely voluntary
- I understand that no incentives or rewards will be offered for taking part in the research
- I understand that the research may involve discussing sensitive issues
    - I understand that I am free to skip these questions during the interview if I wish
    - I understand that a staff member will provide me with a de-briefing sheet after the interview with details of how to get further support if I wish
- I understand that during the meeting I can let the researcher know if I no longer consent to take part in the research
- I understand that after the meeting I can withdraw my consent to take part in the research, up until my audio file has been deleted
- I understand that I can request to access or remove any of my data, up until my audio file has been deleted
- I understand how I can find out what happens with this project
- I know how to get more information about the research

If you understand the information sheet and consent form and would like to participate in the study, please provide your written consent by providing the details below:

Signature:

Print Name:

Date:

Appendix C: Interview schedule and any instructions for interviewing here

Schedule of Semi-Structured Interview Topics – People in custody who have repeatedly self-injured.

Below is a schedule of topics to be discussed during semi-structured interviews with people in custody who have engaged in a single, or repeated episode of self-injury, with some example questions. The same schedule will be used for each interview for people in custody in this category in the research. An alternative schedule will be used for people in custody who have not engaged in self-injury and/or suicidal behaviour in custody.

- **Background information, early years, history of self-injury and suicidality, and involvement in treatment.**

Name	
Age	
Male or Female	M F
Offence	
Sentencing status	On remand Sentenced
Sentence length	
Number of previous incarcerations	
P19 history	
Educational background	None J/Cert L/Cert Higher Certificates (6) Degree (7) Postgraduate Diploma (9) Higher Doctorate (10)
Unemployment	

before prison								
Homelessness before prison								
What is your ethnic/cultural background?	Irish	Asian or Asian Irish	Black or black Irish	Roma				
	Irish Traveler	Chinese	African	Other (including mixed (specify)				
	Any other white background	Any other Asian background	Any other black background					
Relationship status?	Single	In a relationship	Married	Widowed	Divorced	Separated		
Do you receive visits or telephone calls from friends or family?	Yes – telephone calls Yes – visits No	If so, who?	How often?					
Do you have children?	Yes No	**If yes, how many? Ages**	**Who is taking care of your childrn?**	Living with their mum	Living with family members or extended family memb	Within care	Living with foster parents	Adopted.

					er network			
ACE's as a child	Abuse		Neglect			Household dysfunction		
	Physical Emotional Sexual		Physical Emotional			Mental illness Mother treated violently Divorce		
Experience of substance dependence?	Alcohol		Drugs?			Both?		
History of violence	In the community				In prison			
Have you ever had contact with psychiatric services in prison or in the community?	Yes				No			

- Self-injury behaviours and environment

History of Self-injury in the community	History of Attempted suicide in the community
Prompt questions Did you self-injure in the community before you came to prison?	Did you ever try to complete suicide in the community before you came to prison?

When was the first episode of out-of-prison self-injury	When was the first attempt to complete suicide out-of-prison?

Self-injury in prison	Attempted suicide in prison
Prompt Questions Have you ever self-injured in prison? When was the first episode while in prison? If no, have you ever thought about harming yourself?	Have you ever attempted to complete suicide in prison? When was the first attempted suicide while in prison? If no, have you ever thought about suicide?

Can you list the types of self-injury or suicidality you have undertaken previously in prison or in the community?	Prison	Community
Cutting		
Drug Overdose		
Alcohol		
Drowning		
Hanging, strangulation and suffocation		
Steam, vapor and hot objects		
Blunt objects		
Fire/flames		
Petroleum products, solvents, vapors		
Chemicals/noxious substances		
Firearm		

Where did you hurt yourself?	
Torso	upper limb

Head	lower limb
abdominopelvic region	Neck

Ligature and overdose		
Did you use a ligature?	Y	N
Overdose?	Y	N

- **The perceived risks of their self-injury and/or suicidality and their strategies to reduce use of harm.**

Expected final outcome

"At the time of your self-injury or suicidality, what final outcome did you most intend and expect?"	

- Circumstances in which self-injury occurred.

When you self-injure or tried to complete suicide, were you alone or in company?	Alone	In company
Single Cell	Double Cell	Triple Cell
Did you seek medical attention?	Yes	No

- **Experiences related to their self-injury behaviour or suicidality (and thus current circumstances):**

- Experiences outside of/prior to prison ➢ *E.g. "Can you identify any experiences in your life before prison, which may be related to your behaviour?"*	
- Experiences inside of prison ➢ *E.g. "Can you identify any experiences since you've been in prison, which may be related to your behaviour?"*	

- Trajectory leading up to current circumstances ➢ *E.g. "From your perspective, why do you think you self-injury or have suicidal thoughts?"*	

- **Understandings of their self-injury behaviour or suicidality in prison:**

- Risk factors ➢ *E.g. "What kind of things contribute to this kind of behaviour happening?"* ➢ What was happening before your recent episode of self-injury and/or suicidality? ➢ What are the factors in prison that make you more likely to hurt yourself?	
- Protective factors ➢ *E.g. "What kind of things can help prevent this kind of behaviour happening?"* ➢ *What are the factors in prison that make you less likely to hurt yourself?*	

- Behavioural /emotional function ➢ *E.g. "What kind of things does this behaviour achieve for you"?* ➢ *What does self-injury do for you?* ➢ *What emotions do you manage by self-injuring?* ➢ *Did you really want your life to end, or did you want your problems to go away?*	➢ To die (see section below if yes) ➢ To get someone to do something you want ➢ To get something you want (money, drugs etc.) ➢ To reduce tension / express emotion ➢ To gain social status ➢ Attention seeking ➢ Sensation seeking ➢ To control / change situation ➢ Defence, Distance ➢ Proximity, Affiliation ➢ Self-esteem

Please describe how you are managing your self harm/your thoughts and feelings? Prompts; day to day, triggers/pressures, meaningful activities, available supports, interventions offered/received.	
Please describe any particular coping strategies that you use? Promotes; practical/mental/practice and leaning, any strategies you particularly like/dislike?	
What were the things that helped you the most to stop self-harming (and why) Prompts; people, places, activities/what makes you feel better/what is important?	

What were the things that you find unhelpful or cause you difficulty in stopping you from self-harming and why? Prompt: people, places, activities, processes, what makes you feel worse/barriers to overcome.	
What advice would you offer to others going through a similar experience? What advice would you give to those that are supporting you?	
Is there anything else you would like to tell me about your experiences of self-harming that I've not already asked?	

- **Conditions for suicide –** if yes to function was to die.

	Evidence +	**Evidence -**
Pain		
Hopelessness		
Connection (support from friends/family, peers, relationship with staff)		
Capability **access to means/ligature points** **alcohol or drugs as a disinhibitor** **fearlessness** **pain insensitivity** **Deliberate and active means to increase preparedness.** **greater history of painful and provocative life events)**		

- **Self-injurious behaviour and/or suicidality and their risk reduction strategies**

Have you ever thought of harming yourself and stopped, or managed to do less harm to yourself than you wished?	
How did you stop yourself from self-injury or complete suicide on those occasions, or reduce risk?	
How do you avoid self-injury or experiencing suicidality in prison, or reduce risk of serious harm?	

- **Changing their self-injury behaviour and suicidality**

• Reducing self-injury behaviour ➢ *E.g. "What would less harmful behaviour look like for you?", "What kinds of things would help this happen for you?"*	
• Improving suicidality ➢ *E.g. "What would safe behaviour look like for you?", "What kinds of things would help this happen for you?"*	

- **Thoughts on current environment:**

- Comparison to other prison environments ➢ *E.g. "How is being here similar/different to other places you have been in prison?"*	
- Positive aspects ➢ *E.g. "Can you identify a particular aspect of your current*	

environment that you like/find helpful?"	
- Negative aspects ➢ *E.g. "Can you identify a particular aspect of your current environment that you do not like/find helpful, and would like to change?"*	
- Relations in prison ➢ *E.g. "What kind of relationships do you have with others (people in custody/staff/management) in prison?"*	

- **Psychological health and well-being:**

- Understanding of psychological health and well-being ➢ *E.g. "What does being 'psychologically healthy' or 'psychologically well' mean for you?*	
- Impact of experiences related to prison on psychological health and well-being ➢ *E.g. "Can you identify any experiences in your life, either before or within prison, which may have impacted your psychological well-being?"*	

- Impact of prison on psychological health and well-being ➢ *E.g. "Can you identify any relationship between prison and your psychological well-being?*	
- Impact of current circumstances on psychological health and well-being ➢ *E.g. "In what ways do you think being in prison has impacted your psychological well-being, if any?*	
- Changing psychological health and well-being ➢ *E.g. "What would improve psychological well-being look like for you?", "What kinds of things would help this happen for you?"*	

- Participants additional thoughts on any of the topics discussed/any relevant topics not discussed

Schedule of Semi-Structured Interview Topics – People in custody who have attempted suicide.

Below is a schedule of topics to be discussed during semi-structured interviews with people in custody who have engaged in a single, or repeated episode of self-injury, with some example questions. The same schedule will be used for each interview for people in custody in this category in the research. An alternative schedule will be used for people in custody who have not engaged in self-injury and/or suicidal behaviour in custody.

- **Background information, early years, history of self-injury and suicidality, and involvement in treatment.**

Name	
Age	
Male or Female	M F
Offence	
Sentencing status	On remand Sentenced
Sentence length	
Number of previous incarcerations	
P19 history	
Educational background	None J/Cert L/Cert Higher Certificates (6) Degree (7) Postgraduate Diploma (9) Higher Doctorate (10)
Unemployment	

before prison								
Homelessness before prison								
What is your ethnic/cultural background?	Irish	Asian or Asian Irish	Black or black Irish	Roma				
	Irish Traveler	Chinese	African	Other (including mixed (specify)				
	Any other white background	Any other Asian background	Any other black background					
Relationship status?	Single	In a relationship	Married	Widowed	Divorced	Separated		
Do you receive visits or telephone calls from friends or family?	Yes – telephone calls Yes – visits No	If so, who?	How often?					
Do you have children?	Yes No	**If yes, how many? Ages**	**Who is taking care of your childrn?**	Living with their mum	Living with family members or extended family memb	Within care	Living with foster parents	Adopted.

					er network			
ACE's as a child	Abuse		Neglect			Household dysfunction		
	Physical Emotional Sexual		Physical Emotional			Mental illness Mother treated violently Divorce		
Experience of substance dependence?	Alcohol		Drugs?			Both?		
History of violence	In the community				In prison			
Have you ever had contact with psychiatric services in prison or in the community?	Yes				No			

- Self-injury behaviours and environment

History of Self injury in the community	History of Attempted suicide in the community
Prompt questions Did you self-injure in the community before you came to prison?	Did you ever try to complete suicide in the community before you came to prison?

When was the first episode of out-of-prison self-injury	When was the first attempt to complete suicide out-of-prison?

Self-injury in prison	Attempted suicide in prison
Prompt Questions Have you ever self-injured in prison? When was the first episode while in prison? If no, have you ever thought about harming yourself?	Have you ever attempted to complete suicide in prison? When was the first attempted suicide while in prison? If no, have you ever thought about suicide?

Can you list the types of self-injury or suicidality you have undertaken previously in prison or in the community?	Prison	Community
Cutting		
Drug Overdose		
Alcohol		
Drowning		
Hanging, strangulation and suffocation		
Steam, vapor and hot objects		
Blunt objects		
Fire/flames		
Petroleum products, solvents, vapors		
Chemicals/noxious substances		
Firearm		

Where did you hurt yourself?	
Torso	upper limb
Head	lower limb
abdominopelvic region	Neck

Ligature and overdose		
Did you use a ligature?	Y	N
Overdose?	Y	N

- **The perceived risks of their self-injury and/or suicidality and their strategies to reduce use of harm.**

Expected final outcome

"At the time of your self-injury or suicidality, what final outcome did you most intend and expect?"	

- Circumstances in which self-injury occurred.

When you self-injure or tried to complete suicide, were you alone or in company?	Alone	In company
Single Cell	Double Cell	Triple Cell
Did you seek medical attention?	Yes	No

- **Experiences related to their self-injury behaviour or suicidality (and thus current circumstances):**

- Experiences outside of/prior to prison ➢ *E.g. "Can you identify any experiences in your life before prison, which may be related to your behaviour?"*	
- Experiences inside of prison ➢ *E.g. "Can you identify any experiences since you've been in*	

prison, which may be related to your behaviour?"	
- Trajectory leading up to current circumstances ➢ *E.g. "From your perspective, why do you think you self-injury or have suicidal thoughts?"*	

- **Understandings of their self-injury behaviour or suicidality in prison:**

- Risk factors ➢ *E.g. "What kind of things contribute to this kind of behaviour happening?"* ➢ What was happening before your recent episode of self-injury and/or suicidality? ➢ What are the factors in prison that make you more likely to hurt yourself?	
- Protective factors ➢ *E.g. "What kind of things can help prevent this kind of behaviour happening?"* ➢ *What are the factors in prison*	

that make you less likely to hurt yourself?	
- Behavioural /emotional function ➢ *E.g. "What kind of things does this behaviour achieve for you"?* ➢ *What does self-injury do for you?* ➢ *What emotions do you manage by self-injuring?* ➢ *Did you really want your life to end, or did you want your problems to go away?*	➢ To die (see section below if yes) ➢ To get someone to do something you want ➢ To get something you want (money, drugs etc.) ➢ To reduce tension / express emotion ➢ To gain social status ➢ Attention seeking ➢ Sensation seeking ➢ To control / change situation ➢ Defence, Distance ➢ Proximity, Affiliation ➢ Self-esteem

Please describe how you are managing your self harm/your thoughts and feelings? Prompts; day to day, triggers/pressures, meaningful activities, available supports, interventions offered/received.	
Please describe any particular coping strategies that you use? Promotes; practical/mental/practice and leaning, any strategies you particularly like/dislike?	
What were the things that helped you the most to stop self-harming (and why)	

Prompts; people, places, activities/what makes you feel better/what is important?	
What were the things that you find unhelpful or cause you difficulty in stopping you from self-harming and why? Prompt: people, places, activities, processes, what makes you feel worse/barriers to overcome.	
What advice would you offer to others going through a similar experience? What advice would you give to those that are supporting you?	
Is there anything else you would like to tell me about your experiences of self-harming that I've not already asked?	

- **Conditions for suicide –** if yes to function was to die.

	Evidence +	**Evidence -**
Pain		
Hopelessness		
Connection (support from friends/family, peers, relationship with staff)		
Capability **access to means/ligature points** **alcohol or drugs as a disinhibitor** **fearlessness** **pain insensitivity** **Deliberate and active means to increase preparedness.**		

greater history of painful and provocative life events)		

- **Self-injurious behaviour and/or suicidality and their risk reduction strategies**

Have you ever thought of harming yourself and stopped, or managed to do less harm to yourself than you wished?	
How did you stop yourself from self-injury or complete suicide on those occasions, or reduce risk?	
How do you avoid self-injury or experiencing suicidality in prison, or reduce risk of serious harm?	

- **Changing their self-injury behaviour and suicidality**

• Reducing self-injury behaviour ➢ *E.g. "What would less harmful behaviour look like for you?", "What kinds of things would help this happen for you?"*	
• Improving suicidality ➢ *E.g. "What would safe behaviour look like for you?", "What kinds of things would help this happen for you?"*	

- **Thoughts on current environment:**

- Comparison to other prison environments ➢ *E.g. "How is being here similar/different to other places you have been in prison?"*	

- Positive aspects ➢ *E.g. "Can you identify a particular aspect of your current environment that you like/find helpful?"*	
- Negative aspects ➢ *E.g. "Can you identify a particular aspect of your current environment that you do not like/find helpful, and would like to change?"*	
- Relations in prison ➢ *E.g. "What kind of relationships do you have with others (people in custody/staff/management) in prison?"*	

- **Psychological health and well-being:**

- Understanding of psychological health and well-being ➢ *E.g. "What does being 'psychologically healthy' or 'psychologically well' mean for you?*	
- Impact of experiences related to prison on psychological health and well-being ➢ *E.g. "Can you identify any experiences in your life, either before or within prison, which may have impacted your psychological well-being?"*	

- Impact of prison on psychological health and well-being ➢ *E.g. "Can you identify any relationship between prison and your psychological well-being?*	
- Impact of current circumstances on psychological health and well-being ➢ *E.g. "In what ways do you think being in prison has impacted your psychological well-being, if any?*	
- Changing psychological health and well-being ➢ *E.g. "What would improve psychological well-being look like for you?", "What kinds of things would help this happen for you?"*	

- Participants additional thoughts on any of the topics discussed/any relevant topics not discussed

Schedule of Semi-Structured Interview Topics – People in custody who have not previously engaged in self-injury and/or suicidal behaviour in custody.

Below is a schedule of topics to be discussed during semi-structured interviews with people in custody who have not engaged in an episode of self-injury, or suicidal behaviour in custody with some example questions. The same schedule will be used for each interview for people in custody in this category in the research.

- **Background information, early years, history of self-injury and suicidality, and involvement in treatment.**

Name	
Age	
Male or Female	M F0
Offence	
Sentencing status	On remand Sentenced
Sentence length	
No of previous incarcerations	
P19 History	
History of violence	

Educational background	None J/Cert L/Cert Higher Certificates (6) Degree (7) Postgraduate Diploma (9) Higher Doctorate (10)
Homelessness	

before prison								
Unemployment before prison								
What is your ethnic/cultural background?	Irish	Asian or Asian Irish	Black or black Irish	Roma				
	Irish Traveler	Chinese	African	Other (including mixed (specify)				
	Any other white background	Any other Asian background	Any other black background					
Relationship status?	Single	In a relationship	Married	Widowed	Divorced	Separated		
Do you receive visits or telephone calls from friends or family?	Yes – telephone calls Yes – visits No	If so, who?	How often?					
Do you have children?	Yes No	**If yes, how many? Ages**	**Who is taking care of your children?**	Living with their mum	Living with family members or extended family	With in care	Living with foster parents	Adopted.

				member network				
ACE's as a child	Abuse		Neglect			Household dysfunction		
	Physical Emotional Sexual		Physical Emotional			Mental illness Mother treated violently Divorce		
Experience of substance dependence?	Alcohol		Drugs?			Both?		
Have you ever had contact with psychiatric services in prison or in the community?	Yes				No			
History of violence	In the community				In prison			

Self-injurious behaviours and environment

Self-injury in the community	Attempted suicide in the community
E.g.	E.g.,

Have you ever self-injured in prison? When was the first episode while in prison? If no, have you ever thought about harming yourself?	Have you ever attempted to complete suicide in prison? When was the first attempted suicide while in prison? If no, have you ever thought about suicide?

Self-injury in prison	Attempted suicide in prison
E.g. Have you ever self-injured in prison? When was the first episode while in prison? If no, have you ever thought about harming yourself?	E.g. Have you ever attempted to complete suicide in prison? When was the first attempted suicide while in prison? If no, have you ever thought about suicide?

If history Please describe your experience of moving to a period where you are no longer self-harming? What was process of change, awareness of the process, how long did it take, what prompted it.	
If no history Please describe your experience of not self-harming in prison?	
Please describe how you are managing your self harm/your thoughts and feelings?	

Prompts; day to day, triggers/pressures, meaningful activities, available supports, interventions offered/received.	
Please describe any particular coping strategies that you use? Prompts; practical/mental/practice and learning, any strategies you particularly like/dislike?	
Based on your ability to cope, how do you feel about your achievements? Prompts; likelihood of seeking help from others, ongoing support, what have you learnt, view of the future	
What advice would you offer to others who are struggling? What advice would you give to those that are supporting others who are not coping?	
Is there anything else you would like to tell me about your experiences of prison and how you have coped that I've not already asked?	

- **Absence of conditions for suicide**

	Evidence +	**Evidence -**
Pain		
Hopelessness		
Connection (support from friends/family, peers, relationship with staff)		
Capability access to means/ligature points		

alcohol or drugs as a disinhibitor fearlessness pain insensitivity Deliberate and active means to increase preparedness. greater history of painful and provocative life events)		

- **Self-injurious behaviour and/or suicidality and their risk reduction strategies**

Have you ever thought of harming yourself and stopped, or managed to do less harm to yourself than you wished?	
How did you stop yourself from self-injury or complete suicide on those occasions, or reduce risk?	
How do you avoid self-injury or experiencing suicidality in prison, or reduce risk of serious harm?	

- **Experiences related to the absence of self-injury behaviour or suicidality (and thus current circumstances):**

- Experiences inside of prison ➢ *E.g. "Can you identify any experiences since you've been in prison, which may help you to cope?"*	
- Trajectory leading up to current circumstances ➢ *E.g. "From your perspective, why do you think you do not*	

self-injury or have suicidal thoughts?"	

- **Understanding of strategies used by people in custody to reduce risk or avoid harming themselves.**

How do you keep yourself safe in prison?	
What strategies do you use to reduce the risk of you hurting yourself?	

- **Thoughts on current environment:**

- Comparison to other prison environments ➢ *E.g. "How is being here similar/different to other places you have been in prison?"*	
- Positive aspects ➢ *E.g. "Can you identify a particular aspect of your current environment that you like/find helpful?"*	
- Negative aspects ➢ *E.g. "Can you identify a particular aspect of your current environment that you do not like/find helpful, and would like to change?"*	
- Relations in prison ➢ *E.g. "What kind of relationships do you have with others (people in custody/staff/management) in prison?"*	

- **Psychological health and well-being:**

- Understanding of psychological health and well-being ➢ *E.g. "What does being 'psychologically healthy' or 'psychologically well' mean for you?*	
- Impact of experiences related to prison on psychological health and well-being ➢ *E.g. "Can you identify any experiences in your life, either before or within prison, which may have impacted your psychological well-being?"*	
- Impact of prison on psychological health and well-being ➢ *E.g. "Can you identify any relationship between prison and your psychological well-being?*	
- Impact of current circumstances on psychological health and well-being ➢ *E.g. "In what ways do you think being in prison has impacted your psychological well-being, if any?*	
- Changing psychological health and well-being	

➢ *E.g. "What would improved psychological well-being look like for you?", "What kinds of things would help this happen for you?"*	

- Participant's additional thoughts on any of the topics discussed/any relevant topics not discussed.

Schedule of Semi-Structured Interview Topics – People in custody who have engaged in a single episode of self-injury.

Below is a schedule of topics to be discussed during semi-structured interviews with people in custody who have engaged in a single, or repeated episode of self-injury, with some example questions. The same schedule will be used for each interview for people in custody in this category in the research. An alternative schedule will be used for people in custody who have not engaged in self-injury and/or suicidal behaviour in custody.

- **Background information, early years, history of self-injury and suicidality, and involvement in treatment.**

Name	
Offence	
Age	
Male or Female	M F
Sentencing status	On remand Sentenced
Sentence length	
P19 History	
History of violence	

Educational background	None J/Cert L/Cert Higher Certificates (6) Degree (7) Postgraduate Diploma (9) Higher Doctorate (10)			
What is your ethnic/cultural	Irish	Asian or Asian Irish	Black or black Irish	Roma
	Irish Traveler	Chinese	African	Other (including mixed (specify)

background?								
	Any other white background		Any other Asian background		Any other black background			
Relationship status?	Single	In a relationship	Married	Widowed	Divorced	Separated		
Do you receive visits or telephone calls from friends or family?	Yes – telephone calls Yes – visits No	If so, who?	How often?					
Do you have children?	Yes No	**If yes, how many? Ages**	**Who is taking care of your children?**	Living with their mum	Living with family members or extended family member network	With in care	Living with foster parents	Adopted.
ACE's as a child	Abuse		Neglect			Household dysfunction		

	Physical Emotional Sexual	Physical Emotional	Mental illness Mother treated violently Divorce
Experience of substance dependence?	Alcohol	Drugs?	Both?
History of violence	In the community		In prison
Have you ever had contact with psychiatric services in prison or in the community?	Yes		No

- Self-injury behaviours and environment

Self-injury in the community	Attempted suicide in the community
E.g. Have you ever self-injured in prison? When was the first episode while in prison? If no, have you ever thought about harming yourself?	E.g., Have you ever attempted to complete suicide in prison? When was the first attempted suicide while in prison? If no, have you ever thought about suicide?

Self-injury in prison	Attempted suicide in prison
E.g. Have you ever self-injured in prison? When was the first episode while in prison? If no, have you ever thought about harming yourself?	E.g. Have you ever attempted to complete suicide in prison? When was the first attempted suicide while in prison? If no, have you ever thought about suicide?

Can you list the types of self-injury or suicidality you have undertaken previously in prison or in the community?	Prison	Community
Cutting		
Drug Overdose		
Alcohol		
Drowning		
Hanging, strangulation and suffocation		
Steam, vapor and hot objects		
Blunt objects		
Fire/flames		
Petroleum products, solvents, vapors		
Chemicals/noxious substances		
Firearm		

Where did you hurt yourself?	
Torso	upper limb
head	lower limb
abdominopelvic region	Neck

Ligature and overdose		
Did you use a ligature?	Y	N
Overdose?	Y	N

- **The perceived risks of their self-injury and/or suicidality and their strategies to reduce use of harm.**

Expected final outcome

"At the time of your self-injury or suicidality, what final outcome did you most intend and expect?"	

- Circumstances in which self-injury occurred.

When you self-injure or tried to complete suicide, were you alone or in company?	Alone	In company
Single Cell	Double Cell	Triple Cell
Did you seek medical attention?	Yes	No

- **Experiences related to their self-injury behaviour or suicidality (and thus current circumstances):**

- Experiences outside of/prior to prison ➢ *E.g. "Can you identify any experiences in your life before prison, which may be related to your behaviour?"*	
- Experiences inside of prison ➢ *E.g. "Can you identify any experiences since you've been in prison, which may be related to your behaviour?"*	
- Trajectory leading up to current circumstances	

➢ *E.g. "From your perspective, why do you think you self-injury or have suicidal thoughts?"*	

- **Understandings of their self-injury behaviour or suicidality in prison:**

- Risk factors ➢ *E.g. "What kind of things contribute to this kind of behaviour happening?"* ➢ What was happening before your recent episode of self-injury and/or suicidality? ➢ What are the factors in prison that make you more likely to hurt yourself?	
- Protective factors ➢ *E.g. "What kind of things can help prevent this kind of behaviour happening?"* ➢ *What are the factors in prison that make you less likely to hurt yourself?*	

- Behavioural /emotional function ➢ *E.g. "What kind of things does this behaviour achieve for you"?* ➢ *What does self-injury do for you?* ➢ *What emotions do you manage by self-injuring?* ➢ *Did you really want your life to end, or did you want your problems to go away?*	➢ To die (see section below if yes) ➢ To get someone to do something you want ➢ To get something you want (money, drugs etc.) ➢ To reduce tension / express emotion ➢ To gain social status ➢ Attention seeking ➢ Sensation seeking ➢ To control / change situation ➢ Defence, Distance ➢ Proximity, Affiliation ➢ Self-esteem

Please describe how you are managing your self harm/your thoughts and feelings? Prompts; day to day, triggers/pressures, meaningful activities, available supports, interventions offered/received.	
Please describe any particular coping strategies that you use? Promotes; practical/mental/practice and leaning, any strategies you particularly like/dislike?	
What were the things that helped you the most to stop self-harming (and why) Prompts; people, places, activities/what makes you feel better/what is important?	
What were the things that you find unhelpful or cause you difficulty in stopping you from self-harming and why?	

Prompt: people, places, activities, processes, what makes you feel worse/barriers to overcome.	
What advice would you offer to others going through a similar experience? What advice would you give to those that are supporting you?	
Is there anything else you would like to tell me about your experiences of self-harming and how you overcame this that I've not already asked?	

- **Conditions for suicide –** if yes to function was to die.

	Evidence +	**Evidence -**
Pain		
Hopelessness		
Connection (support from friends/family, peers, relationship with staff)		
Capability access to means/ligature points alcohol or drugs as a disinhibitor fearlessness pain insensitivity Deliberate and active means to increase preparedness. greater history of painful and provocative life events)		

- **Self-injurious behaviour and/or suicidality and their risk reduction strategies**

Have you ever thought of harming yourself and stopped, or managed to do less harm to yourself than you wished?	
How did you stop yourself from self-injury or complete suicide on those occasions, or reduce risk?	
How do you avoid self-injury or experiencing suicidality in prison, or reduce risk of serious harm?	

- **Changing their self-injury behaviour and suicidality**

• Reducing self-injury behaviour ➢ *E.g. "What would less harmful behaviour look like for you?", "What kinds of things would help this happen for you?"*	
• Improving suicidality ➢ *E.g. "What would safe behaviour look like for you?", "What kinds of things would help this happen for you?"*	

- **Thoughts on current environment:**

- Comparison to other prison environments ➢ *E.g. "How is being here similar/different to other places you have been in prison?"*	
- Positive aspects ➢ *E.g. "Can you identify a particular aspect of your current environment that you like/find helpful?"*	

- Negative aspects ➢ *E.g. "Can you identify a particular aspect of your current environment that you do not like/find helpful, and would like to change?"*	
- Relations in prison ➢ *E.g. "What kind of relationships do you have with others (people in custody/staff/management) in prison?"*	

- **Psychological health and well-being:**

- Understanding of psychological health and well-being ➢ *E.g. "What does being 'psychologically healthy' or 'psychologically well' mean for you?*	
- Impact of experiences related to prison on psychological health and well-being ➢ *E.g. "Can you identify any experiences in your life, either before or within prison, which may have impacted your psychological well-being?"*	
- Impact of prison on psychological health and well-being	

➢ *E.g. "Can you identify any relationship between prison and your psychological well-being?*	
- Impact of current circumstances on psychological health and well-being ➢ *E.g. "In what ways do you think being in prison has impacted your psychological well-being, if any?*	
- Changing psychological health and well-being ➢ *E.g. "What would improve psychological well-being look like for you?", "What kinds of things would help this happen for you?"*	

Please describe your experience of moving to a period where you are no longer self-harming? What was process of change, awareness of the process, how long did it take, what prompted it.	
Please describe how you are managing your self harm/your thoughts and feelings? Prompts; day to day, triggers/pressures, meaningful activities, available supports, interventions offered/received.	
Please describe any particular coping strategies that you use? Promotes; practical/mental/practice and leaning, any strategies you particularly like/dislike?	
What were the things that helped you the most to stop self-harming (and why)	

Prompts; people, places, activities/what makes you feel better/what is important?	
What were the things that you found unhelpful or caused you difficulty in stopping you from self-harming and why? Prompt: people, places, activities, processes, what makes you feel worse/barriers to overcome.	
Based on your recent achievements, how do you feel about the progress you have made? Prompts; likelihood of seeking help from others, ongoing support, what have you learnt, view of the future	
What advice would you offer to others going through a similar experience? What advice would you give to those that are supporting you?	
Is there anything else you would like to tell me about your experiences of self-harming and how you have overcame this that I've not already asked?	

- Participants additional thoughts on any of the topics discussed/any relevant topics not discussed

Appendix D: Questionnaires/Surveys/scales and any associated evaluation documents

Beck Hopelessness Scale (HS; Beck et al, 1974)

Beck Hopelessness Scale

Instructions: The Beck Hopelessness Scale is a self-report scale that was made to assess and measure the level of hopelessness that you're feeling. Please answer each question by selecting TRUE or FALSE based on how you've been feeling for the past week prior to answering this assessment, including today.

Statement	True	False
1. I look forward to the future with hope and enthusiasm	○	○
2. I might as well give up because I can't make things better for myself	○	○
3. When things are going badly, I am helped by knowing they can't stay that way forever	○	○
4. I can't imagine what my life would be like in 10 years	○	○
5. I have enough time to accomplish the things I most want to do	○	○
6. In the future, I expect to succeed in what concerns me most	○	○
7. My future seems dark to me	○	○
8. I expect to get more good things in life than the average person	○	○
9. I just don't get the breaks, and there's no reason to believe I will in the future	○	○
10. My past experiences have prepared me well for the future	○	○
11. All I can see ahead of me is unpleasantness rather than pleasantness	○	○
12. I don't expect to get what I really want	○	○
13. When I look ahead to the future, I expect I will be happier than I am now	○	○
14. Things just won't work out the way I want them to	○	○
15. I have great faith in the future	○	○
16. I never get what I want so it's foolish to want anything	○	○
17. It is very unlikely that I will get any real satisfaction in the future	○	○
18. The future seems vague and uncertain to me	○	○
19. I can look forward to more good times than bad times	○	○
20. There's no use in really trying to get something I want because I probably won't get it	○	○

*to be written by your psychologist/therapist **Hopelessness score:**

Beck, Aaron T. BHS, Beck Hopelessness Scale. San Antonio, Tex. : New York :Psychological Corp. ; Harcourt Brace Jovanovich, 1988.

Beck Depression Inventory (BDI, Beck, Ward, Mendelson, Mock & Erbaugh, 1961)

BDI®-II

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today.** Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
- 0 I do not feel sad.
- 1 I feel sad much of the time.
- 2 I am sad all the time.
- 3 I am so sad or unhappy that I can't stand it.

2. Pessimism
- 0 I am not discouraged about my future.
- 1 I feel more discouraged about my future than I used to be.
- 2 I do not expect things to work out for me.
- 3 I feel my future is hopeless and will only get worse.

3. Past Failure
- 0 I do not feel like a failure.
- 1 I have failed more than I should have.
- 2 As I look back, I see a lot of failures.
- 3 I feel I am a total failure as a person.

4. Loss of Pleasure
- 0 I get as much pleasure as I ever did from the things I enjoy.
- 1 I don't enjoy things as much as I used to.
- 2 I get very little pleasure from the things I used to enjoy.
- 3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings
- 0 I don't feel particularly guilty.
- 1 I feel guilty over many things I have done or should have done.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6. Punishment Feelings
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7. Self-Dislike
- 0 I feel the same about myself as ever.
- 1 I have lost confidence in myself.
- 2 I am disappointed in myself.
- 3 I dislike myself.

8. Self-Criticalness
- 0 I don't criticize or blame myself more than usual.
- 1 I am more critical of myself than I used to be.
- 2 I criticize myself for all of my faults.
- 3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10. Crying
- 0 I don't cry any more than I used to.
- 1 I cry more than I used to.
- 2 I cry over every little thing.
- 3 I feel like crying, but I can't.

_____ Subtotal Page 1

Continued on Back

26 27 28 29 30 A B C D E 281283-1 32

Product Number 0154018392

11. Agitation

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.
2b I sleep a lot less than usual.

3a I sleep most of the day.
3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.
2b My appetite is much greater than usual.

3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

_____ Subtotal Page 2

_____ Subtotal Page 1

_____ Total Score

Beck Anxiety Inventory (Beck et al., 1988)

BAI®

AME _____ DATE _____

elow is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each mptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

	NOT AT ALL	MILDLY It did not bother me much.	MODERATELY It was very unpleasant, but I could stand it.	SEVERELY I could barely stand it.
1. Numbness or tingling.				
2. Feeling hot.				
3. Wobbliness in legs.				
4. Unable to relax.				
5. Fear of the worst happening.				
6. Dizzy or lightheaded.				
7. Heart pounding or racing.				
8. Unsteady.				
9. Terrified.				
10. Nervous.				
11. Feelings of choking.				
12. Hands trembling.				
13. Shaky.				
14. Fear of losing control.				
15. Difficulty breathing.				
16. Fear of dying.				
17. Scared.				
18. Indigestion or discomfort in abdomen.				
19. Faint.				
20. Face flushed.				
21. Sweating (not due to heat).				

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40 41 42 43 44 45 A B C D E
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Rosenberg Self Esteem Questionnaire (Rosenberg, 1989).

Scale:

Instructions

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

1. On the whole, I am satisfied with myself.

Strongly Agree Agree Disagree Strongly Disagree

2. At times I think I am no good at all.

Strongly Agree Agree Disagree Strongly Disagree

3. I feel that I have a number of good qualities.

Strongly Agree Agree Disagree Strongly Disagree

4. I am able to do things as well as most other people.

Strongly Agree Agree Disagree Strongly Disagree

5. I feel I do not have much to be proud of.

Strongly Agree Agree Disagree Strongly Disagree

6. I certainly feel useless at times.

Strongly Agree Agree Disagree Strongly Disagree

7. I feel that I'm a person of worth, at least on an equal plane with others.

Strongly Agree Agree Disagree Strongly Disagree

8. I wish I could have more respect for myself.

Strongly Agree Agree Disagree Strongly Disagree

9. All in all, I am inclined to feel that I am a failure.

Strongly Agree Agree Disagree Strongly Disagree

10. I take a positive attitude toward myself.

Strongly Agree Agree Disagree Strongly Disagree

Scoring:

Items 2, 5, 6, 8, 9 are reverse scored. Give "Strongly Disagree" 1 point, "Disagree" 2 points, "Agree" 3 points, and "Strongly Agree" 4 points. Sum scores for all ten items. Keep scores on a continuous scale. Higher scores indicate higher self-esteem.

Difficulties in Emotion Regulation Scale (DERS)

Please indicate how often the following statements apply to you by writing the appropriate number from the scale below on the line beside each item.

1----------2----------3----------4----------5

almost never	sometimes	about half the time	most of the time	almost always
(0-10%)	(11-35%)	(36-65%)	(66-90%)	(91-100%)

_____ 1) I am clear about my feelings.
_____ 2) I pay attention to how I feel.
_____ 3) I experience my emotions as overwhelming and out of control.
_____ 4) I have no idea how I am feeling.
_____ 5) I have difficulty making sense out of my feelings.
_____ 6) I am attentive to my feelings.
_____ 7) I know exactly how I am feeling.
_____ 8) I care about what I am feeling.
_____ 9) I am confused about how I feel.
_____ 10) When I'm upset, I acknowledge my emotions.
_____ 11) When I'm upset, I become angry with myself for feeling that way.
_____ 12) When I'm upset, I become embarrassed for feeling that way.
_____ 13) When I'm upset, I have difficulty getting work done.
_____ 14) When I'm upset, I become out of control.
_____ 15) When I'm upset, I believe that I will remain that way for a long time.
_____ 16) When I'm upset, I believe that I will end up feeling very depressed.
_____ 17) When I'm upset, I believe that my feelings are valid and important.
_____ 18) When I'm upset, I have difficulty focusing on other things.
_____ 19) When I'm upset, I feel out of control.
_____ 20) When I'm upset, I can still get things done.
_____ 21) When I'm upset, I feel ashamed at myself for feeling that way.
_____ 22) When I'm upset, I know that I can find a way to eventually feel better.
_____ 23) When I'm upset, I feel like I am weak.
_____ 24) When I'm upset, I feel like I can remain in control of my behaviors.
_____ 25) When I'm upset, I feel guilty for feeling that way.
_____ 26) When I'm upset, I have difficulty concentrating.
_____ 27) When I'm upset, I have difficulty controlling my behaviors.
_____ 28) When I'm upset, I believe there is nothing I can do to make myself feel better.
_____ 29) When I'm upset, I become irritated at myself for feeling that way.
_____ 30) When I'm upset, I start to feel very bad about myself.
_____ 31) When I'm upset, I believe that wallowing in it is all I can do.
_____ 32) When I'm upset, I lose control over my behavior.
_____ 33) When I'm upset, I have difficulty thinking about anything else.
_____ 34) When I'm upset I take time to figure out what I'm really feeling.
_____ 35) When I'm upset, it takes me a long time to feel better.
_____ 36) When I'm upset, my emotions feel overwhelming.

Reverse-scored items (place a subtraction sign in front of them) are numbered 1, 2, 6, 7, 8, 10, 17, 20, 22, 24 and 34.

Calculate total score by adding everything up. Higher scores suggest greater problems with emotion regulation.

SUBSCALE SCORING:** The measure yields a total score (SUM) as well as scores on six sub-scales:

1. Nonacceptance of emotional responses (NONACCEPT): 11, 12, 21, 23, 25, 29
2. Difficulty engaging in Goal-directed behavior (GOALS): 13, 18, 20R, 26, 33
3. Impulse control difficulties (IMPULSE): 3, 14, 19, 24R, 27, 32
4. Lack of emotional awareness (AWARENESS): 2R, 6R, 8R, 10R, 17R, 34R
5. Limited access to emotion regulation strategies (STRATEGIES): 15, 16, 22R, 28, 30, 31, 35, 36
6. Lack of emotional clarity (CLARITY): 1R, 4, 5, 7R, 9

Total score: sum of all subscales

**"R" indicates reverse scored item

REFERENCE:

Gratz, K. L. & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment, 26,* 41-54.

DBT Ways of Coping (Neacsui, 2010)

Data Entry Initials: _____ Client ID #: _____
Date: _____ Date: _____
Second Entry: _____ Assessment: _____ Session: _____
Date: _____

DBT-Ways of Coping Checklist
CITATION: Dialectical Behavior Therapy Ways of Coping Checklist (DBT-WCCL): Development and Psychometric Properties. Neacsiu, A.D., Rizvi, S.L., Vitaliano, P.P., Lynch, T.R., & Linehan, M.M. Journal of Clinical Psychology. In press.

The items below represent ways that you may have coped with stressful events in your life. We are interested in the degree to which you have used each of the following thoughts or behavior to deal with problems and stresses.

Think back on the **LAST ONE MONTH** in your life. Then check the appropriate number if the thought/behavior is: never used, rarely used, sometimes used, or regularly used (i.e., at least 4 to 5 times per week). Don't answer on the basis of whether it seems to work to reduce stress or solve problems—just whether or not you use the coping behavior. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

0 Never Used **1 Rarely Used** **2 Sometimes Used** **3 Regularly Used**

I have:

1	Bargained or compromised to get something positive from the situation.	0	1	2	3
2	Counted my blessings.	0	1	2	3
3	Blamed myself.	0	1	2	3
4	Concentrated on something good that could come out of the whole thing.	0	1	2	3
5	Kept feelings to myself	0	1	2	3
6	Made sure I'm responding in a way that doesn't alienate others.	0	1	2	3
7	Figured out who to blame.	0	1	2	3
8	Hoped a miracle would happen.	0	1	2	3
9	Tried to get centered before taking any action.	0	1	2	3
10	Talked to someone about how I've been feeling.	0	1	2	3
11	Stood my ground and fought for what I wanted.	0	1	2	3
12	Refused to believe that it had happened.	0	1	2	3
13	Treated myself to something really tasty.	0	1	2	3
14	Criticized or lectured myself.	0	1	2	3
15	Took it out on others.	0	1	2	3
16	Came up with a couple of different solutions to my problem.	0	1	2	3
17	Wished I were a stronger person — more optimistic and forceful	0	1	2	3
18	Accepted my strong feelings, but not let them interfere with other things too much.	0	1	2	3
19	Focused on the good things in my life.	0	1	2	3
20	Wished that I could change the way that I feellt.	0	1	2	3
21	Found something beautiful to look at to make me feel better.	0	1	2	3
22	Changed something about myself so that I could deal with the situation better.	0	1	2	3
23	Focused on the good aspects of my life and gave less attention to negative thoughts or feelings.	0	1	2	3

24	Got mad at the people or things that caused the problem	0	1	2	3
25	Felt bad that I couldn't avoid the problem.	0	1	2	3
26	Tried to distract myself by getting active.	0	1	2	3
27	Been aware of what has to be done, so I've been doubling my efforts and trying harder to make things work.	0	1	2	3
28	Thought that others were unfair to me.	0	1	2	3
29	Soothed myself by surrounding myself with a nice fragrance of some kind.	0	1	2	3
30	Blamed others.	0	1	2	3
31	Listened to or played music that I foundind relaxing.	0	1	2	3
32	Gone on as if nothing had happened	0	1	2	3
33	Accepted the next best thing to what I wanted.	0	1	2	3
34	Told myself things could be worse.	0	1	2	3
35	Occupied my mind with something else.	0	1	2	3
36	Talked to someone who could do something concrete about the problem	0	1	2	3
37	Tried to make myself feel better by eating, drinking, smoking, taking medications, etc.	0	1	2	3
38	Tried not to act too hastily or follow my own hunch.	0	1	2	3
39	Changed something so things would turn out right.	0	1	2	3
40	Pampered myself with something that felt good to the touch (e.g., a bubble bath or a hug)	0	1	2	3
41	Avoided people	0	1	2	3
42	Thought how much better off I was than others.	0	1	2	3
43	Just took things one step at a time.	0	1	2	3
44	Did something to feel a totally different emotion (like gone to a funny movie).	0	1	2	3
45	Wished the situation would go away or somehow be finished.	0	1	2	3
46	Kept others from knowing how bad things were.	0	1	2	3
47	Focused my energy on helping others.	0	1	2	3
48	Found out what other person was responsible.	0	1	2	3
49	Made sure to take care of my body and stay healthy so that I was less emotionally sensitive.	0	1	2	3
50	Told myself how much I had already accomplished.	0	1	2	3
51	Made sure I respond in a way so that I could still respect myself afterwards.	0	1	2	3
52	Wished that I could change what had happened.	0	1	2	3
53	Made a plan of action and followed it.	0	1	2	3
54	Talked to someone to find out about the situation	0	1	2	3
55	Avoided my problem	0	1	2	3
56	Stepped back and tried to see things as they really are	0	1	2	3
57	Compared myself to others who are less fortunate.	0	1	2	3
58	Increased the number of pleasant things in my life so that I had a more positive outlook.	0	1	2	3
59	Tried not to burn my bridges behind me, but leave things open somewhat.	0	1	2	3

-

Data Entry Initials: _____ Client ID #: _____
Date: _____ Date: _____
Second Entry: _____ Assessment: _____ Session: _____
Date: _____

DBT-Ways of Coping Checklist
CITATION: Dialectical Behavior Therapy Ways of Coping Checklist (DBT-WCCL): Development and Psychometric Properties. Neacsiu, A.D., Rizvi, S.L., Vitaliano, P.P., Lynch, T.R., & Linehan, M.M. Journal of Clinical Psychology. In press.

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0 Never Used **1 Rarely Used** **2 Sometimes Used** **3 Regularly Used**

I have:

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2	Counted my blessings.	0	1	2	3
3	Blamed myself.	0	1	2	3
4	Concentrated on something good that could come out of the whole thing.	0	1	2	3
5	Kept feelings to myself	0	1	2	3
6	Made sure I'm responding in a way that doesn't alienate others.	0	1	2	3
7	Figured out who to blame.	0	1	2	3
8	Hoped a miracle would happen.	0	1	2	3
9	Tried to get centered before taking any action.	0	1	2	3
10	Talked to someone about how I've been feeling.	0	1	2	3
11	Stood my ground and fought for what I wanted.	0	1	2	3
12	Refused to believe that it had happened.	0	1	2	3
13	Treated myself to something really tasty.	0	1	2	3
14	Criticized or lectured myself.	0	1	2	3
15	Took it out on others.	0	1	2	3
16	Came up with a couple of different solutions to my problem.	0	1	2	3
17	Wished I were a stronger person — more optimistic and forceful	0	1	2	3
18	Accepted my strong feelings, but not let them interfere with other things too much.	0	1	2	3
19	Focused on the good things in my life.	0	1	2	3
20	Wished that I could change the way that I feellt.	0	1	2	3
21	Found something beautiful to look at to make me feel better.	0	1	2	3
22	Changed something about myself so that I could deal with the situation better.	0	1	2	3
23	Focused on the good aspects of my life and gave less attention to negative thoughts or feelings.	0	1	2	3

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Appendix E: Other supporting documentation *that is not listed above here but is relevant to your study: For Example: a listing of support groups, a training programme for researchers, a debriefing doc, or a protocol for dealing with stressed participants.*

De-Briefing Sheet

"Addressing Self-Injury & Suicide: the lived experience of people in custody in Ireland and the factors that contribute towards resilience, desistance and persistence".

Thank you for taking part in this research. Your responses will help us better understand how self-injury behaviour and suicidality is addressed in the Irish Prison Service, and the experiences of people in custody. This is important, so that we can identify what seems to be working well in custody, and also what needs to be improved. As explained to you previously, taking part in this research involves meeting with the researcher for one interview (approx. 1 hour).

I would like to remind you once more of the ways that this research will protect your privacy. Please know that the researcher will protect your identity as much as possible, and keep all your information safe and destroy and archive as appropriate. However, if you have indicated to the researcher that (a) you may cause harm to yourself or others, (b) you were the perpetrator or victim of any undocumented criminal activity, and/or (c) you were the victim of serious harm from someone else, the researcher will have to report this information. The researcher will have let you know during the interview if they will be reporting this information.

The interview may have involved talking about some sensitive topics (e.g. recalling incidents of harm). If you feel distressed by anything that was discussed in the interview, it is important that you try to get some support. Here are some ways you can get some support:

1. If you feel that you need immediate and urgent support after taking part in this research, speak to an available member of prison staff.

2. You can also get support from a Psychologist.
   - If you need to speak to a Psychologist urgently, please ask your class officer or the Assistant Chief Officer (ACO) who will see if they can get you an urgent appointment.

3. If you would like to speak to a Chaplain, ask your class officer or the ACO to arrange an appointment.

4. If you would like to speak to a GP, ask your class officer or the ACO to arrange an appointment.

If you would like to receive an update on the research, please let a member of staff know (e.g. your Class Officer), and they will contact the researcher on your behalf. The researcher will provide a staff member with a written research update for you.

Safety Protocols

The following safety protocols outline how various risky situations will be prevented, and appropriately recognised and managed should they arise. They have been informed by the researcher's previous experience working with forensic populations, the researcher's training in risk reduction and management (e.g. breakaway techniques, personal protection training, self-injury and suicide awareness training), guidance from the project supervisors, guidance from IPS staff and the Durham University Home Visits/Face-to-Face Interview Guidelines for Staff/Students.

Protocol 1: Risk of Harm to Researcher

The following measures will be put in place in order to **prevent** risk of harm to the researcher:

- The researcher will check-in with the project supervisors via e-mail before and after each interview with a person in custody takes place.
- Project supervisors and some IPS staff will be aware of the time and location of interviews.
- The researcher has previously received training in breakaway techniques from HMPS and personal protection training from the IPS.
- For interviews with People in custody:
    - One Prison Officer will remain outside the interview room for the duration of the interview.
    - Based on advice from prison management, interviews may take place in consultation room or in a screened interview room which would separate the researcher and person in custody with a Perspex screen.
    - Where possible, the researcher will wear a personal alarm and/or the interview room will have a panic alarm on the wall.

Protocol 1(a): Minor Risk of Harm to Researcher

The following signs will be taken to indicate a **minor** risk of harm to the researcher:

- Insulting language
- Threatening language
- Increased tempo or volume of voice
- Tense facial expression (e.g. narrowing of eyes, clenched jaw)
- Tense body language (e.g. clenched fists)

If the participant exhibits the above signs, the following steps will be taken:

1. The researcher will attempt to de-escalate the situation, for example by using calming and reassuring language and body language
2. The researcher will offer the participant a short break if they would like to take some time to calm down
3. If the risk of harm is reduced (i.e. the above signs are no longer present), the researcher will ask if the participant would like to continue
4. If the risk of harm is thought to increase (i.e. the above signs persist or escalate), the researcher will follow protocol 1(b)

Protocol 1(b): Moderate or Severe Risk of Harm to Researcher

The following signs will be taken to indicate a **moderate or severe** risk of harm to the researcher:

- Verbal threats to harm the researcher
- Physical attempts to harm the researcher

If the participant exhibits the above signs, the following steps will be taken:

1. The researcher will terminate the interview
2. The researcher will call for assistance from prison staff by using an alarm or raising their voice for help
3. If possible, the researcher will exit the interview room
4. In the unlikely event a participant could physically attack the researcher, the researcher will self-defend as appropriate, using trained techniques and reasonable force
5. Following the incident, the researcher will inform the Prison Governor and the project supervisors of the incident
6. Following the incident, the researcher will complete the necessary incident reporting procedures for both the IPS and Durham University.
7. Following the incident, the researcher will discuss the incident during supervision, and seek further support if needed

Protocol 2: Risk of Harm to Others

The following signs will be taken to indicate a risk of harm to others:

- Expression of own desire/intent/plans to harm a named/alluded to individual within or outside of the IPS
- Expression of desire/intent/plans to enlist the assistance of someone else to harm a named/alluded to individual within or outside the IPS
- Disclosure of someone else's desire/intent/plans to harm a named/alluded to individual within or outside the IPS

If the participant exhibits the above signs, the following steps will be taken:

1. The researcher will inform the participant of the necessity of breaching confidentiality, as previously consented to
2. If necessary or most appropriate, the researcher will terminate the interview
    - Following the interview, the researcher will report the disclosed information to the Chief Officer in charge and the Prison Governor
    - If the disclosed information indicates immediate risk (e.g. likely to be carried out by someone else at that moment in time), the researcher will inform the closest member of prison staff (e.g. the Prison Officers outside the interview room door)
    - If the disclosed information includes specific details about harm to others (e.g. victim, means to be used, time, location), this information will be emphasised
3. The relevant IPS staff will take the necessary steps to manage the risk
4. The researcher may re-schedule the interview for another time, if deemed appropriate in consultation with supervisors and IPS management

Protocol 3: Risk of Harm to Self

The following signs will be taken to indicate a risk of harm to self:

- Expression of desire to self-injury or complete suicide
- Threatening to self-injury or complete suicide
- Disclosing plans to self-injury or complete suicide

If the participant exhibits the above signs, the following steps will be taken:

1. The researcher will inform the participant of the necessity of breaching confidentiality, as previously consented
    - The participant will be assured that this is solely for the purpose of their own safety and wellbeing
    - The participant will be encouraged to seek the appropriate support (e.g. self-refer to the Psychology Department, Chaplaincy or Healthcare Team)
2. If necessary or most appropriate, the researcher will terminate the interview
    - The participant will be assured that this is solely for the purpose of their own immediate safety and wellbeing, and that the interview can be re-scheduled if they wish
3. Following the interview, the researcher will report the disclosed information to the Chief Officer in charge and the Prison Governor
    - If the disclosed information indicates immediate risk (e.g. likely to be carried out during or immediately after the interview), the researcher will inform the closest member of prison staff (e.g. the Prison Officers outside the interview room door)
    - If the disclosed information includes specific details about harm to self (e.g. means to be used, time, location), this information will be emphasised
4. The relevant IPS staff will take the necessary steps to manage the risk
5. The researcher may re-schedule the interview for another time, if deemed appropriate in consultation with supervisors and IPS management

Appendix F: Thematic Maps

Figure 2 shows a Thematic Map of Prisoner's Qualitative Results

Figure 2

Themes Identified During Interviews

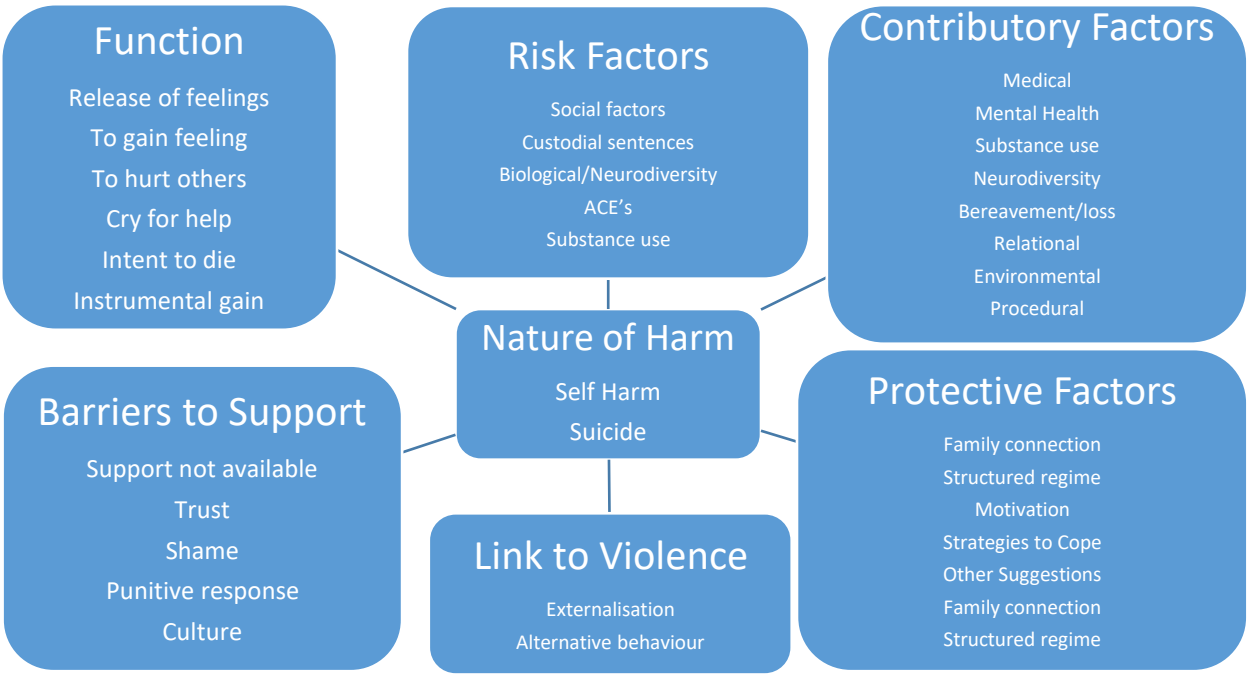

Figure 3

Thematic Map of Prisoner's Qualitative Findings based on PTMF