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Title	The accuracy and predictive value of incarcerated adults' accounts of their self-harm histories: findings from an Australian prospective data linkage study
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General comments (author response in bold)	This paper, which reports on how well self-reported self-harm histories align with medically verified self-harm was interesting to read and well-written. I have some questions, some suggestions for clarification and on the implications of their findings. Introduction 1. In the introduction the authors discuss how reporting has changed in the Canadian correctional systems with respect to self-harm. What is the current practice in Australia? Please describe briefly the context in Australia (page 4 lines 36-42). **In the revised manuscript we have added the following text: "In Australia there is no federal correctional system, as each state or territory system operates independently. In Queensland, adults are asked upon reception whether they have ever self-harmed; this is combined with records from previous incarcerations and, on some occasions, information gathered informally from police, mental health records, or family members. However, this is provided on an ad hoc basis only, with no system in place for routinely obtaining such collateral information" (page 5, line 1).** Methods 2. It would be helpful if the authors could provide some information about the Passports study (page 5 lines 13-25). How were the participants recruited? What was the service brokerage intervention? Would this intervention have any impact on future medical help-seeking? The latter is unclear from the information provided. **In the revised manuscript, we have added the following text: "Trained researchers, employed independently of Queensland Corrective Services (QCS), obtained a list of all potentially eligible participants for each prison, from the QCS Integrated Offender Management System (IOMS). These lists were updated weekly during recruitment. Individuals identified as potentially eligible were approached by researchers and invited to participate in the study; this included screening for eligibility, explaining the project in plain language and obtaining informed, written consent. Researchers recorded the outcome of each approach (not eligible, eligible [participated or declined], unknown [missed or unavailable]) to permit calculation of a recruitment fraction" (page 5, line 18). We have also added: "Participants in the intervention group received a personalised booklet summarising their health status and medication needs, and identifying appropriate community health services; trained workers made weekly telephone contact in the first 4 weeks post-release to identify emergent health needs and promote health service contact. Participants in the control arm received usual care" (page 6, line 5).** 3. Under the section on administrative and clinical data please clarify that the linkage rate reported is for the link between correctional and medical records. Sentence 1 reports the medical data. Sentence 2 provides information on the linkage rate. Sentence 3 then speaks to the correctional records. It might be best to describe the medical sources of data, followed by the correctional source of data and then the linkage procedure and rate (page 5 lines 30-50). **The linkage rate reported in this paragraph refers to the accuracy of the linkage method, demonstrated in a previous data linkage study; as such, it does not refer to the linkage rate between correctional and medical records in this study. Indeed, accuracy cannot be determined in absence of a gold standard, such that only validation studies are able to generate these statistics. Sentence 2 refers to the baseline data being linked with medical data, and to clarify this we have amended the revised manuscript to read: "Baseline interview data were linked probabilistically with clerical review...." (page 6, line 17). Sentence 2 (about the linkage process) follows sentence 1 (about the medical records) because the linkage process in sentence 2 refers only to the medical data. In the revised manuscript we have added this sentence: "Linkage with correctional records and prison medical records was deterministic, based on a unique prisoner identification number" (page 6, line 25). The first sentence of the Results section explains the linkage rate achieved in the current study: "All analyses were conducted on the 1315 participants (99.2%) for whom linked health and correctional records were obtained" (page 9, line 23).** 4. Identification of self-harm in prison medical records: I note here that the authors used a yes-no self-harm indicator based on staff report of risk of self-harm. Was the self-harm indicator used to identify which medical records to review and if so, would there be a concern that some medical records might have been missed by relying on this indicator (page 5 lines 38-45)? **The medical record searches were not based on staff report of risk of self-harm. All records for all participants were screened in full, irrespective of their identified self-harm risk (and with no knowledge of such risk status at the time of screening). As such, selection bias and measurement are very unlikely to have impacted on this process. In order to clarify this, in the revised manuscript, we have amended this section to read "We searched all ED and hospital records for International Classification of Diseases (ICD) diagnosis codes for self-harm (X60-X84), and searched the ICPC-2 coding of the free-text field of all prison medical records for all participants to identify self-harm events. Additionally, free text fields in all ambulance and ED records, and all free text notes made by the coding staff who abstracted the prison medical records, were screened by a member of the study team (KM) to increase case ascertainment. KM was blinded to participants' self-harm status during the screening process" (emphasis added in this response letter only, not in the revised manuscript) (page 7, line 13).** 5. Please describe briefly how rapport was established prior to asking questions about self-harm given that this is a difficult topic to address with a participant (page 6 lines3-4). **In the revised manuscript, we have added the following text, with accompanying references: "Interviewers were experienced with interviewing vulnerable populations about sensitive topics, were extensively trained (by a psychologist), and were independent of both corrections and the prison health service. Substantial reporting of stigmatised behaviours, including prohibited behaviours that could have implications for sentencing, indicated a high degree of rapport between participants and interviewers. Participants were advised that they were not required to answer any questions that they did not wish to, but that all responses would be kept strictly confidential" (page 5, line 28).** 6. During the medical record review, was severity of self-harm categorized? Also how might severity affect your findings? It would be useful to know how the free-text field was coded for self-harm (page 6 lines 19-42).

	Severity of self-harm was not recorded, as our primary outcome of interest was purely the incidence of self-harm events. Regarding the free-text field searching, we have added the following text to the revised manuscript: "All ED, ambulance and prison health records for all participants were coded as either '0 = Did not involve self-harm' or '1 = Involved self-harm', with the latter category comprising any health service contact resulting from behaviours fitting into any one of five categories: (1) cutting/burning, (2) self-poisoning, (3) self-battering, (4) non-recreational risk-taking, or (5) other self-harm." (page 7, line 20). 7. I am curious about the inclusion of violent vs. non-violent offences (including sex offenses). Can you contextualize how violent vs. non-violent crimes might relate to self-harm (page 7 lines 31-35). **In the revised manuscript we have added the following sentence (with accompanying references): "The inclusion of violent offences in the model was based on the known association between violent offending and increased risk of both self-harm and suicide" (page 9, line 7).** Interpretation 8. The authors suggest that health professionals may not document patient self-reports of self-harm because they do not agree it was a self-harm event. I'm curious, what types of self-harm might not be recorded as an event (page 11 lines 8-11)? **We have amended this sentence in the revised manuscript to read: "Second, some participants may have reported incidents that they considered self-harm but which would not have been identified as such by health professionals, such as hair-pulling, lip-biting, or putting oneself at risk from others" (page 12, line 23).** 9. Within the interpretation and conclusion sections, the authors note that self-reported history of self-harm may be an inadequate source of information (or insensitive measure) to determine risk of self-harm in prison settings and the community. Given the difficulties linking community and correctional medical records what are some solutions that could be proffered? I am also curious about what happens in Australian correctional settings around screening and treatment and during discharge planning. **In Australia, routine linkage of health and correctional records is not technically difficult, and in fact this already occurs in one Australia jurisdiction (Western Australia). Implementing this as part of routine practice in Australia is therefore a matter of political will, and the same is likely to be the case in some other countries with well-developed administrative data and data linkage infrastructure. We therefore advocate strongly for this in the paper. Although there is no federal correctional system in Australia, all jurisdictions screen for mental health problems (including self-harm) upon reception. However, self-harm history/risk is not assessed with validated screening tools. Our study has demonstrated that linking records is feasible and could be more widely adopted.** 10. What are some ways to improve the discharge planning process and are there any model interventions to address self-harm for people being released from prison. On the top of page 12, for example, the authors suggest that there is a need for "targeted support and preventive strategies." What might these be? What are some suggestions of ways to move forward in corrections to ensure that proper care is delivered within and outside prison? **In the revised manuscript we have added the following text (with accompanying references): "Trials of interventions such as dialectical behaviour therapy (DBT) and mentalization-based treatment (MBT), both of which have demonstrated some effectiveness in reducing self-harm in treatment-seeking adults, are warranted with this population. One trial of MBT in justice involved adults is currently underway in the UK" (page 13, line 20).** 11. Also, at the top of page 12 the authors discuss the Canadian context with respect to the federal corrections mental health strategy. It would be most helpful to have more information on what is happening with respect to mental health strategy and care for people who may self-harm or attempt suicide within Australian corrections. I would be interested if the authors have suggestions as to how to implement a better monitoring system in the Australian context. **(page, line).** **In the revised manuscript we have added the following text: "In Australia there is no federal correctional system, as each state or territory system operates independently. In the state of Queensland, adults are asked upon reception whether they have ever self-harmed; this may be combined with records from previous incarcerations and, on some occasions, information gathered informally from police, mental health records, and family members. However, this is provided on an ad hoc basis only, with no system in place for routinely obtaining such collateral information" (page 5, line 1).** Additional comments 12. Page 9 line 20-21: please remove the 's' from self-harms and add an 's' to the following word – event(s). **We have made these amendments in the revised manuscript (page 10, lines 2-3).**