Focal Point Ireland: national report for 2017 - Prison

Health Research Board. Irish Focal Point to the European Monitoring Centre for Drugs and Drug Addiction

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This document was prepared for publication by the staff of the HRB National Drugs Library

Please use the following citation:
Health Research Board. Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction (2018) ***Focal Point Ireland: national report for 2017 – prison***. Dublin: Health Research Board.

Other reports in this National report series can be found at
http://www.drugsandalcohol.ie/php/annual_report.php

(2018) *Focal Point Ireland: national report for 2017 – drug policy*.
(2018) *Focal Point* Ireland: national report for 2017 – treatment.
(2018) *Focal Point* Ireland: national report for 2017 – drug markets and crime.
(2018) *Focal Point Ireland: national report for 2017 – prevention*.
(2018) *Focal Point Ireland: national report for 2017 – legal framework*.
(2018) *Focal Point Ireland: national report for 2017 – harms and harms reduction.*
(2018) *Focal Point Ireland: national report for 2017 – drugs.*

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0. Summary

0.1 National profile

There are 14 institutions in the Irish prison system comprising 11 traditional 'closed' institutions, two open centres, which operate with minimal internal and perimeter security, and one 'semi-open' facility with traditional perimeter security but minimal internal security (the Training Unit). The majority of female prisoners are accommodated in the purpose-built Dóchas Centre adjacent to Mountjoy prison in Dublin and the remainder are located in a separate part of Limerick prison.

Political responsibility for the prison system in Ireland is vested in the Minister for Justice, Equality and Defence. The Irish Prison Service (IPS) operates as an executive agency within the Department of Justice, Equality and Defence. It is headed by a Director General supported by seven directors. The Office of the Inspector of Prisons is a statutory, independent office established to carry out regular inspections of the 14 prisons and to report to the Minister for Justice, Equality and Defence. Four policy documents have a particular bearing on the provision of drug-related healthcare in the Irish prison system – the IPS policy and strategy document, Keeping drugs out of prisons, and the National Drugs Strategy (interim) 2009–2016, the IPS three-year strategic plan 2012–2015, and the joint IPS–Probation Service strategic plan 2015–2017.

The IPS offers multidimensional drug rehabilitation programmes for prisoners. Prisoners have access to a range of medical and rehabilitative services, such as psychosocial services and work and training options, which assist in addressing their substance misuse. As well as addiction counselling, substitution treatment and detox are the main treatment modalities offered within the prison estate. Methadone substitution treatment is available in 11 of the 14 prisons (accommodating over 80% of the prison population). The Medical Unit in Mountjoy Prison has 18 beds specifically allocated for an eight-week drug-free programme. The aim of the programme is to assist participants in achieving a drug-free status. Six community-based organisations (CBOs) are funded to provide services in the prison system.

0.2 New developments

A recent report, Healthcare in Irish prisons (Reilly 2016), recommended that prison healthcare services be brought under the responsibility of the Department of Health, and operated by the Health Service Executive (HSE). In addition, the report recommended that a Director of Healthcare, who is a registered healthcare professional, should be appointed immediately. The duty of the director would be to manage healthcare in prisons and oversee the transition of healthcare from the IPS to the HSE. The report also stated that the provision of healthcare in Irish prisons should not be confined to that which is provided by doctors and nurses, but should embrace all aspects of care, including addiction, psychiatric and psychology services.

On 17 July 2017, the Irish Taoiseach launched Reducing Harm, Supporting Recovery – a health-led response to drug and alcohol use in Ireland 2017-2025 (Department of Health 2017). Key actions of Reducing Harm, Supporting Recovery specific to the Irish prison population include the following:

- Providing training to enable the delivery of screening, brief intervention and onward referral in line with national screening and brief intervention protocols for problem substance use among prisoners.
- Further develop a range of service-specific problem substance use interventions for prisoners in line with best international practice.
- Determining the prevalence of NPS use in prison settings, with a view to developing specific training for staff and appropriate interventions.
- Establishing a Working Group to explore ways of improving progression options for people exiting prison, with a view to developing a new programme of supported care and employment.

1. National profile

1.1 Organization

1.1.1 Overview of prison services

Political responsibility for the prison system in Ireland is vested in the Minister for Justice and Equality. The Irish Prison Service (IPS) operates as an executive agency within the Department of Justice and Equality. It is headed by a Director General supported by five directors. In 2016, the annual budget for the IPS was €332.058 million. At end 2016 there were 3,215 staff in the IPS, including civilian grades and headquarters staff.

The IPS deals with male offenders who are 17 years of age or over and female offenders who are 18 years of age or over. In 2016, the overall daily average number of prisoners in custody was 3,718; the comparable number in 2015 was 3,722. The average number of female offenders in custody was 95, which represented a 27% decrease on the 2015 average of 131. There was an overall decrease of 1,824 (13%) in the numbers committed to prison under sentence, i.e. from 13,987 in 2015 to 12,163 in 2016.

There are 14 institutions in the Irish prison system; this comprises 11 traditional 'closed' institutions; two open centres, which operate with minimal internal and perimeter security; and one 'semi-open' facility with traditional perimeter security but minimal internal security (the Training Unit). The majority of female prisoners are accommodated in the purpose-built Dóchas Centre near Mountjoy Prison in Dublin and the remainder are located in a separate part of Limerick Prison. A breakdown of the Irish prison population in 2016 and IPS locations is shown in Table 1.1.1.1 and Figure 1.1.1.1 (Irish Prison Service 2017).

Table 1.1.1.1 Irish prison population, 2016

Prison name	Description	Operational capacity	Population (average 2016)
Mountjoy Prison	Closed, medium-security prison for males aged 18 years and over. It is the main committal prison for Dublin city	554	515
Dóchas Centre	Closed, medium-security prison for females aged 18 years and over. It is the committal prison for females committed on remand or sentenced from all courts outside the Munster area	105	109
Training Unit, Mountjoy	A semi-open, low-security prison for males aged 18 years and over, with a strong emphasis on work and training	96	90
Arbour Hill Prison	A closed, medium-security prison for males aged 18 years and over.	142	134
Castlerea Prison	Closed, medium-security prison for males aged 18 years and over. It is the committal prison for remand and sentenced prisoners in the west of Ireland.	340	293
Cork Prison	Closed, medium-security prison for males aged 18 years and over. It is the committal prison for the south west of Ireland	273	253
Limerick Prison	Closed, medium-security prison for males and females aged 18 years and over. It is the committal prison for the mid-west of Ireland	242	252
Loughan House	Open, low-security prison for males aged 18 years and over.	140	116
Shelton Abbey	Open, low-security prison for males aged 19 years and over.	115	101
Portlaoise Prison	A closed, high-security prison for males aged 18 years and over. It is the committal prison for those sent from the Special Criminal Court	291	198

Prison name	Description	Operational capacity	Population (average 2016)
Midlands Prison	Closed, medium-security prison for males aged 18 years and over. It is the committal prison for the Irish midlands	870	814

Source: IPS website 2017

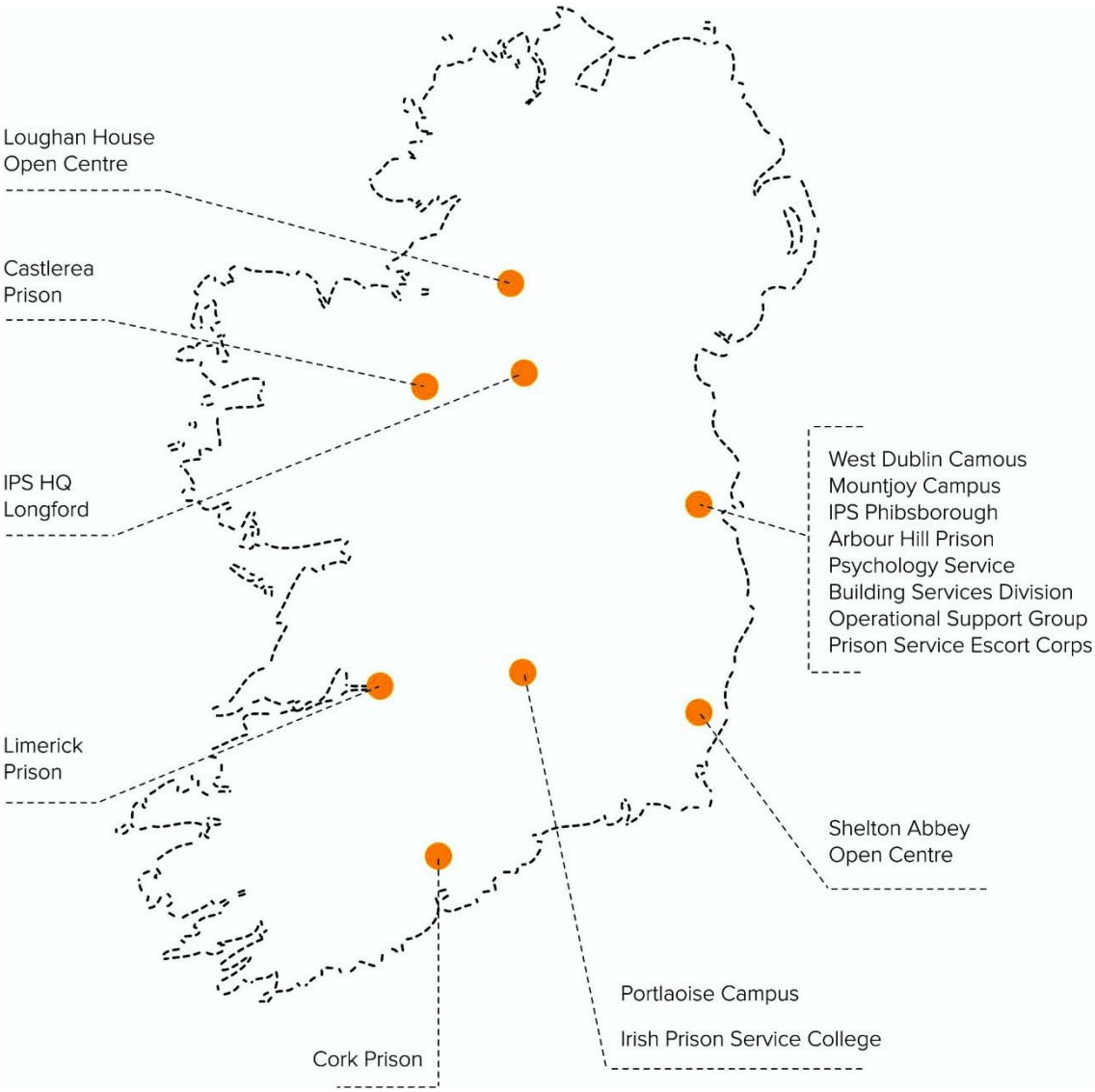

Figure 1.1.1.1 IPS locations in Ireland
Source: IPS, 2017

1.2 Drug use and related problems among prisoners

1.2.1 Drug use prior to imprisonment and inside prison

In 2010 the National Advisory Committee on Drugs (NACD) commissioned a study to:

- describe the nature, extent and pattern of consumption for different drugs among the prisoner population;
- describe methods of drug use, including intravenous drug use, among the prisoner population;
- estimate the prevalence of blood-borne viruses among the prisoner population and identify associated risk behaviours; and
- measure the uptake of individual drug treatment and harm reduction interventions (including hepatitis B vaccination) in prison.

The NACDA published this study in 2014 ((Drummond*, et al.* 2014)) and a summary was included in the 2014 National Report (Section 4.3.2).

1.2.2 Drug related problems, risk behaviour and health consequences

Much of the information available relating to drug use in Irish prisons and responses is obtained through answers to Parliamentary Questions (PQs) put to the Minister for Justice and Equality in Ireland's national assembly, Dáil Éireann.

In response to a PQ regarding the therapeutic services and treatment programmes that are available for prisoners with addiction issues; the waiting lists for referrals to such services and treatments; and the number of drug-free wings in prisons, on 11 July 2017 (Flanagan 2017, 11 July), the Minister for Justice and Equality, Deputy Charles Flanagan, stated that he had been advised by the IPS that any prisoner who enters the custody of the IPS while presenting with addiction issues has access to addiction services, and is actively encouraged to engage with those services.

The treatments available are based on the principles of best practice, and are similar to those available in a community setting. This includes access to harm reduction methods, detoxification, stabilisation and opiate replacement therapies. These interventions are based on a multiprofessional approach to ensure that the prisoner's motivation, commitment and likelihood of success are always at the centre of planned care.

The IPS had advised Minister Flanagan that the healthcare team which delivers these treatments includes, inter alia, GP specialist addiction services, consultant addiction psychiatrists, specialist addiction nurses, addiction counsellors, addiction links workers, pharmacists, primary care GPs, and prison nurses. Minister Flanagan also stated that the IPS works very closely with the Probation Service as well as community, voluntary and statutory agencies to maintain a pathway of care, thus ensuring that supports remain in place for prisoners on their release from custody.

All prisoners have access to group and individual counselling services where they can address their own personal requirements, and specific support arrangements can be put in place and implemented during the prisoner's period in custody. The person in custody can also benefit from peer support groups, music therapy, and a nine-week psychosocial-based programme similar to community residential treatment services which assists the person in remaining drug free.

In a Joint Committee Meeting held on 8 March 2017 (Carroll 2017, 22 March), Michael Donnellan from the IPS stated that significant change and reform had taken place in the prison system in recent years, addressing many of the issues highlighted by the committee, including prison numbers, overcrowding and prison conditions. The numbers in custody have fallen by 20% since their peak in 2011, and the numbers on temporary release have reduced by almost 70% during the same period. This reduction in numbers has allowed the IPS to progress and enhance several key services, including enhanced pre-release planning and resettlement; structured temporary release; the community return scheme and the community support scheme; the incentivised regime programme; drug treatment facilities; developing the psychology service; integrated sentence management facilities; working with the families of those imprisoned, as well as working with the third-level sector and in-reach services.

In answer to a question from Deputy Jim O'Callaghan regarding drug use in prisons, Fergal Black from the IPS made it clear that drugs are a significant problem in prisons and that prisons are always a microcosm of society. All prisoners who are on committal will see a nurse or doctor within 24 hours. Prisoners who have addiction issues, have a history of opiate use, and test positive for opiates; moreover, where they have been maintained on methadone treatments in the community, they will continue that treatment while they remain in custody. Mr Black stated that there are currently just under 10,000 people on methadone treatments in the community. The IPS has a contract with Merchants Quay Ireland (MQI) to provide addiction counselling in 13 of the 14 IPS institutions. There are also addiction pharmacists in Mountjoy Prison and other facilities, and the IPS engages with GPs who have a special interest in substance misuse. Mr Black also stated that while

the numbers on methadone in the community have continued to rise in recent years, there has been a significant reduction in the numbers on methadone in prisons. He added that compared to 2008, when there were 750 people on methadone maintenance across the prison system, in 2017 there were 465.

With regard to prison being an ideal opportunity for someone to address their addiction issues, Mr Black said the IPS has a self-directed detox programme in the Mountjoy campus where people can reduce their methadone intake by 5 ml a week under the supervision of a doctor and a pharmacist.

Between June 2014 and December 2016 there were 530 patients involved in self-directed detox in Mountjoy Prison. Some 120 have come off methadone completely and 88 were still off methadone at the date of the meeting (8 March 2017). Some 197 prisoners reduced their methadone intake by a minimum of 20 ml. The IPS has a national Drug Treatment Programme (DTP), which operates in the medical unit in the Mountjoy campus. The IPS commissioned a review last year and it is building a full curriculum around that. The IPS also has a number of community-based organisations (CBOs) that work on its behalf (See Section 1.3.3). There are 18 beds in the DTP unit in Mountjoy Prison.

Mr Black stated that when individuals who are using illicit substances come into prison, the first thing prison staff do is try to get them to stop using those substances and get them stabilised on methadone. Then, when and if they are ready, they try to wean them off or detox them from methadone. If that proves successful they proceed to a drug treatment programme and eventually to a drug-free status. Mr Black noted that the IPS needs to provide appropriate locations so that it can maintain a prisoner's drug-free status. In that context, there are more than 20 addiction counsellors from MQI who provide support. There are also 140 nurses who operate 24/7 and doctors with expertise in addiction psychiatry. In addition, there is a range of other services available, including educational services.

All of these services are there to assist people, ultimately, to leave prison and live more purposeful lives. However, Mr Black also acknowledged a comment from Deputy Jack Chambers that rather than providing an ideal place for addiction treatment, a number of prisoners had stated that the prison environment has made their addiction worse and many had developed polydrug use while in prison. Mr Black stated that there is no doubt that drugs and prison are synonymous and there is no way of hiding this.

Mr Black said that the IPS is concerned about other drugs, particularly new psychoactive substances (NPS), and noted the impact of NPS use on violence and deaths among those in custody in UK jails. Although Ireland had not experienced this phenomenon to any significant extent, there have been a small number of episodes. The IPS has consulted with colleagues from Public Health England and the National Health Service to help try to ensure that the IPS is prepared if NPS use becomes a real problem in the way that it has in English and Scottish jails.

Mr Black also made it clear that the IPS has gone to considerable lengths both in providing appropriate treatment services for people who have addictions, and trying to stop contraband from getting into prisons. There are canine units, nets and search procedures in place. However, he stated that the reality is that it is almost impossible to stop drugs from getting into prison, and families are under significant pressure to bring in drugs from a variety of sources.

Regarding the number of persons currently serving custodial or suspended sentences for drug possession, Minister Frances Fitzgerald, in response to a PQ on 31 May 2016 (Clarke and Eustace 2016), stated that she had been informed by the IPS on 30 April 2016 that there were 3,756 prisoners in custody across the prison system. Of this population, 381 (10%) were serving sentences for drugs-related offences. It is not possible to provide the number of persons who were on suspended sentences for drugs offences on that date.

A full breakdown of the offences, taken from the most recent snapshot of the prison population conducted on 30 April 2016, is set out in Table 1.2.2.1. The data include the length of the sentence in each case.

Table 1.2.2.1 Number of people serving sentences for drug-related offences by length of sentence, 2016

Drug-related offence	<3 mths	3 to <6 mths	6 to <12 mths	1 to <2 yrs	2 to <3 yrs	3 to <5 yrs	5 to <10 yrs	10+ yrs	Total
Cultivation of cannabis plants and opium poppy	0	0	1	1	3	7	3	0	15
Possession for sale or supply of drugs valued at €13,000 or more	0	0	0	2	5	20	38	26	91
Possession of drugs for the purpose of sale or supply	0	6	15	26	26	44	66	32	215
Unlawful possession of drug(s)	2	3	0	4	11	15	13	6	54
Unlawful supply/offer to supply controlled drugs	0	0	0	0	0	1	0	0	1
Unlawfully importing or exporting controlled drugs	0	0	0	2	0	2	1	0	5
Total	2	9	16	35	45	89	121	64	381

Source (Fitzgerald F 2016 31 May)

Prison visiting committees reports 2015

A visiting committee is appointed to each prison under the Prisons (Visiting Committees) Act 1925 and the Prisons (Visiting Committees) Order 1925. Members of the 14 visiting committees are appointed by the Minister for Justice, Equality and Defence for a term not exceeding three years. The function of prison visiting committees is to visit at frequent intervals the prison to which they are appointed and hear any complaints which may be made to them by any prisoner. They report to the Minister any abuses observed or found by them in the prison and any repairs which they think are urgently needed. Visiting committee members have free access either collectively or individually to every part of the prison to which their Committee is appointed.

The 2015 review of visiting committee reports (Prison visiting committees 2016) noted that the visiting committee for Mountjoy Prison observed that 'the pervasiveness of a drug culture within the prison can be unsettling to prisoners, prison management and staff'. The committee welcomed the plan for more treatment places for prisoners in Mountjoy Prison, and noted recent findings regarding the upward trend in patterns of drug use in European prisons. The Committee also recommended education and drug risk awareness programmes for families, which could potentially have positive benefits for all. Random appropriate testing and searching of prisoners, visitors and staff need to be further researched, supported and resourced to focus on limiting inflow of illegal and dangerous substances.

The Wheatfield Prison visiting committee noted that extra netting had been installed to prevent prisoners accessing drugs that had been thrown over the prison wall from outside the prison, but that drug use by prisoners is an ongoing concern. Drug-free landings are on offer to prisoners who wish to avail of them, but drugs still end up on these landings. The committee stated that under no circumstances should prisoners who have not been cleared for these landings end up there. A new confidential phone line to report drugs in the prison has been set up and is a welcome addition in the battle against drugs.

The Dóchas Centre visiting committee welcomed the improvements to the centre in 2015. Innovative and progressive programmes have been rolled out during the past few years, many stemming from the Incentivised Regime Policy and Earned Temporary Release Scheme. However, a number of problems flagged in several previous reports remain; these include drug use and the difficulty in accessing addiction or counselling services on release.

1.3 Drug-related health responses in prisons

1.3.1 Drug-related prison health policy

Four policy documents are shaping the provision of drug-related healthcare in the Irish prison system.

1. **IPS three-year strategic plan 2016–2018**

The 3-year strategic plan committed the IPS to providing prisoners with access to the same quality and range of healthcare services as that available to those entitled to General Medical Scheme (GMS) health services in the community. (Irish Prison Service 2016) The recruitment of Assistant Psychologists, who under the supervision of qualified Psychologists will increase the number of those in prison accessing therapies for mental health difficulties. The IPS will Department of Justice endorsement of the recommendation that prison healthcare services be brought under the responsibility of the Department of Health and operated by the Health Service Executive (HSE). The plan promises to implement a prison wide system of random drug testing which can support positive prisoner choices, and assist in making prisons a safer environment and to develop appropriate interventions for offenders presenting with co-morbidities.

(Details from the three policy documents listed below were included in the 2015 National report)

2. **Keeping drugs out of prisons**

In May 2006 the Minister for Justice launched Keeping drugs out of prisons: drug policy and strategy (Irish Prison Service 2006). This set out the steps required to tackle the supply of drugs into prisons, to provide adequate treatment services to those addicted to drugs, and to ensure that developments in the prisons were linked to those in the community.

3. **National drugs strategy (interim) 2009–2016**

The following actions in the NDS relate to treatment in prisons (Department of Community Rural and Gaeltacht Affairs 2009):

- Treatment and rehabilitation (Action 43) – continue the expansion of treatment, rehabilitation and other health and social services in prisons and develop an agreed protocol for the seamless provision of treatment services as a person moves between prison (including prisoners on remand) and the community; and
- Research/information (Action 55) – research prevalence patterns of problem substance use among prisoners.

4. **Joint Irish Prison Service and Probation Service strategic plan 2015–2017**

The strategy sets out the multi-agency approach offender management and rehabilitation from pre- to post-imprisonment that the IPS and Probation Service will pursue in order to reduce re-offending and improve prisoner outcomes. (Irish Prison Service and Probation Service 2015).

1.3.2 Structure of drug-related prison health responses

Primary care is the model of care through which healthcare is provided in the prison system. A number of contracted private services assist the Irish Prison Service (IPS) and Health Service Executive (HSE) in the provision of drug treatment services. The service is delivered by a mix of part-time and full-time doctors and nursing staff. Nurses first began working in the IPS in 1999 (Nursing and Midwifery Planning and Development Unit & Irish Prison Service 2009).

The Probation Service and the Irish Prison Service (IPS) are responsible for managing offenders in the community and in prison, respectively. Both the IPS and the Probation Service are represented on The National Drugs Rehabilitation Implementation Committee (NDRIC) which was set was set up to oversee and monitor implementation of recommendations from the Report of the Working Group on Drugs Rehabilitation (2007).

A range of drug rehabilitation programmes within the prison system are delivered in partnership with Community Based Organisations (CBOs) with a value of €1.14m per annum. The Probation Service engages with offenders who have addiction problems, to ensure the offender has access to required supports. Addiction services are delivered in partnership with 18 CBOs with a value of €1.59m per annum.

Annual funding of approximately €0.22m is provided by the Department of Health through its drug initiative fund to a number of Local Drug and Alcohol Task Forces (LDATFs) to employ community prison links workers.

All of the organisations funded by the Probation Service and the IPS have Service Level Agreements (SLAs). SLAs between the Probation Service and CBOs operate for a year. The SLA between the IPS and MQI operates for three years.

Table 1.3.2.1. Irish Prison Service expenditure on health and addiction services, 2011, 2012 and 2014

	2011	2012	2014
Total health spend	c.9,600,00	c. 9,200,00	c.8,800,00
Of which:			
Drug treatment pharmacy services	743,678	781,709	512,325
Addiction counselling services	1,178,520	1,225,039	1,142,384
Methadone	67,012	78,076	80,169
Total addiction spend	1,989,210	2,084,824	1,734,878
Addiction spend as a % of total health spend	17%	18%	16%

Source: Clarke and Eustace, 2016

Irish Penal Reform Trust (IPRT)

As discussed in the 2016 Prison workbook, a report from the Irish Penal Reform Trust (IPRT) entitled Improving prison conditions by strengthening the monitoring of HIV, HCV, TB and harm reduction: mapping report – Ireland, was published in 2016 (MacNamara*, et al.* 2016). The report forms part of the EU co-funded project, Improving Prison Conditions by Strengthening Infectious Disease Monitoring, which was implemented under the lead of Harm Reduction International. The project aims to reduce the ill treatment of persons in detention and to improve prison conditions through improved and standardised monitoring and inspection mechanisms on HIV, hepatitis C virus (HCV) and tuberculosis. This broader research informed the development of a user-friendly tool to help generate better-informed, more consistent, and sustained monitoring of these diseases and harm reduction in prisons by national, regional and international human rights-based prison monitoring mechanisms.

The Irish report presented the findings of a national mapping exercise carried out to investigate available standards relating to human rights, infectious diseases and prison monitoring. It described the evolution in Ireland of the healthcare and prison systems; illicit drug use and the related legislative and policy context; and, human rights, particularly in the context of judicial care. It then explored the situation in relation to infectious diseases among prisoners. Information was collected through a literature review, analysis of public documents, Freedom of Information requests, and consultation with experts in the prison service.

Among the key findings was that the IPS's provision for HIV and HCV prevention measures did not meet the standards of best practice models found elsewhere in Europe and North America. Furthermore, the IPS did not fulfil its stated objective of providing primary healthcare (prevention, treatment and health rehabilitation) to offenders of at least an equivalent standard to that available to the general population. The authors argued that the IPS's response to the HIV and HCV crisis fell far short of this.

In terms of surveillance, they noted that while the Health Protection Surveillance Centre (HPSC) collected and collated data on notifiable diseases nationally, it was not possible for the authors to distinguish between those identified in the prison setting and the general population. They maintained that while some progress had been made in the adoption of monitoring mechanisms for infectious diseases in Irish prisons, it was less than sufficient in meeting the standards of human rights-based prison monitoring.

The report identified a number of monitoring mechanisms for Irish prisons. These include the Inspector of Prisons, prison visiting committees, and the European Committee for the Prevention of Torture. All of these had been critical of conditions in Irish prisons. The authors also concluded that Ireland's ongoing failure to have ratified the Optional Protocol to the Convention Against Torture presented a threat to the protection of the human rights of prisoners in Ireland.

With regard to addiction, Ms Fíona Ní Chinnéide, acting executive director of the IPRT addressed a Joint Committee Meeting in Dáil Éireann on 8 February 2017 (Ní Chinnéide 2017, 8 February). She stated that Ireland's prison population is characterised by mental health issues, addictions, homelessness, poverty, unemployment, educational disadvantage, chaotic family backgrounds and social marginalisation. In response to a comment from Deputy Clare Daly that an estimated 70% of people in prison have addiction issues, she stated that this comes as no surprise and that it is a well-known international phenomenon. Drugs need to be treated first as a public health issue and second as a criminal justice issue. Ms Ní Chinnéide said the problem starts with the lack of residential treatments in the community. In prison, there are issues around waiting lists for access to addiction treatment. Often, prisoners present with dual diagnosis, both addiction and mental health issues, which need to be treated at the same time.

The IPRT recommends that there is investment in community mental health and addiction treatment services. There should be a diversion of people at the first point within the criminal justice system, i.e. with the police. On committal to prison, there needs to be an assessment and diversion to more appropriate therapeutic treatments and services. Prison conditions and regimes need to be improved, along with improved training for staff. In addition, vulnerable care units need to be established in all prisons, modelled on the successful High Support Unit in Mountjoy Prison, and a shift from pharmacological treatment towards therapeutic interventions. Ms Ní Chinnéide stated that there should be no waiting lists. All prisoners who wish to address their addictions should be able to access treatment, not only methadone but detox beds, drug treatment landings and counselling. Ms Ní Chinnéide again stressed that addiction is a public health issue first, and that previous committees had examined the Portuguese model in this regard.

Jesuit Centre for Faith and Justice (JCFJ)
Eoin Carroll of the Jesuit Centre for Faith and Justice (JCFJ) addressed a Joint Committee Meeting in Dáil Éireann on 22 March 2017 (Carroll 2017, 22 March). Mr Carroll stated that with regard to appropriate sentencing, the balance of resources is skewed heavily towards prison; that punishment in the community should be the norm; and that given these skewed resources, society fails to address some of the underlying reasons why people commit crime, such as poverty, deprivation, social exclusion, educational failure, unemployment, homelessness, mental health and drug addiction. Mr Carroll discussed the findings of a report, Alternatives to Fines and the Uses of Prison (unpublished), which highlighted that the size of the prison estate, and by extension the number of people who are held in prison, is to a large extent a political calculation and that 'despite popular belief to the contrary, imprisonment rates have a very small impact on crime rates and can be lowered significantly without exposing the public to serious risk'. He stated that a number of reports have attempted to forecast prison numbers in Ireland, but all these reports fail to realise that it is ultimately a political decision, and can be as large as the numbers are observed in the USA, or as small as the numbers observed in Scandinavian countries. Mr Carroll stated that a decision should be made around the number of prison places there should be in Ireland and ultimately a cap should be placed on prisoner numbers.

Mr Carroll noted that, unfortunately for the most part, the Irish prison estate is a one-size model. Since 2000, Ireland has continued to increase prison sizes and still relies on closed prisons, with limited access to self-management. New builds since 2000, including the Midlands Prison and Cork

Prison – and also Castlerea Prison – did not try to change the ways people are detained. The Midlands Prison accommodates 870 people which, along with Cork Prison, mimics prison design from the 19th century. He stated that to put this in context, prisons with a maximum capacity for 300 persons are seen as best practice. Prisons seen as progressive, such as Shanganagh Castle and Fort Mitchel, were closed in the early 2000s. Mr Carroll suggested that how people experience prison conditions is heavily influenced by how much time a person spends in their room or cell. Lock-up times have not changed in over 30 years despite constant recommendations for change. The overwhelming majority of people are in closed prisons where the regime involves spending between 16 and 17 hours per day in a cell. The principle of normalisation has been spoken about for decades, including within IPS documentation, in order to make prison life more like that of life in the community. Mr Carroll stated that the current daily routine could not, in any way, be considered normal. The JCFJ recommendations around prison conditions and sizes are to reduce prison sizes and provide accommodation based on security need, avoiding the one-size-fits-all model, and at least 12 hours out-of-cell time with meaningful activity.

The JCFJ is concerned about the dramatic increase in the daily population of women in prison, and the numbers of women being sent to prison annually. Mr Carroll stated that proposed solutions for reducing the number of women in prison – by providing a step-down unit – reflect the failed institutionalised approaches of the past. Large hostel-style accommodation post-release – or as part of a step-down programme – will not dramatically break the cycle of homelessness or poverty. The approach taken within housing organisations, such as the Housing First approach, is required.

Mr Carroll stated that the issue of young adults in prisons is of particular interest to the JCFJ. He noted that imprisonment is inherently a destructive experience for everyone, but particularly for young people, no matter how good the facilities within the prison. A young person's growth and development is linked to decision-making; young people grow by learning from both the positive and negative decisions they make. In prison, however, a person is not allowed to make any decisions, except the decision to keep their head down and cause no trouble. Prison is an environment which strips people of their responsibilities, stunts opportunities for development, makes them feel unsafe, and restricts their opportunities for integration into adult society. The 18-24 age group is a period of what is called 'extended adolescence'. People in this age group are more likely to be impulsive and less able to control aggression and risk-taking than adults. Their impulsiveness and reduced ability to control aggression makes them seem uncooperative, and therefore more liable to punishment within the prison system. Mr Carroll noted that the prison system treats young offenders as if they were fully mature adults, when in fact they should be treated as a distinct group and more like children.

As reported in the 2016 National Report, in 2015 the JCFJ published a report entitled Developing Inside: Transforming Prison for Young Adults, which examines the needs, circumstances and conditions experienced by young adults within the Irish prison system (Jesuit Centre for Faith and Justice 2016). The report recommends that Ireland should avail of an alternative approach based on the principles of education, rehabilitation and reintegration, where continuity of care of young adult offenders is guaranteed. Other recommendations included the following:

- There should be recognition that young adults (aged 18-24) are a distinct group who should be under the remit of the Irish Youth Justice Service.
- Ireland should aim to reduce the number of young adults in prison.
- Young adults should be accommodated in detention centres that are humane and are designed specifically for them and their age group.
- Young adults who are detained, and prison officers, should be in settings where they both feel safe.
- There should be greater accessibility to specialised services within prison and upon release into the community.
- A new regime for young adults in prison should be provided.
- Extended lock-up and 'basic' regime standards should be eradicated. On committal to a prison, young adults should be placed in the 'enhanced' accommodation standard.

- Young adult offenders should be included in operational decision-making of the detention centre and prison.
- There should be a reduction of remand. However, when necessary, all detention centres should have dedicated remand facilities.
- Motivation and support to abstain from drugs in the prison setting should be provided, while also providing harm reduction measures.
- Training of prison staff should be enhanced and should use an evidence-based approach that is based on best international policy and practice.

Culture and organisation in the IPS

The 2015 Prison workbook included a summary of Culture and organisation in the Irish prison service: a road map for the future, a report compiled by the Inspector of Prisons at the time, the late Mr Justice Michael Reilly, and Professor Andrew Coyle, Emeritus Professor of Prison Studies at the University of London. The report examines all aspects of the administration and governance of the IPS and identifies a number of deficiencies in administration, treatment of prisoners and delivery of services by prison staff (Reilly 2015).

Several issues relating to management of prisoners and their rehabilitation were beyond the scope of the report. The authors recommended that a separate review should comprehensively deal with these and should include the following in its terms of reference:

- Healthcare including mental health, and
- Illicit drugs and other substance abuse.

1.3.3 Types of drug-related health responses available in prisons

Drug-related health responses: Overview

The IPS offers multidimensional drug rehabilitation programmes for prisoners. Prisoners have access to a range of medical and rehabilitative services, such as psychosocial services and work and training options, which assist in addressing their substance misuse. Any person entering prison giving a history of opiate use, and testing positive for opioids, is offered a medically assisted symptomatic detoxification, if clinically indicated. Patients can discuss other treatment options with healthcare staff. A consultant-led in-reach addiction service is provided in West Dublin Complex (Cloverhill and Wheatfield). In addition, an addiction specialist GP service is provided in a number of other prisons.

As well as addiction counselling, substitution treatment and detox are the main treatment modalities offered within the prison estate. This may include stabilisation on methadone maintenance for persons who wish to continue on maintenance while in prison, and when they return to the community on release. Prisoners who, on committal to prison, are engaged in a methadone substitution programme in the community will, in the main, have their methadone substitution treatment continued while in prison. Methadone substitution treatment is available in 11 of the 14 prisons (accommodating over 80% of the prison population). The Medical Unit in Mountjoy Prison has 18 beds specifically allocated for a DTP. This programme is eight weeks in duration and is provided by prison staff and the community/voluntary sector. The aim of the programme is to assist participants in achieving a drug-free status.

Six CBOs are funded to provide services in the prison system: MQI (funded under two separate contracts from the IPS and the Probation Service); Ana Liffey Drug Project (ALDP); Coolmine Treatment Centre (CTC); Ballymun Youth Action Project (BYAP); Fusion Community Prison Link (Fusion CPL), and the Matt Talbot Community Trust (MTCT) (all funded by the Probation Service to carry out work both in prison and the community). The Harmony Project is funded by the IPS to provide a module of the DTP in Mountjoy Prison (Clarke and Eustace 2016).

The Probation Service currently commissions 18 CBOs: Aftercare Recovery, Aiséirí in two locations and Ceim Eile (part of the Aiséirí group), BYAP, Clarecare Bushypark, CTC (which has three services: one for women, one for men and a day service), Crinan Youth Project, Cuan Mhuire in four

locations, Fellowship House and Tabor Lodge (both part of the same group), Fusion CPL, MQI (St. Francis Farm, High Park and Aftercare programme) and the MTCT. A range of services is provided, including residential treatment programmes for drug and alcohol addictions, harm reduction counselling and support, recovery and aftercare programmes, community education, therapeutic advice and family support.

Drug-related health responses: community-based organisations (CBOs)

Merchants Quay Ireland (MQI) Annual Review 2015
Addiction counselling services have been provided to the IPS by MQI since 2007 (Merchants Quay Ireland 2016). A voluntary organisation providing services to vulnerable persons, including drug users, MQI operates in 13 prisons throughout the country.

MQI: Overview of services provided
MQI, in partnership with the IPS, delivers a national prison-based Addiction Counselling Service aimed at prisoners with drug and alcohol problems. This service provides structured assessments, one-to-one counselling, therapeutic group work and multidisciplinary care, in addition to release planning interventions with clearly defined treatment plans and goals.
Services offered include:

- Brief interventions
- Motivational interviewing and motivational enhancement therapy
- A 12-step facilitation programme
- Relapse prevention and overdose reduction
- Cognitive behavioural therapy
- Harm reduction approaches
- Individual care planning and release planning

During 2015, a total of 2,725 prisoners accessed the MQI/IPS Addiction Counselling Service.

MQI: Mountjoy DTP
MQI (in partnership with the CBOs ALDP, BYAP and CTC) also coordinates and contributes to the delivery of a structured, multi-agency eight-week DTP in the Mountjoy Medical Unit. The programme assists prisoners in detoxing from methadone and benzodiazepines. During 2015, a total of 52 prisoners availed of the Mountjoy DTP, and of this group, 31 completed their detox.

MQI: Counselling sessions
Counselling sessions refer to the number of one-to-one meetings with prisoners where counselling interventions and care planning are provided. During 2015, 11,657 counselling sessions were delivered to prisoners by the MQI Prison-based Addiction Counselling service, representing a 4% increase on 2014.

MQI: Brief interventions
Brief interventions are one-to-one meetings between a counsellor and prisoner, generally of 30 minutes' duration. These meetings focus on a prisoner's immediate needs or problems which can often be resolved in a brief meeting. During 2015, 3,214 brief interventions were delivered, representing a 7% increase on 2014.

MQI/IPS addiction service developments, 2015
During 2015, the Addiction Counselling Service assisted in the development, and supported the implementation, of a number of IPS initiatives including Incentivised Sentence Management and the Red Cross Overdose Prevention programme. In addition, the Addiction Service developed referral pathways for prisoners to community-based detox and rehab services, including carrying out compressive needs assessments on behalf of detox/ rehabilitation services.

MQI/IPS planned addiction service developments, 2016

In 2016, the prison based Addiction Counselling Service planned to further develop and improve the services that are offered to prisoners. These included the following:

- Piloting psychometric outcome metrics aimed at capturing the impact of the service on clients.
- Developing the group work programme delivered in prisons.
- Developing access to service for prisoners on protection.

Ana Liffey Drug Project (ALDP): prison in-reach and out-reach

The ALDP is a 'harm reduction – low threshold' project CBO working with people who are actively using drugs and are experiencing associated problems. Services include a drop-in service, peer support programme, family support, supervised access visits, literacy support, prison work, street-based outreach service and case management.

The ALDP offers support to service users who have been sentenced to serve time in prison. As part of management and one-to-one work, the ALDP visits and supports prisoners, and also helps prisoners prepare for their release. In Dublin, the ALDP delivers two different programmes based in the drug-free wing of Mountjoy Prison; the programme is for prisoners seeking to live a drug-free lifestyle. One is a six-week programme, whereas the other is a rolling programme for people currently in the process of detox.

In the Midwest and Midlands, a one-to-one outreach programme is available to those who are in prison and wish to lead a drug-free lifestyle, or who are recently released from prison and need additional help or information on remaining drug free.

Coolmine Treatment Centre (CTC): addiction treatment

CTC is a drug and alcohol treatment centre providing community, day and residential services to men and women with problematic substance use, and their families, in Ireland. Established in 1973, CTC was founded on the philosophies of the therapeutic community approach to addiction treatment. During 2015, CTC continued to work with a high number of prison admissions, with 50% of admissions coming directly from the IPS (Coolmine Therapeutic Community 2016). In addition, more than 100 prisoners sought addiction treatment in Coolmine Lodge, a therapeutic community that hosts a five-month residential treatment programme for men who are working towards an independent life free from addiction. CTC has committed to developing a drug-free prison therapeutic community in the Irish prison estate to meet this demand.

The Ballymun Youth Action Project (BYAP): drug-free treatment and detox

The BYAP is a community response to drug and alcohol misuse. This CBO was founded in 1981 after three young people from Ballymun (an area on Dublin's Northside) had died from drug-related causes. As a response that has come from within the community of Ballymun, the overall mission of the BYAP is to reduce the negative impact of drug and alcohol use on the lives of individuals, families, and the community as a whole. The BYAP seek to do this through:

- working with individuals who are using, reducing, or who have stopped using
- drugs and/or alcohol;
- supporting families impacted by drug and alcohol issues;
- supporting the community in their work of prevention and intervention as responses to drug and alcohol issues; and
- building capacity through training and research.

The BYAP provides a range of appropriate therapeutic interventions to drug/alcohol users (with a connection to Ballymun) while they are in prison. The interventions include one-to-one prison sessions, the delivery of the DTP and the Detox Programme within Mountjoy Prison, and assisting individuals with their pre- and post-release choices.

Fusion Community Prison Link (Fusion CPL): prisoner rehabilitation
Established in 1999, Fusion CPL supports the probation service in providing line management for prison liaison workers. Fusion CPL works with drug users who are incarcerated in prison, assisting them to make the transition from prison back to the community. Ideally, this work begins six months before a prisoner's release date.

Matt Talbot Community Trust (MTCT): personal support
The MTCT is a drug-free educational programme endeavouring to create change at a grass roots level in Ballyfermot, a suburb of Dublin. MTCT work tackles the unique social issues that lead to problem drug use and criminal behaviour through the provision of a quality education system and structured person-centred supports. The MTCT provides support for individuals in recovery from addiction and returning from prison.

Its core work is to:

- promote independence, integration and progression in the lives of participants;
- encourage the participant and all members of the community to re-imagine their role within their environment and to become positive contributors to family, community and social stability; and
- build awareness of the issues facing drug user and build the capacity of services to respond.

The organisation works with prisoners to develop a tailored plan that encompasses developing a route into education and/or employment, coupled with social supports such as counselling, key working, family support and group work.

Treated problem drug use in prisons from TDI data
In 2016, 720 cases were treated in prison, as reported through TDI (Table 1.3.3.1). The treatment, mainly counselling, was provided by in-reach voluntary services or the prison medical service. In 2016, 8.0% of cases reported to TDI were treated in prison, similar to previous years. Of those cases treated in prison, 24.7% were new to treatment. The number of new treatment entrants in prison has decreased steadily over the past seven years, from over 50% in 2010 to 24.7% in 2016. The reason for this decrease is not known, however it may reflect improved access to drug treatment, in particular counselling, within the prison service.

Table 1.3.3.1 Treated problem drug use in prison, NDTRS 2010 to 2016

	2010	2011	2012	2013	2014	2015	2016
Total	916	753	636	743	835	774	720
New treatment entrants	471	337	264	270	285	244	178
Previously treated	406	393	324	446	505	517	520
Treatment status unknown	39	23	48	27	45	13	22

Source: NDTRS, 2017

All treatment entrants in prison
In 2016, the main problem drug (65.1%) reported by all treatment entrants was opiates (mainly heroin) (Figure 1.3.3.1). Cannabis was the second most common drug reported (11.9%), followed by benzodiazepines (11.1%). In 2016, 37.4% of cases treated in prison reported ever injecting, a slight increase compared to 2015, when 33.6% of all cases reported ever injecting.

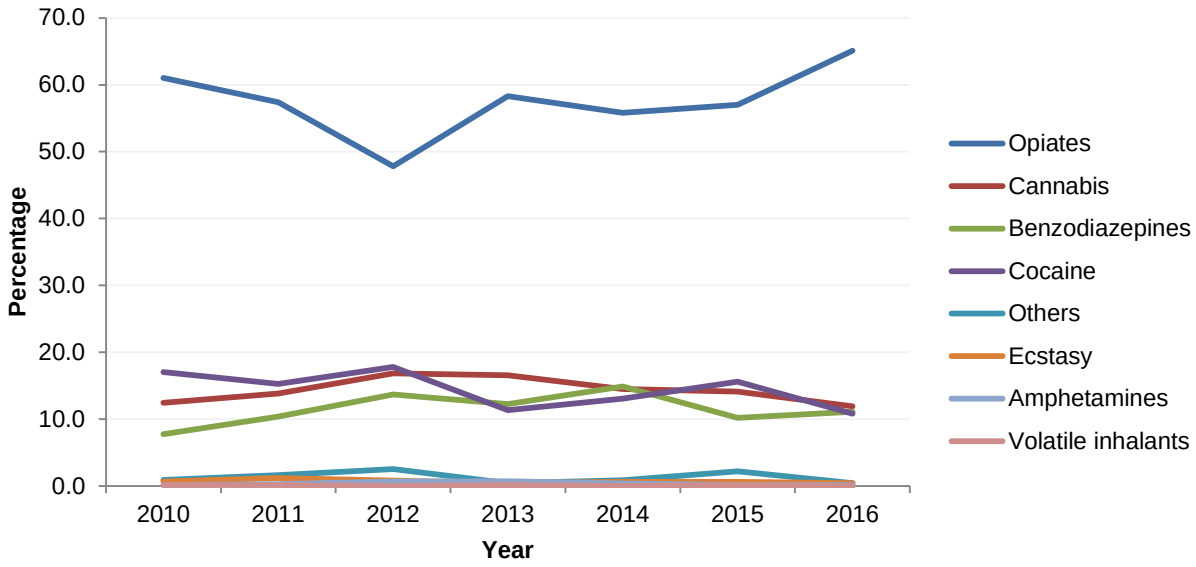

Figure 1.3.3.1 Main problem drug (excluding alcohol), all treatment entrants in prison, by year, NDTRS 2010 to 2016
Source: NDTRS, 2017

In 2016, 83.5% of cases were male. In 2016, the mean age was 31 years (male 30 years; female 33 years).

New treatment entrants in prison
Opiates (mainly heroin) were the main problem drug reported by new entrants, similar to previous years. The proportion reporting heroin has dropped from 52.0% in 2010 to 36.5% in 2016 (Figure 1.3.3.2). In 2016 cannabis (21.3%) was the second most common drug reported, followed by cocaine (20.8%). Almost all new entrants to treatment were male (94.4%) and the mean age was 29 years. Among this group, 20.8% reported ever injecting in 2016, compared to 23.0% reported in 2015.

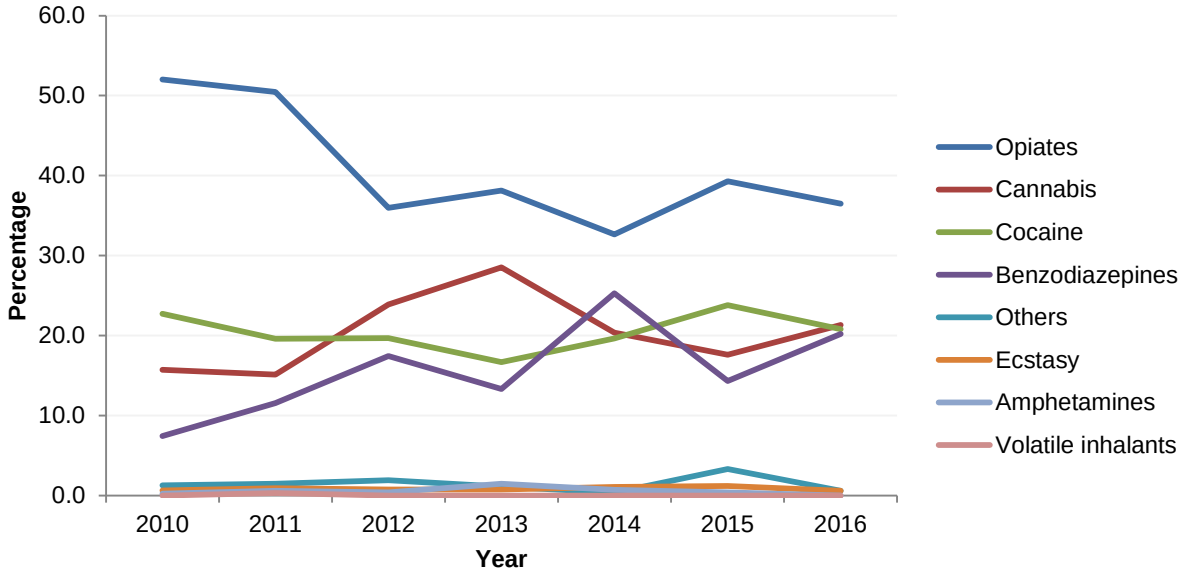

Figure 1.3.3.2 Main problem drug (excluding alcohol), new treatment entrants in prison, by year, NDTRS 2010 to 2016
Source: NDTRS, 2017

1.4 Quality assurance of drug-related health prison responses

1.4.1 Main prison treatment quality assurance standards, guidelines and targets within Ireland

Healthcare in Irish prisons
A report entitled Healthcare in Irish prisons, prepared by the Inspector of Prisons, the late Mr Justice Michael Reilly, was presented to the Tánaiste and Minister for Justice and Equality on 25 November 2016 (Reilly 2016). The three specific aims of the report were to:

- emphasise the absolute entitlement of prisoners to healthcare and the case for such healthcare to be provided by the Department of Health;
- highlight he necessity of carrying out a health needs assessment of prisoners and a staffing needs analysis in each Irish prison; and
- provide guidance to the IPS, to the management of prisons, and the providers of healthcare in the prisons on what will be expected of them in the area of healthcare when inspections are carried out in the future.

Obligation to provide healthcare in prisons equivalent to that in the non-prison community
The report emphasised that the right to health is a fundamental right and that Article 12 of the International Covenant on Economic, Social and Cultural Rights (United Nations Human Rights Office of the High Commissioner 1966) urges State parties 'to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. In addition, it is generally accepted as international best practice that the provision of healthcare in prisons should be equivalent to that available in the non-prison community.

Entitlement to health services in the Republic of Ireland is primarily based on residency and means. In particular, eligibility to access health services depends on whether a person is a medical card holder or not. It is well established that a majority of prisoners come from lower socioeconomic sectors of communities, and that many present with mental health and other pre-existing health problems, often resulting from a chaotic lifestyle. Therefore, the report urged that healthcare should be provided to prisoners on the basis that they are entitled to the same treatment and choices as people in the free community who are in receipt of medical cards.

Healthcare services in Irish prisons are, in the main, provided by the IPS. An exception is the provision of in-reach mental health psychiatric services by the Central Mental Hospital, which come at no cost to the IPS, as this service is funded by the HSE. Doctors are engaged either on a full-time or part-time basis. The report noted that the recruitment of full-time doctors is proving difficult. As a result, the IPS is over-reliant on locum doctors, who by their nature are transitory, to provide medical services to prisons. Nurses are employees of the IPS and as such are answerable to the governors of the prisons to which they are attached.

The report suggested that Ireland could comply with best international practice by ensuring that the present prison-administered healthcare services form close links with the HSE. However, Judge Reilly also stated that the Department of Justice and Equality has acknowledged that the international trend is now towards a service that is within the responsibility of the Department of Health, and that the Committee of Ministers of the Council of Europe, in its official commentary to the revised and updated European Prison Rules 2006 (Council of Europe 2006), states:

The most effective way of implementing Rule 40 [organisation of healthcare] is that the national health authority should also be responsible for providing healthcare in prison, as is the case in a number of European countries.

Judge Reilly noted that there may well be resource issues in transferring responsibility for prisoner healthcare from the IPS to the HSE and the Department of Health. However, he also stated that this cannot be used as an excuse for delaying such a transfer of responsibility. The report stressed that it must be borne in mind that the State accepts a heavy responsibility when it detains a person to ensure the well-being of that person, and that it is internationally acknowledged that a lack of financial means cannot reduce this responsibility.

Necessity of carrying out health needs assessment of prisoners and staffing needs analysis in each Irish prison
The report stated that irrespective of which body is responsible for healthcare in Irish prisons, be it the IPS or the HSE, a comprehensive assessment of the healthcare needs of prisoners in the 14 prisons in the Republic of Ireland must be undertaken. This must be followed by a staffing needs analysis of healthcare personnel within each prison. Judge Reilly noted that no such assessment has ever been undertaken within Ireland, and that it was impossible to express a view on the adequacy of the healthcare currently provided in Irish prisons, as it seemed to operate on an ad hoc basis.

Judge Reilly recommended that a Director of Healthcare, who is a registered healthcare professional, should be appointed immediately. The duty of the director would be to manage healthcare in prisons and to oversee the transition of healthcare from the IPS to the HSE. The report also stated that the provision of healthcare in Irish prisons should not be confined to that which is provided by doctors and nurses, but should embrace all aspects of care, including addiction, psychiatric and psychology services.

Guidance to IPS on what will be expected of them in the area of healthcare when future inspections are carried out
The report indicated that at any time upon request, prison governors and/or healthcare staff should be in a position to make the following available to inspecting officials:

- The health needs assessment for the prison.
- The staffing needs analysis for the prison.
- The number of nurses, doctors, psychiatrists, dentists, other specialists, psychologists, auxiliaries, etc. (engaged full time or part time), and their hours of duty.
- The number of medical referrals to hospital emergency departments for a given period.
- The average time for transfer of prisoners to emergency departments, with the longest and shortest time, for a given period.
- The number of medical referrals to external consultants for a given period.
- The number of cancellations of appointments with external consultants, with reasons for such cancellations, for a given period.

2. New developments

2.1 New or topical developments

Review of drug and alcohol treatment services for adult offenders in prison and in the community
As discussed in the 2016 National Report, an independent review of alcohol and drug treatment services for adult offenders in the community and in prison was published in March 2016 (Clarke and Eustace 2016). The review explored current provision and set out a model of effective practice for the treatment of adult offenders that can facilitate a continuum of care from prison to the community. The authors argued that the prison environment provides a unique opportunity to support individuals to address addiction, and that it is appropriate that a range of treatment and intervention options are provided in the prison estate.

Excluding direct staff and GP costs, the IPS and the Probation Service have combined expenditure of €3.33 million on the provision of addiction services for adult offenders. Spending has declined in recent years (see Table 1.3.2.1). The reduction in overall health spending mirrors a fall in the number of prisoners held in the prison estate as more initiatives, such as community return, have been introduced. However, the authors of the review point out that those who are in the prison system now tend to be more challenging, high risk and chaotic, and their criminality and addictions are more entrenched.

During the review, concern was expressed about the lack of investment in health in the prison systems and the absence of a Clinical Director or Health Director at senior management level. Reduced expenditure on addiction counselling has resulted in a reduction in the number of addiction counsellors provided by MQI and changes in the types of services they provide. Some prisons only have part-time access, and waiting times for addiction counsellors have increased.

Consultations with service providers, the Probation Service, the IPS and the HSE all highlighted a number of recent changes that were affecting capacity to treat offenders with addictions. These included the following:

- A decline in opiate-based addiction and an increase in benzodiazepine, NPS, opiate-based analgesics and other narcotics usage, as well as polydrug abuse.
- Increasing numbers of offenders presenting with comorbidities, most notably mental illness combined with drug and/or alcohol addiction.
- The ready availability of drugs within the prison system.
- Younger people with complex needs, e.g. drug addiction combined with chaotic personal lifestyles, homelessness, mental health issues, poor literacy and communication skills deficits.
- A cohort of offenders moving in and out of the criminal system repeatedly, posing significant challenges to effective treatment.
- Female offenders are more likely to be chaotic substance users than their male counterparts. This results in particular challenges when treating their addictions.

Model of effective practice
The review outlines a model effective practice aligned with the principles set out in the National Drugs Rehabilitation Implementation Committee (NDRIC) framework and refined following consultations with CBOs, prison-based health teams and addiction counsellors, and a review of international literature.

The model recognises that recovery takes time and often requires several episodes of treatment, and that the person in recovery should have a broad range of options available to facilitate the process. Good communication, both within the prison system and between the prison environment and the community, are necessary in order to ensure clear treatment pathways and also to ensure that the opportunity provided by time in prison to address addiction is actually availed of. The core components of the model are pre-work and preparation, referral, assessment, care planning, case management, treatment and recovery management.

Outcomes
Apart from initial outcomes monitored by MQI in Mountjoy Prison, there is currently no robust systematic tracking of outcomes for prisoners treated in the prison estate. The review acknowledged that while work needs to be done regarding the identification and measurement of outcomes, good progress has been made by CBOs in developing outcome models. Most of these are abstinence based, but there is a recognition that other outcomes, such as completing treatment, increased social skills and behavioural change, are also valid outcomes in recovery programmes.

Recommendations
The authors recommended that the IPS adopts this model and provides the required resources and funding to support its implementation. Some of the gaps in provision identified in the review include the availability of drug-free environments within the prison setting for prisoners who have completed detoxification and treatment programmes, and the development of non-opiate-based detoxification services, alcohol treatment services and access to treatment for difficult cohorts such as sex offenders. Coordination of services for prisoners between prison and outside agencies is very important in ensuring that prisoners receive the services they need. Continuum of care depends on reliable referral pathways to HSE treatment services and CBOs, and this process needs to be refined through clearer protocols and mechanisms to support greater interagency information

sharing. A related issue is coordination of services, with a more defined role for prison addiction nurses in care planning and case management.

The authors of the review recognise the considerable progress that has been made in recent years in the management of release planning from prisons, for example the involvement of Integrated Sentencing Managers (ISM). However, prisoners with an addiction still face considerable problems on release from prison, especially if they are homeless. The review makes a number of recommendations which should help the coordination of pre-release planning and communication with Probation Services and other external services. These recommendations include the involvement of relevant prison health staff and a specialised resettlement support service. As coordination and communication between services is an important part of addiction services, the review paid particular attention to the role of SLAs in the overall governance of external providers and CBOs.

Irish Taoiseach launches Reducing Harm, Supporting Recovery – a health-led response to drug and alcohol use in Ireland 2017–2025

On 17 July 2017, the Irish Taoiseach Leo Varadkar joined the Minister for Health Simon Harris and Minister of State Catherine Byrne to launch Reducing Harm, Supporting Recovery – a health-led response to drug and alcohol use in Ireland 2017–2025 (Department of Health 2017). Reducing Harm, Supporting Recovery outlines the direction of Government policy on drug and alcohol use over the period 2017–2025. The strategy aims to provide an integrated public health approach to drug and alcohol use, focused on promoting healthier lifestyles within society.

The strategy contains an ambitious 50-point Action Plan from 2017 to 2020, and provides the scope to develop further actions between 2021 and 2025 to ensure the continued relevance of the strategy to emerging needs into the future. The strategy's vision is to create a healthier and safer Ireland. Key actions of Reducing Harm, Supporting Recovery specific to the Irish prison population include the following:

- Providing training to enable the delivery of screening, brief intervention and onward referral in line with national screening and brief intervention protocols for problem substance use among prisoners.
- Further develop a range of service-specific problem substance use interventions for prisoners in line with best international practice.
- Determining the prevalence of NPS use in prison settings, with a view to developing specific training for staff and appropriate interventions.
- Establishing a Working Group to explore ways of improving progression options for people exiting prison, with a view to developing a new programme of supported care and employment.

For further information on the Reducing Harm, Supporting Recovery drugs strategy see Policy workbook Section 1.1.1.

3. Sources and methodology

3.1 Sources

Notable sources include the Annual Reports of the IPS, reports of the Inspector of Prisons and responses to PQs. Various publications and the IPRT website are also a useful source of information.

Data on treated problem drug use are provided by the National Drug Treatment Reporting System (NDTRS). The NDTRS is a national epidemiological database which provides data on treated drug and alcohol misuse in Ireland. The NDTRS collects data from both public and private outpatient services, inpatient specialised residential centres and low-threshold services. For the purposes of the NDTRS, treatment is broadly defined as 'any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for their substance misuse problems'. The

NDTRS is a case-based, anonymised database. It is coordinated by staff at the Health Research Board (HRB) on behalf of the Department of Health.

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European Monitoring Centre for Drugs and Drug Addiction

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is a decentralised EU agency based in Lisbon. The EMCDDA provides the EU and its Member States with information on the nature, extent, consequences and responses to illicit drug use. It supplies the evidence base to support policy formation on drugs and addiction in both the European Union and Member States.

There are 30 National Focal Points that act as monitoring centres for the EMCDDA. These focal points gather and analyse country data according to common data-collection standards and tools and supply these data to the EMCDDA. The results of this national monitoring process are supplied to the Centre for analysis, from which it produces the annual *European drug report* and other outputs.

The Irish Focal Point to the EMCDDA is based in the Health Research Board. The focal point writes and submits a series of textual reports, data on the five epidemiological indicators and supply indicators in the form of standard tables and structured questionnaires on response-related issues such as prevention and social reintegration. The focal point is also responsible for implementing Council Decision 2005/387/JHA on the information exchange, risk assessment and control of new psychoactive substances.

Acknowledgements
Completion of the national focal point's reports to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) depends on the support and cooperation of a number of government departments and statutory bodies. Among those to whom we would like to express our thanks are the staff of the following:

Customs Drugs Law Enforcement, Revenue
Department of Children and Youth Affairs
Department of Education and Skills
Drugs and Organised Crime Unit, An Garda Síochána
Drugs Policy Division, Department of Justice and Equality
Drugs Policy Unit, Department of Health
Forensic Science Ireland
Health Protection Surveillance Centre, Health Service Executive
Hospital In-Patient Enquiry Scheme, Health Service Executive
Irish Prison Service
National Advisory Committee on Drugs and Alcohol, Department of Health
National Social Inclusion Office, Primary Care Division, Health Service Executive

We also wish to acknowledge the assistance of the coordinators and staff of local and regional Drug and Alcohol Task Forces, voluntary, community-based and other non-governmental organisations.

We wish to thank our HRB colleagues in the Evidence Centre, National Drug Treatment Reporting System, the National Drug-related Deaths Index and the HRB National Drugs Library, all of whom make significant contributions to the preparation of the national report.