Rialtas na hÉireann
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Second Report

Interdepartmental Group to examine issues relating to people with mental illness who come in contact with the Criminal Justice System

Contents

1. Introduction

The Interdepartmental Group to examine issues relating to people with mental illness who come in contact with the criminal justice system includes representatives of the Department of Justice and Equality, the Department of Health, the Health Service Executive, the Probation Service and the Irish Prison Service.

The Interdepartmental Group originated from the Health/Justice Cross-Sectoral Team which was established in 2009 for the purpose of addressing issues arising from the interaction between the criminal justice system and mental health services.

The report of the Thornton Hall Project Review Group, published in 2011, recommended that an interdepartmental group be set up to examine the issue of people with mental illness coming into contact with the criminal justice system. The Health/Justice Cross-Sectoral Team was charged by the then Ministers for Health and Justice and Equality with this task. Specific terms of reference for the Interdepartmental Group were agreed and published in March 2012. The terms of reference are set out in **Appendix B**.

The Interdepartmental Group's first interim report was published in September 2016. That report sets out the work of the Interdepartmental Group in relation to how diversion could be facilitated where appropriate, at all stages of the criminal process up to the conclusion of a criminal trial.

The second report of the Interdepartmental Group explores matters relating to mental health services for prisoners and persons subject to community sanctions, matters relating to patients detained under the Criminal Law (Insanity) Act 2006 and post-release mental health services for former prisoners.

The second report of the Interdepartmental Group also gives an update on the implementation of the recommendations of the Commission of Investigation into the death of Gary Douche. This is provided at **Appendix C**.

2. Summary of Recommendations

1. The Interdepartmental Group recommends that research be carried out to ascertain the prevalence of mental illness/disorder/disturbance in the Probation client population;

2. The Interdepartmental Group recommends that gap analysis regarding relevant services for probationers to be carried out;

3. The Interdepartmental Group recommends that the Probation Service assess staff training needs and take appropriate steps accordingly;

4. The Interdepartmental Group recommends the establishment of clear protocols with the HSE, on accessing community mental health services and possible hospital admission where the level of clinical need from a mental health perspective warrants such an admission;

5. The Interdepartmental Group recommends continued investment of resources into mental health care for prisoners;

6. The Interdepartmental Group recommends that in-reach services should be made available in all prisons;

7. The Interdepartmental Group recommends that urgent action is taken regarding the delays in admitting prisoners to the Central Mental Hospital;

8. The Interdepartmental Group recommends that the full capacity of the CMH be utilised (in particular Unit 5 should be fully opened as a matter of urgency);

9. The Interdepartmental Group recommends consideration be given to an arrangement being put in place to ensure that the CMH always has the ability to accept severely ill prisoners without undue delay even if for a limited period. This could consist of some type of roll over facility for short & fixed term admissions from the Prison system to treat acutely unwell prisoners before returning them to an appropriate facility within a prison;

10. The Interdepartmental Group recommends that, subject to recommendation 9, preparation on the legislative changes necessary to facilitate arrangements for fixed term admissions to the CMH from prisons are put in place. This will facilitate the CMH in always having the ability to accept severely ill prisoners;

11. The Interdepartmental Group recommends that, subject to recommendation 9, the Irish Prison Service, the National Forensic Mental Health Services and the HSE

discuss the operational issues regarding the development of an appropriate facility in a prison.

12. The Interdepartmental Group recommends that the medical card pilot project application scheme be extended to all prisons for those eligible prisoners;

13. The Interdepartmental Group recommends that there is improved support for GP practices;

14. The Interdepartmental Group recommends that the extension of the Pre Release Planning Programme (PREP) for mentally ill prisoners to other prisons should be explored.

15. The Interdepartmental Group recommends that consideration is given to development of a Housing First approach to residential service for persons with multi-factoral complex needs.

3. Mental Health Services for Offenders in the Community

Introduction

Those with a mental illness or mental disorder who come before the Courts having committed a criminal offence may be dealt with in a number of ways: some are diverted directly to mental health services; others may be similarly diverted following an initial remand in custody. If their offending is judged to warrant it, the person may receive an immediate custodial sentence. Others, typically those whose offending is less serious, may receive a supervised community sanction (e.g. probation supervision or community service) or an unsupervised community-based sanction, such as a fine, a dismissal, or a fully suspended sentence, without supervision. This section of the report will deal with those who receive community sanctions supervised by the Probation Service.

Context

The Probation Service manages up to seven thousand offenders in the community at any one time. While it is difficult to quantify exact numbers, anecdotal evidence points to a small but not insignificant percentage of offenders who are referred to the Probation Service experiencing identifiable mental health issues up to, and including major mental illnesses. There are no statistics in this jurisdiction in relation to the numbers or percentage of those under Probation Supervision who have a current mental illness diagnosis. Nevertheless, statistics from Probation risk assessments carried out on those on supervision in the community indicate that up to 40% have a history of engagement with mental health services.

Dr. Twylla Cunningham, a Senior Psychologist on the Probation Board for Northern Ireland stated that psychological assessments of one particular cohort of probationers in Northern Ireland recently found that 73% had "current mental health difficulties". [1] Sirdifield and Marples [1] pointed to a "high complexity of health problems in the offender population," reflected in "an estimated 39% of offenders" (England & Wales) experiencing "a mental illness while on probation." UK evidence also points to a high prevalence of personality disorder among offenders being supervised in the community.

Many Probation Service staff have considerable experience in working with offenders with mental health issues yet challenges can arise. Managing risk of harm and reoffending among persons on probation supervision is a key responsibility of the Service. Failure to manage the risks associated with mental distress will likely have a significant impact on

[1] http://www.europris.org/file/presentations-group-sessions-mental-health-workshop-6-7-december-2017-dublin/?download=1

the likelihood of an individual coming into further conflict with the criminal justice system.

Mental health issues may have a direct, or indirect, link with continued offending. Such distress can significantly impact upon the Service's capacity to intervene effectively to achieve reintegration and reduce risk of harm and reoffending. The Probation Service seeks to ensure the individual receives the care required, to fulfil the obligation in helping create a safer and fairer society, through reducing the risk of re-offending.

Current Challenges

In the community, many of those clients of the Probation Service experiencing mental illness, disorder or distress receive appropriate support and intervention through their families, their General Practitioners, or community based mental health services. It can be difficult, however, for Probation Officers in working with clients, to access appropriate mental health services for persons on probation supervision in the community who require assessment and treatment particularly where they are not already linked in to services or may have 'fallen out' of dual services.

The combination of drug misuse and mental health issues, for example, often precludes clients from either service. Many of these and other clients can present with challenging and disruptive behaviours which can impact their ability to access or retain local community services. This is contrary to the spirit of the 'Vision for Change' policy, and in practice presents an ongoing challenge to the Probation Service in managing the offending behaviour of these offenders in the community.

Many of the offenders with mental illness or other mental health issues who end up on probation supervision arrive there without prior assessment. This can further compound the challenges of effectively supervising that person, in the absence of a pre-sentence assessment, which might for example have proposed, specific supervision conditions, specifically suited to addressing the relevant mental health issues.

It is important to note that where someone with a mental illness, for example, is accessing and co-operating with appropriate psychiatric treatment, the probation supervision plan is enabled to address other offence-relevant issues.

In custody, prisoners assessed on committal may, in the course of their sentence, be referred to forensic psychiatric services. These are provided on an in-reach basis, primarily by the National Forensic Mental Health Service. This is further explored in Chapter three.

Probation Officers work as part of multi-disciplinary teams, mainly with prisoners who will be under post-release supervision in the community. Continuity of care between the prison based mental health service and community mental health teams is essential.

A very small number of cases in the community under Court ordered post release supervision, having left prison, retain specialist forensic input, provided by the National Forensic Mental Health Service. Others fall out of the system, whether forensic or general mental health services, and do not maintain links to ongoing appropriate care.

The Probation Service supports the McMorrow recommendations that the pre-release programme should continue for a period after release. The importance of strengthening links with community mental health services are critical in managing an offender's transition from custody to the community.

In keeping with generic health service provision, when a client of the Probation Service experiences a mental health problem, he/she is encouraged to make contact with their GP. Having a medical card is critical to this. The GP will either identify the problem and treat it or refer the person on to the locally based consultant-led mental health team. Where there is a history of existing or past engagement with mental health services, the Probation Officer will encourage and assist the client to re-engage with that service. Some clients attend community psychiatric clinics and day services, allowing Probation Officers link with medical and support staff as appropriate.

Conclusion

There is a higher prevalence of mental illness, mental disorder and disturbance within the population under Probation Service supervision, compared to the population in general. A small, but significant, percentage of probationers have significant mental health issues. Because of their relatively low level of index offence seriousness – and ironically, sometimes allied to their presentation of mental disturbance - some of these offenders attract community sanctions with supervision by the Probation Service rather than custodial sentences.

Mental health policy, as espoused in the 'Vision for Change,' states:

> *'It is essential that there are linkages between the Probation Service and the relevant generic mental health services and, where appropriate, FMHS to ensure a linked approach and, in particular, continuity of care.'*

The Probation Service endorses this view and is committed to supporting its clients in accessing appropriate mental health assessment, diagnostic and treatment services to enable them to lead healthier lives and to desist from re-offending.

Probation Officers currently work with such medical and psychiatric services as may be available locally, to ensure that clients presenting with relevant issues receive appropriate treatment. Clear deficiencies, in terms of appropriate assessment, diagnosis and treatment, available on a clear and consistent basis nationally, need to be addressed.

Recommendations

- The Interdepartmental Group recommends that research be carried out to ascertain the prevalence of mental illness/disorder/disturbance in the Probation client population;

- The Interdepartmental Group recommends that gap analysis regarding relevant services for probationers to be carried out;

- The Interdepartmental Group recommends that the Probation Service assess staff training needs and take appropriate steps accordingly;

- The Interdepartmental Group recommends the establishment of clear protocols with the HSE, on accessing community mental health services and possible hospital admission where the level of clinical need from a mental health perspective warrants such an admission.

4. Mental Health Services for Prisoners in custody

Background

The prevalence of severe mental illness is higher amongst prisoners than among the general population (possibly 10 times higher[2]). This is not unique to Ireland. There are a number of factors that contribute to this.

In a number of countries a decline in the number of psychiatric hospital beds has been associated with an increase in the number of mentally ill people being dealt with by the criminal justice system. A study carried out by Winnie S Chow and Stefan Priebe [3] on how institutional mental healthcare has changed in Western Europe since 1990 shows that in Ireland, the number of adult psychiatric beds has fallen from approximately 265 beds per 100,000 head of population in 1990 to approximately 60 beds per 100,000 head of population in 2011.

Persons with mental illness who experience a psychotic episode may behave in a way that leads to a criminal justice intervention and receive criminal sentences without regard to any underlying mental illness. Traditionally only in the most severe cases would a defendant enter a defence of insanity.

Substance abuse unfortunately is relatively widespread among the prison population and there is evidence to suggest a link between early abuse of certain drugs and mental illness. There is also evidence that in those with serious mental illness, there is an increased risk of violent offending in those with co-morbid substance abuse. [4]

Prison removes people from the normal family and social supports and the environment of a prison is not in itself conducive to mental wellbeing. Prisoners have a right to the same quality of mental health treatment (equivalence of care) as a person in the community. Indeed there is an argument that it is in the public interest that mental health treatment for prisoners should be given priority.

The practice in the Irish Prison system up to 1999, was that primary mental health care was provided within the prison environment and those with more complex needs had to be treated outside the prison system. There were no mental health in-reach services provided and primary care meant access to a General Practitioner. A person with a mental illness had to be transferred to the Central Mental Hospital (CMH) for treatment. A limit in the capacity (including beds, consultant psychiatrists (2) and support staff) of the CMH, meant there could be severe delays before a prisoner with a severe mental illness could be accepted and treated in the CMH. While on the waiting list, the option most availed of

[2] Orla O'Neill, National Overview of Forensic Mental Health Services 2011
[3] Chow WS, Priebe S. BMJ Open 2016
[4] Kennedy et al, Mental Illness in Irish Prisoners, National Forensic Mental Health Services 2005

in severe cases, was to keep the prisoner in isolation in a cell designed to minimise the self-harm, a prisoner might inflict on him or herself. This was and is, distressing for the prisoner as well as staff.

Changes since 1999

Since 1999 there has been a very significant improvement in the mental health services provided to prisoners.

Irish Prison Service Psychology Service

The core work of the IPS Psychology Service is to address the mental health and offence-related needs of those in prison. Specifically, the Psychology Service provide various evidence-based primary, secondary and tertiary care talking therapies for people in custody who experience mental health difficulties. Interventions include 'whole population initiatives' in conjunction with the multi-disciplinary team to raise awareness of mental health, individual therapy and group based interventions. The Service, which is often seen as providing only 'offence focused work', is keen to explain that offence focused work very often includes mental health interventions, particularly considering mental health and personality can be risk factors in offending behaviour.

The IPS Psychology Service is currently made up of a Head of Service, nine Senior Psychologists (including two vacant posts, one Acting Senior and one locum), 12.6 Staff Grade Psychologists (including three locum Psychologists) and 10 Assistant Psychologists (unqualified Grade). There are two vacant Staff Grade Psychologist posts; one in Castlerea and one in the Violence Reduction Unit (Midlands prison). This is set out in the table at **Appendix A**.

In 2015, the IPS commissioned a review of the IPS Psychology Service by Dr. Frank Porporino (a Canadian Psychologist with significant experience in the provision of Psychological Services in custodial settings). Dr. Porporino noted that the Service was neither supported nor embedded within the IPS. Key recommendations were made to support the future direction of Psychological Services in the IPS. This report, 'New Connections: Embedding Psychology Services and Practice in the Irish Prison Service' is available on the IPS website. [5]

Dr. Porporino noted that the IPS Psychology Service was under-resourced when compared to international norms. He indicated that international standards recommend one psychologist to 150 people in custody, and one psychologist to approximately 80 people in custody in specialist areas such as high secure units and equivalent. While some

[5] Frank J. Porporino, Ph.D., New Connections, Embedding Psychology Services and Practice in the Irish Prison Service, June 2015

improvements have been made and additional resources were recruited, the current IPS Psychology Service ratio is some way off this standard.

The Psychology Service offers an open referral system; anyone can refer to the service. The large majority of referrals are in relation to mental health, including Mood Disorders, Post Traumatic Stress Disorder, Adjustment Disorder, Complex Bereavement, self-harm and suicidal behaviour, Eating Disorder, Bipolar Disorder, Psychosis and Schizophrenia, Addiction, Impulse Control, Obsessive Compulsive Disorder, as well as Personality Disorder and Personality Disorder traits. The Psychology Service provide a range of group and individual evidence informed approaches to intervene with these presentations. It works with individuals presenting with developmental disorders, learning difficulties, traumatic brain injuries and cognitive decline. The Service completes cognitive assessments as clinically necessary.

Furthermore, the Psychology Service is involved in the co-management of a Violence Reduction Unit (VRU) in Midlands prison. This 10 bed unit which opened in November 2018 is managed jointly by Operations and Psychology with a particular focus on men with violent histories and particularly complex mental health and personality difficulties.

All prisoners are now medically assessed 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 who, subject to his/her findings, may make certain recommendations to the Governor for the care of the prisoner.

National Forensic Mental Health Service (NFMHS)

The National Forensic Mental Health Service (NFMHS) at the Central Mental Hospital (CMH) provides a Mental Health Prison In-Reach and Court Diversion Service (PICLS) programme to the Irish Prison Service. This includes consultant forensic psychiatrists, non-consultant hospital doctors, community forensic psychiatric nurses, social workers and other staff.

The Standards of Care for both primary healthcare and the provision of services to prisoners with mental health difficulties are outlined in the McMorrow Commission Report (Section 1.2 page 42) and include assessment, prison in-reach, ongoing treatment within the prison setting or escalation to the forensic hospital setting, where necessary.

The prison in-reach arrangements provided by the NFMHS are an excellent example of partnership working and provide an invaluable service to the significant body of prisoners who suffer from a mental disorder. Furthermore, the NFMHS in-reach service to prisons has been expanded in recent years with an additional consultant, CPN and social work resources.

With regard to prisons where there is no in-reach service such as Castlerea, Limerick and Cork, an agreement is in place with the NFMHS to refer prisoners for forensic assessment to prisons where such a service exists. It is acknowledged that this arrangement is far from ideal and the advent of a consultant led service in-reach service in each prison is the optimal solution.

Fortunately, approval has been granted to the HSE, to provide consultant led mental health services to Limerick, Cork and Castlerea prisons. This will be a welcome development, which for the first time will see NFMHS in-reach services available in all closed prisons. The new consultant post holders will report directly to Professor Kennedy, Executive Clinical Director, NFMHS with regard to clinical work with prisoners. The consultants will also perform a community role providing sessions for the local Community Mental Health Team (CMHT). As such, the three consultant appointments should harness better integration between prison healthcare staff and Community Mental Health Teams.

Current Consultant led in-reach services

The table below shows the current consultant led in-reach services provided in Prisons as part of the National Mental Health Service (2018). All numbers are Whole Time Equivalents (WTE).

Prison	CFP		NCHD	CMHN	HRO	SW
Arbour Hill	0.1		0.1	0.2		
Castlerea	0.5			1		1
Cork				1		1
Cloverhill	1.5		3.6	3	1	
Dóchas	0.2		0.1	01		0.8
Limerick	0.5					1 (vacancy)
Midlands	1.0			2		
Mountjoy	0.3		0.2	2		1.2
Oberstown	0.2			1 (vacancy)		1
Portloaise	0.2		0.1			
Shelton Abbey	When required			Once a month		
Wheatfield	0.2		0.2	1.4		

Legend			
CFP	Consultant Forensic Psychiatrist	**HRO**	Housing Resettlement Officer
NCHD	Non-Consultant Hospital Doctor	**SW**	Social Worker
CMHN	Community Mental Health Nurse		

The Irish Prison Service (IPS), in collaboration with the NFMHS, has established two dedicated areas where high support is provided to vulnerable prisoners with mental illness. These are D2 wing in Cloverhill Prison (predominantly for remand prisoners) and

the High Support Unit (HSU) in Mountjoy (predominantly 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 themselves or to others, can be separated from the general prison population and are closely monitored in a safer environment. The High Support Units have managed vulnerable and mentally ill prisoners in a more effective and humanitarian environment and has resulted in greater access to care and regular reviews by the prison in-reach team. The establishment of other HSU's remains under consideration, although this is dependent on the availability of sufficient resources to staff them.

The NFMHS also provide an assessment and liaison service for all other prisons. Clinicians in other prisons (outside of the CMH catchment area), arrange a transfer to NFMHS services, mainly in Cloverhill (D2 wing) or to the HSU in Mountjoy, when a prisoner requires a forensic assessment or access to an admission bed in the CMH.

A Psychiatric In-reach and Court Liaison Service (PICLS) is delivered by the NFMHS in-reach team at Cloverhill Prison. The diversion system ensures as far as possible that those people presenting before the courts, or indeed at an earlier stage of the criminal justice system, where the infraction is a reflection of an underlying mental illness, are referred and treated appropriately. This approach has reduced the number of mentally ill people committed to prison, under sentence.

The IPS continues to work with the Health Service Executive/National Forensic Mental Health Service (NFMHS) to seek to ensure the appropriate provision of Psychiatric services to those in custody with mental health needs in all closed prisons. The IPS is seeking to finalise an agreed Memorandum of Understanding (MOU) with the HSE in respect of mental health provision by the NFMHS.

The Interdepartmental Group strongly recommends that the goal of providing an in-reach service in all the closed prisons should be pursued. This should result in an acceptable level of treatment and care being provided, subject to capacity issues in the CMH.

Conclusion

The provision of mental health services to prisoners has improved significantly since 1999. Resources need to continue to be invested to ensure that the level of treatment and care is maintained and improved. In particular emphasis should be placed on achieving the goal of the provision of in-reach services to all closed prisons.

The most pressing problem is the small number of prisoners who are severely mentally ill and do not have access to treatment for a sustained period of time due to capacity issues in the CMH. This needs to be addressed urgently.

Recommendations

- The Interdepartmental Group recommends continued investment of resources into mental health care for prisoners;

- The Interdepartmental Group recommends that in-reach services should be made available in all prisons;

- The Interdepartmental Group recommends that urgent action is taken regarding the delays in admitting prisoners to the Central Mental Hospital.

5. Access to Residential Treatment

In the 1990's the limits on the capacity of the CMH to accept prisoners was formalised. This related to the number of beds available, consultant psychiatrists and support staff. As a result of lack of capacity, there could be delays before a prisoner with a severe mental illness could be accepted and treated in the CMH. While on the waiting list, the option most availed of in severe cases, was to keep the prisoner in isolation in a cell designed to minimise the self-harm. This was and is distressing both for the prisoner as well as staff.

A waiting list for the admission of prisoners to the Central Mental Hospital (CMH) is operated by the NFMHS and is reviewed on a weekly basis.

The improvements in the mental services provided to prisoners did lead to a situation where waiting times for transfer of prisoners suffering severe mental illness to the CMH had become less of an issue. Over the last eight years, the number of prisoners on the waiting list has generally fluctuated between five and twenty prisoners. It should be noted that all prisoners placed by NFMHS consultants on the waiting list have been clinically assessed as warranting admission to the CMH, which is a tertiary care facility.

The absence of admission beds in the Central Mental Hospital and the consequent waiting list for prisoner admissions poses a significant risk for the Irish Prison Service. The table below includes a snapshot of a period in 2016 where there was a spike in the number of prisoners on the waiting list for admission to the CMH. The growth in the waiting list numbers, represents an increasing risk in safely managing prisoners in custody who are suffering from a severe and enduring mental illness.

For comparison purposes, the figures for similar periods in 2017 and 2018 are included. It is evident that while the numbers dropped slightly to more traditional levels in 2017, there was a further spike to a new high of 33 prisoners on the waiting list for admission to the CMH in May of 2018. The number of prisoners that are on a waiting list to receive the care they urgently need in a therapeutic setting is unacceptably high.

15 August 2016	22 August 2016	29 August 2016	5 September 2016
30	30	28	26
14 August 2017	21 August 2017	28 August 2017	4 September 2017
17	18	19	19
28 May 2018	5 June 2018	11 June 2018	18 June 2018
33	32	31	26

Capacity Issues

Capacity issues have arisen due to a number of factors, including an increase in committals direct from the courts of those found not guilty by reason of insanity. This has resulted in a reduced capability of the CMH to accept transfers of prisoners requiring treatment from the Prison system. There were 29 admissions and discharges in 2016, which is down from 69 in 2012 and an average of 100 per annum a decade ago. The absence of appropriate access to admission beds in the CMH, exacerbates risk in managing prisoners with serious mental illness, which for a small number is likely to be a prominent influence in offending. A lower level of CMH admissions will result in an increased waiting list for prisoners requiring treatment. This will cause greater distress for those suffering mental illness and place additional strain on IPS healthcare and in-reach NFHMS services as well.

Capacity at the Central Mental Hospital remains the biggest issue to overcome, in terms of providing a sufficient therapeutic service to prisoners suffering with mental health problems. This is compounded by the fact that there can be difficulties in having people requiring therapeutic treatment in the community admitted to the CMH and they can go on to commit a crime resulting in them serving a prison sentence.

A study carried out by Winnie S Chow and Stefan Priebe[6] on how institutional mental healthcare has changed in Western Europe since 1990 shows that in Ireland, the number of adult psychiatric beds has fallen from approximately 265 beds per 100,000 head of population in 1990 to approximately 60 beds per 100,000 head of population in 2011. The National Office for Mental Health confirms that since then, Irish general adult psychiatrist beds have fallen further to 20 beds per 100,000 head of population. This figure is extremely low and compares to approximately 45 per 100,000 in the United Kingdom and an average of over 50 per 100,000 in countries north of the Mediterranean.

The study also shows that secure forensic beds have been rising in the majority of countries albeit at a much slower rate than the fall in general adult beds. However, since 2004, Ireland has maintained approximately two secure forensic beds per 100,000 head of population. This is despite prison numbers rising from approximately 60 per 100,000 head of population in 1990 to approximately 79 per 100,000 head of population at the end of 2016.

The opening of the new facility in Portrane will address some of the capacity issues in the medium term. However, the opening of the new facility will not fully address capacity

[6] Chow WS, Priebe S. BMJ Open 2016

issues in the longer term as places are expected to fill up over time from increasing committals from the Courts. This is detailed further in the report.

Staffing and Recruitment Problems

There are currently 97 secure forensic beds in the CMH. Funding was received in 2016 for the renovation of Unit Five. This unit has partially opened and will add an additional six secure forensic beds to the capacity when fully opened. Negotiations are underway with a view to opening the remaining beds as soon as possible.

New Campus – Medium-Term Solution

Construction of a new CMH at Portrane has commenced and should open in 2020. The new 130 bed adult forensic hospital, will replace the 97 bed CMH at Dundrum. The new complex will also include a 10 bed Forensic Child and Adolescent Mental Health Unit and a 30 bed Intensive Care Rehabilitation Unit. This will help address the capacity issue.

It will result in a total of 3.5 beds per 100,000 head of population in Ireland. (Currently, there are 2 beds per 100,000) However, this is still a significantly lower per capita rate than most E.U. Countries. For example: Holland (14 beds per 100,000); Germany (10 beds per 100,000) and Lithuania (4 beds per 100,000), all have significantly higher supply of beds per capita.

The new campus in Portrane will ease some of the capacity issues but based on the committal figures in respect of NGRI (not guilty by reason of insanity) which are outlined below, it will fill up in less than five years. We will then find ourselves in the same position as we do now, with long waiting lists for prisoners requiring treatment in the CMH. A mechanism needs to be established that will allow such patients to receive necessary treatment as a matter of urgency even if only for a limited period. While not ideal, such a mechanism would be a considerable improvement over the existing situation.

Possible Long-Term Solution

As mentioned above, the opening of the new CMH at Portrane will address some of the capacity issues in the medium term. However, this is not scheduled to open until 2020 and does not address the immediate problem of the waiting list of prisoners requiring treatment. Nor will it be a solution in the long term due to increased demand for the beds in the CMH.

For example, in 2016 there were fifteen NGRI (not guilty by reason of insanity) committals from the Courts to the CMH. This is up from an average of two per year in 2012. The number of new NGRI cases, many requiring long term residential care is exceeding capacity and this is having a knock on effect on prisoners on waiting lists requiring treatment in the CMH. Waiting lists are getting longer in prison as there is no

longer a capacity to rotate prisoners into the CMH for treatment due to the lack of capacity.

The Interdepartmental Group explored the possibility of a solution to deal with the increasing number of prisoners requiring therapeutic treatment in the CMH. One such proposal is a model that is used in many EU Countries as well as Canada and most States in Australia. This involves the introduction of appropriate care facilities in a prison.

In an Irish context, this would probably involve identifying suitable areas in selected prisons to be classed as designated centres under Section 3 of the Criminal Law (Insanity) Act 2006 [7]. These designated centres would be staffed by medical personnel from the National Forensic Mental Health Service and Prison Service staff. This proposal would also require legislative change in order to allow a 28 day fixed term assessment / treatment order to be applied to prisoners. The fixed term assessment / treatment order would be renewable to 56 days once only. This would allow acutely unwell patients to be admitted from prison to the CMH for intensive treatment and then returned to a therapeutic environment in a prison to conditions where the treatment is unlikely to be undone.

In effect the CMH would be the acute hospital who would treat and stabilise the patient who would then be returned to a designated centre in a prison setting for ongoing care and where a patient could maintain stability in an environment whereby the relevant prescribed medication could be administered. There would be twelve beds available in the CMH for prison admissions and this would allow 144 fixed term admissions per annum. This would provide the necessary space to allow for immediate treatment of prisoners in the CMH before being returned to a designated centre in a prison centre.

While not an ideal solution, there appears to be a number of practical advantages to this proposal. However, there are also a number of operational issues, which would need to be addressed before a decision could be made on the viability of the proposal. These include the staffing mix, training, location & legislative considerations. The Interdepartmental Group feel that this proposal may be a suitable long-term measure to address the capacity problems mentioned and a good basis to advance discussions between the relevant stakeholders.

Recommendations

- The Interdepartmental Group recommends that the full capacity of the CMH should be utilised (in particular Unit Five should be fully opened as a matter of urgency);

[7] http://www.irishstatutebook.ie/eli/2006/act/11/enacted/en/html

- The Interdepartmental Group recommends consideration be given to an arrangement being put in place to ensure that the CMH always has the ability to accept severely ill prisoners without undue delay even if for a limited period. This could consist of some type of roll over facility for short & fixed term admissions from the Prison system to treat acutely unwell prisoners before returning them to an appropriate facility within a prison;

- The Interdepartmental Group recommends that, subject to recommendation 9, preparation on the legislative changes necessary to facilitate arrangements for fixed term admissions to the CMH from prisons are put in place. This will facilitate the CMH in always having the ability to accept severely ill prisoners;

- The Interdepartmental Group recommends that, subject to recommendation 9, the Irish Prison Service, the National Forensic Mental Health Services and the HSE discuss the operational issues regarding the development of an appropriate facility in a prison.

6. Return to the Community

When mentally ill prisoners come to the end of their sentence and return to the Community, there is an increased risk of morbidity and recidivism. Prisoners are frequently homeless on release, have difficulty in linking in with primary care services and face challenges to establishing what is the appropriate catchment area to access community mental health services. Without ongoing treatment in the community, the danger of a relapse is high, posing a threat to their health and increasing the possibility that they will again come into contact with the criminal justice system.

Role of the Irish Prison Service Psychology Service in offenders leaving custody

Where clinically appropriate, the Psychology Service provide limited support to people leaving custody, however longer term community intervention is not feasible considering commitments within the custodial setting. Where possible and appropriate, the Service will refer to community Psychologists for ongoing intervention, though community wait lists and concerns over the potential needs of people with a forensic history make referring people from prison to community mental health settings a particular challenge.

A new locum IPS Senior Psychologist has been based within the Probation Service Headquarters (Haymarket) since July 2018. This Senior Psychologist is providing psychologically informed consultation to Probation Officers managing very complex cases where mental health and personality difficulties are dominant features. Development of relationships and systems across custodial, Probation Service and community settings to support referrals for those with mental health difficulties is another key responsibility of this new role. This is a most welcomed opportunity for the IPS Psychology Service and the Probation Service. However, it must be stressed that this is a locum position at present.

Pre Release Planning Programme (PREP) for mentally ill prisoners – Mountjoy Prison

To help manage this increased risk, a pre-release planning programme (PREP), deploying with HSE social work expertise was established in Mountjoy Prison.

In March 2015, the HSE's National Forensic Mental Health Service in Mountjoy Prison established a social work service to develop a pre-release planning programme. Three HSE based social workers, with an expertise in community mental health and housing providers in the community, were deployed to Mountjoy Prison, to work alongside the already established in-reach team. A process of participatory action research was used to evaluate the service as it evolved over the subsequent eighteen-month period.

The pre-release planning programme (PREP) supported 32 committals (29 individuals) during the first eighteen months of its implementation. 13% (32/252) of all committals were seen by the in-reach mental health team during this period. 26 (81.3%) of these had a primary diagnosis of psychotic disorder and 24 (75%) had previous contact with psychiatric services. At the time of committal, 17 (53%) were homeless.

Interagency pre-release planning meetings were held for 21 committals (66%) to which community mental health, housing, probation, family and other relevant supports were invited.

Following the intervention, 91% of referrals were accepted by community mental health services. 17% were transferred for admission under the Mental Health Act 2001 and the rest received outpatient follow up. 84% of these attended their first appointment.

In most cases, pre-release mental health plans were achieved, however other social outcomes such as accommodation and benefits were often not accomplished.

The post release plans for two patients with a primary diagnosis of intellectual disability were not achieved due to a lack of HSE funding. These individuals were released to emergency homeless accommodation.

This pre-release planning innovation has shown that collaboration between the National Forensic Mental Health Service (HSE), the Irish Prison Service and community based services, greatly improves sentenced mentally ill prisoner's access to care in the post release period. 91% were accepted by community mental health services.

The project identified two vulnerable subgroups whose needs were not adequately met: those with an intellectual disability and homeless prisoners who are most at risk of self-neglect and reoffending. Future research will address how best to improve service provision for both these groups.

Medical Cards

In 2016, the Irish Prison Service in conjunction with the Health Service Executive introduced a pilot project in Cork Prison to facilitate prisoners who are eligible to receive a medical card, to do so prior to their release. The importance of this is that it provides an immediate link on release to secure the provision of primary care health services and a pathway to community mental health and addiction services. Importantly, providing eligible prisoners with a medical card on release ensures that access to prescribed medication is uninterrupted and prisoners can consult with their GP free of charge. This is one of many protective factors for a prisoner on release.

The issue of reconnecting with community based services is often aggravated by the fact that prisoners have often "burnt their bridges" with local General Practitioners. To address

this problem the prison based IPS staff have developed good working relationships with GP practices to accept prisoners onto their GMS lists.

Since 2016, the medical card initiative has been extended to other prisons and from September 2018 agreement was reached with the HSE to extend the programme to Portlaoise, Midlands, Mountjoy and Cloverhill prisons. This development ensures that the programme is now available to all sentenced prisoners serving more than one year across the prison estate. With the continued withdrawal of the DEASP staff (former community welfare officers) from prisons, the IPS are examining increasing the resettlement service resource in Midlands and Mountjoy prisons to adequately staff the medical card programme.

Prisoners who on release require the provision of residential services from the HSE

The Irish Prison Service (IPS) have sought to put in place more formal and robust arrangements for the transition of a very small number of prisoners, who on release, require residential care due to their medical condition.

The IPS consider that, at any given point in time, there are a small number of prisoners located throughout the twelve prisons within the IPS estate that fall into this category. This number will fluctuate in the context of ongoing committals from the Courts and releases from custody. There is a spectrum of medical conditions pertaining to the prisoners in this category. However, the three main care domains would encompass social care, nursing home care and mental health care.

In the past, the Health Service Executive (HSE) has highlighted that it was not possible to provide the necessary care arrangements for such prisoners as insufficient notice was provided by the IPS. To address this short coming, the IPS has convened a group to meet three times per year to consider upcoming releases and the requirements that would fall to be met by both the HSE and the Probation Service. The Group includes representatives from the Irish Prison Service, Probation Service, Social Care Directorate, HSE and Mental Health Directorate, HSE. This group provides an opportunity to better plan for the release of individuals with complicated medical histories who require residential care and who may also pose specific risk factors related to their offending.

Housing First for Prisoners

Prisoners and other persons convicted before the courts frequently present with high and complex support needs. The challenges faced by such individuals is often compounded by an absence of suitable and stable accommodation, often resulting in the person becoming entrenched in emergency homeless services. A number of voluntary organisations currently work with the Justice agencies, providing housing responses for

those with medium support needs. However, some of those with more complex needs, including health, mental health and addiction problems, remain difficult to place. It is widely recognised that a targeted intervention is needed for this group.

Housing First programmes for prisoners have been successfully delivered internationally, including in New York and Vermont in the USA, where they have impacted on reduced homelessness and incarceration rates for the target group.

A Housing First approach to prisoner resettlement in Ireland was cited in the recent *Oireachtas Joint Committee Report on Penal Reform and Sentencing*[8]:

> *'A coordinated approach to step-down accommodation post-release is needed between the relevant Government departments and housing agencies. A Housing First approach is a useful starting point. Under this model, the outgoing offender is placed in his or her own home and provided with individualised supports based on his or her needs.'*

Furthermore, the report of the *Homelessness Inter-agency Group*[9] mentions the scope for a Housing First project for prisoners:

> *'A targeted Housing First scheme for prisoners could play a role in supporting vulnerable prisoners at risk of homelessness while also supporting reintegration into society and reducing recidivism.'*

The *Strategic Review of Penal Policy* report[10] highlighted the complex relationship between incarceration and homelessness, calling for an increased focus on the provision of accommodation to facilitate the reintegration of offenders into society.

Role of Probation Service with offenders Post-Release.

The Probation Service has officers, professionally qualified social workers, in every prison in the country. Managing risk of harm and reoffending among persons who are subject to supervision orders of the Courts starts while in prison. Assessment commences while in prison and follows the individual into the community. This is an ongoing process and risk assessment informs a plan of intervention.

[8] https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_justice_and_equality/reports/2018/2018-05-10_report-on-penal-reform-and-sentencing_en.pdf
[9] http://rebuildingireland.ie/install/wp-content/uploads/2018/06/Homelessness-Inter-Agency-Group-%E2%80%93-Report-to-Minister-for-Housing-Planning-and-Local-Government.pdf
[10] http://www.justice.ie/en/JELR/Strategic%20Review%20of%20Penal%20Policy.pdf/Files/Strategic%20Review%20of%20Penal%20Policy.pdf

Mental health issues may have a direct relationship with potential reoffending. Risk levels decrease or increase depending on the level of engagement with interventions or treatment identified by assessment.

Probation Officers, in fulfilling their statutory functions, where there are post-release supervision obligations, work collaboratively with the offender and families as appropriate, and in a multi-agency approach with agencies such as An Garda Síochána, Health Service Executive, Tusla (Child and family agency) Mental Health Service, Addiction Services, Employment Service and Housing and voluntary providers. Awareness of escalating and deteriorating behaviour and response to supervision is addressed with the offender and also in conjunction with partner agencies. Underpinning the professional relationship between Probation Officer and offender is the realisation that successful reintegration of offenders with mental health issues is about public and victim safety.

Recommendations

- The Interdepartmental Group recommends that the medical card pilot project application scheme be extended to all prisons for those eligible prisoners;

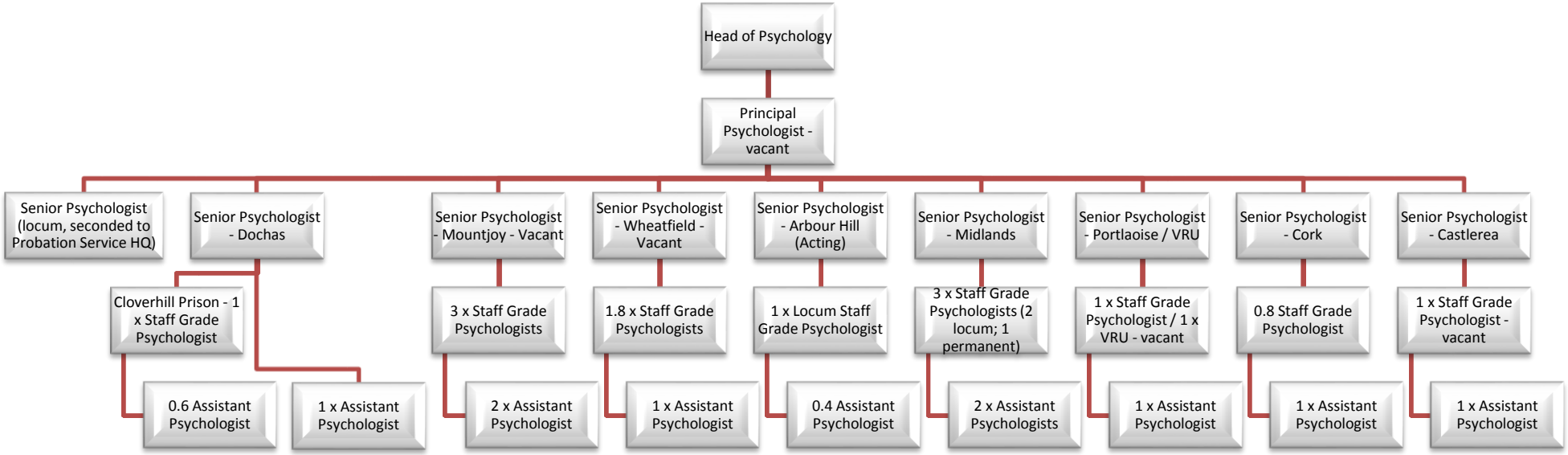
- The Interdepartmental Group recommends that there is improved support for GP practices;

- The Interdepartmental Group recommends that the extension of the Pre Release Planning Programme (PREP) for mentally ill prisoners to other prisons should be explored;

- The Interdepartmental Group recommends that consideration is given to development of a Housing First approach to residential service for persons with multi-factoral complex needs.

7. Appendices

Appendix A – Irish Prison Service Psychology Service Organigram



Appendix B -Terms of reference of the Interdepartmental Group

Pursuant to the recommendation of the Report of the Thornton Hall Project Group (July 2011) the Cross Sectoral Health/Justice Team is charged by the Minister for Health and the Minister for Justice and Equality with examining issues relating to people with mental illness or a mental disorder interacting with the criminal justice system and its agencies and having regard to Government policy in relation to the delivery and future development of the Forensic Mental Health Services. This includes the principles which should underpin the delivery of such services as set out in *A Vision for Change – Report of the Expert Group on Mental Health Policy 2006* shall endeavour in particular:

1) to identify the circumstances where such interactions take place, the agencies and services potentially involved and the issues that arise (including interaction with the Gardaí, decisions to prosecute or not to pursue criminal charges, diversion, persons in custody including imprisonment and post custodial arrangements);

2) to establish if practicable an indication of the annual number of incidents or individuals involved in the different circumstances;

3) to set out existing practices, background and developments;

4) to take into account evidence of good practice in other jurisdictions;

5) to take into account relevant reports and recommendations;

6) to consult as appropriate;

7) to consider the circumstances where it might be appropriate to divert people suffering from a mental illness or mental disorder away from the criminal justice system to more appropriate services, how best to achieve this and whether guidelines, principles or statutory provisions should be introduced to facilitate or inform such diversion;

8) taking into account the resources available and international evidence as to good practice in the field, to consider how best to deliver mental health services to persons properly in the criminal justice system, to facilitate their return in due course to the community and to ensure necessary treatment continues after release and
9) to report to and make recommendations to the Minister for Justice and Equality and Minister for Health for consideration by the Government by mid-2012.

Appendix C – Implementation of the Recommendations of the Commission of Investigation into the Death of Gary Douch [11]

> "The management in place at that time in Cloverhill and Mountjoy Prisons, despite knowledge of and familiarity with Stephen Egan…failed to recognise and evaluate the risk he presented, exacerbated as it was by his serious mental illness, at a time when he was still under the care of the Forensic Mental Health Service. As a consequence, grievous errors of judgement were made in transferring him from Cloverhill Prison to Mountjoy Prison when they did, without consultation with his psychiatrists."
>
> - Report of the Commission of Investigation into the death of Gary Douch [11]

The Inter Departmental Group (IDG) was particularly conscious of the death of Gary Douch in 2006 and the report and recommendations of the McMorrow Commission 2013. In that case, a number of failures led to the death of a prisoner, the most serious case of a death involving mental illness to occur in the Irish Prison system.

Improvements in liaison between the NFMHS and Prison management, the in-reach services now available as well the elimination of the type of overcrowding that contributed to this case should hopefully ensure that this scenario should not occur again.

The Group thought it timely to carry out a review of the recommendations of the McMorrow Commission and the results of this are set out below.

2.1 *The Central Mental Hospital should be replaced or remodelled to allow it to provide care and treatment in a modern, up-to-date humane setting, and its capacity should be maximised, as recommended in the policy document A Vision for Change (Department of Health and Children, 2006)*

Position

This recommendation is being implemented by the construction of the new facility at Portrane. This is scheduled to complete construction in late 2019/early 2020 and open in 2020.

****

2.2 *Immediate consideration should be given to opening up additional "designated centres" under the Criminal Law (Insanity) Act 2006 to ensure more effective and*

[11] Gráinne McMorrow, S.C., Report of the Commission of Investigation into the Death of Gary Douch – Executive Summary and Recommendations, 2014

efficient delivery of forensic mental health services across the Irish Prison System. The Central Mental Hospital is currently the only "designated centre" for the reception, detention, care, and treatment of persons committed or transferred thereto under the provisions of the 2006 Act.

Position

This is under review by the IPS and the HSE in the context of current and planned CMH provision, including the Intensive Care Rehabilitation Unit (ICRU) at the new facility in Portrane. Additional Designated Centres will also be considered over the medium term for the HSE capital programme, which plans for further ICRUs.

****

2.3 *Consideration should be given to locating appropriately resourced "designated centres" within the grounds of prisons. This would allow mentally disordered offenders for whom a high level of security is required to be treated promptly in a proper clinical hospital setting with full 24/7 medical staff and integral "step-down" facilities in situ. The Commission believes that this might also aid the development of multi-disciplinary team working.*

Position

Recommendation 11 of this Report states that *"The Interdepartmental Group recommends that the Irish Prison Service, the National Forensic Mental Health Services and the HSE discuss the operational issues regarding the development of an appropriate facility in a prison."* Further discussions are to take place.

****

2.4 *Four additional multidisciplinary, community-based forensic mental health teams should be provided nationally on the basis of one per HSE region, as recommended in the policy document A Vision for Change (Department of Health and Children, 2006).*

Position

The HSE envisage the provision of four Intensive Care Rehabilitation Units and the first is under construction as part of the new facility at Portrane. There is now a Multi-Disciplinary Forensic Mental Health Service in Castlerea Prison with a similar service in both Cork and Limerick Prisons being developed.

****

2.5 *Urgent consideration should be given to introducing a mandated "Step-down" programme as part of the on-going care plan for all prisoners who have or are*

receiving psychiatric care and treatment as an in-patient or care and treatment as an out-patient. Its duration should be tailored to the particular patient's clinical needs, but should not be for a period of less than one month. This should include special directions regarding accommodation provision, a plan for multi-disciplinary involvement and heightened supervision and monitoring to prevent or detect relapse and thereby afford the possibility of immediate response and intervention. Such a procedure should be incorporated in any Care and Treatment Protocol and its efficacy evaluated and revised periodically.

Position

The IPS has committed to providing areas within prisons, where a prisoner, with specified needs, receives a higher degree of support from both discipline and healthcare staff to ensure that those most in need of monitoring receive the appropriate inputs. These areas are termed Higher Support Units (HSUs) and provide a structured physical environment with increased provision for observation and are employed in the main to assist in the management of prisoners suffering from a mental health disorder. It must be emphasised that HSUs are not hospital units, secure units or challenging behaviour units.

The Safety Observation Cell (SOC) Policy and Close Supervision Cell (CSC) policies are being reviewed and updated following audits of their operation. The Working Group expects to complete the update of policies during 2018.

The new Governor's Committal Interview will allow Governors to make and record recommendations to appropriate services where a need for specific accommodation has been identified.

****

2.6 *The Forensic Mental Health Service should be expanded and reconfigured so as to provide enhanced court diversion services and supporting legislation should be devised to allow this to take place, as recommended in the policy document A Vision for Change (Department of Health and Children, 2006).*

Position

As outlined in this report, the NFMHS do provide a court diversion service which has proved very successful. The view of those providing the service is that no legislative basis is required at present and the Group support that approach.

****

2.7 *Consideration needs to be given as to whether the provision of a separate specialist facility that can offer care and treatment to mentally disordered offenders who also have personality disorders would be worthwhile.*

Position

The Group are of the view that a separate facility for the care and treatment of mentally disordered offenders with personality disorders could not be justified at this point in time.

****

2.8 *The services of the Health Information and Quality Authority (HIQA) should be extended to all prison healthcare facilities.*

Position

The Group understand that the services of HIQA do apply to prison healthcare services to the same extent as they apply to similar services provided outside prisons and this equivalence should continue.

****

2.9 *Consideration should be given to expanding psychology services to prisons. Doing so would enhance risk assessment and screening, provide support, care and treatment to prisoners, and would contribute to the development of multi-disciplinary healthcare models. Psychology services have an important role to play in devising the protocols recommended by the Commission in the areas of risk assessment and screening, in designing and delivering behaviour modification programmes for prisoners, and in assisting the development and implementation of integrated sentencing management and enhanced regimes and in making significant contributions to staff training programmes.*

Position

The IPS Psychology Service is currently made up of a Head of Service, nine Senior Psychologists (including two vacant posts, one Acting Senior and one locum), 12.6 Staff Grade Psychologists (including three locum Psychologists) and 10 Assistant Psychologists (unqualified Grade). There are two vacant Staff Grade Psychologist posts; one in Castlerea and one in the Violence Reduction Unit (Midlands prison).

The Public Appointment Service recently advertised two permanent Staff Grade Psychologist posts for the IPS in Midlands Prison and the new Violence Reduction Unit (VRU). The competition was unsuccessful and the posts will be advertised again in the coming months. In conjunction with the Probation Service, Psychologists are involved in risk assessment. The Service also delivers evidence based mental health and offence related group and individual programmes, sentence management planning and staff training with the IPSC.

Assistant Psychologists will also engage in work with people presenting with primary care mental health difficulties and with the Red Cross on a peer to peer mental health initiative. Assistant Psychologists will co-facilitate Mental Health Act training with Healthcare colleagues.

****

2.11 *In order to support the delivery of prison mental health services, awareness training on mental health and learning disabilities should be made available for all prison officers. The training programme must be developed in conjunction with service users and where appropriate, training should be undertaken jointly with other services to encourage shared understanding and partnership working.*

Position

The IPS has reviewed and updated the mental health/suicide Awareness Training programme for staff. The area of mental health awareness training has been deemed as mandatory training by the IPS. The current STOP4 programme will continue to be delivered to all new recruits. Development of an IPS staff handbook with information on support services available to staff is under consideration. Health Promotion and Awareness Groups are being established in each prison.

Red Cross/Psychology Service are developing a framework for provision of mental health awareness training to prisoners using Red Cross volunteers.

The Mental Health Awareness Training programme has been delivered to 1,416 staff in 2017. A further 33 staff have been trained to end March 2018. An additional 90 staff will be trained by June, with a target of 500 to be trained by year's end.

****

Protocols and Policy

2.12 *As a matter of urgency all stakeholders involved in the health care of prisoners should collaborate with a view to developing a Protocol for the Care and Treatment of Prisoners with Mental Disorders, to be completed within twelve months of the date of publication of this report and implemented as soon as practicable thereafter.*

Position

The draft Memorandum of Understanding between the Irish Prison Service and the National Forensic Mental Health Service has yet to be finalised, taking account of various issues including resolution of legal and resource implications. The matter will be progressed by both agencies as quickly as possible.

****

2.13 *The Protocol when drawn up must have regard to the following rights and principles:*

- ***a.*** *The right of every prisoner to equivalence of care and treatment as compared with persons outside of the prison system*
- ***b.*** *The right of every prisoner to receive mental health care and treatment from the non-forensic mental health services unless there are cogent legal or public policy reasons why this should not be done*
- ***c.*** *The principle that forensic mental health services should be person-centred, recovery oriented and based on evolved and integrated care plans arising from a multi-disciplinary approach to health care and treatment.*
- ***d.*** *The principle that prisoners should be referred to secondary mental health services only in circumstances where the primary health care available in the prison is not sufficient to ensure their proper care and treatment in an appropriate and safe environment.*
- ***e.*** *Recognition that appropriate provision should be made for the care and treatment of "dual diagnosis" prisoners, that is, prisoners with drug / alcohol problems as well as mental health problems. Such provision should reflect the need for mental health services and substance abuse services to work closely together in seeking to address the needs of such prisoners.*
- ***f.*** *Recognition that separate provision for those prisoners diagnosed with both personality disorders and mental illness may be warranted and should be considered.*
- ***g.*** *Recognition of the importance of ensuring continuity of care, particularly for prisoners returning to the prison system having received in-patient care at the Central Mental Hospital.*
- ***h.*** *Recognition of the fact that health services require support from the rest of the prison system to ensure that the prison environment supports the health, emotional wellbeing and mental health of prisoners as far as possible.*
- ***i.*** *Recognition of the importance of encouraging prisoner participation in activities which promote their rehabilitation, self-improvement, behaviour modification and life skills including literacy and education, self-care, anger management, cognitive therapy as well as opportunities for reading, painting, music, exercise, and the opportunity of receiving counselling and support from others.*
- ***j.*** *Recognition of the importance of reconciling the Care and Treatment protocol for the prisoner with his/her integrated sentence management plan.*

Position

The draft Memorandum of Understanding between the Irish Prison Service and the National Forensic Mental Health Service has yet to be finalised, taking account of various issues including resolution of legal and resource implications. The matter will be progressed by both agencies as quickly as possible.

****

2.14 *The Protocol should take into consideration the recommendations made in relation to forensic mental health services in the reports entitled A Vision for Change (Department of Health and Children, 2006) and Forensic Mental Health Services for Adults in Ireland (Mental Health Commission, 2011). The Commission adopts and endorses these recommendations, which can be found in full in section 1.1 of this Report.*

Position

The draft Memorandum of Understanding between the Irish Prison Service and the National Forensic Mental Health Service has yet to be finalised, taking account of various issues including resolution of legal and resource implications. The matter will be progressed by both agencies as quickly as possible.

****

2.15 *The Protocol should adopt and incorporate the relevant parts of the Health Care Standards published by the Irish Prison Service in 2009, particularly Standard 3 (which relates to the provision of mental health services in the prison system) and Standard 4 (which relates to the transfer, release and through-care of prisoners).*

Position

The draft Memorandum of Understanding between the Irish Prison Service and the National Forensic Mental Health Service has yet to be finalised, taking account of various issues including resolution of legal and resource implications. The matter will be Progressed by both agencies as quickly as possible.

****

2.16 *The Protocol should adopt and implement the specific recommendations of the Commission numbered 2.17 – 2.34 below.*

Position

The draft Memorandum of Understanding between the Irish Prison Service and the National Forensic Mental Health Service has yet to be finalised, taking account of various issues including resolution of legal and resource implications. The matter will be progressed by both agencies as quickly as possible.

****

2.17 *When prisoners are undergoing a mental health assessment, this should include a full and detailed assessment of the risk which the prisoner may pose to themselves, other prisoners, prison staff, and to persons visiting the prison.*

Position

The Irish Prison Service have confirmed that currently as part of the initial assessment of prisoners, mental health needs are queried and appropriate referrals are made.

****

2.18 *No prisoner who is receiving mental health care and treatment or who is under on-going review by the Psychiatric In-Reach Service may be moved within a prison or transferred to another prison without the consent in writing of a member of the Psychiatric In-reach Service.*

Position

Operations Circular 13/2014 governs inter-prison transfer arrangements.

This recommendation is being considered as part of the draft Memorandum of Understanding between the Irish Prison Service and the National Forensic Mental Health Service. This has yet to be finalised, taking account of various issues including resolution of legal and resource implications. The matter will be progressed by both agencies as quickly as possible.

****

2.19 *Before agreeing to any proposed transfer of a prisoner to another prison, the Governors of the transferring and receiving prisons must ascertain if the prisoner requires on-going mental health care and treatment, and whether such care and treatment can be provided at the receiving prison.*

Position

Operations Circular 13/2014 governs inter-prison transfer arrangements.

This recommendation is being considered as part of the draft Memorandum of Understanding between the Irish Prison Service and the National Forensic Mental Health Service. This has yet to be finalised, taking account of various issues including resolution of legal and resource implications. The matter will be progressed by both agencies as quickly as possible.

****

2.20 *When a prisoner is transferred to the Central Mental Hospital or another designated centre pursuant to s.15 of the Criminal Law (Insanity) Act 2006, the Governor of the transferring prison and the Clinical Director of the designated centre should communicate in writing with the Mental Health (Criminal Law) Review Board to confirm the details of the transfer so that the Board can expeditiously discharge its function pursuant to section 17 of the 2006 Act.*

Position

This recommendation is being considered as part of the draft Memorandum of Understanding between the Irish Prison Service and the National Forensic Mental Health Service. This has yet to be finalised, taking account of various issues including resolution of legal and resource implications. The matter will be progressed by both agencies as quickly as possible.

****

2.21 *Where the Clinical Director of the Central Mental Hospital or another designated centre forms the opinion that a prisoner no longer requires in-patient treatment at a designated centre but will require on-going out-patient treatment and review, that prisoner should not be returned to the prison system unless and until he or she can be returned to a prison where the required out-patient care and treatment can be provided.*

Position

With the exception of Cork and Limerick prisons, all other prisons have access to National Forensic Mental Health Service Consultant led Teams. In Cork and Limerick there are Consultant provided services and it is planned to enhance the Forensic Mental Health services in these prisons over the coming period

****

2.22 *When the Clinical Director of the Central Mental Hospital or another designated centre consults with the Minister for Justice (or his delegated representative) prior to ordering the transfer of a prisoner back to the prison system under s.18 of the Criminal Law (Insanity) Act 2006, the Clinical Director must inform the Minister in writing of any on-going requirements for care and treatment of that prisoner, and must advise the Minister as to what prison, prisons or area of a prison can provide such care and treatment.*

Position

The Central Mental Hospital provide a discharge summary to the team at the receiving prison.

****

2.23 *Where, following consultation between the Clinical Director of a designated centre and the Minister for Justice, a decision is made to return a prisoner receiving in-patient treatment at the designated centre to a specified prison, the Minister (or his representative) must certify in writing that the Minister is satisfied that all on-going requirements for care and treatment of that prisoner can be met at the specified prison.*

Position

The Irish Prison Service can provide confirmation. However, such confirmation will outline the services available at the prison the patient is returned to and it may not always be possible to provide all services requested by the Central Mental Hospital. By way of illustration, the CMH have clearly stated that the IPS must maintain night nursing cover. However, resourcing effective deployment considerations will likely eliminate or greatly reduce night nursing cover.

****

2.24 *Transfers of a prisoner from the Central Mental Hospital or another designated centre to a prison should not take place late in the evening, at weekends or when medical staff are not available to receive the prisoner on his or her arrival.*

Position

This has been agreed by the Irish Prison Service.

****

2.25 *A prisoner who is returned to the prison system from the Central Mental Hospital or another designated centre must be met and reviewed by a prison doctor and referred to a member of the Psychiatric In-reach Service within two hours of his or her arrival at the prison.*

Position

Existing medical cover in prisons will not allow for this requirement to be met. All such patients will be seen by the prison doctor within 24 hours - subject to implementation of Recommendation 2.24.

****

2.26 *A prisoner who is returned to the prison system from the Central Mental Hospital or another designated centre must be accompanied by a Discharge Summary from the designated centre, outlining any on-going requirements for care, treatment, medication, and review. A copy of the Discharge Summary should also be sent to the Director of Prison Health Care for the Irish Prison Service.*

Position
This is current practise, in accordance with Section 18 of the Criminal Law (Insanity) Act 2006.

****

2.27 *A prisoner who is returned to the prison system from the Central Mental Hospital or another designated centre should be accommodated in a single cell and kept under close observation unless and until he or she is reviewed by a psychiatrist who confirms in writing that the prisoner can share a cell with other prisoners and that all arrangements have been put in place for his or her on-going mental health care and treatment.*

Position
While the Irish Prison Service would be anxious to facilitate such a requirement it is not always operationally possible at present.

In cases where the Discharge Summary recommends single cell placement, Healthcare staff bring this to the attention of the Governor/Chief Officer for action.

A Risk Assessment project Team is in place to develop an efficient and streamlined process for gathering information to inform the assessment and management of prisoners – this includes the work on cell sharing. The Risk Assessment programme is currently at USER Testing stage and the new centralised system, which will cater for prisoner risk and needs analysis taking into consideration cell accommodation will be deployed later this year

****

2.28 *Access by visitors to prisoners who have recently been discharged from the Central Mental Hospital or another designated centre should be regulated by guidelines which protect the health and safety of both the prisoner and the visitor.*

Position
This recommendation is being considered as part of the draft Memorandum of Understanding between the Irish Prison Service and the National Forensic Mental Health Service. This has yet to be finalised, taking account of various issues including resolution of legal and resource implications. The matter will be progressed by both agencies as quickly as possible.

****

2.29 *Records of all medication prescribed and administered to prisoners as a result of any psychiatric treatment or review must be strictly maintained. Administration*

records for such medication should be signed by two medical dispensing staff in order to enhance the clinical monitoring of compliance with prescribed medication. Refusal to take medication or suspicion about non-compliance or suspicions regarding other substance use/abuse must be documented and reported to the prison GP who should then refer the matter to the HSE Psychiatric In-Reach Service. Administration records for such medication should be checked regularly by the prison medical doctor and by the Psychiatric In-Reach Service.

Position

This recommendation has been implemented. The introduction of the electronic patient healthcare management system (PHMS) now ensures that all prescriptions are electronically recorded and the system provides the functionality to record all medication administration. PHMS also supports the review of compliance with medication administration, on an individual prisoner basis, over the required time period. The current dispensing system (Monitored Dose System) also facilitates easy review of compliance with prescribed medication on a weekly basis.

****

2.30 *A prisoner in receipt of mental health care and treatment on an out-patient basis should continue to be kept under regular review by the Psychiatric In-reach Service and by the prison medical staff until a member of the Psychiatric In-reach Service certifies in writing that such review is no longer necessary.*

Position

Prisoners, who prior to committal, were receiving mental health treatment as an outpatient in the community receive appropriate interventions in custody in accordance with this recommendation.

****

2.31 *Information concerning a prisoner's health care and treatment must be recorded clearly, reliably and with sufficient detail to ensure that any decision made concerning that prisoner's care and treatment is made with access to all the information relevant to that decision. The information recorded should include not only the substance of any medical intervention or review, but should also clearly identify the person or persons responsible for each intervention or review.*

Position

The Care and Rehabilitation Directorate of the Irish Prison Service have issued instructions that all healthcare interventions should be appropriately and comprehensively recorded in the prisoner's case notes. Sample auditing is carried out to ensure compliance with these instructions.

****

2.32 *When a prisoner has been diagnosed with a condition requiring care and treatment at the Central Mental Hospital or another designated centre, then as a matter of urgency arrangements should be made for a bed to be provided at the CMH or a suitable designated centre within 72 hours, so that any decision to transfer him/her under s.15 of the 2006 Act can be put into effect at once.*

Position

While all the services involved would like to see such a recommendation implemented the number of prisoners requiring treatment combined with the limitations of the capacity of the CMH means this is not always possible. In the main body of the report, the Group has already identified the delay in admissions as the issue most in need of attention and various possible solutions are being explored further.

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2.33 *With due respect for the confidentiality of prisoners' medical files, the Governor of a prison should be kept informed by prison medical staff and by the Psychiatric In-reach Service of any risk posed by a prisoner who is undergoing mental health care and treatment, to themselves, to other prisoners, prison staff and visitors to the prison.*

Position

The Irish Prison Service support this recommendation and would highlight recent developments in Safety Observation Cells and High Support Units as evidence of stratifying and managing risk.

This recommendation is being considered as part of the draft Memorandum of Understanding between the Irish Prison Service and the National Forensic Mental Health Service. This has yet to be finalised, taking account of various issues including resolution of legal and resource implications. The matter will be progressed by both agencies as quickly as possible.

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2.34 *A protocol should be devised by the Irish Prison Service in conjunction with the National Forensic Mental Health Service setting out the circumstances in which information about a prisoner's mental health care and treatment should be disclosed by prison medical staff and / or members of the Psychiatric In-reach Service to operational staff in a prison and / or the senior management of the Irish Prison Service.*

Position

This recommendation would require further consideration as the disclosure of confidential medical information on a patient by a clinician could potentially expose them to sanction by their professional regulatory body.

This recommendation is being considered as part of the draft Memorandum of Understanding between the Irish Prison Service and the National Forensic Mental Health Service. This has yet to be finalised, taking account of various issues including resolution of legal and resource implications. The matter will be progressed by both agencies as quickly as possible.

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2.35 *The Director of Prison Healthcare for the Irish Prison Service should be given the power to review prisoners' individual medical files or, where appropriate, to appoint an independent medical expert to review such files. If necessary, legislation should be devised to give effect to this power.*

Position

The Care and Rehabilitation Directorate of the Irish Prison Service supports this recommendation, with the caveat of the concerns raised at 2.34. An appointment to the position of Executive Clinical Lead in the Irish Prison Service was made in July 2018.

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