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mental health commission

Access to Mental Health Services for People in the Criminal Justice System

Dr Susan Finnerty, Inspector of Mental Health Services

With special support from Ms Patricia Gilheaney, Inspector of Prisons

Promoting Quality, Safety and Human Rights in Mental Health

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EXECUTIVE SUMMARY

The plight of people who are mentally ill and who have been accused or convicted of a criminal offence has been highlighted over many years to little avail. This group of people has unequal access to mental health services compared to those who have not offended. Ireland is far behind comparable countries in providing a comprehensive forensic mental health service when a mentally ill person encounters the criminal justice system.

There are many gaps in Irish mental health services which lead to mentally ill people ending up in prison. We have an under-resourced mental health service where the only out-of-hours provision is through Accident and Emergency departments. We have no formal pre-arrest diversion. We have an excellent but under-resourced and over-worked court diversion service. We still have people who are severely mentally ill locked in isolation units and other areas of prisons awaiting mental health care in appropriate settings, in particular in the Central Mental Hospital. This fundamentally breaches their human rights and we have been rightly criticised by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) for this. In some prisons, the in-reach teams are substantially under-resourced and struggle to provide a comprehensive service. The inpatient forensic mental health service in the Central Mental Hospital (CMH) provides care and treatment based on international best practice, but the waiting list for a place in the CMH continues to grow as more mentally ill people enter the prison, with insufficient intensive care rehabilitation beds to facilitate the onward recovery journey of residents who could be discharged. The catchment area restrictions mean that homeless people have insurmountable difficulties in accessing local mental health care following release and are often lost to follow-up and likely to reoffend. In addition, general adult services are often reluctant to take on patients with a “forensic history” due to inadequate resourcing and facilities.

After decades of reports stating that the Central Mental Hospital in Dundrum was not fit for purpose, we have a new state-of-the-art building in Portrane with an increase in beds from 102 to 170, including a unit for children and an Intensive Care Regional Unit. This brings our forensic beds from 2 per 100,000 to 3.5 per 100,000, which is still substantially lower than many other European countries. It is not a sufficient number now and won’t be into the future, especially bearing in mind the absence of investment in other areas of general and forensic mental health care.

The very poor resourcing of the forensic mental health teams in Cork and Limerick is quite astounding, especially as there is no coherent plan for the development of these services, even in view of the new women’s prison planned for Limerick. There are no intensive care regional units in the south and west, as set out in the government policy of a “hub-and-spoke” model of forensic mental health services.

Our interviews with service users, prisoners and carers were enlightening and demonstrated what it was like to try to access an appropriate mental health service as well as to wait for such a service for lengthy periods of time, usually in prison. We thank participants for the time they took to talk to us and for sharing their personal stories with us.

We welcome the recent establishment of the High-Level Taskforce to Consider the Mental Health and Addiction Challenges of Persons Interacting with the Criminal Justice System and we hope that it will finally lead to substantial changes in the way that mentally ill people who come into contact with the criminal justice system are treated.

Dr Susan Finnerty
Inspector of Mental Health Services

RECOMMENDATIONS

1. There should be a focused integrated government approach, producing a comprehensive policy on the provision of forensic mental health services into the future. This should include all areas of forensic mental health.

2. There should be a planned, coordinated and organised approach to provision of forensic mental health services nationwide, with a clear governance structure and equality of access throughout the country.

3. Prisoners with severe mental illness in prison should have timely access to treatment in appropriate clinical settings.

4. There should be adequate and safe staffing of all forensic mental health teams.

5. Mental health advice, training and assistance to Gardaí at pre-arrest, arrest, custody and initial court hearing stages should be provided.

6. A comprehensive pre-arrest and court diversion service should be provided nationwide, and this should be adequately staffed.

7. There should be a specialist team to accept referrals for assessment of people with intellectual disability in the prisons. This team should have a national remit and liaise with service providers to arrange diversions and/or release planning.

8. Co-ordination should be improved between local mental health services and forensic mental health services to provide a seamless transition along all steps in the care pathway. This should be responsive to the person's needs, rather than catchment area concerns.

9. Legislative reform should be implemented to remove barriers to diverting remand prisoners and to facilitate hospital transfer on sentencing.

10. ICRUs Intensive Care and Rehabilitation Units should be developed in the south and west of the country to facilitate provision of appropriate care.

11. The recommendations of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment 2019 report should be acted on as a matter of urgency.

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Introduction

"Each citizen should have access to local, specialised and comprehensive mental health service provision that is of the highest standard[1]"

INTRODUCTION

Forensic psychiatry is a specialised branch of psychiatry which deals with the assessment and treatment of mentally disordered people in the criminal justice system, secure hospitals, and the community. It deals with issues arising at the interface between psychiatry and the law and includes assessment of mentally disordered offenders, provision of expert evidence in civil and criminal proceedings and advice to general psychiatrists and other professionals, as well as treatment of mentally disordered people. People receiving inpatient forensic mental health services typically have a history of serious offending. This means that, in addition to meeting people's individual care and treatment needs, forensic mental health services must fulfil a public protection role by managing the risk of harm that such people may pose to others. As such, forensic inpatient care involves a deprivation of liberty and detention in a highly regulated and restrictive environment. This means that people in forensic mental health services can experience significant reductions in their freedoms, autonomy and self-expression. Forensic psychiatric care aims to reduce the risk of recidivism, enhance mental health, and encourage a safe return to society[2]. The placement and treatment of mentally disordered people is the subject of regular mass media coverage, with enormous public interest in high-profile cases. The handling of mentally ill people by criminal justice systems is an indicator of the ability of a society to balance public safety interests with the achievements of modern mental health care and to incorporate basic human rights principles into penal and mental health practice[3].

Forensic mental health care for mentally disordered offenders varies substantially across European Union states[4]. Differences exist concerning the number of forensic beds, average length of stay, availability of dedicated long-stay services, proportion of male and female patients and stratification of hospitals into different security levels[5]. Differences are also observed regarding legal frameworks stipulating under what circumstances individuals are to be admitted into secure care and what this care may look like[6].

The number of psychiatric hospital beds in Western Europe has been falling substantially since deinstitutionalisation began. At the same time, the number of forensic beds and the size of prison populations have increased. Penrose observed in 1939 that there was an inverse relationship between psychiatric hospital beds and the size of prison populations, based on a cross-sectional observational study in 18 European countries[7]. It has been considered that the deinstitutionalisation of mental health services, without appropriate and adequate resourcing of community-based services, has contributed to more mentally ill individuals coming in contact with the criminal justice system, thus contributing to the higher prevalence of mental disorders in prisons nationally.

Cross-sectional and longitudinal studies have tried to test the Penrose hypothesis, with inconsistent conclusions. Only longitudinal studies can explore whether changes in hospital beds and the prison population are really linked. Kelly (2007) found a strong rank correlation in Ireland between 1963 and 2003; specifically, a decline in psychiatric inpatient numbers significantly exceeded the increase in prisoner numbers[8]. In low-and-middle-

1. *Mental Health – A Vision for Change* (hse.ie)
2. Arboleda-Flórez J (2006) Forensic psychiatry: contemporary scope, challenges and controversies. *World Psychiatry*. 2006;5(2):87-91.
3. Salize HJ, Dreßing H (2005) *Placement and treatment of mentally ill offenders – Legislation and practice in EU Member States.* Final Report Central Institute of Mental Health, 15 February 2005.
4. Sampson S, Edworthy R, Völlm B, Bulten E (2016) Long-term forensic mental health services: an exploratory comparison of 18 European countries. *Int J Forensic Ment Health*. https://doi. org/10.1080/14999013.2016.1221484
5. Chow WS, Priebe S (2016) How has the extent of institutional mental healthcare changed in Western Europe? Analysis of data since 1990. BMJ Open 6:10188.
6. Salize HJ, Dreßing H (2005) Placement and treatment of mentally ill offenders – legislation and practice in EU Member States. Pabst Scientific Publishers, Lengerich Berlin Bremen Miami Riga Viernheim Wien Zagreb.
7. Penrose LS (1939) Mental disease and crime: outline of a comparative study of European statistics. *Br J Med Psychol* 1939;18:1–15. 10.1111/j.2044-8341.1939.tb00704

income countries, the association between prison and psychiatric hospital populations may depend on the ability of governments to pay for custodial institutions as well as differences in cultural attitudes to abnormal and criminal behaviour. In high-income countries, psychiatric and prison populations are not related and are probably determined by separate social and political factors[9].

Proposals to admit patients who have committed offences to general psychiatric hospitals can be met with considerable reluctance, even when they are initially stabilised in a forensic unit. Conversely, forensic hospitals are not always receptive to accepting patients for transfer into secure facilities from general psychiatric colleagues. As most patients in forensic units have had previous contact with general psychiatric services or will require transfer to general psychiatry when stabilised, close interaction between general and forensic psychiatry is essential.

Holding patients in conditions of excessive security impedes rehabilitation and has considerable human rights implications. Almost half of long-stay forensic psychiatric patients in Ireland are inappropriately placed. Barriers to discharge include legislative inadequacies, lack of local low-secure facilities and under-resourcing of community psychiatric services[10].

Ireland has an increasing number of people in prisons, who have severe mental illness where access to appropriate mental health services is limited and the facilities within prisons are woefully inadequate. At present, all forensic inpatient services – from high secure to low secure and rehabilitation – are on one campus, with a small number of specialised community residences in Dublin. While termed a *National* Forensic Mental Health Service, this service excludes forensic services in Cork and Limerick, where services are minimally provided by the local HSE services. Some funding for a small number of posts comes from the Central Mental Hospital, and the teams are severely under-resourced.

Human Rights

The placement and treatment of mentally ill people who have committed criminal offences must be considered in the context of human rights. The right of all people to respect for individual human worth, dignity and privacy is not negated by any circumstance, regardless of an individual's history

The A Vision for Change *report in 2006 recommended that every person with serious mental health problems coming into contact with the forensic system should be accorded the right to mental health care in the non-forensic mental health services unless there are cogent and legal reasons why this should not be done.*

8. Kelly BD (2007) Penrose's Law in Ireland: an ecological analysis of psychiatric inpatients and prisoners. *Irish Medical Journal*. 2007 Feb;100(2):373-374.

9. Large MM, Nielssen O (2009) The Penrose hypothesis in 2004: patient and prisoner numbers are positively correlated in low- and-middle income countries but are unrelated in high-income countries. *Psychol Psychother* 2009;82:113–19. 10.1348/147608308X320099

10. O'Neill, C et al. (2003) Long-stay forensic psychiatric inpatients in the Republic of Ireland: Aggregated needs assessment. *Irish Journal of Psychological Medicine* 20(4), 119-125.

of offending or their status as a forensic mental health patient or prisoner. There are concerns that an extensive period of forensic inpatient care can be detrimental, seriously restricting patients' autonomy, quality of life and prospects of future independent living[11].

Adopting a human rights approach to the design and delivery of forensic mental health services means establishing a standard of treatment that respects the dignity of all people within the system. Article 3 of the European Convention on Human Rights (ECHR) establishes a right to be free from torture or inhuman or degrading treatment or punishment. This means that if people are detained, they must be kept in conditions compatible with respect for human dignity. This includes receiving appropriate medical care and treatment if they have a mental disorder and are detained. Article 5 of the ECHR enshrines people's right to liberty and security. This means that people cannot be detained without reason and that deprivations of liberty must not be arbitrary, disproportionate or unjustified. It is permissible to detain mentally disordered people for treatment within forensic mental health services. However, those services must guard against any infringements of people's liberty that are not a necessary part of their care, treatment and risk management. Forensic mental health services must maximise each person's opportunities to achieve recovery and rehabilitation so that they are not subject to restrictions in the future or unduly delayed from moving on to conditions of lesser security.

In clinical practice, a human rights framework refers to responsibilities, commitments and principles that are based in international human rights law. The UN Convention on the Rights of Persons with Disabilities 2006 (CRPD) and the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment 1987 (CAT) are particularly relevant to forensic mental healthcare. The CRPD aims to change attitudes and approaches to persons with disabilities from viewing them as passive recipients of care and services to viewing them as active participants who can claim their rights, be active members of society and make decisions about their own lives based on informed consent. The Convention clarifies how rights apply to individuals with disabilities, identifies areas where adaptations may need to be made in order that they can effectively exercise their rights, and highlights areas where their rights have been violated and therefore must be supported. The Irish Government signed the CRPD in 2007 and ratified it 11 years later in March 2018. Ireland signed CAT in 1992 and ratified the convention a decade later in 2002.

The UN Declaration of Rights of the Mentally Ill emphasises that persons with major mental illness should have equal rights with their non-mentally ill counterparts, including equal rights to bail and liberty[12]. The UN Principles for the Treatment of Prisoners states that prisoners should have access to the health services available in the country "without discrimination on the grounds of their legal situation"[13].

A Vision for Change 2006 recommended that every person with serious mental health problems coming into contact with the forensic system should be accorded the right of mental health care in the non-forensic mental health services unless there are cogent and legal reasons why this should not be done. It was proposed in the policy that the forensic mental health services be expanded and reconfigured to provide court diversion services, and that legislation be devised to allow this to take place.

Recovery

People in forensic mental health services should be treated with dignity and respect. This means that they should be recognised as individuals and that the approach taken to their care, treatment and risk management should reflect a holistic multi-disciplinary assessment of their individual needs and risks. As such, forensic mental health services should refrain from taking a 'one-size-fits-all' approach to people at the same level of security, and should not make decisions based on single elements of a person's case, such as their index offence, in isolation from other factors. Person-centred practice is central to the delivery of the principles outlined above.

11. Vollm B, Bartlett P and Mcdonald E (2016) Ethical issues of long-term forensic psychiatric care. *Ethics, Medicine & Public Health* 2(1), 36-44. doi: 10.1016/j.jemep.2016.01.005 1

12. The UN Declaration of Rights of the Mentally Ill United Nations: Principles for the protection of persons with mental illness and for the improvement of mental health care. General assembly a/RES/46/119. 1991 Principles for the protection of persons with mental illness and the improvement of mental health care (who.int)

13: UN Principles for the Treatment of Prisoners United Nations: Basic principles for the treatment of prisoners. General assembly a/RES/45/111. 1990 OHCHR | Basic Principles for the Treatment of Prisoners

For example, the least restrictive option for an individual will depend on their unique history of risks, progress in treatment, and presentation. Similarly, rehabilitation activities must reflect individual strengths and weaknesses: while one person may need to develop confidence in life skills such as shopping, another might require opportunities to pursue further education or gain employment. These practices need the support of a skilful and experienced workforce who are empowered to adopt a flexible and individualised approach in their work.

In a recent position paper, the Sainsbury Centre for Mental Health highlighted the need to demonstrate use of the recovery model in forensic mental health services. It said: "Risk assessment and management need to become more open, more transparent with service users and staff working collaboratively together. This is particularly important in forensic and high-risk settings, where recovery is just as important a principle as it is in any other part of the mental health service[14]"

Box 1: *The key principles of Recovery*[15]

Hope	Control	Opportunity
Maintaining a belief that it is still possible to pursue one's chosen life goals. Hope is personal and relationships are central. The importance of personal meaning and understanding.	(Re)gaining a sense of control over one's life and one's symptoms. Having choice over the content of interventions and sources of help. Balancing evidence-based practice with personal preference.	The need to build a life 'beyond illness'. Being a part of the community ('social inclusion') and not simply living in it. Having access to the same opportunities that exist for everyone else e.g., with regard to housing, employment, etc.

14. Shepard G, Boardman J, Slade M (2008) *Making recovery a reality.* London: Sainsbury Centre for Mental Health.
15. Repper J and Perkins R (2003) *Social inclusion and recovery: a model for mental health practice.* Elsevier Health Sciences.

Mentally ill people in prison

MENTALLY ILL PEOPLE IN PRISON

Prisons are unsuitable locations for those with mental disorders and the negative effects of incarceration on the mentally ill may be profound. The majority of crimes committed by the mentally ill are minor and non-violent. Only a very small number of individuals with serious mental illness carry out serious offences.

A landmark paper on mental health in prisons internationally by Fazel and Baillargeon recommended that greater healthcare resources be targeted at prisons since they provide "a rare public health opportunity" for screening and treatment[16].

Research has produced two significant findings: the majority of people grossly underestimate the prevalence of mental illness in prison, and there is much less public sympathy for offenders with mental illness than for non-offenders. Both have implications for the delivery of equivalence in care[17].

Brooker and Ullmann (2008) argue that prison has become a 'catch-all' social and mental healthcare service, and a breeding ground for poor mental health[18]. There has been growing recognition of the scale of mental health need in prisons in Europe[19] and in the USA. Worldwide, it is estimated there is an overall prevalence of 3.7% of male and female prisoners with a psychotic illness, and 11.4% with major depression[20]. The over-representation of mental illness in prison populations compared to community samples has long been recognised internationally and is particularly true for pre-trial settings.

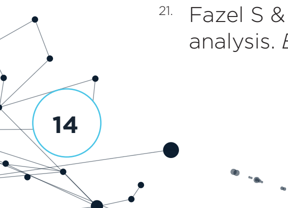
Fazel & Seewald (2012), in a systematic review of the international literature, found a pooled 6-month prevalence of psychosis of 3.6% in male prisoners and 3.9% in female prisoners. The pooled prevalence of major depression was 10.2% in male prisoners and 14.1% in female prisoners. No significant differences in rates of psychosis and depression between remand and sentenced prisoners were identified[21].

Table 1: *Mental health problems in prisons and in the general population*

	Prevalence among prisoners (16 years+)	Prevalence in general population (16-64 years)
Psychosis	8%	0.5%
Personality disorder	66%	5.3%
Depression, anxiety, etc.	45%	13.8%
Drug dependency	45%	5.2%
Alcohol dependency	30%	11.5%

Source: Singleton et al. (2000) Singleton, N., Bumpstead, R., O'Brien, M., Lee, A. & Meltzer, H. (2000) Psychiatric morbidity among adults living in private households, 2000. London: Office for National Statistics.

16. Fazel Z, Baillargeon J (2011) The health of prisoners. *Lancet* 377: 956–965.
17. Brooker C and Ullmann B (2008) Out of sight, out of mind. The state of mental healthcare in prison. Edited by Gavin Lockhart. Policy Exchange.
18. Brooker C and Ullmann B (2008). Out of sight, out of mind. The state of mental healthcare in prison. Edited by Gavin Lockhart. Policy exchange.
19. Fazel S & Danesh J (2002) Serious mental disorder in 23,000 prisoners: a systematic review of 62 surveys. *Lancet* 359: 545-550.
20. Fazel S & Seewald K (2012) Severe mental illness in 33,588 prisoners worldwide: systematic review and meta-regression analysis. *Br J Psychiatry* 200(5): 364–373. doi: 10.1192/bjp.bp.111.096370
21. Fazel S & Seewald K (2012) Severe mental illness in 33,588 prisoners worldwide: systematic review and meta-regression analysis. *Br J Psychiatry* 200(5): 364-373. doi: 10.1192/bjp.bp.111.096370



This over-representation of severe mental illness in prison populations has been well researched in Ireland. Gulati *et al*. in 2019 found the pooled percentage for psychotic disorder in prison in Ireland was 3.6%; for affective disorder 4.3%; for alcohol use disorder 28.3%; for substance use disorder 50.9%; and for homeless on committal 17.4%[22]. In a study of women prisoners, Wright *et al*. found a high prevalence of mental illness and substance misuse problems among women newly committed to prison and in a cross-section of those remanded or sentenced in prison in Ireland, with evidence of a cycle of deprivation and institutionalisation[23]. Curtin *et al*. in 2009 found the prevalence rates of any psychotic illness were 3.8% (remand) and 0.3% (sentenced)[24]. Linehan et al. demonstrated rates of psychosis (the most severe and disabling form of mental illness) in the sentenced prison population was comparable to other jurisdictions but much higher than in other countries in remand settings, and almost 10 times the level in the community[25].

A study looking at referrals to the in-reach psychiatric service in Limerick Prison found 42.2% of those assessed by forensic mental health professionals were diagnosed with a substance misuse disorder and 21.1% with a personality disorder. In total, 20.3% suffered from a psychotic disorder and 10.6% with an affective disorder. Of those seen by psychiatric services, 51.2% required psychotropic medication, 29.2% required psychological input and 59.3% required addiction counselling. In all, 10.6 % of those assessed were diverted from prison, the majority to approved mental health centres.[26]

These studies confirm that a significant proportion of prisoners in Irish prisons present with a current psychotic or major affective disorder, which are potentially treatable mental illnesses.

There are shortfalls in services for two groups overrepresented in the prison population: those who are homeless and those whose illness co-exists with substance misuse[27].

Table 2: *The prevalence of major mental illness, alcohol and substance misuse, and homelessness at the time of committal.*

	Pooled percentage
Psychotic Disorder	3.6%
Affective Disorder	4.3%
Alcohol Disorder	28.3%
Substance abuse	50.9%
Homelessness	17.4%

Source: Gulati G. et al[28]

The co-existence of severe mental illness, substance misuse and homelessness has been studied in international literature; these often co-exist, interacting in ways that intensify the vulnerability of an individual.

22. Gulati G, Keating N, O'Neill A, Delaunois I, Meagher D, Dunne CP (2019) The prevalence of major mental illness, substance misuse and homelessness in Irish prisoners: systematic review and meta-analyses. *Ir J Psychol Med* Mar 2019; 36(1): 35- 45. doi: 10.1017/ipm.2018.15. PMID: 30931873

23. Wright B, Duffy D, Curtin K, Linehan S, Monks S, Kennedy HG (2006) Psychiatric morbidity among women prisoners newly committed and among remanded and sentenced women in the Irish prison system. *Ir J Psychol Med* Jun 2006; 23(2): 47-53. doi: 10.1017/S0790966700009575. PMID: 30290478

24. Curtin K, Monks S, Wright B, Duffy D, Linehan S, Kennedy HG (2009) Psychiatric morbidity in male remanded and sentenced committals to Irish prisons. *Ir J Psychol* Med Dec 26(4):1 69-173. doi: 10.1017/S079096670000063X. PMID: 30282236.

25. Linehan et al. (2005) Psychiatric morbidity in a cross-sectional sample of male remanded prisoners. *Ir J Psychol Med* 22(4): 128.

26. Gulati G, Otuokpaikhsian K, Crowley M, Pradeep V, Meagher D, Dunne CP (2019) Mental healthcare interfaces in a regional Irish prison. *Int J Prison Health* 2019 Mar 11;15(1): 14-23. doi: 10.1108/IJPH-06-2017-0029. Epub 2019 Feb 20. PMID: 30827156.

27. McInerney C, O'Neill C (2008) Prison Psychiatric Inreach and Court Liaison Services in Ireland. *Judicial Studies Institute Journal* 2008: 2.

28. Gulati G, Keating N, O'Neill A, Delaunois I, Meagher D, Dunne CP (2019)The prevalence of major mental illness, substance misuse and homelessness in Irish prisoners: systematic review and meta-analyses. *Ir J Psychol Med* 2019 Mar; 36(1): 35-45. doi: 10.1017/ipm.2018.15. PMID: 30931873.

Acutely disturbed patients with mental illness in prison are often confined to isolation cells; this has no therapeutic benefit for the mentally ill patient and can be harmful if prolonged for more than a short duration. The Inspector of Prisons has found that:

"As a State, Ireland is currently not meeting its obligations to ensure adequate healthcare provision for mentally ill prisoners who are not receiving the treatment they require... Many of these prisoners are accommodated on an extremely restricted daily regime. While the Inspectorate understands that limited out-of-cell time is a measure imposed to ensure the safety needs of mentally ill prisoners and others in the prison, these restrictions amount to inhuman and degrading treatment. The treatment of mentally ill prisoners must be addressed as a matter of extreme urgency."[29]

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) is critical of the use of special observation cells in prisons and calls for their use to be reviewed. It also states that the high-support units at Cloverhill, Cork and Mountjoy prisons, which accommodate mentally ill prisoners, offer poor conditions and inadequate treatment, and must be provided with sufficient resources[30]. The CPT report is contained in *Appendix 1* of this report.

Vulnerability is a major concern for those with mental illness and intellectual disability (ID) in prisons. Bullying may relate to attempts to acquire such prisoners' medication or persuade them to use illicit drugs, and can extend to emotional, financial and sexual exploitation. Placement on vulnerable prisoner wings is an important measure to help manage some of these difficulties. Staff in all prisons we visited for the purpose of this report confirmed that bullying and victimisation of mentally ill prisoners was common.

Victimisation and stigmatisation may lead to a deterioration in the already fragile mental state. Coupled with this is the fact that prison officers are ill-equipped to deal with the complex needs of these prisoners and mental health treatment programmes and resources are severely lacking.

Possible reasons for the disproportionately high rate of major mental illness in Irish remand settings include: the lack of a formal legal mechanism for court diversion in this jurisdiction; the absence of mental health courts; and inadequate investment in community psychiatric services.

Daniel (2007)[31] asks pertinent questions:

- Are our prisons' rehabilitative services set up to provide comprehensive mental health and psychiatric programs to deal with the increasing population with such severe psychopathology and impairment?
- Shouldn't standards of care of psychiatric disorders be respected in the correctional setting as they are in other community provider settings?
- Shouldn't prisoners have access to the same standard of treatment consistent with the principle of equivalence?
- Shouldn't access to specialized diagnostic procedures and assessment protocols, including general and neuropsychological testing, be available and applied to identify neuropsychiatric and behavioral consequences of brain injury and other organic disorders?
- Are states willing to allocate sufficient budget and manpower resources to meet the needs of mentally ill and substance-abusing offenders?

29. Dept. of Justice (2019) *Annual Report of the Inspector of Prisons*.

30. Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 23 September to 4 October 2019 1680a078cf (coe.int).

31. Daniel EA (2007) Care of the mentally ill in prisons: challenges and solutions. *J Amer Academy Psych & Law* 35(4): 406–410.

As Professor Harry Kennedy has said: *"It is remarkable that this attracts so little attention or discussion when the adverse effects including criminalisation of the mentally ill are so obvious[32]."*

Intellectual disability in the Criminal Justice System

There are nine million prisoners worldwide, and typically 0.5-1.5% of prisoners have an intellectual disability ranging from 0% to 2.8% across studies[33]. Persons with intellectual disability are imprisoned approximately seven times more frequently than would be expected by their prevalence in the general population[34]. Many prisoners with intellectual disability may not have been formally diagnosed or identified.

Although there is little substantive data estimating the prevalence of intellectual disabilities within the Irish prison system, people with intellectual disability are overrepresented in all parts of the criminal justice system, including police custody[35]. This finding strengthens the argument for the development of diversion services which, to date, are geographically variable in Ireland.

A study by Gulati *et al*. (2019) found that there is little data to accurately estimate the prevalence of intellectual disabilities in the Irish prison system and the limited data available suggests that this is likely to be higher than international estimates. The only nationwide survey was commissioned by the Department of Justice, Equality and Law Reform in 1999. It found 264 such prisoners across 14 Irish prisons (which represented 10% of the total prisoner population in Ireland at the time of the study) and that 28% had an IQ below 70, suggesting "a significant degree of intellectual disability/mental handicap". The report made recommendations, including:

1. Early Identification and Support
2. Development of Diversion Services
3. Specialised Prison Programmes
4. Post-release Support Services

Twenty-two years later, we are still waiting for these recommendations to be implemented.

There is an urgent need for further research to accurately estimate prevalence in this jurisdiction, and to develop screening, diversion and care path-ways for prisoners with an intellectual disability.

International research shows that people with disabilities face significant barriers when imprisoned. Intellectually disabled people may be in prisons without having had their support needs previously identified or addressed. People with disabilities also face barriers within prison in accessing education and employment opportunities and are exposed to a higher risk of abuse and violence[36]. They may experience more difficulties in following prison rules or prison staff instructions if these are not accessible, or if the environment makes it impossible to obey.

> *"Vulnerability is a major concern for those with mental illness and intellectual disability (ID) in prisons."*

32. Prof. Harry Kennedy, *Irish Examiner*, Mon, 10 Aug 2020.
33. Fazel S, Xenitidis K, Powell J (2008) The prevalence of intellectual disabilities among 12,000 prisoners – a systematic review. *Int J Law Psychiatry*. Aug-Sep; 31(4): 369-73. doi: 10.1016/j.ijlp.2008.06.001
34. Spreat, S (2020) Persons with intellectual disability in prison, *Journal of Intellectual Disabilities and Offending Behaviour*, 11(4), 233-237. doi.org/10.1108/JIDOB-03-2020-0006
35. Gulati, G., Murphy, V., Clarke, A., Delcellier, K., Meagher, D., Kennedy, H., & Dunne, C. P. (2018). Intellectual disability in Irish prisoners: Systematic review of prevalence. International Journal of Prisoner Health, 14(3), 188–196.
36. CRPD Committee, Observations on the Standard Minimum Rules for the Treatment of Prisoners (2013) CRPD/SMR, para. 6.

Box 2: *Difficulties faced by offenders with intellectual disabilities*

As suspects, individuals may:

- Not want their disability to be recognised (and try to cover it up).
- Not understand their rights but pretend to understand.
- Not understand commands, instructions, etc.
- Be overwhelmed by police presence.
- Act upset at being detained and/or try to run away.
- Say what they think officers want to hear.
- Have difficulty describing facts or details of offense.
- Be the first to leave the scene of the crime, and the first to get caught.
- Be confused about who is responsible for the crime and "confess" even though innocent.

Source: People with Intellectual Disabilities in the Criminal Justice Systems: Victims & Suspects by Leigh Ann Davis. The Arc (2009)

Beyond the High Fence, published by the NHS England in early 2019, was co-produced with people with an intellectual disability or autism with lived experience of being in prison or in a secure hospital setting. Problems identified with being in prison included: a lack of nurses with expertise in intellectual disability and autism; a lack of staff understanding of intellectual disability and autism; excessively strict rules and frequent restraints; a lack of emotional support; bullying by other prisoners; and the experience of prison resulting in a detrimental impact on mental health[37].

Autism Spectrum Disorder (ASD) is a significant comorbidity in people with intellectual disability and 70% of those with ASD will have a comorbid intellectual disability[38]. A systematic review found that the prevalence of ASD in 'forensic populations' varies from 2% to 18%[39]. An individual with ASD often interacts with correctional staff and other prisoners differently than do neurotypical individuals. For instance, persons with ASD are highly suggestible and quick to rationalise their behaviour. Their presentation may lack the expected sense of guilt or remorse one would typically expect. Persons with ASD struggle to read other people's faces and easily become confused by others. Their tendency to avoid eye contact may be perceived as lack of interest or guilt. They may overcompensate with a fixed stare that may be perceived as aggressive. During an interview, persons with ASD may interpret what is being said to them literally and not understand hidden meanings, metaphor or sarcasm. These behaviours, if not recognised as such by staff or other prisoners, put individuals with ASD at risk for serious consequences[40]. Because of difficulties with social imagination, problems with flexibility of thought, general naivety, and a tendency toward obsessive and repetitive behaviour, an individual with ASD may not learn from experience[41]. This deficit increases the risk of repeating the problematic behaviour or becoming subject to victimisation. Distress, vulnerability, isolation, and relational issues with staff have all been described. An accurate prevalence estimation of ASD in prison is important in planning and developing prison inreach and secure services to meet the needs of this cohort.

37. beyond-the-high-fence.pdf (england.nhs.uk).
38. Moloney N, Gulati G (2019) Autism spectrum disorder and Irish prisoners. Correspondence, *Ir J Psych Med* 2019 Jul 26. doi:10.1017/ipm.2019.30
39. Rutten AX, Vermeiren R, Van Nieuwenhuizen C (2017) Autism in adult and juvenile delinquents: a literature review. *Child and Adolescent Psychiatry and Mental Health* 11, 45.
40. Michna I, Trestman R, Correctional Management and Treatment of Autism Spectrum Disorder. J Amer Acad Psych & Law Online June 2016, 44(2): 253-258.
41. National Autistic Society (2005) Autism: a guide for criminal justice professionals. London: National Autistic Society.

When a person detained in an Irish prison requires psychiatric treatment, several triage options exist. Some mentally ill prisoners are charged with serious offences and await transfer to the Central Mental Hospital.

"Vulnerability may be magnified when there are comorbidities such as autism spectrum disorder, which can lead to challenges arising from social naivety, sensory difficulties and 'meltdowns' being perceived as challenging behaviour. Placement on vulnerable prisoner wings may mitigate such risks but exposes those placed in such settings to limited social contact, a restricted prison regime and potential stigmatisation"[42].

In Ireland, there are currently nine beds in the Central Mental Hospital for men with intellectual disability and/or autism. This will expand to 20 beds with a second forensic consultant psychiatrist team and access to subacute and rehabilitation within the hospital on the opening of the new Central Mental Hospital in Portrane. There is no dedicated facility for women with intellectual disability or autism.

However, the forensic mental health team work in collaboration with the women's forensic team. There remains a shortage of step-down facilities for people discharged from the Central Mental Hospital. It is often difficult to source local mental health services on discharge or for diversion especially if a person does not have a serious mental illness concomitant with their intellectual disability.

The Central Mental Hospital team for people with intellectual disability also carry out risk assessments and court reports.

ADHD in the Criminal Justice System

ADHD is characterized by symptoms of pervasive and impairing inattention and/or hyperactivity and impulsivity that starts during childhood or early adolescence and persists in around half of individuals into adulthood where it is associated with significant personal, social, and occupational problems[43]. Worldwide prevalence rates estimate that 5.3% of children and 2.5% of adults meet diagnostic criteria for ADHD[44]. Meta-analyses of 42 prisons, based on international data derived from symptom-based clinical diagnostic interviews, indicated that 25.5% of the prison population overall met diagnostic criteria for ADHD, a ten-fold increase among adult prisoners[45]. A further meta-analysis identified 102 studies meeting study criteria (142 study samples) published from 1985 to 2017 with data collected in 28 countries and the pooling of all studies yielded an adolescent/adult ADHD prevalence rate of 26.2%.[46]

Effective identification and treatment of people with attention-deficit/hyperactivity disorder (ADHD) in the prison population is likely to have a positive impact on the offender and society. ADHD is associated with early age criminality with a two to three-fold increased risk of later arrest, conviction, and imprisonment[47] and a high rate of recidivism[48]. While ADHD is a treatable condition which can be managed by a combination of appropriate medication and psychological treatments, among individuals in the criminal justice system ADHD remains both mis- and

42. Dr G. Gulati. Irish Times Fri, Jan 11, 2019

43 Shaw M, Hodgkins P, Caci H, Young S, Kahle J, Woods AG, Arnold LE. A systematic review and analysis of long-term outcomes in attention deficit hyperactivity disorder: effects of treatment and non-treatment. BMC Med. 2012;10:99.

44 Simon V, Czobor P, Balint S, Meszaros A, Bitter I. Prevalence and correlates of adult attention-deficit hyperactivity disorder: meta-analysis. Br J Psychiatry. 2009;194(3):204–11.

45 Young S, Moss D, Sedgwick O et al. A meta-analysis of the prevalence of attention deficit hyperactivity disorder in incarcerated populations. Psychol Med. 2014; 7:1-12

46 Baggio S et al. Prevalence of Attention Deficit Hyperactivity Disorder in Detention Settings: A Systematic Review and Meta-Analysis Front. Psychiatry, 02 August 2018 | https://doi.org/10.3389/fpsyt.2018.00331

47 Mohr-Jensen C, Steinhausen HC. A meta-analysis and systematic review of the risks associated with childhood attention-deficit hyperactivity disorder on long-term outcome of arrests, convictions, and incarcerations. Clin Psychol Rev. 2016;48:32–42.

under-diagnosed and consequently inadequately treated[49].

Those who present with ADHD may be doubly disadvantaged within the criminal justice system whereby difficulties around remaining focused and attentive during, for example, probation interviewing/work can prove problematic and, for those undiagnosed, may result in incorrect interpretations in terms of engagement and attitude, making them more vulnerable within the system[50]. Compared with prisoners without ADHD, prisoners with ADHD symptoms demonstrate a high frequency and severity of functional impairment that worsen in proportion to the severity of their ADHD symptoms.[51]

When appropriately diagnosed and treated for ADHD, there is likely improved ADHD symptom control, emotional lability, and overall functioning. Furthermore, outcome studies indicate reduced rates of transport accidents, criminality, and suicidal behaviour during periods of treatment for ADHD[52].

A Swedish national database study of released prisoners reported that rates of violent reoffending were reduced by 42% during periods when they were receiving antipsychotics, psychostimulants, and/or drugs for addictive disorders, compared to periods in which they were not receiving medication[53] Another Swedish database study reported that among those treated for ADHD, criminal conviction rates were reduced by 32% in men and 41% in women over a 3-year period[54].

In order to address the issue, Quigly and Gavin recommend a comprehensive review of current interventions with a view to incorporating ADHD screening and assessment into prison and youth detention, and developing an Irish-appropriate community mental health diversion model specifically incorporating ADHD into screening, diversion, assessment and treatment[55].

Inreach Psychiatric Services to Irish Prisons

When a person detained in an Irish prison requires psychiatric treatment, several triage options exist.

Some mentally ill prisoners are charged with serious offences and await transfer to the Central Mental Hospital. Treatment in the patient's catchment area service often represents the best option for individuals with severe mental illness charged with a minor offence and deemed to pose low risk to others. In such instances, the court may impose bail or other non-custodial transfer rather than drop charges. This allows for conditions to be put in place to promote compliance with psychiatric treatment. Persons receiving bail are generally expected to comply with specific conditions.

In practice, many are transferred to approved centres (psychiatric inpatient units) in the community, having been granted bail. These patients are often homeless, and there are frequently long delays in obtaining decisions from the Health Service Executive (HSE) regarding catchment area responsibility, leaving mentally ill offenders without a mental health service.

[48] Young S, Wells J, Gudjonsson GH. Predictors of offending among prisoners: the role of attention-deficit hyperactivity disorder and substance use. J Psychopharmacol. 2011;25(11):1524–32.

[49] Young S, Adamou M, Bolea B, Gudjonsson GH, Müller U, Pitts M, Thome J, Asherson P. The identification and management of ADHD offenders within the criminal justice system: a consensus statement from the UK adult ADHD network and criminal justice agencies. BMC Psychiatry. 2011;11(1):32.

[50] Usher, A.M., Stewart, L.A. and Wilton, G. (2013), 'Attention deficit hyperactivity disorder in a Canadian prison population', International Journal of Law and Psychiatry, vol. 36, nos 3–4, pp. 311–315 Watts, S.J. (2018)

[51] Young, S., Gudjonsson, G., Chitsabesan, P. et al. Identification and treatment of offenders with attention-deficit/hyperactivity disorder in the prison population: a practical approach based upon expert consensus. BMC Psychiatry 18, 281 (2018)

[52] Ginsberg Y, Quintero J, Anand E, Casillas M, Upadhyaya HP. Underdiagnosis of attention-deficit/hyperactivity disorder in adult patients: a review of the literature. Prim Care Companion CNS Disord. 2014;16(3):PCC.13r01600. doi:10.4088/PCC.13r01600

[53] Chang Z, Lichtenstein P, Langstrom N, Larsson H, Fazel S. Association between prescription of major psychotropic medications and violent reoffending after prison release. Jama. 2016;316(17):1798–807.

[54] Lichtenstein P, Halldner L, Zetterqvist J, Sjolander A, Serlachius E, Fazel S, Langstrom N, Larsson H. Medication for attention deficit-hyperactivity disorder and criminality. N Engl J Med. 2012;367(21):2006–14.

[55] Quigly E, Gavin B. ADHD and the Irish Criminal Justice System: The Question of Inertia IRISH PROBATION JOURNAL Volume 15, October 2018.

In Ireland, there are currently nine beds in the Central Mental Hospital for men with intellectual disability and/or autism. This will expand to 20 beds with a second forensic consultant psychiatrist team and access to subacute and rehabilitation within the hospital on the opening of the new Central Mental Hospital in Portrane. There is no dedicated facility for women with intellectual disability or autism.

Those requiring transfer for admission are usually unfit to be tried. In practice, consideration of the issue of fitness is frequently deferred to facilitate identification of treatment options.

Visit to Prisons by the Inspector of Prisons and the Inspector of Mental Health Services

During 2020 and 2021, we visited Cloverhill Prison, Mountjoy Men's Prison and Mountjoy Women's Prison (Dóchas Centre) specifically to look at access to appropriate mental health care for prisoners with mental illness. In Cloverhill Prison we met with the Governor, members of the Forensic Mental Health Team, nursing staff and prison officers of various grades. In Mountjoy Prison (Men's and Women's sections) we met with the Campus Governor, the Medical Director and the Director of Nursing. We also spoke with chief prison officers, chief nursing officers, other members of the healthcare teams and prison officers. We also had the opportunity to speak with prisoners.

All categorically stated that severely mentally ill prisoners should not be treated in a prison. They expressed concern about the lengthy waiting list for the Central Mental Hospital and the fear that the new Central Mental Hospital will rapidly reach capacity.

We found that the input from the inreach teams was comprehensive and responsive. The general nursing team in the prison provided a service for people with mental illness to the best of their ability and capacity.

In **Cloverhill Prison**, mentally ill prisoners were held in D2 wing. It was overcrowded with some cells occupied by three men, one sleeping on a mattress on the floor. One prisoner was lying on a mattress on the floor in a cell. He was severely mentally ill, refusing food and drink and refusing medication. He was waiting for a bed in the Central Mental Hospital. There were no therapeutic activities and few recreational activities for the men. There were no mental health care professionals based in the area, which was supervised by prison officers. The inreach forensic mental health team had a very active presence in the wing and provided psychotropic medication where a prisoner consented, and they also provided therapeutic sessions.

In **Mountjoy Men's Prison**, mentally unwell prisoners were accommodated in the 9-bed High Support Unit (HSU) and were progressed to a low support unit when they were well enough. This was staffed by prison officers who had a special interest in mentally unwell prisoners. The inreach team provided a comprehensive mental health service and could decide who was admitted or discharged from the unit. While in a small old part of the prison, every effort had been made to brighten the area and provide recreational activities. However, the area was small and there was little for the prisoners to do during the day. Prisoners told us that they preferred to be away from the main prison when they were unwell and that it was more peaceful and quieter in the HSU. We were informed that mentally ill prisoners were likely to be bullied and abused in the main part of the prison. It was clear that the prisoners were mentally unwell and would be vulnerable on return to the main prison area.

Mountjoy Women's Prison (Dóchas Centre) had a medical unit with single cells where women with severe mental illness are located. During our visit, there were three severely mentally ill women locked in isolation cells, two of whom were waiting for a bed in the Central Mental Hospital. Both had difficulty in articulating their needs due to the severity of their illness. There was regular input from the inreach team, but both needed urgent admission to the Central Mental Hospital and appropriate inpatient mental health care.

Overview of prisons

Table 3: *Overview of prisons*

Prison	No. of prisoners	Facilities for mentally ill prisoners	Current in-reach team resources	Requirements to meet need	Caseload	Waiting list CMH
Mountjoy	755	HDU (9 dedicated beds) LSU (4 dedicated beds)	1 Consultant Psychiatrist (2 days) 2 WTE FCMHNs 1 WTE Senior Forensic Mental Health Social Worker 0.5 WTE BST trainee	Occupational Ther-apist Psychologist 0.5 WTE Housing Support Worker	57 (9 April 2021)	9 (9 April 2021)
Dóchas Centre, Mountjoy Women's prison	140	None	2 Consultant Psychiatrist for 3 half days a week 1 WTE FCMHN 1 WTE Social Worker 1 BST 2 days a week	FCMHN Occupational Therapist Forensic Intellectual Disability Mental Health Nurse	25-35	5-7 days; urgent cases 1-2 days
Cloverhill		D2 wing for vulnerable prisoners	FCMHNs (often 2) 1.5 Consultant Psychiatrist 1 HST trainee 2 BST trainees 1 Housing Support Worker Admin support	FCMHNs Occupational therapist Social Worker Onsite Admin support		
Wheatfield	533 (67 remand)	West-2 with 2 safety observation cells for special security needs.	1 Consultant Psychiatrist 1 day/week 1.4 FMHN 0.2 BST	Occupational therapy Psychology Social Work Housing support services	30-40	2
Arbour Hill	138	No	1 Consultant Psychiatrist 1 day a week 2 x 0.5 FCMHN	Social Worker	25	
Midlands Prison	800	C1 left – for high dependency needs – 12 cells. Highly staffed.	1 Consultant Psychiatrist 2 FCMHNs		80	
Portlaoise Prison		No	No information provided	No information provided	No information provided	No information provided

Prison	No. of prisoners	Facilities for mentally ill prisoners	Current in-reach team resources	Requirements to meet need	Case-load	Waiting list CMH
Castlerea	340	No	0.8 WTE Consultant Psychiatrist 1.0 FCMHN 1.0 WTE Forensic Social Worker	1.0 Consultant Psychiatrist 2 FCMHN 1 NCHD 1 Social Worker	40	
Limerick	210 (males) and 28 (females)	No	0.5 Consultant Psychiatrist 0.1 Community FCMHN Admin 0.1	1.0 WTE Consultant Psychiatrist 1.0 WTE Senior Registrar 1.0 WTE Clinical Nurse Manager 2 1.0 WTE Registered Psychiatric Nurse 1.0 WTE Senior Clinical Psychologist 1.0 WTE Senior Social Worker 1.0 WTE Grade III Clerical Officer		
Cork	280	No	1 Consultant Psychiatrist 3 sessions a week 2 FCMHN 4 days a week (1 on extended leave) 1 Social Worker 4 days a week		60	Less than 7 days

WTE – whole time equivalent; FCMHN – Forensic community mental health nurse; BST – basic specialist trainee; HST – higher specialist trainee

Cloverhill Prison

Cloverhill Remand Prison is the largest male remand prison in the state. Its catchment area serves the majority of the Irish population, so it receives a large proportion of Ireland's remand episodes. The Prison In-reach and Court Liaison Service (PICLS) is based there since 2006.

On 25 February 2021, approximately half the PICLS caseload at Cloverhill were actively psychotic (deluded, thought disordered and/or hallucinating). Over half were homeless. One-third (13 people) were both actively psychotic and homeless. Five were awaiting admission to the Central Mental Hospital while another six were assessed as unfit to be tried and in need of urgent admission to a community psychiatric hospital.

In Cloverhill Prison, those identified as severely mentally ill or otherwise in need of high support from prison nursing and medical staff are placed in a landing for vulnerable prisoners (D2).

The following is an excerpt from the report of the Inspector of Prisons about Landing D2 from an inspection report of the Inspector of Prisons on 3 August 2021:

"There are 12 cells on one side of the landing. The cells were a combination of both single and double occupancy. … On inspection, the environment of the D2 wing was bright, with murals painted on the walls by a prisoner, and an air of openness upon first entering the wing. D2 was recently provided with pineapple furniture specifically designed to be safe,

robust and with anti-ligature features. There was a small yard attached to the wing where prisoners can avail of fresh air and exercise.

"However, the situation on D2 is of serious concern to the Inspectorate. Despite efforts by the Prison Service and the psychiatric team to care for these men, the prison cannot and should not be a holding facility for people in need of and awaiting treatment at the Central Mental Hospital. There are long waiting periods for prisoners identified as needing CMH admission."

Table 4: *(a) CMH and (b) Approved Centre Waiting List at Cloverhill Prison (on 18-19 March 2021)*

(a) CMH waiting list

Name	Number of days on waiting list
A	228
B	305
C	214
D	294
E	43

(b) Approved Centres waiting list

Name	Number of days on waiting list
F	169
G	32
H	18

"Both Cloverhill Prison medical staff and senior management were in agreement that Cloverhill Prison is not the appropriate institution for many of the prisoners on the D2 wing. The people on this wing have significant mental health problems that the prison is not designed or resourced to address[56]."

There are also safety observation cells used in exceptional circumstances for those posing a serious and immediate risk to themselves or others in the context of major mental illness. Remand prisoners are placed on D2 following reception at the discretion of the prison governor, in consultation with prison medical, psychiatric and nursing staff. The staff of the psychiatric inreach team (PICLS) attend there five days a week. This allows higher levels of observation by medical and nursing staff than would be possible in ordinary prison locations, and higher levels of clinical support.

The chaplaincy report for Cloverhill in 2020 states:

"Cloverhill houses some of the most vulnerable men within the prison system ... the ongoing incarceration of those who are psychiatrically unwell is an issue of continuous concern ... These men need urgent psychiatric care in an appropriate therapeutic safe environment but despite tireless efforts from many stakeholders over the years, the issue remains one which needs resolving as a matter of urgency[57]."

56. Office of the Inspector of Prisons. COVID-19 Thematic Inspection of Cloverhill Prison 18-19 March 2021.

57. Chaplains' Reports, Irish Prison Service.

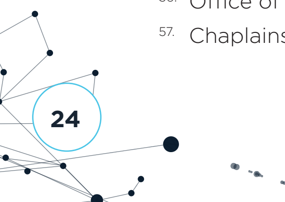
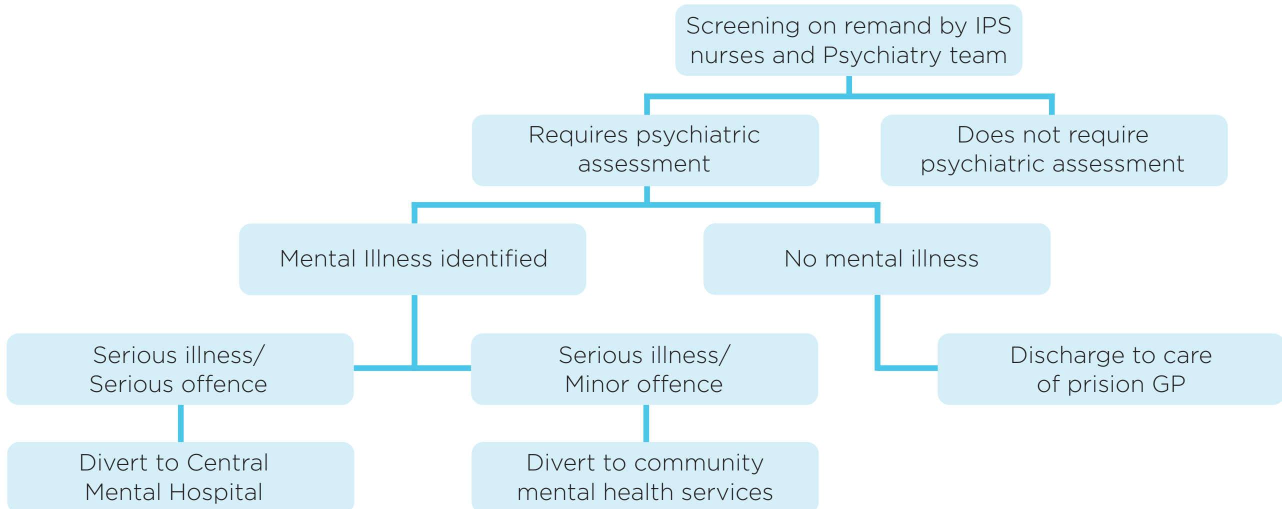


Figure 1: *Prison inreach and court liaison service model flowchart*[58]



The Quality Network for Prison Mental Health Services has repeatedly identified PICLS Cloverhill as understaffed compared with prisons elsewhere (even without considering the separate diversion role of the team).

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)[59] recommended six forensic Community Mental Health Nurses in their most recent report. They also pointed out the limited access to activities, suggesting the need for Occupational Therapy input. Other concerns of the CPT included the large numbers of people with mental illness; long delays for people needing beds in the Central Mental Hospital; delayed access to community beds, especially for people who are homeless; inadequate legislation; and lack of staffing. Since then, there are plans for healthcare assistants, a library and an activity room on D2 and a business plan has been submitted with request for approval for a social worker and an occupational therapist.

Clinics are held in Cloverhill Prison daily. The service diverts and refers patients to mainstream community and homeless mental health service on release or diversion. Some will continue to receive input from the Housing Support Worker in the immediate postrelease period.

For the period 2012-2015, the median time from committal to first assessment was two days for persons with psychosis and three days for persons without psychosis. Delays for non-urgent cases have lengthened in the context of COVID-19 and increased the numbers of severely mentally ill people awaiting beds in the Central Mental Hospital.

58. McInerney C *et al*. (2013) Implementing a court diversion and liaison scheme in a remand prison by systematic screening of new receptions: a 6-year participatory action research study of 20,084 consecutive male remands. *International Journal of Mental Health Systems* 7.

59. Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 23 September to 4 October 2019 1680a078cf (coe.int).

Box 3: *The Psychiatric Prison In-reach and Court Liaison Model: summary of PICLS process (McInerney et al.)*[60]

1. **Screening: identification of prisoners with severe mental illness**
- Previous psychiatric contact
- Psychiatric medication
- History of self-harm
- Homeless
- Observed unusual behaviour
- Charged with homicide or arson
- Referrals from courts, prison, staff community services and other sources

2. **Triage: Identification of appropriate treatment options**

Major offence: major mental illness
- Transfer to Central Mental Hospital

Minor offence: major mental illness
- Inpatient or outpatient community treatment in event of bail or other non-custodial transfer

Major offence: minor mental illness
- Follow-up in prison

Minor offence: minor mental illness
- Prison follow-up

3. **Collateral history & liaison: Continuity of care**
- Relatives
- Community psychiatric services
- Garda Siochana (Police)
- Probation and welfare services
- Solicitor
- Homeless agencies where relevant
- Other agencies as required
- Daily liaison with prison nursing staff
- Weekly case management meetings of all patients actively managed by service.
- Weekly case review meetings with prison medical, nursing and other staff.

4. **Court appearance**
- Court report
- Staff present in court where needed for communication and assistance in transfer to hospital
- Bail conditions sought

5. **Treatment**
- Diversion to appropriate treatment location

Mountjoy Men's Prison

Mountjoy Men's Prison is a closed, medium-security prison for adult males, and is the main committal prison for sentenced prisoners in Dublin city and county. It is Ireland's oldest penal institution, opened in 1850. It has capacity for 755 prisoners.

The prison complex contains a nine-bed High Support Unit (HSU) – an area of the prison reserved for prisoners with acute mental illnesses and other vulnerabilities – and a four-bed low support unit (step down for patients from the HSU). The HSU has single cells and a safety observation cell. It is continuously at capacity and 65% of prisoners have acute psychosis. It is staffed by prison officers with input from the inreach team. Within one year of opening the HSU in 2010, episodes of seclusion in the prison had reduced by 59%. The lack of structured activities in the HSU has been criticised in a recent report by the Committee for Prevention of Torture, in November 2020, and relates to an inspection carried out in late 2019 which emphasised the need for occupational therapy[61]. The Chaplaincy report for 2020 states:

"Prison is not an environment in which to adequately help men to heal. Some men need to be hospitalised and this is an issue of broader national concern. Prison staff do an excellent job, but some men need to be cared for in a more appropriate setting[62]*."*

The Mountjoy Prison inreach mental health service provides court diversion when remand prisoners within the prison are identified as meeting the criteria for Mental Disorder outlined in the Mental Health Act 2001. The Mountjoy inreach team use the PICLS model, triaging the patients according to need. The Mountjoy inreach

60 McInerney, C., Davoren, M., Flynn, G. *et al.* Implementing a court diversion and liaison scheme in a remand prison by systematic screening of new receptions: a 6-year participatory action research study of 20,084 consecutive male remands. Int J of Ment Health Syst 7, 18 (2013). https://doi.org/10.1186/1752/4458-7-18

61. Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 23 September to 4 October 2019

62. Chaplains Reports – Irish Prison Service

team arranged for the diversion of seven individuals to acute psychiatric inpatient units under the Mental Health Act 2001 in 2020. This was an increase from four in the previous year.

In Mountjoy, patients on the inreach team caseload have access to recreational yards, school, gym and a dayroom with a TV, DVD player and games console. Access to these activities has been curtailed by the COVID-19 pandemic. The lack of structured activities on the High Support Unit has been criticised by the European Committee for the CPT in their recent report[63].

To address the complex social needs of the patient caseload and to enhance pre-release planning, a Pre-Release Planning (PReP) Programme was set up.

The key interventions of the PReP Programme are:

1. Establishment of trusting professional relationships with mentally ill prisoners in the pre-release period
2. Liaison with mental health and other support agencies
3. Advocacy
4. Family support
5. Release planning
6. Post-release support
7. Service evaluation through data collection and analysis.

The Mountjoy inreach team has shown that compared to that reported at time of imprisonment, the level of mental health support and quality of accommodation both improved following the intervention of the PReP Programme[64].

Mountjoy Women's Prison (Dóchas Centre)

The Dóchas Centre is a closed, medium-security prison for women aged 18 years and over. It is the committal prison for women committed on remand or sentenced from all courts outside the Munster area. Operational capacity is 140, which was increased in 2020 from the original design capacity of 85. The Phoenix House section in the Dóchas Centre allows more freedom of movement and access to a kitchen. This serves as an incentive for women to move from the basic level of the prisoner-incentive regime to the enhanced level, to avail of accommodation in these areas.

There is a two-stage screening process for all new committals to the Dóchas Centre, which identifies those requiring a forensic mental health assessment. Referrals also come from the prison GP and all potential referrals are discussed with the other prison disciplines at the weekly multi-agency meetings.

The Quality Network for Prison Mental Health Services has repeatedly identified in reports on the service in 2018 and 2019 that the forensic mental health inreach team is understaffed compared with prisons elsewhere (even without considering the separate diversion role of the team). The skill mix in other jurisdictions would typically have a half-time service manager (usually an occupational therapist or social worker in a clinical/governance/management role) as well as onsite admin and more psychologists/psychological support workers to enable regular individual and group sessions in custody e.g., dialectical behaviour therapy (DBT). Current psychology services are formally provided separately by the Irish Prison Service. An adequate forensic inreach team would also typically include a Forensic Intellectual Disability Mental Health Nurse for at least one to two sessions per week per prison. This has been identified as an acute outstanding need by the inreach forensic mental health team.

63. Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 23 September to 4 October 2019.

64. Smith D et al. (2018) Beyond the Walls: An Evaluation of a Pre-Release Planning (PReP) Programme for Sentenced Mentally Disordered Offenders. *Front. Psychiatry*, 2 November 2018. https://doi.org/10.3389/fpsyt.2018.00549

There are three outpatient clinics per week in Dóchas and one specific mental health social work clinic per week. A multi-agency meeting is held once a week.

Approximately 50% of women prisoners are in the Dóchas Centre for less than 12 months, having been convicted of minor offences. Travellers account for 20-30% of female prisoners. There is an increasing number of referrals to the in-reach forensic team which could possibly be dealt with by the local mental health service if there was a pre-arrest diversion service in place. Homelessness among mentally ill women in prison is a significant problem, with difficulties holding onto hostel places while in custody, even if there is a release date. Hostel places are not accepted as addresses for either medical cards or local psychiatric services.

Mentally ill or distressed women prisoners benefit from psychological therapies. Due to the later onset of mental illness, they are more likely to retain activities of daily living skills and respond to occupational therapy input. Being a prisoner and unable to look after their children carries a double stigma.

Table 5: *Social Work Assessment Audit of 54 patients on Dóchas Psychiatry Caseload from 10/08/20-10/01/21*

Psychosocial Domain	Percentage Dóchas Psychiatry Caseload	Remanded	Diverted
Actively Homeless	67%	77%	*100%*
Sleeping Rough	17%	32%	37.5%
Childhood Abuse/Neglect/State Care	41%		
Difficulties with Mothering Role/ Children in Care	31%	36%	50%
Polysubstance Abuse	55.56%		
Ethnic Minority	24.07%	31.82%	
Intellectual Disability	9.26%	18.18%	
Domestic Violence	18.52%	22.73%	50%

Of this caseload:

Table 6: *Legal status of 54 patients on Dóchas Psychiatry Caseload from 10/08/20-10/01/21*

Legal status	Percentage Dóchas Psychiatry Caseload	Median length of stay	Range of length of stay
Remand	41%	3.5 weeks	1-6 weeks
Sentenced less than Life	50%	12 months	1-120 months
Sentence for Life	9%		

Source: Presentation to Inspector of Mental Health Services 2021 by the inreach forensic mental health team

Midlands Prison

Midlands Prison is a closed, medium-security prison for adult males with an operational capacity of 875 prisoners. It is the committal prison for counties Carlow, Kildare, Kilkenny, Laois, Offaly and Westmeath. Within the prison is the National Violence Reduction Unit, which provides improved psychological facilities to selected prisoners within the national prison system in an effort to reduce their challenging behaviour. The inreach team provide a five-day service. Referrals are from the GP in the prison and there is no waiting list for urgent cases. Approximately 50% of the inreach team's caseload have severe and enduring mental illness. However, the team reported very few cases of suicide or self-harm in the cohort of cases seen. There is a weekly multi-agency meeting with the Governor, Chief Officer, Psychology, Chaplain, two nurses and the chief nursing officers. There is no social worker on the inreach team and part of this work is taken up by a resettlement officer (for housing issues) and Integrated Sentence Management Team to ensure prisoners have a medical card, are registered with a GP and the housing authorities, and are facilitated in their reintroduction into the local community.

Cork Prison

Cork Prison is a closed, medium-security prison for adult males. It is the committal prison for counties Cork, Kerry and Waterford. It has 280 prisoners, consisting of both remand and sentenced prisoners.

Prisoners with mental health difficulties are referred by the prison GP following an assessment. There are psychologists and addiction counsellors employed by the Irish Prison Service in the prison.

The inreach forensic team stated that there were long delays of up to a year for prisoners waiting for treatment in the Central Mental Hospital. Prior to admission to the Central Mental Hospital, an assessment must be done by a forensic team from the National Forensic Mental Health Services, despite assessment having already been carried out by a forensic psychiatrist on the prison inreach team.

There is access to Carraig Mór, a psychiatric intensive care unit (PICU) for sentenced prisoners for the Cork city and county area only. This is not available for remand prisoners, who can only be transferred to a designated hospital, i.e., the Central Mental Hospital.

There is one consultant psychiatrist for three sessions a week, two Forensic Community Mental Health Nurses four days a week, and one social worker four days a week on the inreach team. However, the governance structure is confusing:

- The consultant psychiatrist post is funded by and reports to the HSE Cork and Kerry mental health services.
- The social worker is funded by and reports to the National Forensic Mental Health Service.
- One advanced nurse practitioner post is funded by and reports to the HSE Cork and Kerry mental health services.
- One forensic mental health nurse post is jointly funded by and reports to both the National Forensic Mental Health Service and the HSE Cork and Kerry mental health service.

Limerick Prison

Limerick Prison is a closed, medium-security prison for adult males and females. It is the committal prison for males for counties Clare, Limerick and Tipperary and for females for all six Munster counties. It accommodates both sentenced and remand prisoners. The prison has both male and female prisoners – the only other female prison is the Dóchas Centre in Mountjoy Prison in Dublin.

The inreach team is under-resourced., with only 0.5 WTE consultant psychiatrist and 0.1 WTE FCMHN. This necessitates lone working, which is high risk for a clinician in a forensic mental health setting. The current inreach staffing posts are funded and managed by HSE CHO 3, and not by the National Forensic Service. There are only informal links with the National Forensic Service.

The prison GP is the main source of referral to the inreach team. Approximately 10% of the prison population have a mental illness and 29% have an intellectual disability. Since 2014, mentally unwell prisoners are seen within 14 days and there is no waiting list. A discharge plan is in place for each prisoner who attends the forensic inreach team. The team have approximately 130 new cases and 200 follow-ups a year.

A new female prison is due to open in Limerick in 2022, with a south of Ireland catchment, which will put further strain on existing insufficient resources. There appeared to be no plans as to how an inreach forensic team to service this new prison was to be resourced. Mental health services are provided and clinically led on a part-time basis by a consultant

In addition to the waiting list for inpatient care and treatment in the Central Mental Hospital (CMH), there is another waiting list for an assessment by a forensic psychiatrist from the CMH.

psychiatrist, who provides a clinic every Monday. A clinic led by a Community Mental Health Nurse (CMHN) is available every Thursday. There were no other members of a multidisciplinary mental healthcare team available to the prison. The risk of harm to the inreach staff through conducting assessments and reviews in a prison environment is significant. As well as the safety benefits of two clinicians being present, the quality of care and treatment provided is enhanced by input from more than one discipline. In community settings, the average number of referrals to community mental health teams is 50- 100 new patients per year. In addition to the time commitment in the prison, the consultant psychiatrist attended court with court reports, and proactively liaised and engaged with mental health colleagues in Limerick, Clare and North Tipperary. There is no cover provided when the psychiatrist goes on leave. Additional resources for the mental health team are required, in particular additional community mental health nursing, as suggested by the psychiatrist. Access to inpatient forensic mental health services was identified as a challenge.

In addition to the waiting list for inpatient care and treatment in the Central Mental Hospital (CMH), there is another waiting list for an assessment by a forensic psychiatrist from the CMH. It was reported that in the past a forensic psychiatric assessment using the Dundrum Toolkit carried out by any forensic consultant psychiatrist was accepted by the National Forensic Mental Health Service but that that is no longer the case. Such assessments must now be conducted by forensic psychiatrists from the National Forensic Mental Health Service in the Central Mental Hospital. This change in practice may have led to an apparent decrease in numbers of persons on the waiting list for admission to the CMH but it does not include those in custody who are awaiting forensic psychiatric assessment.

Court diversion is in place, with reports prepared for District and Circuit courts (in Kerry, Cork, Limerick, Ennis, Nenagh, Clonmel and Waterford for patients in prison needing diversion) and the High Court in Dublin with court attendance as needed. There is limited pre-arrest diversion through advice to Gardaí and general adult/intellectual disability service/ psychiatry of later life training for An Garda Síochána particularly in respect of Autism Spectrum Disorder and Intellectual Disabilities, and Siege training.

Wheatfield Prison

This is a closed, medium-security place of detention for adult males and for sentenced 17-year-old juveniles. It has an operational capacity for 610 prisoners.

The Irish Prison Service (IPS) provides individual and group psychological therapies to Wheatfield, but waiting lists are long and it is difficult to access psychological assessments. Wheatfield holds weekly multi-agency meetings attended by inreach teams, IPS staff, primary care, addictions, psychology, chaplaincy and probation services to discuss current issues and planning for patients with mental health problems and other vulnerabilities. The inreach team attends weekly multidisciplinary meetings with the GP in the prison and nursing staff.

There are links to homeless mental health services, but this is not sufficient for the needs of discharged mentally ill prisoners and there is no social worker on the prison inreach team. There is a link with housing supports in Cloverhill Prison. There is also a resettlement service provided by the Irish Association for Social Inclusion Opportunities (IASIO) but this is only available to sentenced prisoners.

Wheatfield inreach mental health service provides court diversion when remand prisoners within the prison are identified as meeting criteria for mental disorder as outlined in the Mental Health Act 2001.

Patients in Wheatfield can attend recreational yards, a gym, occupational workshops, and an education programme. However, access to these activities has been curtailed due to COVID-19 restrictions.

Wheatfield takes young people from Oberstown when they reach their 18th birthday. The transition is assisted by a forensic mental health nurse shared between the two centres.

Arbour Hill

Arbour Hill is a closed, medium-security prison for adult males with an operational capacity of 138.

The prisoner profile is largely long-term sentenced prisoners. There are a small number of prisoners on remand and the remainder serve sentences of two years and over. The psychologists in the Irish Prison Service run psychological groups for sex offenders.

There are two psychiatric clinics per week in the prison. The team has developed strong links with prison nursing, probation and psychology services.

Castlerea Prison

Castlerea Prison is a closed, medium-security prison for adult males, with an operational capacity of 340. It is the committal prison for remand and sentenced prisoners in Connaught and also takes committals

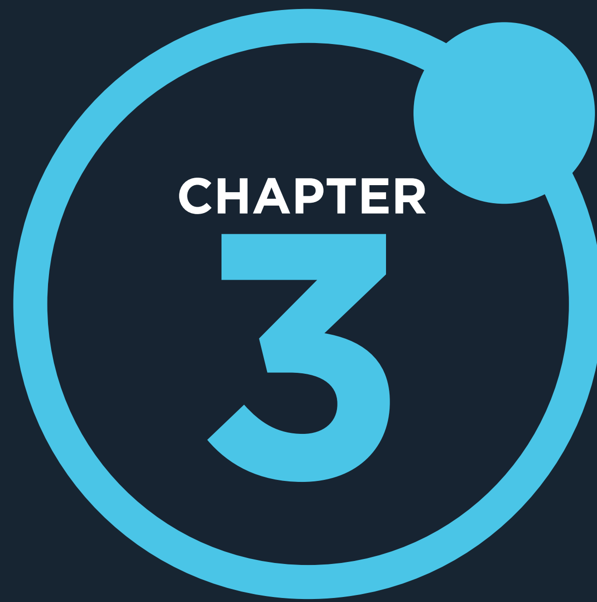
from counties Cavan, Donegal and Longford. The inreach team is funded by the Central Mental Hospital and runs seven clinics per week. The inreach team had one Consultant Psychiatrist, who worked four days a week. There was also a forensic mental health nurse and a social worker who worked five days a week. Multi-Agency Meetings (MAMS) occurred every week.

Referred prisoners are usually seen within two weeks but sooner if urgent. C-Landing is a higher security unit where mentally ill prisoners are sometimes accommodated. It is run on a 23-hour lock-up model. There is a daily schedule for each prisoner (e.g., horticultural activities) but no access to occupational therapy. There are good links with external agencies, such as key workers in Hope and the Simon Community to support the vulnerable adults. Approximately 90% of those coming into the prison (including those with mental health issues) have addiction issues. Intellectual disability, autism, and attention deficit and hyperactivity disorder (ADHD) are also present in the prison population. The model of forensic mental health care provided in Castlerea Prison is similar to the PICLS model in Cloverhill Prison.

NFMHS caseload monitoring

The National Forensic Mental Health Service (NFMHS) caseload in prisons is continually monitored. A process called PCMA (Prison Continuity, Monitoring and Aftercare) is in operation and all prisoners on the NFMHS caseload are accounted for at any given time, including all discharges, inter-prison transfers, releases from court and admissions to the Central Mental Hospital to ensure follow-up has been arranged for people moving from one part of the system to another, either internally (in prisons) or after discharge. This was on foot of the recommendations of the report into the death of Gary Douch, published in 2014[65].

[65] Reports of the Commission of Investigation into the death of Gary Douch – The Department of Justice 2014



The Probation Service

THE PROBATION SERVICE

Those with a mental illness or mental disorder who come before the courts having committed a criminal offence, but whose offending is less serious, may receive a supervised community sanction e.g., probation supervision or community service. Internationally, the prevalence of mental health problems and mental disorder among people subject to probation service supervision is significantly higher than in the general population[66].

Mental health policy, as espoused in *A Vision for Change*[67] states: "It is essential that there are linkages between the Probation Service and the relevant generic mental health services and, where appropriate, forensic mental health services, to ensure a linked approach and, in particular, continuity of care."

It can be difficult for probation officers 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 into services or may have left the service. Access for people in the probation service to local mental health services is variable – some mental health services stating that they do not have the capacity to provide a service for those with a forensic history. The National Forensic Mental Health Service does not have capacity to provide ongoing mental health care in the community. This leads to a gap in service provision for people who may already have difficulty engaging with health services.

Accommodation instability causes difficulties in registering with a GP and accessing a local mental health service. GPs provide mental health treatment and advice, and act as a gateway to other mental health care. However, people under probation supervision are sometimes unable to register with a GP prior to release from prison or are refused registration because of concerns about behaviour difficulties[68]. This can cause problems with accessing care and continuity of care, including gaps in access to medication after release from prison. The combination of drug misuse and mental health issues, for example, often excludes clients from both services. Treatment for addiction is not provided in most mental health services, despite the fact that addiction and mental health problems often co-exist. Many of those with addictions, 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 *A Vision for Change*, and in practice presents an ongoing challenge to the probation service in managing the behaviour of these offenders in the community[69].

A recent research report from the probation service found that there are significant unmet psychological and psychiatric needs among persons subject to probation supervision in Ireland[70]. At least 40% of adults on a Probation Supervision Order, compared to 18.5% of the general population, present with symptoms indicative of at least one mental health problem. Women present with higher rates of active

The National Forensic Mental Health Service does not have capacity to provide ongoing mental health care in the community. This leads to a gap in service provision for people who may already have difficulty engaging with health services.

66. Sirdifield C (2012) The Prevalence of Mental health Disorders among Offenders on Probation: A literature review. *Journal of Mental Health* 21(5): 485–498. doi.org/10.3109/09638237.2012.664305

67. *A Vision for Change*. Report of the Expert Group on Mental Health Policy 2006.

68. Sirdifield C, Marples R, Denney D & Brooker C (2020b) Perceptions of the Effectiveness of Healthcare for Probationers, *International Journal of Prisoner Health*, in press.

69. Interdepartmental Group to examine issues relating to people with mental illness who come in contact with the Criminal Justice System, Second Report, 2018.

70. Power CL (2021) Moving Forward Together: Mental Health Among Persons Supervised by the Probation Service. Probation Service Research Report March 2021.

symptoms and higher rates of contact with services currently and in the past for mental health problems. Approximately 50% of all people supervised by the probation service in the community who present with mental health problems also present with one or more of the following issues: alcohol and drug misuse, difficult family relationships, accommodation instability. There is high mental health comorbidity with alcohol and drug misuse (51%); difficult family relationships (49%); and accommodation instability (47%). This research also found a considerable number of clients were identified as experiencing serious mental health problems but not accessing any service for assessment or intervention. Along with difficulties accessing and engaging with mainstream mental health services, client motivation to engage with services was a significant barrier identified by probation officers along with other issues such as client lack of insight.

Despite this high level of need, people on probation face many barriers to mental health service access including an overall lack of provision; a lack of provision that is appropriate for those with complex health needs such as co-occurring substance use and mental health disorders[71]; stigma and discrimination; accommodation instability; mistrust; problems with inter-agency communication; and negative staff attitudes[72]. This highlights the importance of case management for people in the probation service, which would help to ensure that all needs are met, including mental health needs.

71. Brooker C, Sirdifield C, Ramsbotham D & Denney D (2017) NHS commissioning in probation in England – on a wing and a prayer. *Health and Social Care in the Community* 25(1): 137-144. https://doi.org/10.1111/hsc.12283

72. Brooker C, Sirdifield C & Marples R. Mental health and Probation: a systematic review of the literature, Forensic Science International: Mind and Law, https://doi.org/10.1016/j.fsiml.2019.100003.

Diversion to mental health services

DIVERSION TO MENTAL HEALTH SERVICES

Diversion and Court Liaison

The aim of diversion from the criminal justice system is to identify persons with mental disorders who come into contact with the criminal justice system and, where appropriate, ensure that they are treated in a psychiatric setting – whether residential or non-residential – rather than continuing through the standard criminal justice process. This may be complicated by the difficulty in balancing the mentally ill offender's need for treatment and right to liberty against the public's need for protection from the risk of harm (even though people with mental disorder are only responsible for a small proportion of all violence in society). *A Vision for Change* recommended that every person with serious mental health problems encountering the forensic system be accorded the right to mental health care in the nonforensic mental health services unless there are cogent and legal reasons why this should not be done[73].

There are a wide range of diversion models in operation across jurisdictions such as Australia, Canada, the United Kingdom and the United States. Although they vary in their structure and procedures and operate from different points within the criminal justice process, all have at their core the concept that people with severe mental illness should be handled through the mental health system rather than the criminal justice system. Research has shown that linking the mentally ill accused and offenders to community-based treatment services will have the effect of reducing police contact and the likelihood of criminal recidivism[74]. At the same time, shifting the point of intervention to community-based mental health treatment services may also provide benefits for crowded jails that lack facilities to treat this population adequately, as well as for overburdened courts[75].

There are several points on the pathway through the criminal justice system where an individual with severe mental illness can be identified and diverted to appropriate treatment. These include the point of arrest, police station, court appearances and prison.

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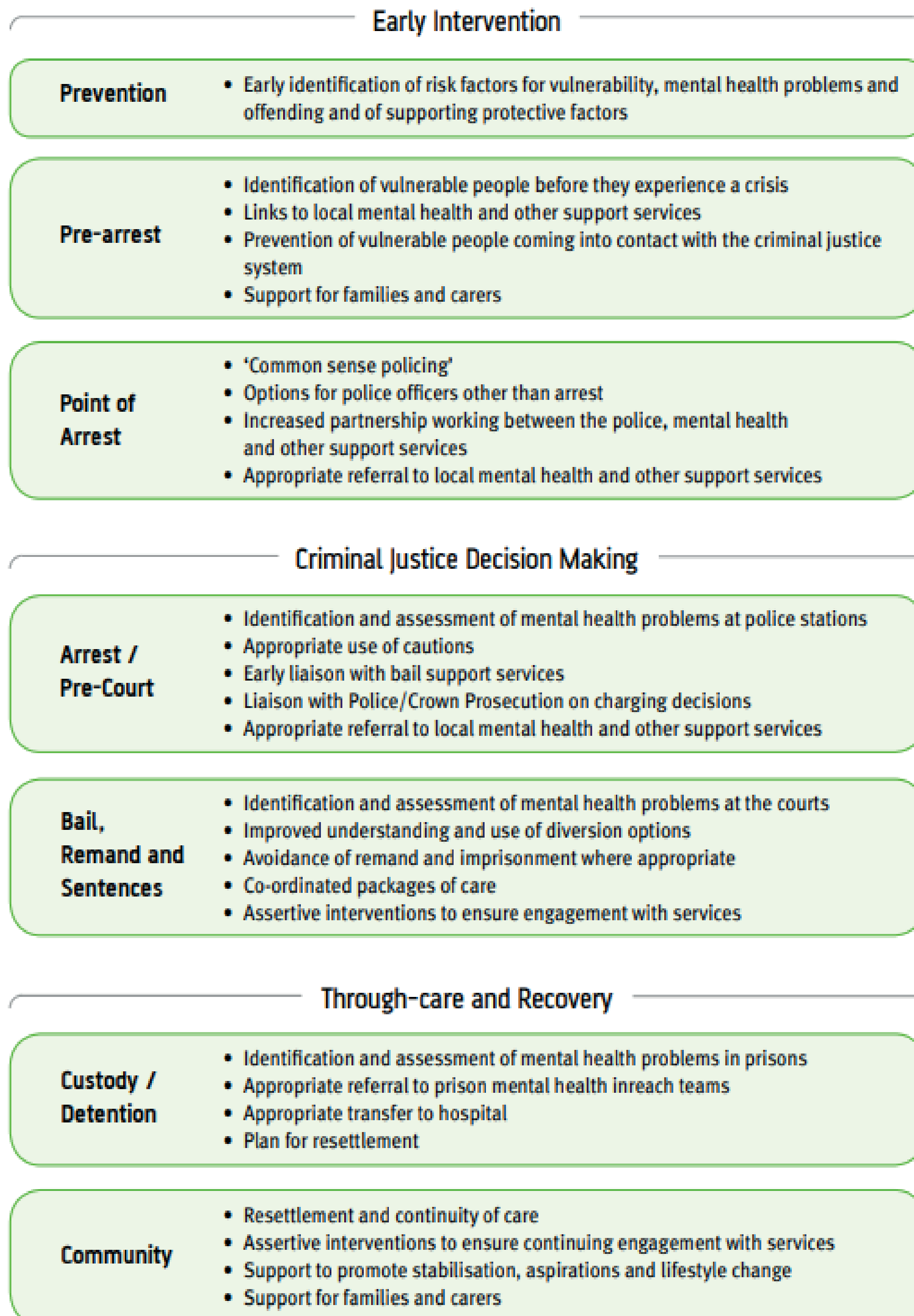
73. Expert Group on Mental Health Policy 2006, p 137.

74. Steadman HJ, Deane MW, Morrissey JP *et al.* (1999) A SAMHSHA research initiative assessing the effectiveness of jail diversion programs for mentally ill persons. *Psychiatr Serv* 50: 1620–1623.

75. Cowell AJ, Broner N, Dupont R (2004) The cost-effectiveness of criminal justice diversion programs for people with serious mental illness co-occurring with substance abuse: Four case studies. *J Contemp Crim Just* 20: 292–314.

Figure 2: *All -stages diversion*



Source: A better way for criminal justice and mental health. 2009 Sainsbury Centre for Mental Health.

Table 7: *Mentally disordered offenders: provisions for psychiatric diversion in England and Wales and Ireland*

Stage of offender pathway	Ireland	England and Wales	Comments in relation to practice in Ireland
Arrest, caution and charge	Gardaí can make an application under the Mental Health Act 2001 and seek assessment by a general practitioner as part of this process.	Pilot schemes in place for 'street triage'. Police can divert to a designated 'Place of Safety' such as a psychiatric intensive care unit for specialist psychiatric assessment.	In practice, Gardaí may transport offender to the emergency department of a general hospital without making an application under the Mental Health Act 2001.
Police custody	Gardaí can seek advice from a general practitioner. They can make an application under the Mental Health Act 2001 and seek assessment by a general practitioner as part of this process.	Police can arrange in-house forensic medical examiner assessment and avail of psychiatric assessment in custody.	There is no secondary care-level psychiatric expertise available to Gardaí at this stage.
Initial court appearance post charge	Limited facility for mental health intervention, apart from use of the Criminal Law (Insanity) Act 2010.	Magistrates Court liaison services are available but are geographically variable.	Psychiatric expertise to the District Court at this stage is very limited in Ireland.
Remand prisoner	Assessment by visiting psychiatrist and prison in-reach team. There is potential for diversion if the prisoner is very unwell.	Assessment by visiting psychiatrist and prison in-reach team. There is potential for diversion if the prisoner is very unwell.	Legally, remand prisoners in Ireland can only be directly diverted from prison to a designated centre (Central Mental Hospital in Dundrum).
Plea/trial hearings in court	There can be a report by a psychiatrist. There is potential for diversion at this stage, e.g., in the case of unfitness to stand trial.	There can be a report by a psychiatrist. There is potential for diversion at this stage, e.g., in the case of unfitness to plead.	There are limited high and medium secure beds. There is very limited access to low secure/ intensive care beds. Approved centres may be reluctant to accept those on bail or from prison, owing to resource and facility limitations, or lack of expertise.
Sentencing hearing in court	Legislation does not provide for hospital treatment on culmination of a case, save for limited circumstances.	Hospital Order is a possibility on culmination of a case.	Legislative change may be required in Ireland to facilitate hospital treatment.
Sentenced prisoner	Assessment by visiting psychiatrist and prison in-reach team. There is potential for diversion if the prisoner is unwell.	Assessment by visiting psychiatrist and prison in-reach team. There is potential for diversion if the prisoner is unwell.	Limited access to secure beds in Ireland impacts on the availability of treatment.

Source: Gulati G, Kelly B, Diversion of Mentally Ill Offenders from the Criminal Justice System in Ireland: Comparison with England and Wales. March 2018 Irish Medical Journal *111(3)*

Mental Health Courts

A formalised court diversion scheme may include the establishment of a mental health court. There are no mental health courts in Ireland. Mental health courts are special criminal courts which aim to divert a group of people for whom prison is an entirely inappropriate place away from the criminal justice system and into mental health treatment programmes. They are problem-solving courts based on the concept of therapeutic jurisprudence, which recognises that the traditional criminal justice system is ineffective in dealing with people with mental disorders. Mental health courts strive to reduce the anti-therapeutic effects of the criminal justice system on the mentally ill and enhance any potential therapeutic effects[76]. The mental health court model was first pioneered in the United States in 1997. The difficulties in the United States in the 1990s are similar to those facing the Irish criminal justice system in 2021, i.e., overcrowding in the prison system and the inappropriate detention of people with mental disorders in prisons.

Ryan and Whelan have looked at the implications for Ireland of a decision to establish mental health courts:

"Issues of voluntariness and competence would have to be considered to ensure that only those defendants who are genuinely competent to decide to enter the court will be accepted into the court.

A continuation of treatment and support following completion of the court programme is vital as a mental health court should not lead to a dead end but hopefully represents a bridge to the [receipt] of essential services on an ongoing basis[77]. Legislation would possibly be needed to establish the mental health court and to give the courts more powers in other forms of diversion. For example, Irish courts should have the specific legislative power to remand a person on bail to a mental treatment centre and to sentence a person to a mental health centre in appropriate cases. The court would not operate alone in diverting the mentally ill but should work in parallel to schemes such as the Prison Inreach and Court Liaison Service scheme at Cloverhill Prison. Critically, the issue of resources could pose a barrier to the establishment of a mental health court in Ireland. Mental healthcare resources are, at present, scarce and prior to even contemplating the establishment of a mental health court, substantial funding would need to be allocated to the development of community mental health treatment facilities".

Moreover: *"... there is a lack of empirical data on mental health courts. It is difficult therefore to determine if mental health courts are as beneficial as their proponents suggest. Part of the problem lies in the fact that the vast majority of available reports are site-specific and do not offer an evaluation of mental health courts as a whole. While all claim to be voluntary, this contention has been called into question and the existence of coercion has been noted as a real concern. While mental health courts have as a stated aim the reduction in the criminalisation and stigmatisation of people with mental disorders, they could be perceived as being more stigmatising with a specialised court resulting in a form of segregation of the mentally ill from "normal" offenders. The need for mental health courts will always be symptomatic of another problem, that is, an inefficient and ailing civil mental health service[78]".*

Prison Inreach and Court Liaison Service (PICLS)

In 2006, Ireland introduced the Prison Inreach and Court Liaison Service (PICLS) with the aim of identifying prisoners with serious mental illness and diverting them to appropriate mental health services as soon as possible. The PICLS team is based in Cloverhill Prison.

The PICLS model was designed to enhance the detection of mental illness through a structured, two-stage screening process and to facilitate the provision of appropriate treatment. Depending on the seriousness of the offence and the severity of the mental illness, prisoners could be diverted to, for example, a secure forensic hospital, a community mental health hospital or another community mental health service.

Since 2006, more than 6,000 people have been taken onto mental health caseloads in Cloverhill, and over 1,500 diverted from Cloverhill Remand Prison to mental healthcare locations outside prison. Between 2006 and 2019, 1,571 people were diverted: 195 to the

[76] Ryan S & Whelan D (2012) Diversion of Offenders with Mental Disorders: Mental Health Courts [2012] 1 Web JCLI. http://webjcli.ncl.ac.uk/2012/issue1/ryan1.html

[77] Schneider RD (2008) Mental Health Courts. *Current Opinion in Psychiatry* 21(5): 510.

[78] Ryan S & Whelan D (2012) Diversion of Offenders with Mental Disorders: Mental Health Courts [2012] 1 Web JCLI. http://webjcli.ncl.ac.uk/2012/issue1/ryan1.htm

Central Mental Hospital, 431 to general adult mental health services, and 945 to community mental health services.

The court diversion service developed by the PICLS team in Cloverhill was the single largest contributor to mitigating the effect of the bed crisis at the Central Mental Hospital in recent years.

Box 4: *Court diversion service by the PICLS team in Cloverhill*

For **534** male prison episodes placed on the Central Mental Hospital waiting list during the five years (2015-2019):

44% were admitted to approved centres

17% admitted to the CMH

23% improved following voluntary treatment in prison

6% had other outcomes

Source: Prison Inreach and Court Liaison Service

The diversion service has enabled the broader forensic service to function in the absence of adequate admission facilities for those who might otherwise be found unfit to be tried and sent to the Central Mental Hospital under Section 4 of the Criminal Law (Insanity) Act.

The PICLS team is not resourced to provide daily input to all District Courts or Garda Stations nationally on an equitable basis. Irregular provision to such locations would not prevent remands to custody.

PICLS attends Cloverhill Prison and District Courts five days weekly. It also provides a court liaison/ the diversion service to District Courts. PICLS provides detailed psychiatric reports regarding diagnosis, fitness to be tried and treatment arrangements in the event of custodial transfer and in the event of bail or other release. These reports are provided voluntarily (where acutely mentally ill people needing healthcare outside prison are identified by the team), and on request by District Court judges. Follow-up reports are also provided as required.

Court Diversion in other parts of Ireland

The Mountjoy Women's Prison (Dóchas Centre) forensic mental health team arranges 20-25 diversions per year under the Mental Health Act 2001 from court or from prison to approved centres nationwide.

- Court Diversion is provided in Connaught
- Court Diversion is provided in Limerick, Clare, Tipperary and Kilkenny
- There is no court diversion service in Cork, Kerry and Waterford.

Box 5: *Outcomes from the PICLS project*

- **2.8%** of remands assessed (0.44% of all committals) were admitted to the national forensic psychiatry unit over the six-year period of observation.
- **5.1%** of those assessed, (0.82% of all committals) were admitted to local (general psychiatry) psychiatric units.
- **10.0%** of those assessed, (1.58% of all committals) were diverted to other community treatment settings, including psychiatric outpatient departments, supported residences, residential rehabilitation facilities and nursing homes.
- Overall, **2.84%** of all committals over the six-year period were diverted from prison to psychiatric care, in hospital or the community [79].

Challenges in Diversion

- Remand prisoners in Ireland can only be directly diverted to a 'designated centre' and the Central Mental Hospital in Dundrum – the only 'designated centre' in the country – has insufficient capacity, with the lowest per capita bed number in comparison to other European countries. Such prisoners cannot be diverted to local mental health services.
- The alternative course – to propose bail at a future court hearing and use civil detention under the Mental Health Act 2001 – can be a complex, delayed process, and depends critically on the ability of local approved centres to accept the patient.

[79] McInerney C, Davoren M, Flynn G *et al*. (2013) Implementing a court diversion and liaison scheme in a remand prison by systematic screening of new receptions: a 6-year participatory action research study of 20,084 consecutive male remands. Int J Ment Health Syst 7(18) (2013). https://doi.org/10.1186/1752-4458-7-18

- There is a lack of Intensive Care and Rehabilitation Units in Ireland, in sharp contrast to the availability of Intensive Care and Low Secure Units in England and Wales, and this limits psychiatric diversion from court and custody in Ireland. There are only two psychiatric intensive care units (PICUs), in Dublin and Cork, both having limited catchment areas. While those who have committed serious offences and suffer major mental illness are diverted to the Central Mental Hospital, in the absence of ICRUs there will continue to be limited diversion to local services of those charged with minor offences but suffering major mental illness.

- Local inpatient psychiatric units in Ireland are often slow to accept patients with offender status owing to inadequate resources, inappropriate facilities, or lack of expertise.

- There is limited scope to divert to hospital at sentencing stage in the absence of a 'hospital order' provision in Irish legislation (as in England and Wales). For sentenced prisoners, legal frameworks for diversion exist in both jurisdictions[80].

Pre-arrest Diversion

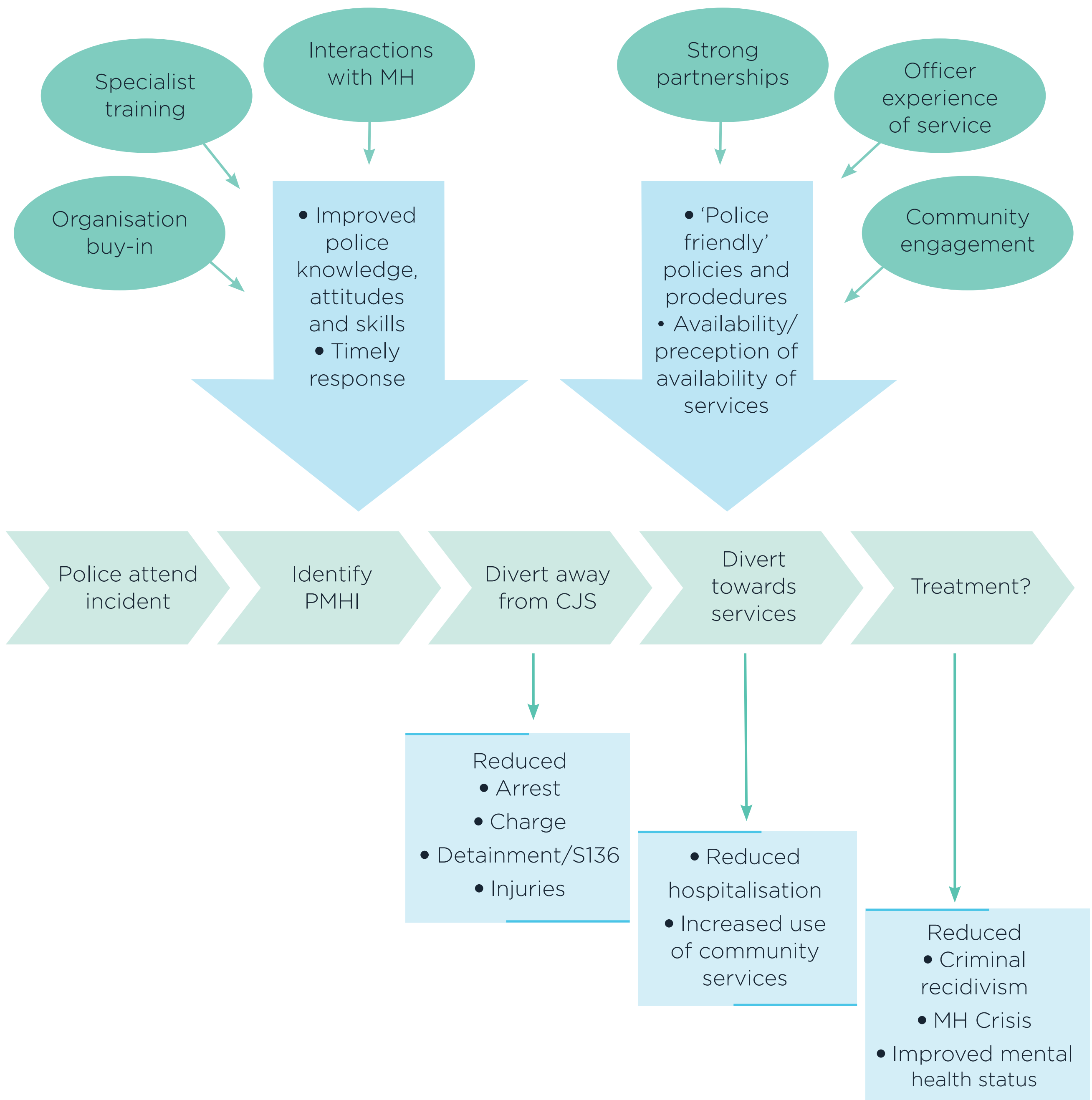
Mental health is recognised as an important part of policing. The role of the police is not a clinical one, but mental health issues are common in the population and will often be found in suspects, victims and witnesses. A person may commit an offence or cause a public disturbance because of their mental health issues. In addition, the police may be first on the scene where a person is in mental health crisis or is a potential suicide. Lack of adequate resourcing of mental health services often means that the police constitute the 'first emergency service' for people experiencing a mental health crisis[81]. Research from the US estimates that 7–10% of police contacts are with people with severe mental illnesses[82]. A Canadian study found that those with a mental illness were twice as likely to be arrested, after controlling for the severity of the offence[83]. The nature of policing and mental health is complex and challenging. Police officers do not have sufficient resources to deal with people with mental health issues or assist individuals in crisis. People with mental health issues who are suspected of an offence can be cautioned, arrested and/or taken into police custody. Arrests where there are low level offences, anti-social behaviour or 'survival crimes' (regulatory offences – such as sleeping on the street, which lead into a cycle of punishment and incarceration that is difficult to overcome) are considered unnecessary or as contributing to the 'criminalisation of mental illness'[84].

Teplin[85] found the use of arrest to be influenced by the limited number of psychiatric beds in the community, the stringent criteria for hospital admission, the reluctance of hospitals to take intoxicated mentally ill persons, and officers' estimation of the likelihood that the person would continue to cause a problem if no action was taken.

The community-based diversion model for persons with mental illness and/or intellectual disability where there is an increased risk of contact with the criminal justice system involves a broader range of stakeholders including social services, voluntary agencies and mental health professionals who work with the police and other emergency services to facilitate support. It has been acknowledged that community diversion has great potential as part of an effective diversion policy[86]. Neighbourhood policing that involves working with persons with mental health difficulties and intellectual disability within their own community is considered important in the prevention of crime in the first instance. This type of diversion process has the potential to address the needs of persons with mental health problems who are homeless and have a co-occurring drug or alcohol addiction.

80. Gulati G, Kelly BD (2018) Diversion of Mentally Ill Offenders from the Criminal Justice System in Ireland: Comparison with England and Wales. *Ir Med J* 2018 Mar 14; 111(3): 719. PMID: 30376236.
81. Lamb HR, Weinberger LE, DeCuir WJ (2002) *The Police and Mental Health*. American Psychiatric Association.
82. Lord VB, Bjerregaard B (2014) Helping Persons with Mental Illness: Partnerships between Police and Mobile Crisis Units. *Victims and Offenders* 2014; 9455–9474.
83. Charette Y, Crocker AG & Billette I (2014) Police encounters involving citizens with mental illness: use of resources and outcomes. *Psychiatr Serv* 2014; 65(4): 511–516. doi: 10.1176/appi.ps.201300053 [PubMed].
84. Schucan Bird K, Vigurs C, Quy K. What Works: Crime Reduction Systematic Review Series. No. 7: Police Pre-Arrest Diversion of People with Mental Health Issues: A Systematic Review of the Impacts on Crime and Mental Health. EPPI Centre, UCL Department of Social Science, University College London.
85. Teplin LA (2000) Keeping the peace: police discretion and mentally ill persons. *Natl Inst Just J* 244: 8–16.
86. Lord Bradley (2009) Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System. London: Department of Health and the Home Office.

Figure 3: *Conceptual model of effectiveness of police pre-arrest diversion interventions*



Source: What Works: Crime Reduction Systematic Review Series No. 7: Police Pre-Arrest Diversion of People With Mental Health Issues[87]

[87] Schucan Bird K, Vigurs C, Quy K. What Works: Crime Reduction Systematic Review Series. No. 7: Police Pre-Arrest Diversion of People with Mental Health Issues: A Systematic Review of the Impacts on Crime and Mental Health. EPPI Centre, UCL Department of Social Science, University College London.

Lamb *et al*. (2002) identified possible models of police response to mental health crises that occur when police officers are on patrol or called to an incident:

1. **Specialist police officer's response:** where there is selection and training of designated specialist officers. The first and probably best known of these schemes is the Crisis Intervention Team (CIT) based in Memphis.

2. **Specialist mental health professional response:** in the US, there are examples of specialist mental health teams that have been established to respond to crises.

3. **Joint team:** where a mental health and police team is on-call to respond to identified mental health emergencies.

4. **Phone triage:** an approach where mental health professionals are available to offer advice or information to police officers[88].

The ideal service would identify and divert patients at the point of arrest or in police stations before they enter custody, thus reducing the number of mentally ill minor offenders entering prison.

England has the following diversion models in place to a varying level nationwide:

Liaison and Diversion
These services aim to divert individuals at their earliest possible point of contact with the justice system. Teams of specialist mental health-trained staff are located at police custody suites or courts in order to assess and refer on to more appropriate mental health services outside the justice system.

Street Triage
Police-related mental health triage (often referred to as 'street triage') involves a joint mental health service and policing approach to an individual in crisis or at risk. There are significant variations in street triage models. These schemes aim to de-escalate and manage situations involving the police in which there is a suspicion that mental illness may be a factor. In some cases, usually involving lower-level crimes, these services have assisted in improving outcomes by preventing people being unnecessarily detained in police custody, and instead signposting them to more appropriate health and social care services.

Embedded staff in police contact control room
For a person in a mental health crisis, at times, the police contact control room (CCR) can be their first point of contact. For the most part, the embedded staff are mental health professionals, although in a few forces they are augmented by paramedic professionals. These services are designed to help triage calls to CCRs that may be from individuals experiencing mental health problems to ensure that they get an appropriate response to their call.

Appropriate Adults

The UK government, under various legislation, provides for attendance of 'appropriate adults' to support communication between police and the vulnerable suspect, including people with mental illness, learning disabilities, traumatic brain injury, dementia and autism. The role of the appropriate adult is to advise and support the vulnerable suspect appropriately, to ensure that the interview is being conducted properly and fairly, and to facilitate.

The AA safeguard has received criticism. Reasons include that too few adult detainees are provided with an AA, because custody officers are either ill-trained or ill-disposed to identify vulnerability. The use of AAs may also be low because of problems procuring them[89]. Research has shown that AAs may not fully understand their role, may be compliant with or actively disempowered by police, make little contribution or, conversely, make inappropriate interventions[90]. The role has been characterised as a complex and demanding one, requiring the determination of what constitutes "fair" questioning, what advice should be given and where intervention is necessary[91].

88. Lamb HR, Weinberger LE, DeCuir WJ (2002) *The Police and Mental Health*. American Psychiatric Association.

89 Nemitz, T., & Bean, P. (2001). Protecting the rights of the mentally disordered in police stations: The use of the appropriate adult in England and Wales. International Journal of Law and Psychiatry, 24(6), 595–605.

90 Nemitz, T., & Bean, P. (2001). Protecting the rights of the mentally disordered in police stations: The use of the appropriate adult in England and Wales. International Journal of Law and Psychiatry, 24(6), 595–605.

91 Medford, S., Gudjonsson, G. H., & Pearse, J. (2003). The efficacy of the appropriate adult safeguard during police interviewing. Legal and Criminological Psychology, 8(2), 253–266.

Three fundamental, and inter-related, problematic aspects of AA provision have been identified: (1) Inadequate identification of suspects' vulnerabilities and their need for AAs; (2) The availability of AAs is insufficient. (3) The quality of AA provision is variable[92].

Crisis Intervention Team

Self-selected trained officers serve as specialised frontline responders who redirect individuals with mental illnesses, when appropriate, to treatment services instead of the judicial system. Specialised crisis response sites, open 24 hours a day, to which officers can bring individuals in need of psychiatric assessment, may be a critical factor for the success of CIT programs[93]. A key component is a central psychiatric emergency drop-off with a no-refusal policy that gives police transports priority so officers can be back out on the street within 15–30 minutes. Specifically, CIT is a police-based specialised response.

It appears that the CIT model is effective in relation to at least some of its stated goals. It can be considered evidence-based for officer-level outcomes, such as improved knowledge about mental illness; better attitudes toward mental illness, individuals living with mental illness, and treatments for mental illness; selfefficacy during interactions with persons with mental illness; reduced use of force; and linkage to mental health services. But evidence is more mixed or lacking for 'rare event' outcomes related to arrests, injury and deaths.[94]

Effectiveness of Pre-arrest Diversion

In response to the many challenges referenced earlier with respect to mental illness, police-led and coresponse intervention models have begun to spread globally. Although programme outcomes have not always been clearly specified for every initiative, the most common are:

Box 6: *Potential outcomes of pre-arrest diversion*

1. Reducing the risk of injury to police and the person with mental illness when dealing with mental health-related incidents
2. Improving awareness among frontline police of the risks involved in the interaction between police and the person with mental illness
3. Improved collaboration with other government and non-government agencies in the response to, and management of, mental health crisis incidents
4. Reducing the time taken by police in the handover of persons with mental illness into the health care system
5. Reduced arrests through diverting the person with mental illness to the healthcare system, and thus reduced penetration into the justice system
6. Reduced recidivism
7. Improved therapeutic outcomes[95].

92 The Home Secretary's Commission on Appropriate Adults 2 There to help © National Appropriate Adult Network 2015

93. Steadman HJ, Stainbrook KA, Griffin P *et al.* (2001) A specialized crisis response site as a core element of police-based diversion programs. *Psychiatr Serv* 52: 219 –222.

94. Watson A, Compton M (2019) What Research on Crisis Intervention Teams Tells Us and What We Need To Ask. *J Am Acad Psychiatry Law* 47(4). doi:10.29158/JAAPL.003894-19

95. Butler A (2014) Mental Illness and the Criminal Justice System: A Review of Global Perspectives and Promising Practices. School of Criminology, Simon Fraser University, International Centre for Criminal Law Reform and Criminal Justice Policy.

Research suggests that pre-booking (pre-arrest) police-based diversion interventions achieve part of their objective in that they divert people into care[96]. But effectiveness in linkages to services seems to be related to a variety of moderating factors.

Effectiveness of Crisis Intervention Teams

Watson *et al*. observed that the degree of availability of mental health services is positively associated with diversion into care. They conclude that in communities where mental health resources are accessible, Crisis Intervention Team-trained police officers are more likely to link people to mental health services than are officers who have not been trained. Ritter *et al*. reported that people suspected of illicit drug use or of violence toward others are more likely to be taken to jail than to treatment; these two call types account for 12.8% and 18.5% of total police contacts with people with mental illnesses, respectively[97]. This suggests that among people with mental illnesses, there is a group of people demonstrating behaviours that result in arrest. One way to address this could be by broadening the scope of pre-booking intervention to allow for earlier intervention to prevent police contact. For example, Earl *et al*. described a programme called the Neighbourhood Outreach Scheme (NOS) that was designed to pre-empt crises and police contact[98]. In this programme, a community psychiatric nurse accepts referrals from police and mental health specialists to follow up with vulnerable people from the neighbourhood who do not meet thresholds for a mental health crisis or criminal intervention. They found a significant decrease in the number of police contacts at six-month follow-up. This suggests a role for diversion that seeks to prevent the need for police contact by intervening further upstream but still involving a partnership between the police and mental health services. The evidence on the effectiveness of police-based pre-booking diversion programmes in reducing arrests (i.e., reducing criminalisation) of people with mental illnesses is limited. In addition to being limited, the existing evidence is not strong. There is moderate evidence that these programmes increase linkages to mental health services.

Compton *et al*. (2008) reviewed research on CIT, although the body of research is limited. They found preliminary support for the notion that the CIT model may be an effective component in connecting individuals with mental illnesses who come to the attention of police officers with appropriate psychiatric services. On a systems level, CIT – in comparison to other pre- and post-diversion programmes – may have a lower arrest rate and lower associated criminal justice costs[99]. Subsequent research has supported an association between CIT and lower arrest rates of persons with mental illnesses[100]. CIT officers were more likely to direct persons with mental illnesses to mental health treatment and CIT officers used less force as subject resistance increased than officers who were not CIT trained[101]. However, in a review of the effectiveness of police crisis intervention training programs, Rogers *et al*. found little evidence in the peer-reviewed literature that shows CIT's benefits on objective measures of arrests, officer injury, citizen injury, or use of force[102]. A systemic review by Kane *et al*. (2017) concluded that there was, overall, a positive impact of the intervention under consideration, but no well-designed randomised controlled trials had been completed.

96. Dewa C *et al*. (2018) Evidence for the effectiveness of police-based pre-booking diversion programs in decriminalizing mental illness: A systematic literature review. PLoS One. 2018; 13(6): e0199368. Jun 19. doi:10.1371/ journal.pone.0199368

97. Ritter C, Teller JL, Marcussen K, Munetz MR, Teasdale B (2011) Crisis intervention team officer dispatch, assessment, and disposition: Interactions with individuals with severe mental illness. *Int J Law Psychiatry* 2011; 34(1): 30–38. doi: 10.1016/j.ijlp.2010.11.005 [PubMed].

98. Earl F, Cocksedge K, Rheeder B, Morgan K, Palmer J. (2015) Neighbourhood outreach: a novel approach to Liaison and Diversion. *Journal of Forensic Psychiatry and Psychology* 2015; 5573–5585.

99. Compton M, Bahora M, Watson A, Oliva JR (2008) Comprehensive Review of Extant Research on Crisis Intervention Team (CIT) Programs. *J Am Acad Psychiatry Law* 36: 47–55.

100. Steadman H, Deane M, Borum R, Morrissey J (2000) Comparing outcomes of major models of police responses to mental health emergencies. *Psychiatric Services* 51(5): 645–649.

101. Watson A, Fulambarker A (2012) The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners. *Best Pract Ment Health* Dec; 8(2): 71.

102. Rogers MS, McNiel DE, Binder RL (2009) Effectiveness of Police Crisis Intervention Training Programs. *J Am Acad Psychiatry Law* 2019 Dec; 47(4): 414-421. doi: 10.29158/JAAPL.003863-19. Epub 2019 Sep 24. PMID: 31551327.

Effectiveness of Street Triage

A systematic review of the effectiveness of street triage found that street triage may reduce the number of people taken to a place of safety under S136 of the Mental Health Act (England) where that power exists or reduce the use of police custody in other jurisdictions[103].

Rogers *et al*. looked at the evidence base for models of police-related mental health triage (street triage) interventions[104]. Most interventions involved police officers working in partnership with mental health professionals. These interventions were generally valued by staff and showed some positive effects on procedures (such as rates of detention) and resources, although these results were not entirely consistent and not all the important outcomes were measured. They concluded that most published evidence that aims to describe and evaluate various models of street triage interventions is limited in scope and methodologically weak. There remains a lack of evidence on which to evaluate the effectiveness of street triage, and the characteristics and experience of and outcomes for service users. There is also wide variation in the implementation of the co-response model, with differences in hours of operation, staffing, and incident response.

Overall, rather than indicating that one approach is more effective than another, there is a need for a multi-faceted approach within a structured and integrated model, such as the CIT model[105].

Ireland, compared with England and Wales, has few pathways available to Gardaí in accessing early clinical advice. In Ireland, access to psychiatry in acute policing situations can be limited to those requiring formal assessment for involuntary psychiatric admission, under the provisions of the Mental Health Act 2001. For a person to be admitted involuntarily to an approved centre under the 2001 Act, another person must make an application to a GP, who then has to make a recommendation to an approved centre. The consultant psychiatrist in the approved centre must then decide whether or not to make an admission order. In addition, a member of An Garda Síochána can make an application to a GP under section 12 of the 2001 Act subject to certain criteria. It was expected that section 12 applications would only be made in exceptional cases. In 2020, the largest number of applications (32%) for involuntary admissions from the community came from An Garda Síochána. The Mental Health Commission confirmed in its 2020 Annual Report that 616 admission orders to an approved centre were made following an application by a Garda. What is not clear is what happened in relation to the balance of the cases (5,140), which did not require hospital admission. For example, how long were people detained and in what environment, were they seen by a GP and were they put in contact with local mental health services or other support agencies? Also of concern and unclear is the level of training of Gardaí to make the relevant assessment under section 12(1) of the Mental Health Act, i.e., "… that a person is suffering from a mental disorder and that because of the mental disorder there is a serious likelihood of the person causing immediate and serious harm to himself or herself or to other persons". The Mental Health Commission is currently liaising with An Garda Síochána on these issues.

A crisis intervention team is proposed for Limerick, which will consist of mental health professionals and members of An Garda Síochána. It will be the first of its kind in Ireland and will hopefully be the first step in pre-arrest diversion across the country. Careful planning and evaluation of the project is essential to ensure that the most effective model is implemented.

[103] Puntis S, Perfect D, Kirubarajan A, Bolton S, Davies F, Hayes A, Harriss E, Molodynski A (2018) A systematic review of co-responder models of police mental health 'street' triage. *BMC Psychiatry* 2018 Aug 15; 18(1): 256. doi: 10.1186/s12888-018- 1836-2. PMID: 30111302; PMCID: PMC6094921.

[104] Rodgers M, Thomas S, Dalton J, Harden M, Eastwood A (2019) Police-related triage interventions for mental health-related incidents: a rapid evidence synthesis. Southampton (UK): NIHR Journals Library; 2019 May. PMID: 31162918.

[105] Kane E, Evans E, Shokraneh F (2018) Effectiveness of current policing-related mental health interventions: A systematic review. *Crim Behav Ment Health* 2018 Apr; 28(2): 108-119. doi: 10.1002/cbm.2058. Epub 2017 Oct 19. PMID: 29052275.

The Central Mental Hospital

THE CENTRAL MENTAL HOSPITAL

Forensic psychiatric care must be provided within the least restrictive setting possible, while simultaneously maintaining appropriate levels of security. It is widely accepted that the level of security appropriate for an individual patient should match the risk posed: to self, other patients, visitors, staff and the general public. This presents particular challenges for the design of forensic psychiatric hospitals, which are required to provide both a therapeutic and a safe material environment, often for extended periods of treatment and rehabilitation[106].

Security is the process by which risk is managed and this is divided into:

(1) relational security: the knowledge and understanding staff have of a patient and their environment, and the translation of that information into appropriate responses and care;

(2) procedural security: the policies and procedures in place to maintain safety and security; and

(3) physical security: the fences, locks and personal alarms that keep people safe[107].

Kennedy comments that relational security is nearer to quality of care and is closely linked to resources and recurring costs. It includes staff-to-patient ratios but also the provision of appropriate multi-disciplinary teams with the right range of skills and the availability of the right range of therapeutic activities. It relates to the formation of the therapeutic alliance between staff and patients based on a detailed knowledge of the patient. It is closely linked to risk assessment and risk management[108].

The National Forensic Mental Health Service Model of Care has been developed for the new Central Mental Hospital in Portrane.

Criminal Law (Insanity) Act 2006

The Criminal Law (Insanity) Act 2006 (section 15) provides for transfer of prisoners to the Central Mental Hospital, voluntarily or involuntarily, where the person suffers from a mental disorder as certified by two medical practitioners. Section 15 does not provide for transfer of persons with mental illness to psychiatric facilities other than the Central Mental Hospital. Under section 4 of the Criminal Law (Insanity) Act 2006, judges may order transfer to a “designated centre” of defendants found to have a mental disorder and to be unfit to be tried. The Central Mental Hospital, Ireland’s only forensic psychiatric hospital, is the only centre so designated.

The current Irish model of high-, medium- and low- secure facilities on one site is similar to those of states with populations of similar size to Ireland (3 to 5 million), e.g., Australian states (Victoria, New South Wales), German states, or Scandinavian provinces. The UK model is of high-, medium- and low-secure institutions each on separate sites, under separate management. In other states, central units are supported by local low-secure units (acute psychiatric intensive care units and longer-term low-secure units). These local units serve populations of 350,000. Local low- secure units operate with the single central unit as a ‘flat’ hub-and-spoke network. There is good evidence that providing adequate local low-secure resources prevents excessive reliance on medium and high security, probably by enabling early intervention for challenging people with severe and enduring mental illness and challenging behaviour.[109]

Kennedy comments that relational security is nearer to quality of care and is closely linked to resources and recurring costs.

106. Royal College of Psychiatrists (2014) *Standards for medium secure services*. London: Quality Network for Forensic Mental Health Services.

107. Kinsley, J. (1998) Security and therapy. In Managing High Security Psychiatric Care (eds C. Kaye & A. Franey). London: Jessica Kingsley

108. Kennedy HG (2002) Therapeutic uses of security: mapping forensic mental health services by stratifying risk. *Advances in Psychiatric Treatment* (2002) 8: 433–443.

109. Kennedy H (2006) *The Future of Forensic Mental Health Services in Ireland (editorial)*. June 2006. *Irish Journal of Psychological Medicine* 23(2): 45-46.

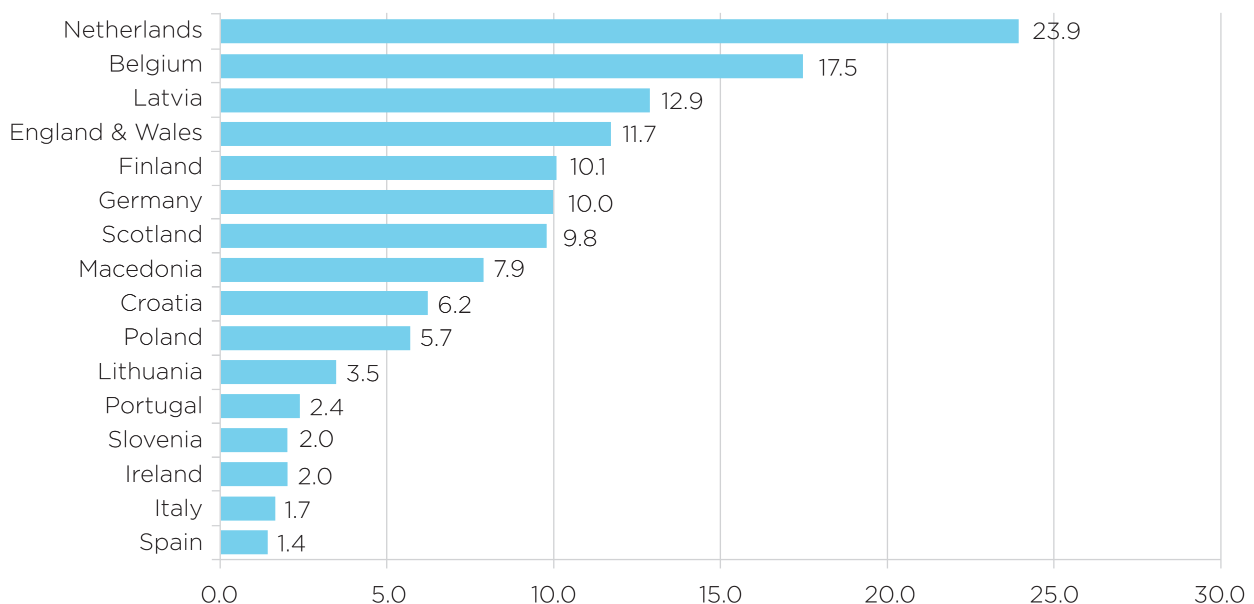
Bed Capacity

A study published in June 2020 in the *Social Psychiatry & Psychiatric Epidemiology* journal found Ireland was third from bottom out of 16 European countries for forensic inpatient prevalence rate per 100,000, with two beds per 100,000[110].

The number of prisoners on the waiting list for the Central Mental Hospital under the Criminal Law (Insanity) Act 2006 is 22[111]. There is no one awaiting transfer for the Central Mental Hospital from approved centres under the Mental Health Act 2001.

The new Central Mental Hospital, located in Portrane in north Co. Dublin, will increase the current bed capacity from 102 inpatient beds to 170 (bringing the ratio from 2 to 3.5 per 100,000), which is still a third of the average in modern European states. As outlined elsewhere in this report, the lack of adequate diversion and community resources coupled with the lack of intensive care regional units and acute psychiatric intensive care units means increasing numbers of mentally ill people in the prison system will continue to put pressure on the Central Mental Hospital and within a short time the CMH will be at capacity again.

Figure 4: *Forensic inpatient prevalence rate per 100,000 year 2013*



Notes:
Netherlands: Numbers of beds. Prevalence for TBS is 11,1. Latvia: Riga district only
Finland: subnational data, underestimated rate of unknown extent Germany: Baden-Württembery and Bavaria not included
Croatia: subnational data, rate underestimated of about 20%

Source: Tomlin J et al., Forensic mental health in Europe: some key figures, Social Psychiatry and Psychiatric Epidemiology (2021) 56:109–117

110. Tomlin J *et al*. (2021) Forensic mental health in Europe: some key figures. *Social Psychiatry and Psychiatric Epidemiology* (2021) 56: 109–117.

111. As of 23 September 2021.

Long stays in forensic inpatient care

Some patients, due to a perceived long-term risk, spend their entire lives in secure forensic settings in mixed populations (that is, with 'shorter-term' patients leaving the system quicker, but who may be more acutely unwell than the long-term patient population). With some individuals spending their entire lives in secure settings, restrictions on personal freedoms become more apparent, including restrictions on patient rights to family life and sexual expression. There are strong ethical and financial concerns arising from potentially unnecessarily protracted stays in secure care. Secure settings are extremely restrictive, characterised by a loss of privacy, repetitive daily routines, and low-stimulation environments. Although this may be necessary for some patients, it is of concern that some individuals remain in secure care for potentially inappropriate lengths of time. Secure care provision is also very expensive and in the UK absorbs 1% of the entire NHS budget and 10% of the mental health budget. Services must therefore aim to target only those individuals who require and will benefit from secure care provision[112].

In several Western countries, the average duration of patient stay in highly secure forensic settings has been rising[113]. In countries where dedicated long-stay services exist, the percentage of long-stay patients (usually defined as a period of treatment >5 years) was estimated to be 15–20%. Prevalence of long stay across all three English high-secure settings was 23.5%, ranging from 21.6% to 26.5%. Within a medium-secure sample, the prevalence of long stay was 18.1%[114]. As many as 27% of patients in both high- and medium-secure settings stay at least 10 years[115] and a substantial proportion of forensic patients in medium-secure settings stay longer than the two years originally recommended for such units[116] [117]. In 2003, O'Neill[118] found that almost half of forensic inpatients remained in the Central Mental Hospital for more than two years. The large number of older patients (about one-third of the long-stay population are over 50) has important implications for service planning for this patient group.

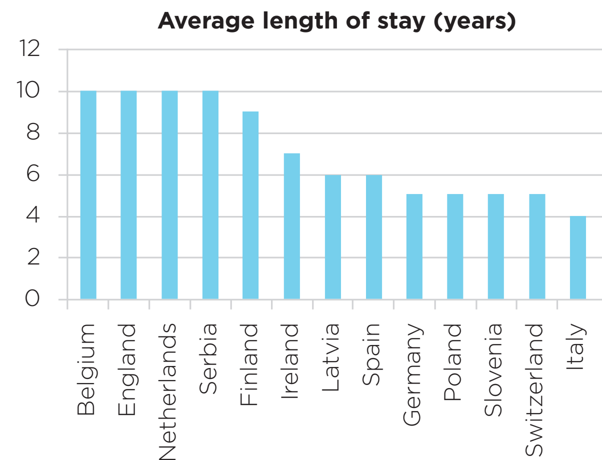
Currently, 54 patients in the Central Mental Hospital have been there for more than five years and the majority are likely to continue to require care and treatment in a therapeutically safe and secure hospital setting[119].

Some patients, due to a perceived long-term risk, spend their entire lives in secure forensic settings in mixed populations (that is, with 'shorter-term' patients leaving the system quicker, but who may be more acutely unwell than the long-term patient population).

112. Hare Duke L, Furtado V, Guo B *et al*. (2018) Long-stay in forensic-psychiatric care in the UK. *Soc Psychiatry & Psychiatr Epidemiol* 53(3): 313–321. https://doi.org/10.1007/s00127-017-1473-y
113. Sharma A, Dunn W, O'Toole C & Kennedy HG (2015) The virtual institution: Crosssectional length of stay in general adult and forensic psychiatry beds. *International Journal of Mental Health Systems* 9(1): 1–12. doi:10.1186/ s13033-015-0017-7
114. Hare Duke L, Furtado V, Guo B et al. (2018) Long-stay in forensic-psychiatric care in the UK. *Soc Psychiatry & Psychiatr Epidemiol* 53(3): 313-321. https://doi.org/10.1007/s00127-017-1473-y
115. Rutherford M, Duggan S (2008) Forensic Mental Health Services: facts and figures on current provision. *Br J Forensic Pract* 2008; 10: 4–10.
116. Edwards J, Steed P, Murray K (2002) Clinical and forensic outcome 2 years and 5 years after admission to a medium secure unit. *J Forensic Psychiatry* 13(1): 68–87.
117. O'Neill C, Heffernan P, Goggins R *et al*. (2003) Long-stay forensic psychiatric inpatients in the Republic of Ireland: aggregated needs assessment. *Ir J Psychol Med* 20(4): 119–25.
118. O'Neill C, Heffernan P, Goggins R *et al*. (2003) Long stay forensic inpatients in the Republic of Ireland: aggregated needs assessment. *Irish J of Psychol Med* 20(4): 119-125.
119. Professor Harry Kennedy in correspondence with the author.

Community-based services do not always provide sufficient levels of care for a subgroup of forensic patients for whom living in a community setting may not be appropriate. This poses a risk of disproportionately long and protracted stays in forensic institutions. Alternatively, unstable patients may be prematurely discharged, which may lead to worse overall outcomes, poorer quality of life, and increased violence and readmission risk. There has been some recognition of this group of patients at international level. A review of the international literature revealed two European countries that have responded proactively to the needs of those patients who require long-term forensic-psychiatric care. Long-stay units have been developed in both the Netherlands and Germany. It has been found in the Netherlands that purposely designed long-stay wards may attract some cost savings compared to regular treatment wards, as well as increased patient satisfaction due to their focus on quality of life. By identifying the characteristics of long-stay patients, the system can support service improvements not only to better facilitate patient discharge, but also to aid in the development of more cost-effective pathways with better quality of life for patients genuinely requiring longer-term care[120].

Figure 5: *Average length of stay of forensic inpatients at medium- and high-secure levels*[121]



Violent crime, legal status (restrictions on discharge), male gender, psychosis, substance misuse and absconding all predicted longer lengths of stay[122 123].

[120] Hare Duke L, Furtado V, Guo B *et al.* (2018) Long-stay in forensic-psychiatric care in the UK. *Soc Psychiatry Psychiatr Epidemiol* 53: 313–321. https://doi.org/10.1007/s00127-017-1473-y

[121] Sampson S, Edworthy R, Völlm B & Bulten E (2016) Long-Term Forensic Mental Health Services: An Exploratory Comparison of 18 European Countries, *International Journal of Forensic Mental Health*, doi: 10.1080/14999013.2016.1221484

[122] Andreasson H, Nyman M, Krona H, Meyer L, Anckarsäter H, Nilsson T *et al.* (2014) Predictors of length of stay in forensic psychiatry: the influence of perceived risk of violence. *Int J Law Psychiatry* 37(6): 635–642. doi:10.1016/j.ijlp.2014.02.038. Epub 2014 Mar 14.

[123] Davoren M, Byrne O, O'Connell P *et al.* (2015) Factors affecting length of stay in forensic hospital setting: need for therapeutic security and course of admission. *BMC Psychiatry* 15, 301. https://doi.org/10.1186/s12888-015-0686-4

Women’s Forensic Mental Health Services

WOMEN'S FORENSIC MENTAL HEALTH SERVICES

Women in the forensic mental health system have frequently been found to have complex and multiple needs due to having simultaneous mental disorders, high rates of previous trauma and high levels of psychological distress[124]. Women are far more likely than men to report a background of sexual, physical and emotional abuse prior to offending[125]. Historically, research has been difficult due to low numbers of women in secure care, making obtaining robust data regarding the demographic characteristics and experiences of these women a challenge. The studies available on women in forensic mental health systems show that women in custodial settings have higher rates of mental illness and psychological distress and present with highly complex health needs and multiple diagnoses. They have complex social situations including family dynamics, childcare/custody issues, unemployment, social isolation, and low socio-economic status[126]. Studies have shown that 50-60% of these women have experienced physical or sexual abuse in childhood and/or adulthood[127]. Areas affecting the lives of women and their children include welfare benefits, drug treatment, housing, education, employment, and reunification with children[128].

As individual histories of women in secure hospital services are characterised by early trauma and pathological attachment structures, this causes them to be particularly sensitive to feelings of abandonment and rejection[129]. While forensic female inpatients often have fewer criminal convictions than do their male counterparts, female patients are frequently among the more difficult patients to manage in services, because their behaviour can be chaotic and challenging, often including self-harm or problematic anger and aggression toward fellow patients and staff[130]. The compounding trauma of many patients who are estranged from children, and the impact – including at times for staff – of patients who have committed offences against their children, can also create significant service challenges. It has been stated that female forensic patients require the restrictions of physical security less frequently than do their male counterparts, with the most important aspect of security being relational rather than external perimeters and geographical isolation. Increased relational and procedural security may take the form of specific therapeutic intervention and high levels of nursing support and supervision[131].

All forensic mental health services should maintain a safe and effective process of treatment and rehabilitation through the stratification of patients according to the risks they present.

124. Binswanger IA, Merrill JO, Krueger PM *et al.* (2010) Gender differences in chronic medical, psychiatric, and substance-dependence disorders among jail inmates. *Am J Public Health* 100(3): 476–482.

125. Bloom B, Covington S (2008) Addressing the Mental Health Needs of Women Offenders.

126. Anumba N, De Matteo D, Heilbrun K (2012) Social Functioning, Victimization, and Mental Health among Female Offenders. *Criminal Justice and Behavior* 39(9): 1204-1218.

127. Sacks JY (2004) Women with co-occurring substance use and mental disorders (COD) in the criminal justice system: a research review. *Behav Sci Law* 22(4): 449-466. doi: 10.1002/bsl.597. PMID: 15282834.

128. Bloom B, Owen B, Covington S (2004) Women Offenders and the Gendered Effects of Public Policy. *Review of Policy Research* 21(1): 31-48.

129. Barber M, Short J, Clarke-Moore J *et al.* (2006) Editorial, a secure attachment model of care: meeting the needs of women with mental health problems and antisocial behaviour. *Crim Behav Ment Health* 16: 3–10. doi: 10.1002/cbm.56

130. Women's Service and Pathways across the Forensic Mental Health Estate March 2019. The Forensic Network. http://www.forensic.network.scot.nhs.uk/

131. Women's Service and Pathways across the Forensic Mental Health Estate March 2019. The Forensic Network. http://www.forensic.network.scot.nhs.uk/

All forensic mental health services should maintain a safe and effective process of treatment and rehabilitation through the stratification of patients according to the risks they present. Stratification of patients, by allocating them to appropriate levels of security according to their dangerousness, is essential for the safe and effective deployment of limited resources. Patients should be detained at no greater level of security than is necessary. This principle can be seen in the organisation of secure psychiatric services according to stratified risk. The absence of agreed pathways and services for women creates difficulties accessing appropriate services at medium and low security. It can delay women's rehabilitation and progress into the community. It also makes it more likely that they will have to move away from their home to access appropriate care and treatment.

Currently there are 10 beds for women with mental illness in the Central Mental Hospital for nationwide referrals under section 21(2) of the Mental Health Act 2001 (those who exceed the capacity of their local approved centre), as well as admissions directly from court or those transferred from custody in the Dóchas Centre or Limerick Women's Prison under section 15 of Criminal Law (Insanity) Act 2006 for treatment of their mental illness.

At the time of writing, all women in the Central Mental Hospital are accommodated in the same unit regardless of need, diagnosis, risk or stage of recovery. This is in contrast to the stratification of men in the same hospital. This was commented on by the Committee for the Prevention of Torture following a visit to the Central Mental Hospital in 2010: "… the overall situation for female patients remains unsatisfactory. Due to their limited numbers, female patients in different phases of their treatment are accommodated in a single unit with a uniform regime, in disregard of different needs as regards security. This situation requires immediate attention from the Irish authorities"[132]. The lack of forensic care pathways raises human rights concerns on the grounds of gender discrimination.

Assurances have been given that there will be stratification of women's services on the opening of the 20-bed women's unit in the new Central Mental Hospital in Portrane.

Forensic mental health services need to develop clear pathways for women from high-secure settings through to community services. This must include agreed pathways in and out of secure care, including transfers from prison. Parity of provision with men must be developed for women throughout the forensic system. Such provision should respond to any differences in needs between men and women while ensuring consistency in relational, physical and procedural security between services[133].

[132] Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 25 January to 5 February 2010.

[133] Independent Review into the Delivery of Forensic Mental Health Services Scotland Feb 2021.

Children's Forensic Mental Health Services

CHILDREN'S FORENSIC MENTAL HEALTH SERVICES

Forensic Child and Adolescent Mental Health Services (FCAMHS) work with high-risk young people where there are mental health concerns, both within and outside youth justice settings and processes.

Box 6: *Forensic Child and Adolescent Mental Health Services*

FCAMHS:
- provide a specialist service for high-risk young people that is not otherwise available
- ensure clear links between youth justice provision (community and custodial), other secure or specialist settings for high-risk young people and core provision whether within specific CAMHS or other services.

The FCAMHS care pathway:
- aids early intervention in high-risk cases as a means of improving outcomes and reducing risk and vulnerability.

Source: Hindley et al., Forensic mental health services for children and adolescents[134]

A forensic mental health service working with high-risk young people – whether based in a community, inpatient or custodial setting – should be founded on a number of key principles, including:

1. Ensuring that team members have specialist competencies in the identification and treatment of mental disorders in young people, together with similar competencies in forensic mental health.
2. Ensuring that primacy is given to the needs of young people as guided by relevant legislation; that the principle of proportionality is respected; and that the least restrictive treatment measures are used to meet identified needs and prevent harm to others.
3. Ensuring that there is a clear understanding of the principles of children's safeguarding and knowledge of the means of escalating concerns both in individual cases and where systemic failings are encountered.
4. Understanding of the range of provision within children's services as a whole in which high-risk young people with mental disorders may be encountered (this includes practical understanding of the means whereby access to and, if necessary, transfer from such provision can be facilitated).
5. Maintaining clarity of purpose and a clear understanding of the interplay between specialist and generic mental health functions in everyday clinical work.
6. Ensuring initial ease of access to the service for families and professionals who have concerns about emotional and mental issues in relation to a high-risk young person.
7. Maintaining close links at all times with families or others with parental responsibility for young people.
8. Ensuring clear links both clinically and strategically between local, regional and national provision and supporting transition of young people to adult mental health or other provision as required[135].

The high rate of psychiatric and neurodevelopmental disorder in adolescent offender populations is well documented. Table 8 compares the prevalence of various mental disorders in adolescents in normal community samples with those involved in offending behaviour. Studies have confirmed high levels not only of diagnoses of emotional and behavioural disturbance, but also of more general comorbid 'complex needs' (among which are 'looked after' status, substance misuse, special educational needs, previous experience of abuse, and family disruption).[136 137]

134. Hindley N, Lengua C & White O (2017) Forensic mental health services for children and adolescents: Rationale and development. *BJPsych Advances* 23(1), 36-43. doi:10.1192/apt.bp.114.013979

135. Hindley N, Lengua C & White O (2017) Forensic mental health services for children and adolescents: Rationale and development. *BJPsych Advances* 23(1), 36-43. doi:10.1192/apt.bp.114.013979

136. Kroll L, Rothwell J, Bradley D et al. (2002) Mental health needs of boys in secure care for serious or persistent offending: a prospective, longitudinal study. *Lancet* 2002 Jun 8; 359(9322): 1975-1979. doi: 10.1016/s0140-6736(02)08829-3. PMID: 12076552.

137. Chitsabesan P, Kroll L, Bailey S et al. (2006) Mental health needs of young offenders in custody and in the community. *British Journal of Psychiatry* 188(6): 534-540. doi:10.1192/bjp.bp.105.010116

Table 8: *Prevalence of various mental disorders in adolescents*

	Reported prevalence, %	
Type of disorder	**In general population**	**In young offenders**
Psychotic disorder	0.4	1-3.3
Depressive disorder	0.2-3	8-29
Anxiety disorder	3.3	9-21
Post-traumatic stress disorder	0.4	11-25
Substance use disorder	7	37-55
Intellectual disability	2-4	23-32
Dyslexia	10	21-43
Communication disorders	5-7	60-65
Attention-deficit hyperactive disorder	3-9	11.7-18.5
Autism spectrum disorder	0.6-1.2	15
Traumatic brain injury	24-31.6	65

Source: Mental disorder in adolescents in the general population and in criminal justice settings (UK)[138]

At the time of publication, there are no forensic CAMHS inpatient or community services in Ireland.

A number of young people with severe mental illness and challenging behaviour are currently receiving care in the UK due to the current lack of facilities in Ireland. This 'out of jurisdiction' care causes great difficulties for families and alienates the child from supports they may have in Ireland. A 10-bed forensic CAMHS unit will open shortly in the National Forensic Mental Health Service campus in Portrane and the practice of transferring young people with forensic mental health needs to other jurisdictions should then cease.

An inreach forensic mental health service provides psychiatric input for the residents in Oberstown when required.

Oberstown Children Detention Campus (Oberstown) is Ireland's national facility for the detention of children remanded or sentenced by the courts.

Located in Lusk, Co. Dublin, the campus is based in custom-built premises comprising residential accommodation units for young people as well as education, recreation, visiting, medical and other facilities. Oberstown accommodates young people up to the age of 18 on detention or remand orders. In 2020, Oberstown was authorised to accommodate a maximum of 48 boys and 6 girls.

Oberstown operates under the Children Act 2001 (the 2001 Act), as amended, under the auspices of the Department of Children, Equality, Disability, Integration and Youth (DCEDIY), formerly the Department of Children and Youth Affairs.

Approximately half of the young people have a mental health need, and one in four has been prescribed medication for a mental health concern[139]. The HSE Forensic Child and Adolescent Mental Health Service (FCAMHS) provides psychiatric services to young people in Oberstown. In 2020, FCAMHS and the Assessment Consultation Therapy Service (ACTS) received a total of 76 referrals.

138. Hindley N, Lengua C & White O (2017) Forensic mental health services for children and adolescents: Rationale and development. *BJPsych Advances* 23(1): 36-43. doi:10.1192/apt.bp.114.013979

139. Oberstown Children's Detention Campus Annual Report 2020.

Community Forensic Mental Health Teams

FORENSIC COMMUNITY MENTAL HEALTH TEAMS

Community forensic mental health teams (CFMHTs) play an important role in helping people to safely discharge from forensic inpatient services and remain well in the community. They also support people through acute periods of mental ill health, helping them to avoid unnecessary returns to forensic inpatient services. Functions of Community Forensic Mental Health Teams include:

1. Consultation and liaison with local mental health teams and other agencies to provide specialist advice.
2. Management of a defined caseload of high-risk individuals in the community and patients with complex needs on restriction orders .
3. Provision of a resource to multi-agency public protection arrangements (MAPPA) in the area.
4. Provision of education and training to other services.
5. Some court liaison and diversion arrangements.
6. Oversight of patients in secure hospitals[140] .

CFMHTs require fully multi-disciplinary staff teams in order to manage the diverse needs of those on their caseloads. Social workers have an especially important role in supporting the development of accommodation options and support package arrangements. Community service resource and development should be given its due place in whole-service planning. There has been a disparity in provision for these services compared with medium- and high-security services.

The demands of a forensic mental health population are different from those of a general mental health population. Forensic patients are more likely to pose significant risk (compared with general adult patients) should they have a relapse of their illness. If it were not for the risks posed by a relapse of symptoms, it is likely that they would not be followed up by forensic community services[141]. Opinion is divided on who should follow up patients leaving secure care. Chaloner and Coffey[142] believe that community supervision of such patients requires sensitive handling, a sound knowledge of mental health law and a firm understanding of risk management.

They also suggest that the word 'forensic' causes controversy among mental health professionals outside of secure care, as they often see 'the forensic patient' as dangerous.

Surveying all 37 community forensic mental health teams in England and Wales at the time, Judge *et al*. (2004) found that most operated in parallel with adult mental health services. All teams were concerned with risk assessment and management and very few had developed treatments to reduce offending behaviour. The authors found support for the development of a parallel community forensic service but felt that more research was required to evaluate such services[143].

A comparison of outcomes of aftercare provided by forensic and by general adult psychiatric services following discharge from medium-secure units revealed that:

- Forensic services supervised fewer high-risk patients than did general psychiatric services.
- Neither service was superior in outcome.
- There was no difference in readmission rates.
- If readmission did occur, individuals who had been followed up by local services usually went to local psychiatric hospitals, but those followed up by forensic services usually went back to medium security.
- There was no difference in terms of criminal reconvictions and type of offence, except for a slight variance in the rate of violence[144].

140. Standards for Community Forensic Mental Health Services Editors: Dr Jeremy Kenney-Herbert, Dr Mark Taylor, Dr Ramneesh Puri and Dr Jaspreet Phull CCQI 147 2013 Royal College of Psychiatrists.

141. Natarajan M, Srinivas J, Briscoe G, Forsyth F (2012) Community forensic psychiatry and the forensic mental health liaison model. *Advances in Psychiatric Treatment* 18(6): 408–415. doi: https://doi.org/10.1192/pt.bp.109.006940

142. Chaloner C, Coffey M (2000) *Forensic Mental Health Nursing: Current Approaches*. Blackwell Science.

143. Judge J, Harty MA, Fahy T et al (2004) Survey of community forensic psychiatry services in England and Wales. *Journal of Forensic Psychiatry & Psychology* 15: 244–253.

144. Coid JW, Hickey N, Yang M (2007) Comparison of outcomes following aftercare from forensic and general adult *British Journal of Psychiatry* 190: 509–514.

Models of Care in Forensic Community Mental Health Services

Box 7: *Models of care for mentally disordered offenders on discharge from medium-secure units*

Parallel: Forensic services that use this model provide both the inpatient and community components of the patient's care. Readmission would be to the medium-secure unit and the forensic team would expect to provide a full long-term community service to patients under their care.

Integrated: In this model, medium-secure units provide inpatient treatment and once the need for such security has ended, general adult services take over the longer-term treatment/ rehabilitation and integrate the patient into their services. Readmission, if necessary, would be to a local general psychiatric hospital.

Hybrid: This model runs integrated services but uses 'shared care' in the critical period following discharge, with forensic services retaining long-term responsibility for the 'critical few' who are high-risk offenders, such as those on restriction orders. If readmission is necessary, it will usually be to a local general psychiatric hospital; in certain circumstances the patient will return to the medium-secure unit (particularly in the case of the 'critical few').

Source: Natarajan *et al.*

An integrated model of care for 'high-risk' patients – those thought likely to pose a high risk to others – should not be solely the reserve of forensic psychiatrists. The integrated model has the advantage of minimising stigma, providing support and education for staff, and enabling forensic expenditure to be provided for a wider group of patients and staff than would otherwise be possible[145]. Tighe *et al*. (2002) looked at whether teams should be parallel, hybrid or integrated into general teams.

They concluded that, rather than being mutually exclusive, these models should sit on a continuum and the model chosen should depend on the demographics of the population being considered. In discussing the practical application of roles for each type of service, they stress that the integrity of practitioners can be maintained in both parallel and integrated services by having explicit lines of accountability[146].

Coid, Hickey and Yang (2007) compared the effectiveness of the forensic (parallel) and general adult psychiatric services (integrated) in relation to clinical and offending outcomes. They found no evidence of superiority as measured by reoffending behaviour or rehospitalisation for either service. The research recommended that if forensic specialist services are to develop a parallel model of 'after care' in the future they will need to develop new community-based interventions, which take account of the needs of high-risk patients, to reduce risk[147].

[145] Whittle M & Scally M (1998) Model of forensic psychiatric community care. *Psychiatric Bulletin* 22(12): 748-750. doi:10.1192/pb.22.12.748

[146] Tighe J, Henderson C, Thornicroft G (2002) Mentally disordered offenders and models of community care provision. In *Care of the Mentally Disordered Offender in the Community* (ed. A Buchanan) 89–110. Oxford Medical Publications.

[147] Coid JW, Hickey N, Yang M (2007) Comparison of outcomes following after-care from forensic and general adult psychiatric services. *Br J Psychiatry* 2007 Jun; 190: 509-514. doi: 10.1192/bjp.bp.106.023044. PMID: 17541111.

Service User Views

SERVICE USER VIEWS

Throughout the preparation of this report, we were aware of the people who were recipients of forensic mental health care because of offending behaviour in the context of severe mental illness. We were also aware that our descriptions of the various elements of forensic mental health care was the story of their journey and we wanted to hear what this journey had been like from both service users and their families. While we were also aware that memories for dates and timeframes may be affected by the extent of mental illness, we were more concerned about service users' perception of what happened to them and how they felt that journey could be improved.

In order to gather these stories, we met with service users, both in groups and individually, including those who were then detained in the Central Mental Hospital. We also met with families and carers of people who were, or had been, patients in the Central Mental Hospital. With the help of staff, we also distributed questionnaires asking about service users' experiences from the time they were taken into the Garda station to their community placement following discharge from the Central Mental Hospital. During our visits to Cloverhill Prison and Mountjoy Men's and Women's Prisons, we also spoke to prisoners with mental illness.

Garda station

Nineteen service users answered questions about their time in the Garda station. Service users' views of spending time in the Garda station when taken into custody was that Garda officers were "nice and kind" and that they were treated well. The majority remembered seeing a doctor at some point during their stay in the Garda station but only 5 out of 19 remembered seeing a member of a mental health team. The length of time spent in the Garda station ranged from a "few hours" to three days. Out of 19 service users who replied to the question about detention in a Garda station, 17 said they ended up in prison, while 2 were referred to a psychiatric hospital.

Prison

While in prison, many spent time in a high dependency unit or vulnerable prisoners' area and all stated that they had been assessed and offered treatment by a mental health team. Twelve service users also said they had been locked into a special observation cell for periods ranging from three hours to 11 days. When asked what this was like they stated that it was "claustrophobic", "frightening", "cold and lonely", "horrific", and that "I wanted to kill myself". One person said that it was "OK".

The wait for transfer from a prison to the Central Mental Hospital was described as ranging from one day to 18 months.

Central Mental Hospital

Describing what life was like in the Central Mental Hospital, service users stated that staff were kind and supportive. Some complained that it was "boring".

Among the issues raised by service users were not enough visitors; not long enough to spend with their children; lack of access to phone calls, lack of access to computers especially for education, listening to music and playing games; and lack of sports channels on TV. Some service users told us that moving from a higher-security level to a lower level was too slow and that there was not enough communication from management. Some of those in the women's unit pointed out that all women – regardless of the acuteness of their illness and need for differing levels of security – were treated in the same way, unlike the forensic inpatient services for men, thus outlining gender differences in the treatment and care provided.

Several service users were very positive about their stay in the Central Mental Hospital, saying that it had helped them and that their mental illness had improved. There was a general optimism about moving to the new Central Mental Hospital in Portrane, in particular the en-suite bedrooms and the increase in space.

Families were also pleased about the new Central Mental Hospital building. Concerns were raised about its remoteness from shops, coffee shops and other community facilities, and they were worried that leave for service users would be reduced as a consequence. The current lack of internet access was raised, especially for training and education. The families emphasised the importance of a recovery-orientated forensic mental health service. Currently, all service users, with the exception of Unit 7 and Laurel Lodge, are locked in their bedrooms at night and families questioned the need for this in all cases and expressed the hope that this policy could be reviewed.

Conclusion

CONCLUSION

Prisoners and those in the community who have had a forensic history must have the same access to and quality of mental health care as the general population. The overriding finding during this review was that this is not the case in Ireland. People who have had a mental illness and who have offended because of their mental illness are not afforded the same access to mental health services as those who have not offended. Legal, mental health and human rights policies advocate the provision of equivalent access to psychiatric treatment for mentally disordered offenders as for those in the community with mental illness. Since the early 1990s, there has been a vision of 'equivalence of care' for prison health, indicating that people in prison should receive the same standard and delivery of healthcare as they would if they were not in prison, but this is not yet embedded and some prisoners are receiving inappropriate or no treatment for their mental illness.

The right to healthcare is not negated by the fact that a person commits an offence because they were mentally unwell. The findings in this report show that mentally ill people are being criminalised and this suggests the need for several changes in both the criminal justice and mental health systems.

There is no doubt that the forensic mental health services available in Ireland provide excellent evidence-based care. Forensic mental health teams provide inpatient care in the Central Mental Hospital, inreach services to prisons, and court diversion. They do this in often difficult circumstances, with poorly resourced teams, which has resulted in the dangerous practice of lone working on one team.

People with major mental illness increasingly present to the courts with minor offending behaviour rather than to psychiatric services. Many mentally ill people who have committed minor offences can be appropriately and safely managed in general psychiatric healthcare settings. There is a lack of diversion for mentally ill people to local psychiatric services in Ireland and currently there are no prearrest diversion teams in place, unlike in other jurisdictions. This has resulted in mentally ill people coming before the courts for minor offences and ending up in the prison system. Irish courts should not be expected to act as a substitute for local mental health services in identifying mental illness and deciding on the most appropriate treatment.

The pilot crisis intervention team planned for Limerick is to be welcomed. The roll-out of such a system requires careful planning and adequate funding and should be based on best available evidence.

There is an absence of an integrated system of forensic mental health services delivery in Ireland. While the overall plan appears to be a 'hub-and-spoke' model, there are missing spokes. There are no Intensive Care and Rehabilitation Units outside of the new Central Mental Hospital in Dublin and there are no community forensic mental health teams. There are informal arrangements with local mental health services, but these are variable and appear to be based on 'goodwill', as there is no onus on services to accept diversions, even when the catchment area is established beyond doubt.

The services in Cork and Limerick are outside the National Forensic Mental Health Service, but there is part funding from the National Forensic Mental Health Service for a very small number of posts in Cork, leading to fragmented governance structures. There is lack of clarity about the future of the Cork and Limerick forensic mental health services.

People we spoke to expressed frustration about a lack of resources in low-secure services and in the community. This was often linked to the idea that the Central Mental Hospital receives a disproportionate amount of funding, to the neglect of other areas of forensic mental health.

The new National Forensic Mental Health Service in Portrane is a welcome replacement for the current Victorian premises in Dundrum, which has been deemed unfit for purpose for many years. At the present resourcing of diversion, the provision of extra beds in the new facility in Portrane will alleviate the crisis for only a short period at most. Actions will still be necessary to address issues of capacity and the impact it is having on people moving through the system. Without this the system will grind to a halt. A recent stand-off at the gate of the Central Mental Hospital over the admission of a severely mentally ill patient illustrates the frustration of the judiciary, the prison services and the national forensic mental health services at the lack of capacity in the Central Mental Hospital to provide treatment for people who are seriously mentally ill. Voices of service users and carers echo this frustration.

While the number of mentally ill people in prison waiting for a bed in the Central Mental Hospital is rising, there are insufficient rehabilitation, low-secure and community facilities at the other end for people to move on to when their high- and medium-secure needs have been met. This thus exacerbates the unethical lack of access for urgent high-secure therapeutic care and must be seen as failure of our system. The successful rehabilitation of people through forensic inpatient services relies ultimately

on the availability of places in the community and community support for them to return to.

Forensic mental health services should be underpinned by an ethos of recovery, focus and rehabilitation. As such, people need to be able to move from higher levels of security through lower levels of security and back into their communities in a timely way and when this is indicated. People's transitions between secure services and discharges to the community are being delayed. As they wait, they are not being held in the least restrictive conditions necessary to manage their risk. This is – at the very least – an infringement of their human rights. There are concerns that an extensive period of forensic inpatient care can be detrimental in that it seriously restricts patients' autonomy, their quality of life, and their prospects for future independent living.

People need to be supported by clear pathways into and out of forensic mental health services. The importance of strengthening links with community mental health services is critical in managing an person's transition from custody to the community. A coordinated policy response is required but there appears to be limited appetite for a change from the present catchment area system of community mental health teams and approved centres. This leads to systemic discrimination against mentally ill offenders who are homeless or in unstable accommodation.

It is not good enough that society allows people who are severely mentally ill and frightened by their symptoms and their surroundings to be locked in an isolation cell in a prison waiting for appropriate mental health care in suitable settings. People with mental illness who have offended because of their mental illness are among our most vulnerable citizens and should have access, like the rest of society, to adequate mental health services, which is their right.

Appendix

APPENDIX 1

Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 23 September to 4 October 2019 Close Supervision Cell

63. The use of Special Observation Cells (SOCs) is also integrally linked to one of the most pressing issues within Irish prisons, namely the treatment of prisoners who are mentally ill. At the time of the visit, there were some 25 prisoners on the waiting list for admission to the Central Mental Hospital (CMH) and the delegation met many of them in the prisons it visited. The most acutely unwell prisoners awaiting transfer to the CMH were being managed in a SOC. At the time of the delegation's visit to Cloverhill Prison on 29/30 September, two of the 10 prisoners awaiting transfer to the CMH had been managed in a SOC since 17 September. When the CPT's delegation met one of the men, he was lying naked in his cell, with the cell smeared with faeces and puddles of urine on the floor. There were no blankets in the cell and his poncho lying next to him was soaked in urine. Prison officers explained that the door to the SOC was only opened using the protection of a shield to pass him food. During his time in the cell, he had not been provided with a shower or let out of the cell. The other man was in a similarly distressed state and he too had not been afforded a shower or allowed out of his cell since his placement. Despite both of these men being very unwell, neither of them had had an individual care and treatment plan drawn up as directed by the recently revised Standard Operating Procedures (SOPs) for a SOC. Moreover, nursing staff were unable to engage with either man inside the SOCs as prison officers were not willing to unlock the cells. Further, there was poor recording of any interventions, including whether the two men had taken food. In the CPT's view, such a situation might amount to inhuman and degrading treatment.

64. While one of the men was bailed by the High Court to a psychiatric hospital in the community on 2 October 2019, it was disappointing to learn that he had still not been afforded a shower prior to his transfer. As regards the other person held in a SOC, the CPT learned that due to his homeless status he would not be accepted by a community hospital and would have to wait for a bed to become available in the CMH. The CPT's delegation requested the Irish authorities to ensure that a care plan be put in place immediately for this man, and for any other persons accommodated in a SOC pending transfer to a mental health care facility; such a plan should include being monitored directly by a psychiatric nurse (1:1), the door to the SOC being left unlocked during the day, access to a shower and outdoor exercise and increased access to chaplaincy and psychology services.

79. The approach towards the provision of mental health services for prisoners is set out in the 2006 policy document "A Vision for Change" and the system described in previous CPT visit reports regarding mental health in-reach service and high support units in certain prisons remained in place at the time of the 2019 periodic visit. Moreover, the same challenges outlined in the report on the 2014 visit were again in evidence. In the course of the visit, the CPT's delegation paid follow up visits to the D2 unit in Cloverhill Prison and the High Support Unit (HSU) at Mountjoy Prison, and it visited the Vulnerable Prisoner Unit (VPU) at Cork Prison for the first time.

80. At Cork Prison, the VPU consisted of six cells and was accommodating five prisoners at the time of the visit. The cells were sombre with poor access to natural light, the environment was noisy, and the prisoners were offered no purposeful activities apart from access to the exercise yard. Further, there was minimal staff interaction with the vulnerable men located on the unit. As regards the nine-cell HSU in Mountjoy Prison, where eight prisoners were being held at the time of the visit (one had just been transferred to the Central Mental Hospital), it was disappointing to note there was still a complete lack of structured activities for this group of prisoners, nearly all of whom had a severe and enduring long-term mental health illness. The proposed programme of activities remained theoretical and unengaging. There was still no occupational therapy, individual or group psychotherapy or recreational therapy; only pharmacotherapy. In sum, the prisoners wandered idly around the unit or the yard and watched television. Further, the delegation met one prisoner who was completely neglected, living in a dirty and squalid cell. As was the case in 2014, the mental health team, which is comprised of a psychiatrist and a mental health nurse, visited the HSU once a week. The CPT recommends that at both the VPU in Cork Prison and the HSU in Mountjoy Prison, a programme of structured activities be developed for prisoners held on these units. It also recommends that steps be taken to ensure that all prisoners kept on these units are held in clean cells and provided with

the necessary support to maintain their hygiene. Further, the HSU should introduce occupational therapy sessions for the prisoners.

81. The largest unit in the country holding prisoners who are mentally ill is located in Wing D2 of Cloverhill Prison. Over the past 10 years, the unit has had to expand as more and more severely unwell persons have entered prison. The landing was comprised of 15 single cells (three of which were occupied by cleaners) and five double cells. In addition, it had two SOCs and four CSCs, which often accommodated mentally ill prisoners. On the first day of the delegation's visit, the unit was accommodating 29 prisoners, including two persons in the SOCs (see paragraph 63 above), 10 of whom were on the waiting list to enter the Central Mental Hospital. Three days later, the unit was overflowing with seven prisoners having to sleep on mattresses on the floor, which the duty doctor confirmed was a regular feature for the landing. The CPT recommends that steps be taken to ensure that mentally ill prisoners do not have to sleep on mattresses on the floor in Wing D2 of Cloverhill Prison.

82. The Prison In-reach and Court Liaison Service based at Cloverhill Prison will assess around 300 prisoners a year, of whom some 100 are actively psychotic. Studies have shown that the percentage of remand prisoners with psychotic disorders in Ireland (9.3%) is more than twice the percentage of prisoners with psychotic disorders found internationally (3.6%). Despite this evident increase in the number of mentally ill prisoners entering Cloverhill Prison, the resources provided for the care and management of these persons has been cut. At the time of the visit, the mental health team consisted of 1.3 FTE consultant, 2.8 FTE junior doctor posts and 1.6 FTE senior registrar and only two nurses (one of whom was on long-term sick leave). This team needs to be reinforced urgently. There should be at least six mental health nurses, as well as an occupational therapist, a psychologist, a social worker and some administrative support. Further, the current focus seems to be solely around the psychiatric diagnoses, drug treatment and whether the prisoner is waiting for a place in a psychiatric hospital. On the other hand, there was a lack of discussion or planning about the day-to-day care of the men on D2 Wing. The CPT's delegation observed that they were offered no structured activities and that there was little engagement with staff. Given that prisoners can spend months on the unit much more needs to be done. The CPT recommends that the mental health team working on the D2 Wing at Cloverhill Prison be substantially reinforced in the light of the above remarks. Further, a programme of structured activities should be developed for prisoners held on the wing.

83. A major concern is the rising number of homeless persons who are ending up in prison and more particularly on Wing D2 which had risen to 32% in 2014 and was thought to be closer to 50% in 2019. Many of the persons coming to D2 could be granted bail by the courts but because of their homeless status they are excluded from Health Service Executive (HSE) community mental health team services, so they are left to languish in prison. Moreover, their mental health condition continues to deteriorate as they are too ill to consent to treatment. Prison must not become a solution for managing mentally ill homeless persons and the Irish authorities need to put in place a comprehensive policy (i.e., one that includes housing, welfare, primary care, mental health care, substance misuse) in order to tackle this issue. The CPT recommends that urgent steps be taken, including of a legislative nature, to ensure that mentally ill homeless persons in prison, who the courts are willing to bail, can be transferred rapidly to a psychiatric facility in the community to receive appropriate treatment.

84. The Irish authorities have in the past agreed with the CPT that a prison setting cannot be expected to offer the full range of therapeutic options that should be available in a psychiatric hospital and, as highlighted again above, even as regards pharmacotherapy a prison setting imposes restrictions. Consequently, while these measures recommended above may alleviate the situation, the fundamental principle is that mentally ill persons should not be held in prison but transferred to an appropriate health care facility or, more specifically, the Central Mental Hospital (CMH) given its statutory role. However, the CPT's delegation received several accounts that the new expanded CMH in Portrane, due to open in mid-2020, will not result in enough additional beds being available for mentally ill prisoners despite an increase in the number of beds in the hospital. The CPT recognises that there needs to be a multi-pronged approach to addressing the mental health needs of prisoners. Addressing access to care in the community for homeless persons who are mentally ill is one. In addition, the CPT supports the proposal for the development of two new Intensive Care Rehabilitation Units

(ICRUs) to be located in the southern and western regions of the country and the Committee would like to be updated on the feasibility of such units being opened and the timeline. It would also like to be informed whether there are plans to create additional step-down beds in the community and to increase the provision of psychiatric low-secure settings.

85. Further, as the CPT highlighted in 2014, if the HSUs and VPUs in prisons are to provide a stepping stone towards admission to a psychiatric hospital or a step-down unit for managing persons returned to prison from a psychiatric facility, it is essential that they be provided with the appropriate resources.
This means that an HSU should not only be visited on a regular basis by a mental health team (psychiatrist, psychologist and psychiatric nurse) but that the staffing complement should include psychiatric nurses, occupational therapists and officers with special training to work with mentally ill prisoners, and a structured programme of activities should be offered to all prisoners accommodated within an HSU. The CPT recommends that the Irish authorities enhance the availability of beds in psychiatric care facilities for acute mentally ill prisoners.
Further, it recommends that the staffing at all HSUs and VPUs be reviewed in order to include the appropriate expertise to offer a structured programme of activities beneficial to the prisoners, in the light of the above-mentioned remarks. Moreover, the CPT would like to be informed when the new CMH in Portrane is opened and fully functional. It would also like to be informed how many prisoners were waiting to be admitted to the CMH as of 1 May, 1 July and 1 September 2020 and how many of these prisoners were being managed in a SOC.