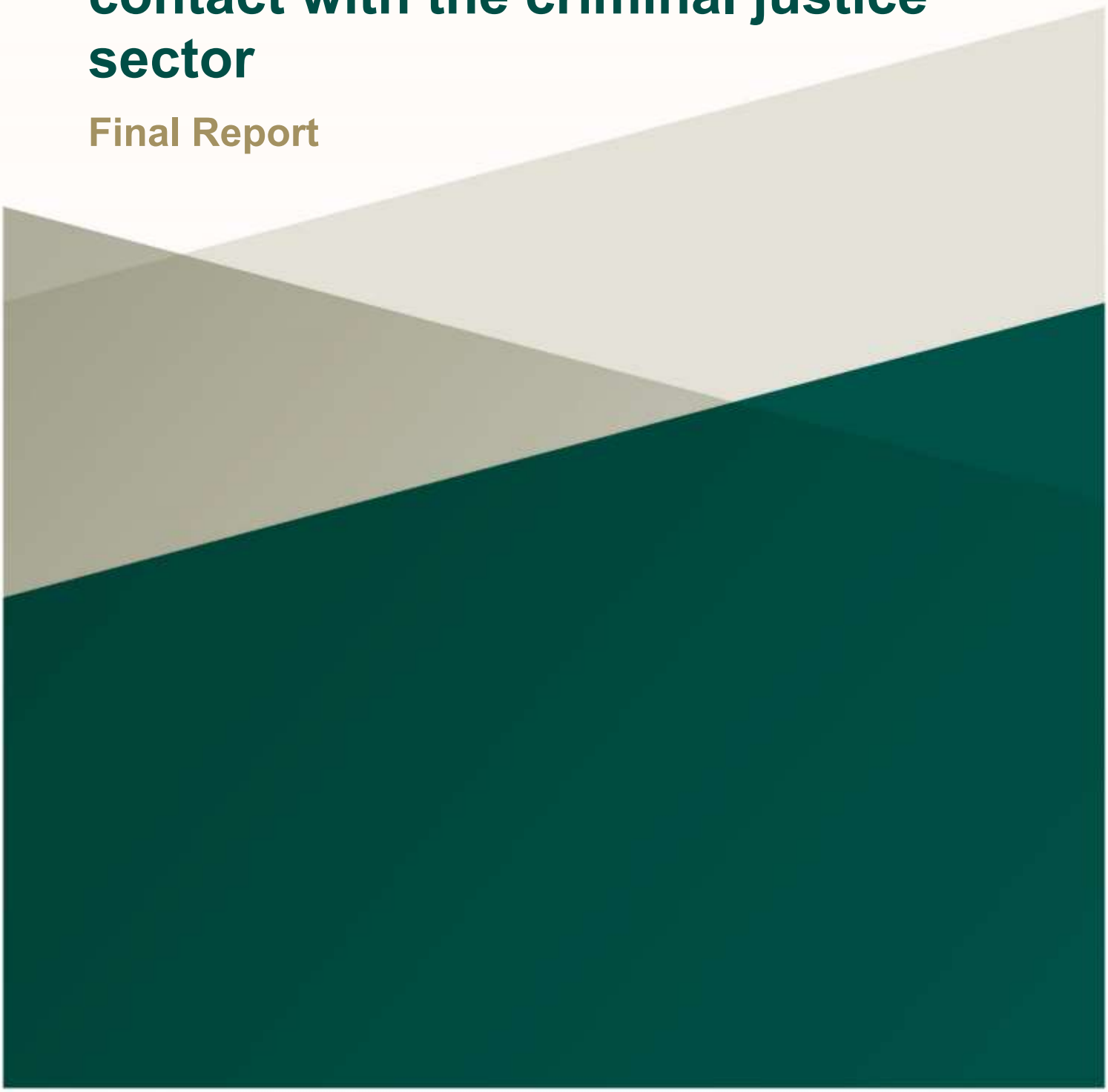
An Roinn Sláinte
Department of Health

An Roinn Dlí agus Cirt
Department of Justice

High Level Task Force to consider the mental health and addiction challenges of those who come into contact with the criminal justice sector

Final Report



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Executive Summary

It is increasingly recognised that the criminal justice system and in particular prison are not suitable to address the specific needs and challenges of those with mental health and drug addictions. The two reports of the Interdepartmental Group (IDG) to examine issues relating to people with mental illness who come in contact with the Criminal Justice System (dating from 2012 and 2018) contain recommendations on addressing the issues around this complex challenge. The Programme for Government: Our Shared Future committed to the establishment of a Task Force to consider the mental health and addiction issues of persons in prison and primary care support on release. It also acknowledged the recent Mental Health Policy *Sharing the Vision* (StV) and commits to establishing the National Implementation and Monitoring Committee to oversee this work.

The High Level Task Force's (HLTF) Terms of Reference, set out in Chapter 1 of this report, were drafted with a focus on achieving the Group's objectives as determined by its mandate from Government.

Noting the previous work of the IDG and developments which have already taken place or are taking place in the criminal justice and health areas, the Task Force has concentrated on identifying where further improvements can be made which will make a meaningful difference to the treatment of persons with mental health and addiction difficulties within the criminal justice system.

In framing its recommendations the Task Force has given indicative timelines for their implementation. This approach recognises that some immediate improvements can be effected in the short term (in the next 12 to 18 months) within existing resources or frameworks. Other recommendations will require a greater degree of time and effort to put in place and may require additional resourcing or planning meaning that their implementation is expected to be in the medium term (within the next 3 year period). Other recommendations have a longer implementation timeframe. In this regard the HLTF recognises that a longer planning and development phase will be involved meaning that they are expected to be delivered within the next 5 year period.

That said, the Task Force is of the view that much can be achieved in the short term. Many of the recommendations build on the existing infrastructure, creating better connectivity and linkages between services to better support those in the criminal justice system with mental health and/or addiction issues. The Task Force is also convinced of the need to move with speed and determination, particularly in respect of those recommendations which have been identified as implementable in the short term, and in many cases build on aspects of services which are already being provided but require greater resourcing and roll-out. Now must be the time for action and implementation of proven approaches.

The following is a brief overview of this Report including the high level outcomes from the three subgroups:-

Chapter 1 provides an overview of the work of the HLTF since its first meeting in April 2021 including the establishment of three subgroups to carry out the work of the HLTF. This approach was chosen to both accurately capture the entirety of individuals' interactions with the criminal justice system at all stages and to enable work to progress simultaneously on several fronts. The HLTF identified the need for truly holistic engagement with this issue from the very initial contact with the criminal justice system, right through to release and support in the community.

Chapter 2 provides some detail on the policy context, values and guiding principles which informed the work of the Task Force. These overarching themes provided focus to the three subgroups in their approach to developing their recommendations.

Chapter 3 provides a detailed account of the work and recommendations of *Subgroup 1: Diversion*.

This subgroup looked at the very first contacts and seeking to divert individuals from progressing into the criminal justice system taking the IDG recommendations that An Garda Síochána implement a diversion policy for use in suitable cases when members come in contact with adults with mental illness who may have committed a minor offence as a starting point. Subgroup 1's work concludes that a multi-agency approach to implementing a new Garda diversion policy is ultimately required to prevent individuals and vulnerable persons with mental health difficulties becoming inappropriately trapped in the criminal justice system.

Subgroup 1's examination revealed a system which is not presently well constituted to maximise opportunities for diversion. There are shortcomings in both structure, for instance as regards the administration of the adult caution scheme, and resourcing, particularly when it comes to An Garda Síochána responding to incidents and individuals with a mental health crisis which limit the capacity of An Garda Síochána, and other parties, to pursue effective diversionary pathways. The subgroup's work also shows that not enough has been achieved in terms of realising the recommendations from the IDG reports relating to diversion.

To address the shortcomings found subgroup 1 examined where improvements could be made to the current system to ensure that, where possible and appropriate, persons presenting with mental health difficulties are diverted from the criminal justice system. This group has identified a number of recommendations which will ensure that health interventions are the primary response for this cohort. Some of the key recommendations arising from subgroup 1's work are discussed below, and all the subgroups recommendations are listed.

Subgroup 1 has strongly recommended the introduction of crisis intervention teams as a means of ensuring greater cross-agency collaboration, identifying the Crisis Intervention CAST model as an integral part of a diversion model which should be progressed in the short term. In recommending this approach, the subgroup has requested that a pilot crisis intervention team project in the Limerick area receives full support to develop the concept of a community hub as a focus for providing assistance to persons who come to Garda attention – whether in relation to mental health, addiction or other issues. The learnings from this pilot, multi-disciplinary approach, will inform the further roll-out of this approach on a national level.

This subgroup also made a number of recommendations which focus on strengthening the existing adult caution scheme to ensure an efficient and effective means of implementing a prosecution avoidance policy for use in suitable cases when Garda members come in contact with adults with mental illness, addiction challenges or related situational problems who may have committed a minor offence.

Noting that Gardaí are frequently first responders in crisis situations, the subgroup has also identified areas where guidance, training and awareness raising within An Garda Síochána can be strengthened in the short term to better equip members in these situations. Importantly, the subgroup recommends the development of a more progressive, emphatic and inclusionary approach by An Garda Síochána in dealing with persons who may be experiencing mental health and addiction difficulties.

In the course of its work, the subgroup noted that effective cross-agency collaboration can be hindered by the inability to share information between agencies. They make a number of recommendations aimed at improving data sharing arrangements whether on a memorandum of understanding basis or strengthening the existing legislative framework.

Short Term=12-18 months Medium Term=18 months – 3 years Long Term=5 years

Subgroup 1:

1.1

Amendment to Adult Caution Scheme

The scheme should now consider the use of adult cautions on direction from the ODPP where previous convictions and cautions already exist once evidence of crisis, mental illness, addiction or situational trauma are identified.

Implementation Period – Short Term

1.2

Aligning the operation of the Adult Caution Scheme with the prosecutor guidelines

Aligning the operation of the Adult Caution Scheme with the prosecutor guidelines so that mental health difficulties are treated in a uniform manner and opportunities for diversion are supported in all appropriate cases.

Implementation Period – Short Term

1.3

Consideration for expanding the offences under the Adult Caution Scheme

The extension of the Adult Caution Scheme to cover simple possession of other drugs could have the beneficial effect of preventing a ‘person in crisis’ from entering the Criminal Justice system and may represent an opportunity for signposting to appropriate health services.

Implementation Period –Medium to Long term

1.4

Use of the public interest principle from the Prosecutor Guidelines

Greater focus on using the public interest principle from the Prosecutor Guidelines 5th Edition in relevant cases involving persons experiencing mental health difficulties and addiction problems, to promote flexible responses to individual cases which maximise opportunities to divert people away from the criminal justice system.

Implementation Period – Short Term

1.5

Diversionary Elements An Garda Síochána – Knowledge and Awareness of services in the community

Provision of information and signposting to community-based support services by AGS following an adult caution or non-prosecution in the public interest. Regional Guidance based on services available within the relevant area that is accessible via mobility device. Training should be planned and integrated to align appropriately with the work of the Garda Youth Diversion Bureau and the implementation of the Youth Justice Strategy 2021-2027.

Implementation Period – Short Term

1.6

Progressive and Empathic approach by An Garda Síochána

Creating a more progressive, empathic and inclusionary approach for AGS through updating guidelines and practices for front-line and supervisory Gardaí.

Implementation Period – Short-medium Term

1.7

Guidance Definition to be integrated into the relevant policies of An Garda Síochána and agencies with the Criminal Justice family.

In order for practical implementation and use the subgroup proposes that this definition be a guidance definition whereby the individual needs to “fit” the guidance definition as opposed to “meet” which avoids labelling in terms of the prerequisite for diagnosis as any individual can experience temporary trauma.

Implementation Period – Short-Medium Term

1.8

Mental Health and Addiction Awareness Training in An Garda Síochána

Provision of cross disciplinary awareness training in AGS to promote diversionary approaches in appropriate cases, including with regard to mental health, addiction, homelessness, lack of maturity or other circumstances which may contribute to some offending behaviours. Such training should be planned and integrated to align appropriately with the work of the Garda Youth Diversion Bureau and the implementation of the Youth Justice Strategy 2021-2027.

Implementation Period – Short-Medium Term

1.9

Cross-agency collaboration – CAST Pilot Limerick

The potential to use the Crisis Intervention CAST model as an integral part of a diversion model should be progressed by quantifying the resources across agencies, including Garda and HSE, which are required to operate it in a given area. The subgroup strongly recommends that the pilot project receive full support to develop the concept of a community hub as a focus for providing assistance to persons who come to Garda attention.

Implementation Period –Short to Medium Term

1.10

Development of a pilot Distress Brief Intervention (DBI) programme in conjunction with the Limerick CAST project and one other AGS Division/HSE Health area is to provide a framework for improved inter-agency co-ordination, collaboration and co-operation across a wide range of care settings, interventions and community supports.

Enhance diversionary practices for those experiencing crisis and situational trauma that inevitably leads to mental health difficulties. The approach moves towards the shared goal of providing a compassionate and effective response to people in distress improving experience and outcomes for those experiencing distress and those providing support. The linkage to the services that hold Service Level Arrangements (SLA) is crucial. A pilot DBI programme should be planned and integrated to align appropriately with the work of the Garda Youth Diversion Bureau and the implementation of the Youth Justice Strategy 2021-2027.

Implementation Period – Short- Medium Term

1.11

Consider the requirement for legislation to further support the mental health diversion

Consideration should be given to the need and opportunities for legislation to further support a mental health diversion policy.

Implementation Period – Long Term

1.12

Expand the Health Information Bill to include information sharing with additional state agencies

Examine if there is scope to include, subject to safeguards and strong governance rules, information sharing to agencies within the criminal justice family where it is consistent with the health-related purposes set out in the Bill it would help those in need to access services and commence positive action plans with appropriate service providers.

Implementation Period – Medium-Long Term

1.13

Expansion of the Spent Convictions Act

Consideration should be given to expanding the applicability of the spent convictions scheme to individuals who may have multiple historical convictions. This would enable the spent convictions legislation to be utilised by individuals who may have historically acquired convictions as a consequence of mental health difficulties and addiction issues or situational trauma. This would allow a wider use of the Probation Act, Adult Caution and be used as rationale for a non-

prosecution in the public interest. It will also help with rehabilitation of and positive action plans for the individual. In conclusion historical convictions should not be a barrier to diversion.

Implementation Period – Medium-Long Term

1.14

The Probation Act should not be recorded as a conviction or used as a barrier to diversion

An individual who received the Probation Act should have it recorded however, it should not be listed as a conviction when considering eligibility for the adult scheme or used negatively in a non-prosecution public interest decision.

Implementation Period – Medium Term

1.15

Progressive use of the Probation Act

The appropriate use of the Probation Act in cases of offenders who fit the guidance definition can have a positive outcome for the individual involved. It is recommended that the criminal justice system and actors therein make full use of the potential of the Probation Act.

Implementation Period – Short-Medium Term

1.16

Ensure that problems relating to Data Sharing and Legal issues can be resolved with reference to all relevant proposals and initiatives.

It is recommended that consideration is given to the implications on the multi-agency projects within the scope of the Policing, Security and Community Safety legislation. The subgroup believes the appropriate departments should legislate for additional powers to share data than is already defined in the GDPR/Data Protection Act.

Implementation Period – Medium-Long Term

1.17

Ensure Linkage and Collaboration between Diversion Programmes Nationally

The synergies between the Health Diversion Programme and the Task Force should be explored and perhaps a joint submission to the Criminal Justice Strategic Committee is warranted.

Implementation Period – Medium Term

1.18

The Department of Health and the Department of Justice should agree on an appropriate mechanisms to coordinate the work.

Ensure effective coordination of work to design diversion initiatives in relation to mental health, drugs possession and young adults, and with reference as appropriate to the new Community Safety Structures envisaged in the Policing Security and Community Safety Bill 2021. An appropriate interagency structure should be identified to oversee the development of a coherent and integrated approach to diversion from the criminal justice system with regard to health and welfare issue.

Implementation Period – Medium-Long Term

1.19

Development of Pilot Pre-Charge Offender Reparation Referral – RJS (Restorative Justice Service)

A pilot project run within one of the participating district court areas whereby the local Gardaí (Inspector or Superintendent Rank) can refer directly to the RJS (Restorative Justice Service) if a suitable case and fits the guidance definition of person in crisis as proposed by the subgroup. Such a pilot should be planned and integrated to align appropriately with the work of the Garda Youth Diversion Bureau and the implementation of the Youth Justice Strategy 2021-2027. This recommendation includes the wider use of hybrid orders in the District courts so there is no criminalising of medical conditions.

Implementation Period – Short-Medium Term

1.20

AGS to ensure details of all voluntary services recognised by the HSE through Service Level Arrangements (SLA) are available to officers on mobility devices to enable diversionary practices and signposting

Access to the voluntary services recognised by the HSE is crucial to the diversionary model outlined by the subgroup. It is recommended that all relevant information regarding services with SLAs be made available to officers via existing mobility apps and the Garda Portal intranet.

Implementation Period – Short Term

1.21

Rollout of Dual Diagnosis Services Nationally to Assist Diversionary Practices

The development of a Mental Health and Addiction Dual Diagnosis Service through the National Clinical Programmes has commenced. This is a very welcome development which emerged from the Dual Diagnosis Clinical Programme working group. The works, if implemented, will be another component of the expanding multi-agency approach. The programme has the potential to be of significant benefit to individuals with co-occurring mental health difficulties and substance use problems and the ideal resource for those individuals that the HLTF has identified. Dual diagnosis needs have been highlighted in HSE reports and national drug strategies going back to 2007, including the 2012 National Substance Misuse Strategy.

Implementation Period – Medium-Long Term

1.22

Establishment of Criminal Justice Secure Email domain between the partner agencies to facilitate diversion and safe sharing of information.

The establishment of CJSM (Criminal Justice Secure Email) in neighbouring jurisdictions who operate a safe domain between the partner agencies is recommended whereby information sharing and emails cannot go externally outside this secure system. The decision for diversion suitability can be made in conjunction with partner agencies or it can be used a red flag risk system and interventions can be made by support services.

Implementation Period – Medium-Long Term

1.23

Provision for a Standardised Assessment Form

A standardised assessment form will reduce the burden on individuals who wish to receive public services from having to provide the same information to different public bodies and it will also facilitate the effective administration of public health services and supports. This would need to be coordinated by the Department of Health.

Implementation Period – Short-Medium-Long Term

1.24

Provide High Spec Technological upgrades to enable implementation of recommendations.

Many of the recommendations require a specific technological upgrade. The resources required should be implemented as a priority. The upgrades, applications and capabilities should include a high spec digital platform that underpins the modernisation of the processes and services.

Implementation Period – Short-Medium-Long Term

Chapter 4 details the work and recommendations of *Subgroup 2: IPS/NFMHS Capacity*. This subgroup examined the existing and future needs of individuals within the carceral criminal justice system. The objective of Subgroup 2's work was to ensure that there is adequate provision of services to meet the mental health and dual diagnosis needs of those in prisons.

The group considered the issue of increasing the capacity of forensic mental health services across the prison estate and for those who require admission to the CMH as a priority. This involved the development of an evidence base for step down care and exploration of all options to open additional forensic beds. This work involved a robust analysis of current capacity and modelling of future capacity needs. It also considered the use of Approved Centres in support of forensic mental health services and the issue of any legislative requirements to support this.

Subgroup 2's work led the group to a number of conclusions, these are detailed in Chapter 4, including that that there should be equitable access to mental health services across the prison estate. The group's work revealed a system that faces a number of fundamental challenges in the short, medium and long term, when it comes to making equitable access across the prison estate a reality and that there is little throughput through the various units in Dundrum as all Units were at 100% capacity at all times. This has reduced CMH admissions to minimal levels. This has generated a waiting list for admission to the CMH however this option will not be available for the majority of patients.

The recommendations from this subgroup focus on how improvements can be made to the existing care arrangements. While noting the opening of the new CMH facility in Portrane in the near future will greatly assist in alleviating the existing bed capacity pressures on the system, the subgroup recognises that a range of additional measures will be required to ensure greater throughput in the new facility. Some of the key recommendations arising from Subgroup 2's work are discussed below, and all the subgroups recommendations are listed.

The group recommends that there should be a single system of governance for forensic mental health services across the prison estate. They also agree that the Portrane model of care is the appropriate clinical pathway to manage patients following their admission to the CMH. The group recognises the need for egress solutions to ensure that the CMH bed capacity is optimised and throughput of patients can be achieved. In this regard they recommend that further ICRUs (Intensive Care Rehabilitation Units) are planned.

Subgroup 2 found that there is a requirement to discharge prisoners back to prison once they have been assessed and treated such that they are no longer in need of care and treatment that can only be given in hospital as defined in section 18 of the Criminal Law (Insanity) Act 2006. To support this they recommend that the development of safe areas (intoxicant free and violence free) within the prison service estate should be explored. This would afford an opportunity for prisoners returning from inpatient hospital treatment to extend their recovery and rehabilitation period and facilitate a further sustained period of stabilisation before reintegration into the general prison population.

The group's work confirms that imprisonment in and of itself is not an automatic indicator that a person requires the high level of therapeutic security provided by the CMH. All prisoners who require mental health treatment in a clinical setting will be assessed and appropriately referred by NFMHS clinicians to the service which best provides for the level of therapeutic security required. For professional consistency and appropriateness the Dundrum Toolkit will be used in determining the most appropriate level of therapeutic security required. This also supports the recommendation in *Sharing the Vision* that persons with mental health issues will be cared for in the least restrictive and most clinically appropriate environment.

Subgroup 2 :

2.1

Alignment of Health Needs Assessment (HNA) recommendations

The implementation of the HNA recommendations pertaining to the mental health requirements in all prisons should be aligned with the recommendations of the Task Force so that prisoners should have timely access to the full range of specialist forensic mental health services where clinically required.

Implementation Period – Medium Term

2.2

Further Research on Mental Health and Addiction

Research to be conducted to update information on the prevalence and impact of mental health conditions and addiction across the prison estate.

Implementation Period – Medium Term

2.3

Single system of governance for forensic mental health services

There should be a single system of governance for forensic mental health services across the prison estate. This should be explored further by the HSE and IPS by means of a formal agreement on the provision of a National Forensic Mental Health Service under the aegis of the CMH in all closed prisons and with the collaboration of community mental health services.

Implementation Period – Short Term

2.4

CMH Portrane Model of Care

The Group have agreed with the new Portrane model of care as the appropriate clinical pathway to manage patients following admission to the CMH.

Implementation Period – Short Term

2.5

Prisons should not be designated under Criminal Law (Insanity) Act 2006

The Group did not consider that prisons should be designated under the Criminal Law (Insanity) Act 2006 for the purpose of treating prisoners with a mental health condition.

Implementation Period – Short Term

2.6

Facility to meet Long Term Medium Secure (LTMS) male bed capacity requirements in CMH Portrane

It is recommended to develop a facility that provides a model of care that delivers a supportive environment that "normalises" care and recovery for vulnerable individuals who require LTMS. The modelling analysis indicates that these LTMS bed requirements will peak in the early phase of the Portrane development at 42 beds and reduce in subsequent years.
Planning for this facility should commence at the earliest opportunity in order to meet the male bed capacity requirements for the new CMH in Portrane.
The scope of this planning should include:

- Development of a model of Care for LTMS
- Consideration of Capital requirements
- Development of a Workforce Plan
- Consideration of a broad range of shorter term alternatives including but not exclusive to the use of FICRU (Portrane) and PICUs/ICRUs regionally to provide LTMS accommodation on an interim basis.

Implementation Period – Short Term

2.7

Access to Mental Health Care

Every person with mental health difficulties coming into contact with the forensic system should have access to comprehensive stepped (or tiered) mental health support that is recovery-

orientated and based on integrated co-produced recovery care plans supported by advocacy services as required.

Implementation Period – Medium Term

2.8

Development of PICUs

Subject to the work of the NIMC Specialist Group on Acute Inpatient Bed Capacity which is considering Inpatient bed provision, the development of PICUs is considered as a priority as envisaged by the *Sharing the Vision* Recommendation 46. In this regard, sufficient Psychiatric Intensive Care Units (PICUs) should be developed with appropriate referral and discharge protocols to serve the regions of the country with limited access to this type of service

Implementation Period – Short Term

2.9

Development of Intensive Care Rehabilitation Units (ICRUs)

The development of further Intensive Care Rehabilitation Units as should be prioritised following successful evaluation of operation of the new ICRU on the Portrane Campus. Work should commence on planning of further ICRUs and a Design Team should be established at the earliest opportunity.

Implementation Period – Short Term

2.10

Sources of funding

Sources of funding for what would be a resource intensive development for the development of PICUs and on planning further ICRUs would need to be identified and considered.

Implementation Period – Short Term

2.11

Approved Centres should be considered for designation on a regional basis

A small number of Approved Centres should be considered for designation on a regional basis so that care could be provided for patients who have committed a minor offence, require a low level of security and suffer from a severe and enduring mental health condition. The use of these centres should be subject to clear clinical risk assessment and security admission criteria as per the Dundrum Toolkit.

Implementation Period – Short Term

2.12

A Safer Prison Environment

The IPS should establish a Working Group with Terms of Reference to include:

1. To identify a suitable facility/unit in accordance with the recommendations of the Mental Health Task Force that would provide care and accommodation for prisoners on their transfer back from CMH/FICRU or an Approved Centre in order that they can maintain stability and advance on a pathway to recovery before they return to general population.

2. To develop appropriate governance arrangements (including clinical admission/discharge criteria) for this facility.

3. To identify clinical and operational resource requirements.

This work should commence at an early opportunity with a reporting timeframe of circa 9 months or earlier.

Implementation Period – Short Term

2.13

Pilot dual diagnosis programme

A pilot dual diagnosis programme in a prison should be established at the earliest opportunity. This would provide the basis further learning with the potential for a broader rollout across the prison estate.

Implementation Period – Short Term

2.14

Specialist dual diagnosis service

The provision of a specialist dual diagnosis service supporting prisoners with a mental health difficulties and substance misuse should be established across the IPS estate.

Implementation Period – Medium Term

2.15

Mental Health and Addiction lead

The IPS should appoint a Mental Health and Addiction Lead to support this work.

Implementation Period – Short Term

2.16 Legislative Changes

A number of proposed changes to legislation relating to the future CMH capacity are recommended to be considered. These proposals are complementary to the other recommendations and considered as a longer term action.

i) Unfitness to Stand Trial

There should be a delay between the making of an order in Court under Section 4(6) Criminal Law (Insanity) Act (CLIA) and the execution of the order for example two weeks. This would allow the National Forensic Mental Health Service or other Designated Centres to ensure that a bed is available. Ideally it would also allow a consultant from the designated centre to carry out a pre-admission assessment and report on this to the court. An alternative is to review section 4 of the CLIA with a view to assisted decision making. This would ensure compliance with the UN CRPD and would guarantee the right to a fair trial for all.

Implementation Period – Long Term

ii) Not Guilty by Reason of Insanity (section 5, CLIA)

The diagnostic step (requirement of legally defined mental disorder) should be preserved however the three part test of insanity should be narrowed as the capacities referred to are not mutually exclusive. The preservation of any one of them should carry with it preserved some degree of responsibility. The complete negation of responsibility leading to a verdict of Not Guilty by Reason of Insanity (NGRI) should have a high threshold. To be found NGRI should require the presence of mental disorder and all three conditional tests. Those meeting a lesser standard should instead be considered under diminished responsibility. In addition, the term "unable to refrain from committing the act" is difficult to interpret clinically and should be abolished.

Implementation Period – Long Term

iii) Diminished responsibility (section 6, CLIA)

The diminished responsibility defence should be made much more accessible in relation to all indictable offences tried in the Circuit Court. It should never be available for offences that are acquisitive or related to fraud or deception.

Implementation Period – Long Term

iv) Provision of Hybrid orders should be considered

These are available under the Mental Health Act for England and Wales whereby a fixed tariff prison sentence is imposed and part of the tariff can be in a secure psychiatric hospital (designated centre and approved centre) for no longer than is necessary for treatment. The remainder of the sentence would be passed in a custodial setting. That custodial setting might be an ordinary prison, a high security prison or an open prison or probation/parole service in the community. The prison setting should be violence free and drug free as outlined earlier in this report.

Implementation Period – Long Term

v) Provision of community treatment orders (CTO) should be considered

This would enable alternative therapeutic settings to be available for offenders. It would be helpful to involve probation officers in the management of CTOs in a forensic context. However, it is noted that the Expert Group Review of the Mental Health Act did not recommend this in the amendments to the Mental Health Act. This was on the basis that involuntary detention was considered as an option of last resort when it was not possible to treat a person in the community and that this approach was consistent with the commitments to UN CRPD. The alternative is provision of CTOs by means of criminal Justice legislation.

Implementation Period – Long Term

vi) Provision of a Statutory Instrument to ensure therapeutic safety in CMH Portrane and other designated centres

There is a concern regarding the legal basis to inspect CMH as a designated centre and this is under consideration by the Department of Health. The General Scheme of a Bill to amend the Mental Health Act provided for the Minister for Health to make regulations for designated centres and it is intended to retain this provision in the Mental Health Bill

Implementation Period – Long Term

Chapter 5 details the work and recommendations of Subgroup 3: Community issues including throughcare from custody.

The focus of Subgroup 3's work was an examination of service provision in the community and the related processes involved in a prisoner's throughcare from custody to community. The scope of this, inclusive of all contact between persons with mental health and addiction issues and the criminal justice system is extensive, including the later stages of an individual's interactions with the criminal justice system as a person moves back from prison into the community. Subgroup 3's objective is to ensure that there are sufficient safeguards in place and adequate provision of services to prevent individuals from relapsing into damaging behaviours undermining the rehabilitative efforts made by the individual and the State.

Subgroup 3's work revealed a system that faces a number of challenges, both structural and resourcing, in terms of ensuring that best practice is achieved consistently when it comes to dealing with individuals who face mental health and addiction issues. At the same time, and consistent with the overall conclusions of the HLTF, the group's work also shows much excellent work is evident across the health and justice sectors, with a range of projects operating on a small scale which, with investment, are likely to have significant impact on the challenges faced by the target group. Subgroup 3's recommendations have been designed to take advantage to the maximum extent possible of these proven approaches, building on existing best practice and stressing the need to expand access to same in as short a time period as practicable. The recommendations made by this subgroup reflect the three broad areas of focus: courts, community and throughcare. Some of the key recommendations arising from Subgroup 3's work are discussed below, and all the subgroups recommendations are listed

Subgroup 3 has identified a need for a national service to screen and/or assess for mental ill-health issues or other care requirements e.g. HSE Primary Care, dual diagnosis etc. amongst those appearing before the Court. The criminal justice system and courts deal in law and are not by their nature well equipped to best assess or support individuals with mental health and addiction issues, but at the same time if the courts are to fulfil their duty these are indispensable activities. From their examination of existing practice in this area the group viewed this as a natural development of the role of the existing Prison Inreach and Court Liaison Service ('PICLS') which the group observes has operated so effectively to date. Subgroup 3 thus strongly supports the full resourcing and expansion of PICLS.

Subgroup 3's work revealed a system that is fundamentally dependent on the effectiveness of communication and cooperation between the different stakeholders involved in the provision of services to those with mental health and addiction issues in contact with the criminal justice system. The group underscores that piecemeal, ad hoc arrangements are not achieving the close degree of interconnection needed to best support the cross-sectoral efforts involved in addressing the mental health and addiction challenges of individuals interacting with the criminal justice system. Subgroup 3 have made recommendations designed to reinforce the interconnections between relevant the stakeholders including calling for a memorandum of understanding between the HSE, criminal justice agencies and other key stakeholders such as Local Authorities is required to deliver a partnership approach that creates easy access to case management services, and endorsing the HSE Single Integrated Case Management model and recommending the extension of that pilot and its alignment with case management models in place in both the Probation Service and Irish Prison Service.

Subgroup 3's work also dealt with the critical stage of release, and the group's recommendations reflect the very important part this time plays in bedding in rehabilitative gains made during time in custody. If not properly managed, including through intensive planning and support provision to the individual the period of release and its immediate wake can be extremely fraught. To this end Subgroup 3 has recommended that the National Forensic Mental Health Service 'Pre-Release Planning Programme' (PReP) should be expanded to have national coverage across the prison estate.

Subgroup 3:

Recommendations - Courts

3.1

Screening and Assessment

The model of service provision and staffing requirement will need to be scoped and resourced. Consideration should be given to aligning this team with Probation Service Court Liaison teams.

Implementation Period – Short Term

3.2

Care Pathways

Clear pathways for access to primary, community and mental health services, between the HSE and criminal justice agencies, are required. These pathways should be formalised and regularly reviewed against agreed performance metrics to ensure positive client outcomes.

Implementation Period – Short Term

3.3

Problem Solving Court Framework

The Department of Justice, in conjunction with the Department of Health, should develop a framework, achieving the aims of a Problem Solving Court (such as the Drugs Court) to enable positive treatment and behavioural outcomes for persons appearing before the court. The framework could potentially involve models of bail supervision, an increased use of community sanctions, a specific mental health court or other such options.

Implementation Period – Medium Term

3.4

The Probation Service

The Probation Service should be resourced to recruit staff (psychology or nursing) to enable increased competence at a regional and national level in the assessment of mental health within pre-sanction reports prepared for the Criminal Courts and to support effective offender management.

Implementation Period – Short Term

3.5

Training

A training needs analysis and related training programme should be actioned for staff across the criminal justice sector to ensure a relevant degree of understanding of mental health, mental difficulties and the services available to meet the needs of such persons appearing before the courts.

Implementation Period – Short Term

3.6

Research

Research should be commissioned to establish the extent of persons with mental health difficulties and addiction issues (dual diagnosis) appearing before the courts and to establish the broader needs of this cohort (e.g. accommodation, employability etc.).

Implementation Period – Short-Medium Term

3.7

Tracking

Track the outcomes of the implementation of the Task Force's recommendations – with a specific reference on social inclusion/marginalised groups.

Implementation Period – Short-Medium Term

3.8

Further Supporting the Judiciary

It is recommended that the Department of Justice, working with relevant stakeholders, conduct research to assess the impact of the alternative sanctions available under law, any barriers to their utilisation and any opportunities to improve their uptake and effectiveness. It is further recommended that, where appropriate, the results of this research be utilised to inform a programme of judicial education to ensure that the judiciary are fully supported in the application of such alternatives to imprisonment.

Implementation Period – Short-Medium Term

(i) Recommendations - Community:

3.9

Memorandum of Understanding

A memorandum of understanding between the HSE, criminal justice agencies and other key stakeholders such as Local Authorities is required to deliver a partnership approach that creates easy access to case management services that include counselling, key working, outreach, addiction, mental health assessment, homeless placement and housing advice so that mental health difficulties can be treated within social inclusion/primary care and prison settings.

Implementation Period – Short-Medium Term

3.10

Integrated Multi-agency Model of Case Management

The HSE Single Integrated Case Management model, which is being piloted to support people experiencing homelessness in Dublin, should be further expanded to align with case management models in place in both the Probation Service and Irish Prison Service.

Implementation Period – Short Term

3.11

Social Inclusion Case/Key workers

In keeping with Sláintecare and the Enhanced Community Care Network model, Social Inclusion Case/Key workers should be allocated to each Community Health Network to ensure coordination and access to pathways. Such case managers should work with the Probation Service, homeless services and others, as required, to support offenders in the community and those before, during and after custody.

Implementation Period – Short-Medium Term

3.12

Assertive Outreach Teams

Such teams should be expanded to make specialist mental health care and housing supports available to people experiencing homelessness, mental illness and severe distress and to divert clients away from entering the criminal justice system.

Implementation Period – Short Term

3.13

The potential to establish direct referrals pathways

Direct referrals pathways between the Probation Service and Community Mental Health Services should be explored, inclusive of screening tools, agreed referral criteria, enhanced bi-lateral liaison and outcome analysis.

Implementation Period – Short Term

(ii) Recommendations – Throughcare :

In addition to those recommendations made in the Courts and Community sections:

3.14

Prison Inreach Services

The National Forensic Mental Health Service 'Prison Inreach and Court Liaison Service' should be expanded to enable its services to be fully provided in all committal prisons.

Implementation Period – Short Term

3.15

IPS Psychology Service

Should be resourced to at least the levels recommended in the “New Connections” review of the Service (Porporino, 2015). This resourcing should include funding a review to make recommendations to enhance recruitment and retention.

Implementation Period – Short Term

3.16

Prison Health Care

Prison health care services should be resourced to fully replicate the range of services available in the community.

Implementation Period – Short-Medium Term

3.17

PReP

The National Forensic Mental Health Service ‘Pre-Release Planning Programme’ (PReP) should be expanded to have national coverage across the prisons estate.

Implementation Period – Short Term

3.18

Case Management

HSE Social Inclusion Case Managers should begin engagement with prisoners at the earliest point prior to release to ensure continuity of care as the prisoner’s release date may be brought forward for a number of reasons resulting in an earlier than anticipated release date.

Implementation Period – Short-Medium Term

3.19

Reducing Attrition

Maintaining engagement and motivation at the point of release Attrition would be reduced if all prisoners had a community agreed discharge plan in place with an identified case manager prior to release.

Implementation Period – Short-Medium Term

3.20

Research and Data Analytics

Limited information is collected about the profile of those involved with the criminal justice system. As part of its data holdings, the CSO has access to and use of other administrative datasets such as those of the Departments of Employment and Social Protection, Revenue, Education and other agencies. Other information which would be useful in predicting the risk of recidivism include; age at first offence, prior arrests, family status, health status (including mental health and addiction), accommodation status, ethnicity and education level. The addition of these variables could be used to enrich the existing prison and probation datasets to provide a better understanding of the underlying factors that lead offenders to reoffend or conversely, to lead a crime free life.

Implementation Period – Short-Medium Term

3.21

Research on the intersection of homelessness and criminality

Conduct research into the scale of overlap between the homeless and criminal justice sectors to develop a more informed response to the throughcare needs of those existing custody, inclusive of the needs of minority groups, young persons and women.

Implementation Period – Short-Medium Term

Foreword from the Chair

Mental health is not something one can neatly pack away. It is not something that can be easily segmented off from other issues in society, or indeed from other aspects of our lives as individuals. Our mental health affects us to the very core of our being and can also touch on every aspect of our lives even our mundane daily tasks. Yet for too long we as a society have attempted to compartmentalise issues regarding mental health, either by "othering" those with acute or chronic mental health difficulties or by failing to take account of the impact mental health difficulties can have on individuals as they interact with our society.

Thankfully, we live in a society that rightfully is now more open and informed about the prevalence and difficulties of mental health difficulties and addiction. While this increased knowledge and compassion is welcome, it is not enough by itself. We are called to ensure that our values are upheld not only for ourselves and those who are like us but also in respect of those who are the most vulnerable in society, and even those who may have found themselves in less than favourable contact with the criminal justice system. Until care can be accessed equally and appropriately by all, including the most marginalised, we will not be living up to the high standards we properly expect of ourselves as an enlightened people.

The work of this Task Force confirms that in the criminal justice sector we can see the consequences of failing to adequately address mental health difficulties in stark relief. These consequences arise in a multitude of ways, and throughout an individual's interactions with the criminal justice sector. I would like to emphasise that it is extremely important and very appropriate that the Government made the commitment to establish this Task Force. It is not in the public interest to have individuals caught up in the criminal justice system who might be better diverted from criminality through other means. It is not in the public interest to have individuals in prison who are not receiving the mental health care and treatment that they need. It is not in the public interest to have prisoners released without adequate safeguards concerning their return to the general population risking undoing rehabilitative progress and perpetuating a cycle of crime and misery.

Adequately and intelligently addressing the mental health difficulties and dual diagnosis issues of those in contact with the criminal justice system is not a luxury or in any sense an indulgence of those who have committed crime. It is the realistic and responsible approach to maximising public safety, strengthening rehabilitative efforts and ensuring that public money is used in the most effective way possible.

I would like to express my deep gratitude to the individuals who agreed to participate as members of the High Level Task Force and those who participated as members of the subgroups. Each of these individuals worked with enthusiasm and in a collaborative spirit, on top of their normal responsibilities. I wish to express my thanks to the Minister for Justice, Minister for Health, Minister of State for Mental Health and Older People and the Minister of State for Public Health, Wellbeing and the National Drugs Strategy. Addressing the needs of people who interact with the criminal justice system may not be the most appealing challenge from a political perspective so I appreciate that the Ministers and Government had the courage and commitment needed. I am glad to see that the importance of the interconnection between health and justice in this area has been recognised by establishing this Task Force as a joint effort between the two pillar Departments.

I wish to express my gratitude to officials from the Department of Health and the Department of Justice who both participated in the HLTF and its subgroups. Secretariat functions for the Task

Force were provided by officials from the Department of Justice, recognising the particular difficulties faced by the Department of Health during the public health emergency. I am thankful for the work of the Secretariat for keeping the Task Force progressing. I wish to express special thanks to officials who were instrumental in establishing and the early work of the Task Force, who have now moved on, Assistant Secretary Colm Desmond of the Department of Health, and Principal Officer Deborah White and Higher Executive Officer Yvonne Phillips of the Department of Justice.

I wish in particular to express my deep gratitude and heartfelt thanks to those who agreed to take on the additional responsibility of acting as chairs of the subgroups: Subgroup 1, Chief Superintendent Gerard Roche, An Garda Síochána; Subgroup 2, John Devlin, Clinical Director, Irish Prison Service; and, Subgroup 3 Mark Wilson, Director, Probation Service. Their work, commitment and leadership was essential in driving forward the work of the Task Force, and I note that each accepted this additional responsibility on top of their existing responsibilities.

Throughout my life, and from my experience in elected office including as Minister of State for Primary Care, Mental Health and Disability I have seen first-hand the challenges faced in ensuring that we provide a system of care that addresses the many complex needs and situations that present. I am not alone in my view that these challenges are magnified by the fact that they occur at the often difficult intersection of justice and health matters. While this reality must be acknowledged, it is not all negative, it means that there is opportunity to do much better with the system we currently have if we can ensure that the linkages and collaboration between the varied parties can be streamlined and maximised. I agreed to undertake the role of Chair because I believe that meaningful change can be implemented in an effective manner.

As I consider the work undertaken, and the scope of the challenge in implementing these recommendations moving forward, I am heartened that the focus of all members has resolutely been on making real changes and identifying truly implementable plans. I believe it is a positive that in spite of the volume of work, and material presented below there has been no suggestion of any radical new invention, rather there is a realistic and determined focus on ensuring that we can achieve significant improvement by better integrating and resourcing the services that exist today. In taking the approach of breaking the work down into its three natural stages, as represented in the subgroups it is clear that there is significant scope to achieve improvements at all points in an individual's interactions with the criminal justice system.

Whether from the very earliest stages of interaction where a properly resourced system of Crisis Intervention Teams, utilising and connecting with the existing resources and services available can help ensure individuals who can be better treated in a health context are properly assessed and diverted away from imprisonment; to the adequate provision of health services to those in prison enabling appropriate scaling of care to match the need, allowing individuals to move between prison and hospital and back with greater ease as appropriate; to the provision and adequate resourcing of community services that can help break cycles of criminality and misery such as the proven and world class Prison In-reach and Court Liaison Service (PICLS), it is clear that opportunities exist for improvement. Improvements that will not only individually improve the availability and quality of service but will act as a mutually reinforcing and self-perpetuating virtuous cycle. Keeping those who can be better supported elsewhere away from prison, in turn reduces the pressures on both the prison service and our national forensic mental health service. This reduced pressure should enable the new care pathways to function with greater effectiveness helping to avoid service bottlenecks and ensuring that individuals in need receive the best possible treatment. Improvements in access to treatment in prison for those with mental health difficulties and dual diagnosis issues in turn should lead to greater rehabilitative outcomes, making the re-entry into general society of such individuals a less challenging and fraught prospect with knock-on benefits for the services in the community as well as society generally. As the brief example

above illustrates and as the detailed reports of the subgroups below bear out, the ideas and services that are required to make this improved system a reality already exist or are being worked on right now in Ireland, ready to be taken advantage of and put fully into practice. What is needed to turn this from aspiration to achievement is a Government ambitious and brave enough to pursue it, and committed to implementation on a cross departmental, interagency basis.

Kathleen Lynch – Chair, High Level Task Force

CHAPTER 1: The High Level Task Force

Introduction – High Level Task Force (HLTF)

The healthcare needs of vulnerable, sometimes seriously ill, people who interact with the criminal justice system are complex and require whole of systems consideration and urgent action. It is widely acknowledged that these people are too ill to be in prison as they require urgent medication and treatment. There is a vital need to put in place properly resourced, appropriately located systems of care for these most vulnerable people in society.

The Task Force was established to progress the Government's commitment to ensure the critical mental health needs and dual diagnosis treatments for people while imprisoned and primary care support on release, in order to ensure the safety of the public and better outcomes for the people themselves.

The Department of Justice consulted with Department of Health on the establishment of the Task Force and the appointment of an independent chair.

Ms Kathleen Lynch, former Minister of State for Primary Care, Mental Health and Disability agreed to undertake the role of chair.

Recognising the current burdens faced by colleagues in the Department of Health, Department of Justice officials provided the secretariat. However, implementation obligations will fall to a range of Departments and bodies.

Establishment of the HLTF

As the subject matter for the work of the Task Force has substantial implications for a wide cross-section of health agencies and the Justice sector, in addition to senior officials from both Departments, the membership incorporates senior officials from relevant stakeholders, including representatives from the HSE, Central Mental Hospital, the Irish Prison Service, the Probation Service, and An Garda Síochána. The membership of the HLTF is as follows:

- Kathleen Lynch: Chair - former Minister of State for Primary Care, Mental Health and Disability
- Prof. Harry Kennedy: Executive Clinical Director, Central Mental Hospital
- Seamus Hempenstall: Principal Officer, Dept. Health
- Michael Murchan: Assistant Principal, Dept. Health
- Deirdre O'Flaherty Administrative Officer, Dept. Health
- Paula Hillman: Assistant Garda Commissioner, AGS
- Gerard Roche: Chief Superintendent, AGS
- Andrew Lacey: Superintendent, AGS

- Jim Ryan: Head of Operations for Mental Health Services, HSE
- Dr Eamon Keenan: National Clinical Lead-Addiction Services, HSE
- Pat Bergin: Head of Service, Forensic Mental Health Service, HSE
- Mark Wilson: Director, Probation Service
- John Devlin: Clinical Director, Irish Prison Service
- Enda Kelly: National Nurse Manager, Irish Prison Service
- Rosemarie Tobin: Principal Officer, Dept. of Housing, Local Government and Heritage (from February 2022)
- Ruairi Ferrie: Assistant Principal Officer, Dept. of Housing, Local Government and Heritage (from December 2021)
- Tony O'Donovan: Principal Officer, Dept. Children, Equality, Disability, Integration and Youth
- Ben Ryan: Assistant Secretary, Dept. Justice
- Mary O'Regan: Principal Officer, Dept. Justice
- John Dunphy: Dept. Justice, Secretariat
- Oonagh Ffrench: Dept. Justice, Secretariat
- Kerrie Keegan: Dept. Justice, Secretariat
- Siobhan McArdle Assistant Secretary, Dept. Health (January to May 2022)

With thanks also to the following who contributed to the Task Force:

- Colm Desmond: Assistant Secretary, Dept. Health (April to July 2021)
- Eamonn Waters: Principal Officer, Dept. Housing, Local Government and Heritage (April to December 2021)
- Graham Hopkins: Assistant Principal, Dept. Housing, Local Government and Heritage (April to December 2021)
- Deborah White: Principal Officer, Dept. Justice, Secretariat (April to September 2021)
- Yvonne Phillips: Higher Executive Officer, Dept. Justice, Secretariat (April to August 2021)

Terms of Reference

The HLTF is to report to the Government through the Ministers for Justice and Health. The terms of reference (ToR) of the HLTF were the subject of discussion between the Departments of Justice and Health and are as follows:

(i) To assess how best to take forward the recommendations from the first and second reports of the Inter Departmental Group to examine issues relating to people with mental health difficulties coming into contact with the criminal justice system (summary of recommendations attached).

(ii) To consult with stakeholders and consider relevant reports, proposals, recommendations and strategic actions including, but not limited to, the recommendations of the Council of Europe Committee for the Prevention of Torture reports and the ongoing work of the Steering Group on the Health Needs Assessment under way in the Irish Prison Service, with a view to identifying any additional actions relating to people with mental health challenges or a dual diagnosis of mental health and drug or alcohol addiction challenges who come into contact with the criminal justice system that may be necessary.

(iii) To prepare a High Level Implementation Plan by end of 2021 outlining lead responsibilities and timelines for any actions identified in (i) and (ii) with operational subgroups being set up as necessary.

(iv) Report on implementation periodically to relevant Ministers and Ministers of State.

IDG Recommendations

The Interdepartmental Group (IDG) to examine issues relating to people with mental illness who come in contact with the criminal justice system included representatives of the Department of Justice and Equality, the Department of Health, the Health Service Executive, the National Forensic Mental Health Service, An Garda Síochána, the Office of the Director of Public Prosecutions, the Probation Service and the Irish Prison Service.

Under the ToR for the HLTF, the group is required to assess how best to take forward the recommendations from the first and second reports of the Inter Departmental Group. The Group's first report from 2012 focused on how diversion at all stages of the criminal process could be facilitated up to the conclusion of a criminal trial. The second report from 2018 focused on matters relating to mental health services for prisoners, persons subject to community sanctions and post-release health services. It also considered matters relating to patients detained under the Criminal Law (Insanity) Act 2006

The outstanding recommendations from both IDG reports have been reviewed, and assigned to appropriate HLTF subgroup. The subgroups were required to provide draft high level implementation plans, including assigning responsibility and timelines to the HLTF. In turn the HLTF will finalise the high level implementation plan and is working to have the plan ready by year end.

Getting to Work

Operational Subgroups:

The HLTF chose to utilise an operational subgroup approach to enable progress on all areas to occur simultaneously. Three subgroups were established and the recommendations arising from the reports of the two Interdepartmental Groups were appropriately assigned.

The three subgroups are:

- Subgroup 1: Diversion. Chaired by Chief Superintendent Gerry Roche, Limerick Garda Division AGS.
- Subgroup 2: IPS/CMH Capacity. Chaired by John Devlin, Clinical Director, Irish Prison Service.
- Subgroup 3: Community issues including through-care from custody. Chaired by Mark Wilson, Director, Probation Service.

Work to Date and Reporting:

The HLTF has met ten times in plenary format. The HLTF has considered the outstanding IDG recommendations and allocated responsibility for these to each subgroup as relevant.

Each subgroup has met twelve to fourteen times, and agreed their terms of reference with the HLTF chair.

The subgroups prepared as-is process maps, detailing the existing services, and input for the interim report.

In accordance with the ToR, the HLTF has provided a high level implementation plan for the recommendations. The high level implementation plan is required to identify and assign responsibilities for the actions required to implement, and to provide timelines for action.

Consultation

The Task Force has consulted with relevant stakeholders, as required, such as the Mental Health Commission, Inspector of Prisons, Prison Visiting Committees, Irish Penal Reform Trust and academia.

The Task Force has determined that a focused consultation is the best means of ensuring meaningful input. The approach was to develop policies to a sufficient degree that these can then be tested with key stakeholders. Consultation in the form of presentations have been provided by the Irish Penal Reform Trust, as well as the addition of internal and external experts to the Task Force's subgroups.

The HLTF Chair met the renewed All Party Oireachtas Group on Penal Reform, co-chaired by Deputy (formerly Senator) Ivana Bacik and Deputy Jennifer Carroll McNeil supported by the Irish Penal Reform Trust, on 26 May 2021. The Irish Penal Reform Trust also made a presentation to the HLTF in plenary format in July 2021. The HLTF also met with Crowe Consulting who undertook the Health Needs Assessment with the Irish Prison Service. The subgroups also engaged in some ad hoc consultation on points of particular interest to support the work they undertook, including the Office of the Director Public Prosecutions.

Chapter 2: Context, Values and Guiding Principles

Policy Context :

The High Level Task Force's work has not been undertaken in a 'green field' site from a policy perspective. The HLTF recalls the work of the Interdepartmental Group (IDG) to examine issues relating to people with mental illness who come in contact with the criminal justice system. The Group's first report from 2012 focused on how diversion at all stages of the criminal process could be facilitated up to the conclusion of a criminal trial. The second report from 2018 focused on matters relating to mental health services for prisoners, persons subject to community sanctions and post-release health services.

The HLTF acknowledges the existing policy context and in particular, *Sharing the Vision* (StV), Ireland's National Mental Health policy, which was published in 2020, and has informed the Task Force's work. StV is the successor to A Vision for Change (AVFC), and builds upon the recommendations set out in the 2006 policy. AVFC was recognised as a progressive strategy for mental health in Ireland. Many significant changes and improvements have taken place over the lifetime of the policy since 2006 and many of its recommendations are still considered relevant to the ongoing development of the mental health system.

Over the course of its 10-year lifespan, StV seeks to enhance the provision of mental health services and supports across a broad continuum from mental health promotion, prevention, early intervention to specialist, acute services, as well as NFMHS. Within StV, the NFMHS is defined as ''*…concerned with the treatment of people with mental health difficulties who come in contact with law enforcement agencies …*'' (page 50).

The policy reinforces the need for '' *every person with mental health difficulties coming into contact with the forensic system to have access to a comprehensive stepped (or tiered) mental health service that is recovery-oriented and based on integrated co-produced recovery care plans supported by advocacy services as required*.'' (Page 50). Furthermore, StV clearly states that persons with mental health difficulties who come into contact with the forensic system should have equal access to high quality mental health services, as any other group within society.

In addition and with particular relevance to the co-morbid addiction issues that are also part of the HLTF's focus, the Task Force acknowledges Reducing Harm, Supporting Recovery (RHSR), published in 2017. RHSR sets out the Government's strategy to address substance misuse in society up to 2025. It aims to provide an integrated public health approach to substance misuse. The 2017 report also illustrates that there is a clear association between substance misuse and offending behaviour.

The HLTF considers that the current mental health policy, *Sharing the Vision*, and Reducing Harm, Supporting Recovery remain the solid policy platforms and these are fully endorsed by the Task Force.

Values:

The High Level Task Force is independent in its work and in making its recommendations. The Task Force acknowledges however that its membership is primarily comprised of individuals working in the criminal justice and health system through relevant Departments and agencies. Examining the values of these Departments and agencies which undergird the treatment of individuals with mental health difficulties and addiction issues in contact with the criminal justice system is instructive in developing the values of the HLTF itself.

The two principal Departments represented in the membership of the HLTF are the Departments of Justice and Health. The Department of Justice's Statement of Strategy 2021 to 2023 identifies that Department's values as (p6):

- Collaborative: We will work together with others in trust and partnership
- Professional: We will be impartial, accountable and ethical
- Open: We will be responsive and informative, communicating to make meaningful connections

The Department of Health's Statement of Strategy 2021 to 2023 identifies that Department's values as (p3):

- Engaging with the public and service users
- Respect and fair and equal treatment of all
- Collaboration, innovation and forward thinking
- Professionalism, leadership and accountability
- Integrity, impartiality and value for money

The HLTF's membership also includes representatives from key stakeholders from relevant agencies including the Health Service Executive, An Garda Síochána (AGS), the Irish Prison Service, and the Probation Service. The HSE Corporate Plan 2021 – 2024, identifies the HSE's values of (p2) '*Care, Compassion, Trust and Learning'*. The AGS Code of Ethics 2017 identifies the organisations values of '*Honesty, Accountability, Respect, Professionalism and Empathy*'. The Irish Prison Service identifies their values as '*Team Work, Integrity, Potential, Safety and Support*".

The Probation Service describe their core values in the following manner[1]:

- Crime results in hurt and damage to victims and communities and must be met by an effective sanction,
- Where appropriate, community sanctions are more fitting and effective than custody,
- By engaging effectively with communities, particularly through a restorative justice model to address crime, we can enhance public safety and reduce offending patterns,
- Each person has innate value, dignity and capacity for positive change; and will be treated fairly, openly and with respect,
- As with all members of society, offenders must accept personal responsibility for their behaviour,
- We recognise the importance of accountability, efficiency, effectiveness and value for money in the provision of a quality public service.

Informed by the above, the HLTF has identified the following core values:

1. ***Respect for the individual***: each individual is deserving of respect and dignity. This applies equally to all including to individuals with mental health difficulties and addiction issues interacting with the criminal justice system as well as the staff working to provide care and treatment in difficult circumstances.

2. Collaboration at the core: individuals with mental health difficulties and addiction issues coming in contact with the criminal justice system have multifaceted needs that no one arm of the State can properly address alone. Collaboration between relevant stakeholders is inherently necessary for an effective response to these complex needs. Collaboration cannot be an afterthought but must be the default modus operandi built into systems and processes.

3. Professionalism in policy and practice: responding to those with complex needs is challenging, to ensure this is done effectively professionalism must be encouraged and developed at all times and in all situations. This means not only ensuring that policy is evidenced based to the greatest extent possible, but that these policies are professionally put into practice with the commensurate resourcing, staffing and training required.

Underpinning Guiding Principles:

The HLTF is independent and its work is not solely the purview of any one of the Departments or agencies that are represented amongst its membership. At the same time the HLTF has regard to and been informed by the values and principles that underpin the activities of its constituent members as well as the wider policy context discussed above.

[1] The Probation Service, About Us; http://www.probation.ie/EN/PB/AboutUsPage?readform#:~:text=We%20recognise%20the%20importance%20of,of%20a%20quality%20public%20service.

Notwithstanding operational pressures, competing priorities and resource limitations within the health services, the following guiding principles have been agreed to inform the work of the Task Force:

- Commitment to equality and human rights.
- Health led approach.
- Prison as a sanction of last resort.

By keeping a focus on the guiding principles, it is intended to make a meaningful difference to the lives of those with mental health and addiction difficulties who encounter the criminal justice system.

In prioritising interventions for this cohort, it is acknowledged that loss of liberty can have profound impact on the life of the person concerned by removing them from familial, social, health and other protective factors, destabilising healthcare interventions and potentially compounding their illness. It is further acknowledged that being convicted before the courts can have a life restricting impact with regard to personal circumstances, status and employment. By conducting its work mindful of these guiding principles, the HLTF aims not only to enhance the effectiveness of health and criminal justice interventions for the benefit of the individual recipients and their families but also the safety and confidence of the public.

The HLTF considers that these guiding principles are the necessary prerequisites to build a virtuous cycle which helps reduce the prevalence of mental health difficulties and addiction issues within the criminal justice system. This improved approach should work by reducing pressure on resources and staff, allowing for more timely and effective interventions for those who require it, reinforcing the essential rehabilitative and re-integrative work undertaken as part of the criminal justice response leading to reduced recidivism for this vulnerable cohort of the population.

Commitment to Equality and Human Rights

The HLTF's work has been informed by the guiding principle of commitment to equality and human rights. Section 42 of the Irish Human Rights and Equality Commission Act 2014 establishes a positive duty on public bodies to have regard to the need to eliminate discrimination, promote equality and protect the human rights of staff and the people to whom services are provided.

Public bodies in Ireland are required to comply with the Public Sector Human Rights and Equality Duty ('the Public Sector Duty'). The definition of a public body for the purposes of the Duty includes:

- a Department of State
- a local authority
- the Health Service Executive
- a university or institute of technology
- an education and training board

- any other person, body or organisation established under statute, or under any scheme administered by a Government Minister, excluding the Defence Forces
- a company wholly or partly financed by or on behalf of a Government Minister, in pursuance of powers conferred by or under another enactment
- a company where the majority of shares are held by or on behalf of a Government Minister

In addition, any other person, body, organisation or group financed wholly or partly out of moneys provided by the Oireachtas, may, in the public interest, be prescribed as a public body by the Minister for Justice, following consultation with the Irish Human Rights and Equality Commission. With this in mind it is clear that there is a statutory duty on the various Departments and agencies represented on the HTLF to be committed to equality.

Section 29 of the Irish Human Rights and Equality Act 2014 defines human rights, for the purposes of the Public Sector Duty, as meaning those rights and freedoms of individuals which are protected by the Irish Constitution; by the European Convention on Human Rights Act 2003; and by provisions in other international treaties which have been given "the force of law" in Ireland.

Equality rights arise under the Constitution and international law, and many of the State's equality and anti-discrimination protections are derived from EU law including the EU Charter on Fundamental Rights and the EU Equality Directives which underpin Ireland's equality legislation. Ireland's principal equality legislation is set out in the Employment Equality Acts 1998-2015 and the Equal Status Acts 2000-2015. Many human rights treaties, to which Ireland is a signatory, recognise the right of everyone to the highest attainable standard of physical and mental health. At the core of Ireland's human rights treaty commitments is a range of principles that underpin the fulfilment of all civil and political, social and economic rights for all people.

This Public Sector Duty is consistent with the core functions and values of the various Departments and agencies who interact with individuals with mental health difficulties and addiction issues as they come in contact with the Criminal Justice System. So it is appropriate that the HLTF's work and recommendations have been informed by the guiding principle that the public sector should commit to value and promote equality and human rights through their day to day work, whether in delivering key public service, developing policy and legislation in an inclusive human rights compliant manner or in doing their work in an efficient, fair manner with integrity and respect for human dignity. Furthermore, equity is a core value underpinning *Sharing the Vision*, our national mental health policy. The policy, which reflects human rights as a service delivery principle, further maintains that access to mental health services and supports should be characterised by inclusiveness, fairness and non-discrimination.

By being guided by a firm commitment to equality and human rights, the HLTF's work is further informed by some attendant conclusions. These conclusions reinforce the guiding principle and include that there should be equivalence of access to services/care for all those engaged with the criminal justice system. Just as a failure to provide timely and sufficient care for a physical injury

and illness would be recognised as intolerable we should expect and accept no less a level of care and access to services for those with mental health difficulties and addiction issues.

Health-Led Approach

The HLTF's Terms of Reference required the group to examine the needs of individuals coming in contact with the criminal justice system who have mental health difficulties and addiction issues. Mental health difficulties and addiction issues are inherently health matters. As such, the substantive focus of the HLTF's work lies in addressing these health needs in the first instance and not primarily the prism of criminal justice. The HLTF is agreed that, and its work has been informed by, the guiding principle that health interventions should be the primary response, where possible.

Of relevance, in particular but not limited to addiction issues, the HLTF notes the Government's National Drugs and Alcohol Strategy, "Reducing Harm, Supporting Recovery - a health-led response to drug and alcohol use in Ireland 2017-2025". That strategy recognises the need for a balanced health-led approach - reducing demand, while also reducing access to illegal drugs, and is aimed at reducing the number of people criminalised for the possession of drugs for personal use. This demonstrates that health-led approach to a criminal justice concern, where the issue at hand and contributing to the criminality is health based, is appropriate and has already been embraced by the Government in respect of one element of the HLTF's remit.

Ancillary to a health-led approach, is the conclusion that to reinforce this guiding principle, there must be a seamless care pathway for those concerned to ensure continuity of care. Self-evidently and borne out in the experience of Task Force members and research generally, health needs do not end at the point of arrest or sentencing. The HLTF has adopted this conclusion and attempted to ensure it is reflected throughout the entirety of an individual's interactions with the criminal justice system through the work of each of the subgroups. Taking this guiding principle and conclusion, the HLTF has identified opportunities to ensure a seamless care pathway for care at each stage, whether from diverting individuals from arrest to treatment, to setting out care pathways allowing movement between treatment levels as required for those in custody, to strengthening the access to, support for accessing care in the community.

Guided by the principle of a health-led approach the High Level Task Force aims to build a model of intervention that is person-centred, inclusive of a pathway of care which is responsive to those with complex needs, and which supports outcome focused client engagement. *Sharing the Vision* adopts a human rights-based approach, emphasising the importance of consent, capacity, and a person-centred perspective that focuses on enabling recovery through an emphasis on personal decision-making supported by clinical best practice. The HLTF acknowledges that an individual

deemed to have capacity may, in some instances, not adhere to clinical advice. When a person is diverted away from the criminal justice system and towards mental health services, it is important to recognise that no individual that is considered to have capacity can be forced to engage with mental health supports and treatments should they not wish to do so, This is not to say that there will be no need for criminal justice sanctions or measures in respect of individuals with mental health difficulties or addiction issues. Rather the HLTF re-emphasises that the guiding principle in these situations should be a health-led approach, which rightly recognises that treating the underlying health need in the first instance will be essential to an effective resolution from a criminal justice standpoint. Without obviating the genuine need for a criminal justice response, the HLTF concludes that the first line of response must be health-led and that this health response can ideally be a part of a structured community sanction where this is necessary and appropriate. As articulated, in respect of substance misuse, in Reducing Harm, Supporting Recovery (2017) '*substance misuse is harmful to the individual and can lead to an increase in criminal activity, causing harm and victimisation in communities. Where this is the case, the importance of access to targeted substance misuse interventions for those subject to criminal justice sanctions in the community, such as probation supervision, can provide an opportunity to support and effect change in the lives of these individuals and their communities'*.

Prison as a sanction of last resort

The work of the HLTF exists at the intersection of the health and criminal justice spheres. The work of the HLTF rightly focuses on the need to address shortcomings in the provision of healthcare, but by necessity the HLTF must also grapple with the criminal justice realities involved in addressing the specific needs of this vulnerable cohort of the population.

While punishment for those who commit crime is a central element of our justice system, the rehabilitation and reintegration of offenders is at the core of our penal system. Particularly with reference to the individuals with mental health difficulties and addiction issues, the HLTF has been guided by this rehabilitative and re-integrative principle.

The HLTF considers that criminal sanctions represent punishment for crimes committed against individuals and society. The HLTF recalls that all sanctions imposed, whether custodial or community based, represent a visible punishment and interrupt a person's liberty or freedom of movement. The HLTF notes that punishment alone, as experience and research have shown, does not prevent offending or make everyone safer. Interventions and services to promote pro-social behaviour, rehabilitation, and desistance from offending are necessary to drive and sustain real change. The HLTF considers that this general rehabilitative principle is especially pertinent in respect of individuals with mental health difficulties and addiction issues. This is not to be misunderstood as not holding people to account for the harm they have done to individuals and

communities. In this regard, it is important to ensure the judiciary retain the discretion to hand down proportionate sentences in cases of serious crimes, and to recognise that prisons remain an appropriate sanction in such instances.

The HLTF notes the 2018 Report on Penal Reform and Sentencing by the Joint Oireachtas Committee on Justice and Equality ('the 2018 Report'). The 2018 Report recommended that prison should be a last resort for minor criminal offences and says that '*the emphasis of a progressive penal and sentencing policy should be on investment in community-based sanctions and non-custodial sentences. Community based sanctions are not only more effective in many cases, but can generate community payback and result in enormous savings compared to the costs of incarceration'*.

In the contribution of the Irish Penal Reform Trust to the Joint Oireachtas Committee, particular attention was drawn to the connection between imprisonment, recidivism and mental health difficulties and addiction issues, '*the prison population is characterised by mental health issues, addictions (often together: "dual diagnosis"), homelessness, poverty, unemployment, educational disadvantage, chaotic family backgrounds and social marginalisation. An estimated 70% of people in prison have addictions (85% of female prisoners); and the prevalence of mental illness ranges from 16% to 27% among male prisoners, and from 41% to 60% among female prisoners. In this context, it is not surprising that reoffending rates on release from prison are high, with 45.1% of prisoners committing a further offence within 3 years of release.*' It is also noted that there is some evidence that prison itself may be criminogenic, that is to say imprisonment may be more likely to lead to further criminality rather than putting an end to it, as discussed by Professor Ian O'Donnell in his 2020 report on recidivism, "An Evidence Review of Recidivism and Policy Responses". These are further evidence of the appropriateness of the HLTF's guiding principle that prison should be sanction of last resort.

This guiding principle naturally leads to certain ancillary conclusions that reinforce the overarching position that imprisonment should only be utilised when absolutely necessary and where no more suitable alternative can be employed. These further conclusions which have informed the HLTF's work include that persons presenting with mental health difficulties should be diverted from the criminal justice system where possible and appropriate and that this diversion should take place at the earliest point (i.e. pre court, pre conviction, pre detention). These principles are in line with recommendations 55 and 87 of *Sharing the Vision*, which reinforce the importance diverting people with mental health difficulties away from the criminal justice system at the earliest possible stage, and ensure their needs are met within community and/or non-forensic mental health settings.

Chapter 3: Subgroup 1

Mental Health and Addiction Challenges of persons interacting with the Criminal Justice System

Subgroup 1: Diversion

The implementation of a diversion approach by An Garda Síochána for use in suitable cases when members come in contact with adults with a mental illness or addiction who may have committed a minor offence

Executive Summary

This is the final report of subgroup 1 which is an interdepartmental group establishment as part of a High Level Taskforce appointed to consider the mental health difficulties and addiction challenges of persons interacting with the criminal justice system. The Interdepartmental Group under the independent Chair Ms. Kathleen Lynch, have examined issues relating to people with mental illness who come in contact with the criminal justice system includes representatives of the Department of Justice, An Garda Síochána the Department of Health, the Health Service Executive, the Probation Service and the Irish Prison Service.

The establishment of the Taskforce is key to ensuring the critical mental health needs and addiction treatments for people who end up within the criminal justice system. Subgroup 1 is primarily focused at the point of first instance who offending occurs and implementation of a meaningful diversion policy within An Garda Síochána can lead to improved outcomes to the individual which will result in reduced demands on policing, courts and consequentially the prison system. The group set out to identify suitable cases when Gardaí come in contact with adults with mental illness who may have committed a minor offence.

Over a 12 month period the Departments and bodies on subgroup 1 have worked collectively to identify and set out the implementation actions required to provide appropriate care for vulnerable persons interacting with the Criminal Justice System. The subgroup has prepared this report with recommendations that will contribute to the high level implementation plan that will be published by the Taskforce by the end of the year. In identifying a meaningful diversion policy within An Garda Síochána it is clear that providing appropriate healthcare and responding to the needs of the vulnerable who interact with the criminal justice system must be to the fore.

Subgroup 1 in fulfilling their role with the Taskforce have consulted extensively with other relevant stakeholders including the Mental Health Commission, Inspector of Prisons, Irish Penal Reform, Office of the Director of Public Prosecutions, Community Restorative Justice projects and representatives from academia.

The Taskforce will achieve a more integrated and holistic approach to identified persons interacting with the criminal justice system that will reflect on previous publications in this area including *Sharing the Vision* and the Interdepartmental Groups established to examine issues relating to people with mental illness who come in contact with the Criminal Justice System from 2009, 2012 and 2018. It is also in line with the national and European drugs strategies as well as the Youth Justice Strategy 2021-2027. The recent report by the Garda Inspectorate that examined the standard of treatment, safety and wellbeing provided to persons in custody in Garda Síochána stations highlighted the need for the HLTF work in that Garda custody records showed 48 per cent of those in custody in that period had consumed or had a dependency on alcohol, drugs or both; 25 per cent had poor mental health or had engaged in self-harm; and 14 per cent had drug or alcohol issues as well as poor mental health. It is a priority of the subgroup that processes and policies will be recommended to help reduce the need for persons within these cohorts to be in the custody setting from the outset. The development of an achievable implementation plan is central

to the members of subgroup 1 which has the added clarity of short, medium and long term objectives.

Recommendations

Number 1

Amendment to Adult Caution Scheme

The Adult Caution Scheme, while not in itself a form of diversion, provides an important mechanism to facilitate the development of a mental health/addiction diversion model and its role in supporting diversion from the Criminal Justice system. The amendment to the scheme should be specifically cognisant of Mental Health and Addiction Challenges of persons interacting with the Criminal Justice System. The amendment will not see a significant structural change but enhance the terminology and language of the scheme to reflect the need for flexibility and consideration of the situation of persons with mental health difficulties, addiction issues or other significant life challenges, and the desirability of diverting such people away from the Criminal Justice system. The scheme should now consider the use of adult cautions on direction from the ODPP where previous convictions and cautions already exist once evidence of crisis, mental illness, addiction or situational trauma are identified.

Implementation Period – Short Term

Number 2

Aligning the operation of the Adult Caution Scheme with the prosecutor guidelines

Aligning the operation of the Adult Caution Scheme with the prosecutor guidelines so that mental health difficulties are treated in a uniform manner and opportunities for diversion are supported in all appropriate cases.

Implementation Period – Short Term

Number 3

Consideration for expanding the offences under the Adult Caution Scheme

In December 2020 AGS announced that it had collaborated with the Director of Public Prosecutions and that an expansion of the Adult Caution Scheme to include four additional offences had been approved. Section 3 of the Misuse of Drugs Act 1977/84 (simple possession) is now included in the scheme but only applies to the possession of cannabis and cannabis resin. No other controlled drugs are permitted under the Scheme. The confinement of the Adult Caution in relation to Section 3 offences for cannabis and cannabis resin only will create a number of practical difficulties. These include the identification of the substance as cannabis or cannabis resin at a time when there has been an increase in the use of different forms of cannabis (edibles, vaping, shatter etc.) and an increase in synthetic cannabinoids which may be difficult to differentiate from cannabis. In addition,

the opening up of the Night Time Economy will result in an increase in a number of stimulant type drugs that will have the potential to cause mental health difficulties e.g. MDMA or cocaine. In terms of the cohort of individuals this subgroup is focusing on the prevalence of amphetamine use is a considerable concern. The extension of the Adult Caution Scheme to cover simple possession of other drugs could have the beneficial effect of preventing a 'person in crisis' from entering the Criminal Justice system and may represent an opportunity for signposting to appropriate health services.

Implementation Period –Medium to Long term

Number 4

Use of the public interest principle from the Prosecutor Guidelines

Greater focus on using the public interest principle from the Prosecutor Guidelines 5th Edition in relevant cases involving persons experiencing mental health difficulties and addiction problems, to promote flexible responses to individual cases which maximise opportunities to divert people away from the criminal justice system.

Implementation Period – Short Term

Number 5

Diversionary Elements An Garda Síochána – Knowledge and Awareness of services in the community

Provision of information and signposting to community-based support services by AGS following an adult caution or non-prosecution in the public interest. Regional Guidance based on services available within the relevant area that is accessible via mobility device. Training should be planned and integrated to align appropriately with the work of the Garda Youth Diversion Bureau and the implementation of the Youth Justice Strategy 2021-2027.

Implementation Period – Short Term

Number 6

Progressive and Empathic approach by An Garda Síochána

Creating a more progressive, empathic and inclusionary approach for AGS through updating guidelines and practices for front-line and supervisory Gardaí.

Implementation Period – Short-Medium Term

Number 7

Guidance Definition to be integrated into the relevant policies of An Garda Síochána and agencies with the Criminal Justice family.

The subgroup have proposed a definition for person in crisis that is based on the Toronto definition with additional input from academics and practitioner in Ireland. The proposed definition is as follows *an individual experiencing a mental health crisis whether it is due to a diagnosed mental illness, addiction challenge, intellectual or developmental disability or a temporary breakdown in coping skills due to situational trauma*. In order for practical implementation and use the subgroup proposes that this definition be a guidance definition whereby the individual needs to "fit" the guidance definition as opposed to "meet" which avoids labelling in terms of the prerequisite for diagnosis as any individual can experience temporary trauma.

Implementation Period – Short-Medium Term

Number 8

Mental Health and Addiction Awareness Training in An Garda Síochána

Provision of cross disciplinary awareness training in AGS to promote diversionary approaches in appropriate cases, including with regard to mental health, addiction, homelessness, lack of maturity or other circumstances which may contribute to some offending behaviours. Such training should be planned and integrated to align appropriately with the work of the Garda Youth Diversion Bureau and the implementation of the Youth Justice Strategy 2021-2027.

Implementation Period – Short-Medium Term

Number 9

Cross-agency collaboration – CAST Pilot Limerick

The potential to use the Crisis Intervention CAST model as an integral part of a diversion model should be progressed by quantifying the resources across agencies, including Garda and HSE, which are required to operate it in a given area. The subgroup strongly recommends that the pilot project receive full support to develop the concept of a community hub as a focus for providing assistance to persons who come to Garda attention – whether in relation to mental health, addiction or other issues. Significant international collaboration with similar models overseas has highlighted the potential progression in the area. The subgroup believes that the CAST project is superbly placed to develop an integrated diversion model incorporating use of Adult Caution Scheme, diversionary interventions, non-prosecutorial practices and the Support Hub to facilitate appropriate therapeutic and/or personal supports thereafter. It is also positioned perfectly to conduct relevant research, develop the appropriate rollout of training nationally and learn further from expert supports.

Implementation Period –Short to Medium Term

Number 10

Development of a pilot DBI programme in conjunction with the Limerick CAST project and one other AGS Division/HSE Health area is to provide a framework for improved inter-

agency co-ordination, collaboration and co-operation across a wide range of care settings, interventions and community supports.

Enhance diversionary practices for those experiencing crisis and situational trauma that inevitably leads to mental health difficulties. The approach moves towards the shared goal of providing a compassionate and effective response to people in distress improving experience and outcomes for those experiencing distress and those providing support. The linkage to the services that hold Service Level Arrangements (SLA) is crucial. A pilot DBI programme should be planned and integrated to align appropriately with the work of the Garda Youth Diversion Bureau and the implementation of the Youth Justice Strategy 2021-2027.

Implementation Period – Short- Medium Term

Number 11

Consider the requirement for legislation to further support Mental Health diversion

Consideration should be given to the need for and opportunities to develop legislation to further support Mental Health diversion. In certain instances the lack of conditionality will be a weakness. However conditional diversion is not necessarily to be preferred approach in all cases it can depend on the individual, and motivated voluntary compliance may provide better results than a conditional approach in some cases however, with a legislative basis, a more robust and comprehensive suite of mental health interventions to be developed.

Implementation Period – Long Term

Number 12

Expand the Health Information Bill to include information sharing with additional state agencies

It is clear that the bill is restricted to the processing of heath information in the private and public side of health services and across the health care setting. While this a positive, the Bill is silent in respect of the sharing of health information beyond the health services sector which may be required in cases suitable to the subgroups work. Examine if there is scope to include information sharing to agencies within the criminal justice family where it would help those in need to access services and commence positive action plans with appropriate service providers. It would alleviate the reliance on consent and impractical data protection legislation.

Implementation Period – Medium-Long Term

Number 13

Expansion of the Spent Convictions Act

The Criminal Justice (Spent Convictions and Certain Disclosures) Act 2016 outlines that the following convictions become spent after 7 years: All convictions in the District Court for motoring

offences except for convictions for dangerous driving which are limited to a single conviction. All convictions in the District Court for minor public order offences and a single conviction (other than a motoring or public order offence) in the District Court which resulted in a term of prison term of 12 months or less (or a fine). Consideration should be given to expanding the scope of Ireland's spent convictions system to individuals who may have multiple historical convictions. This would enable the spent convictions legislation to be utilised by individuals who may have historically acquired convictions as a consequence of mental health difficulties and addiction issues or situational trauma, who it is noted are more likely to come into contact with the criminal justice system. This would allow a wider use of the Probation Act, Adult Caution and be used as rationale for a non-prosecution in the public interest. It will also help with rehabilitation and positive action plans of the individual. In conclusion historical convictions should not be a barrier to diversion.

Implementation Period – Medium-Long Term

Number 14

The Probation Act should not be recorded as a conviction or used as a barrier to diversion

It is agreed that an individual who received the Probation Act, should have it recorded however, it should not be listed as a conviction when considering eligibility for the adult scheme or used negatively in a non-prosecution public interest decision. It also has the potential to be a barrier to a person in crisis with mental health difficulties or addiction issues to progress within society in terms of employment and housing for example.

Implementation Period – Medium Term

Number 15

Progressive use of The Probation Act – a catalyst to services

The appropriate use of the Probation Act in cases of offenders who fit the guidance definition can have a positive outcome for the individual involved. While this observation is perhaps outside the subgroups terms of reference which focuses on a diversion policy for An Garda Síochána at first instance, the group feels that the existing statute has potential in the context of the overall work of the Task Force.

Implementation Period – Short-Medium Term

Number 16

Ensure that problems relating to Data Sharing and Legal issues can be resolved with reference to all relevant proposals and initiatives.

The Data Sharing and Governance Act is set to replace Section 38 of the Data Protection Act 2018 with a set of new requirements for data sharing between public bodies. There is no other specific provision under law permitting or requiring such data sharing. While the majority of recommendations of the subgroup is based around individual consent to avail of diversion the

referral aspect will be undermined with the enactment of data sharing legislation. It is recommended that consideration is given to the implications on the multi-agency projects within the scope of the Policing, Security and Community Safety legislation. The subgroup believes the appropriate departments should legislate for additional powers to share data than is already defined in the GDPR/Data Protection Act.

Implementation Period – Medium-Long Term

Number 17

Ensure Linkage and Collaboration between Diversion Programmes Nationally

The synergies between the Health Diversion Programme and the Task Force should be explored and perhaps a joint submission to the Criminal Justice Strategic Committee is warranted.

At the outset it is important to note that the Adult Caution is not a diversion programme and the diversion of an individual from AGS to the HSE requires further consideration and possibly legislative change, the Implementation group of the Health Diversion Programme is considering this.

Implementation Period – Medium Term

Number 18

The Department of Health and the Department of Justice should agree on appropriate mechanisms to coordinate the work

Ensure effective coordination of work to design diversion initiatives in relation to mental health, drugs possession and young adults, and with reference as appropriate to the new Community Safety Structures envisaged in the Policing Security and Community Safety Bill. An appropriate interagency structure should be identified to oversee the development of a coherent and integrated approach to diversion from the criminal justice system with regard to health and welfare issue.

Implementation Period – Medium-Long Term

Number 19

Development of Pilot Pre-Charge Offender Reparation Referral –RJS (Restorative Justice Service)

The subgroup examined existing Restorative Justice programmes operating in various district court areas that include offender Reparation Programme resulting in proceedings being dismissed. In such schemes the Court, provides the offender the option of participation in the offender Reparation Programme before final sanction is decided. The offender attends meeting with the assigned RJS Case Worker and the Reparation Panel which is made up of one representative from An Garda Síochána, the Probation Service and the Community meet. The victim is contacted and advised of the case being referred to RJS. Information and options are provided to the victim

with regard to level of participation and / or input they might be interested in. Victim participation is completely voluntary. Part of the process involves engagement with supports and services in the community. The subgroup is recommending that a pilot project run within one of the participating district court areas whereby the local Gardaí (Inspector or Superintendent Rank) can refer directly to the RJS (Restorative Justice Service) if a suitable case and fits the guidance definition of person in crisis as proposed by the subgroup. Such a pilot should be planned and integrated to align appropriately with the work of the Garda Youth Diversion Bureau and the implementation of the Youth Justice Strategy 2021-2027. This recommendation includes the wider use of hybrid orders in the District courts so there is no criminalising of medical conditions.

Implementation Period – Short-Medium Term

Number 20

Details of all voluntary services recognised by the HSE through Service Level Arrangements (SLA) made available to AGS via mobility devices to enable diversionary practices and signposting

Access to the voluntary services recognised by the HSE is crucial to the diversionary model outlined by the subgroup. The dissemination of the relative services with SLAs via existing mobility apps and the Garda Portal intranet.

Implementation Period – Short Term

Number 21

Rollout of Dual Diagnosis Services Nationally to Assist Diversionary Practices

The subgroup is aware that the development of a Mental Health and Addiction Dual Diagnosis Service through the National Clinical Programmes has commenced. This is a very welcome development which emerged from the Dual Diagnosis Clinical Programme working group. The work if implemented will be another component of the expanding multi-agency approach. The programme has the potential to be of significant benefit to individuals with co-occurring mental health difficulties and substance use problems and the ideal resource for those individuals that the HLTF has identified. Dual diagnosis needs have been highlighted in HSE reports and national drug strategies going back to 2007, including the 2012 National Substance Misuse Strategy.

Implementation Period – Medium-Long Term

Number 22

Establishment of Criminal Justice Secure Email domain between the partner agencies to facilitate diversion and safe sharing of information.

The subgroup are aware of CJSM (Criminal Justice Secure Email) in neighbouring jurisdictions operate a safe domain between the partner agencies whereby information sharing and emails cannot go externally outside this secure system. The decision for diversion suitability can be made

in conjunction with partner agencies or it can be used a red flag risk system and interventions can be made by support services.

Implementation Period – Medium-Long Term

Number 23

Provision for a Standardised Assessment Form

The subgroup believes a standardised assessment form will reduce the burden on individuals who wish to receive public services from having to provide the same information to different public bodies and it will also facilitate the effective administration of public health services and supports. This would need to be coordinated by the Department of Health.

Implementation Period – Short-Medium-Long Term

Number 24

Provide High Spec Technological upgrades to enable implementation of recommendations.

The subgroup recognised that many of the recommendations require a specific technological upgrade. The resources required should be implemented as a priority. The upgrades, applications and capabilities should include a high spec digital platform that underpins the modernisation of the processes and services.

Implementation Period – Short-Medium-Long Term

IDG Recommendations identified as fitting with the work of this group:

Recommendations 1 – 14 (IDG Report 2012 *) **Recommendations 15 – 29 (IDG Report 2018**)**
1. An Garda Síochána implement a diversion policy as described in this Interim Report for use in suitable cases when they come in contact with adults with mental illness who may have committed a minor offence. *Subgroup 1 have carried out substantial work to progress this recommendation.*
2. The Department of Health consider whether any amendments to sections 9 and 12 of the Mental Health Act 2001 are required to facilitate the operation of a Garda diversion policy. *Department of Health & An Garda Síochána have submitted extensive observations and comments as part of the Mental Health Act 2001 review. Representatives of both agencies on subgroup 1 contributed to same.*
3. The Department of Health consider the implications of any changes to the procedures for involuntary admission to approved centres under the Mental Health Act 2001 for the duration of detention in Garda stations of persons taken into custody under section 12 of the Act. *Subgroup have examined this recommendation and comments included in the report*
4. An Garda Síochána, Office of the Director of Public Prosecutions and the HSE consider whether it will be necessary to develop protocols and/or guidelines for the operation of a Garda diversion policy. *Subgroup have carried out substantial work to progress this recommendation.*
6. That prison in-reach, court liaison and diversion services should not be put on a formal statutory basis at this time. *Subgroup 1 primarily working towards diversion at first instances but legislative recommendations made in the report.*

Terms of Reference Subgroup 1 Diversion

This subgroup will:

• Revitalise the IDG recommendation that An Garda Síochána implement a diversion policy for use in suitable cases when members come in contact with adults with mental illness who may have committed a minor offence;

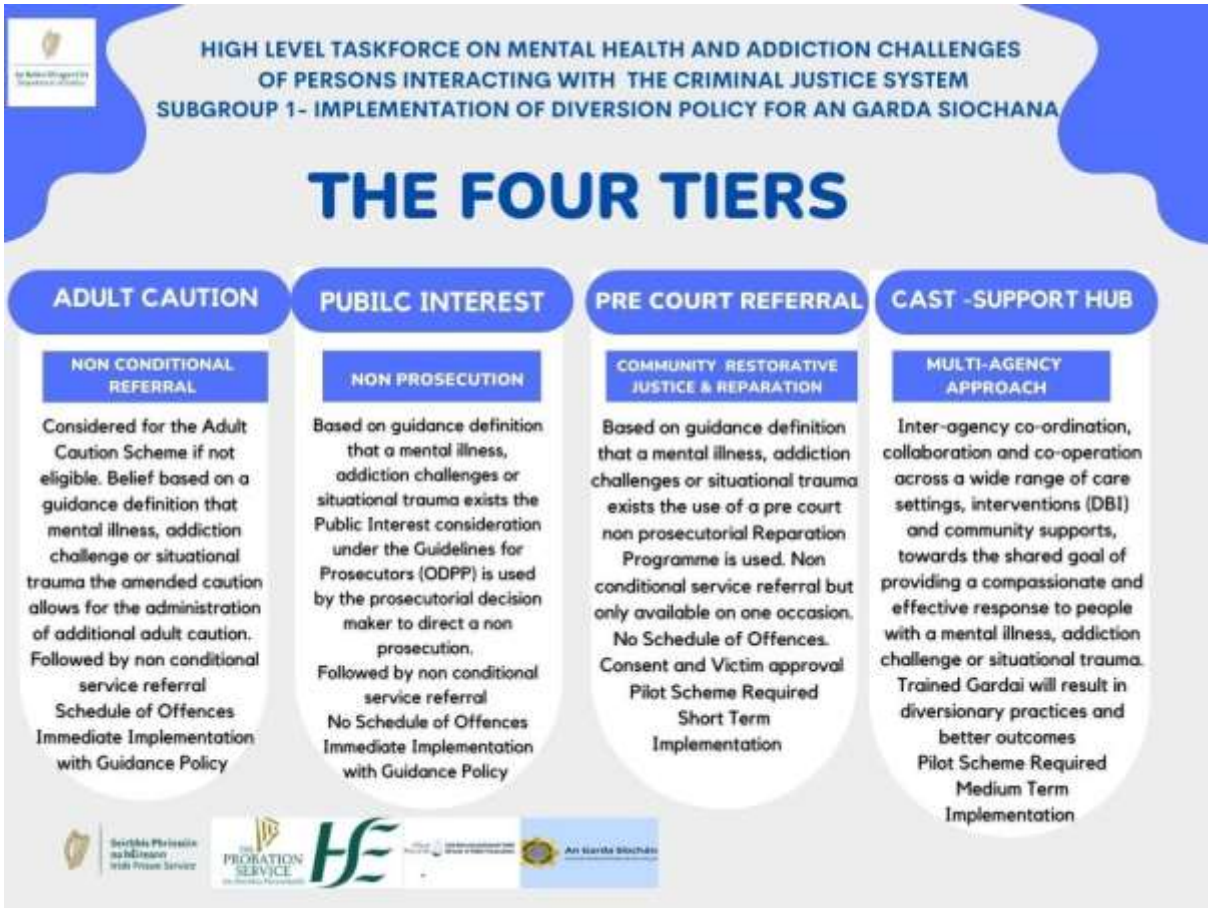
• Examine the IDG recommendation that An Garda Síochána, the Office of the Director of Public Prosecutions and the HSE consider whether it will be necessary to develop protocols and/or guidelines for the operation of a Garda diversion policy;

• Explore synergies between mental health and addiction services so that prevention opportunities are mainstreamed for individuals, including children, coming in contact with the criminal justice system;

• Ensure the structure and framework can be responsive to groups with specific needs, including 18-24 year olds, in line with the Youth Justice Strategy 2021-2027; and

• Consult with relevant stakeholders as deemed necessary.

Subgroup 1 – Diversion "The Four Tiers"



1. Introduction and Background

The following is the final report submission for subgroup 1: Diversion. This report is prepared for the overarching Interdepartmental Group which is examining issues relating to people with mental illness who come in contact with the criminal justice system. As part of the process the Government enabled the establishment of a new High Level Taskforce (HLTF) to consider various silos of the criminal process in Ireland. The Taskforce has set out to improve the critical mental health needs for people and provide and primary care support to ensure improved outcomes for individuals and for society. The subgroups are coordinated by the Department of Justice and holistically chaired by former Minister of State, Ms Kathleen Lynch. Subgroup 1 has outlined twenty four (24) recommendations in respect of diversionary options for persons interacting with the Criminal Justice System with Mental Health and Addiction Challenges. These recommendations along with submissions from the other subgroups will be considered by the HLTF as it prepares its final report.

2. Composition of Subgroup 1: Diversion

Chief Superintendent Gerry Roche of the Limerick Garda Division is the chairperson of subgroup 1 which examines a diversion policy for persons with mental health difficulties, situational trauma and vulnerability. The work of the subgroup was coordinated by Penal and Policing Policy, Dept.

of Justice. This work commenced in June 2021 and subgroup 1 has met on multiple occasions over the last nine months.

The membership of the subgroup is outlined below with representatives from the Department of Health, Irish Prison Service, HSE, Dept. of Justice, Probation Services, Dept. of Children, Equality, Disability, Integration and Youth, An Garda Síochána (Implementation Team for the Crisis Intervention Team CAST Project).

- Gerard Roche, (Chair) Chief Superintendent, AGS
- Andrew Lacey, Superintendent AGS
- Dr Eamon Keenan, National Clinical Lead-Addiction Services, HSE
- Grace Sheahan, Executive Officer, AGS
- Brendan Sheehy, Assistant Principal Officer, Community Safety Policy, Dept. of Justice
- Seamus Hempenstall, Principal Officer, Mental Health Unit, Dept. of Health
- Michael Murchan Assistant Principal Officer, Mental Health Unit, Dept. of Health
- Deirdre O'Flaherty, Administrative Officer, Mental Health Unit, Dept. of Health
- Eoin Ryan, Regional Manager, Probation Service
- Enda Kelly, National Nurse Manager, Irish Prison Service
- Tony O'Donovan, Principal Officer, Child Welfare Advisor, Children Detention Unit, Dept. of Children, Equality, Disability, Integration and Youth
- John Dunphy, Assistant Principal Officer, Penal and Policing Policy, Dept. of Justice
- Oonagh Ffrench, Higher Executive Officer, Penal and Policing Policy, Dept. of Justice
- Kerrie Keegan, Executive Officer, Criminal Collaboration, Dept. of Justice

3. Terms of Reference subgroup 1: Diversion

Subgroup 1 was tasked with revitalising the IDG recommendation that An Garda Síochána implement a diversion policy for use in suitable cases when members come in contact with adults with mental illness who may have committed a minor offence. This process would include the examination of the IDG recommendation that An Garda Síochána, the Office of the Director of Public Prosecutions, HSE and other stakeholders would adopt a multi-agency approach to implementing a new Garda diversion policy and ultimately prevent individual's and vulnerable persons with mental health difficulties coming in contact with the criminal justice system. Subgroup 1 has also consulted with other relevant stakeholders, as required, including the Mental Health Commission, Inspector of Prisons and academic experts in the discipline of psychiatry.

4. Use of the Adult Caution Scheme and Public Interest Prosecutorial Decision Making

It is noted that the title of the working group refers to AGS Diversion Policy. At the earliest stage the subgroups work identified that the existing adult caution scheme and the existing prosecutorial avoidance emerged as the foundation of our work. While AGS diversion may be the title of the Working Group, it is important to note that the Adult Caution Scheme is not a diversionary scheme. However the subgroup are in agreement that with some amendments and change of focus in

certain areas the Adult Caution Scheme is an existing non statutory binding scheme that can successfully deliver on the subgroups terms of reference and objectives. The Adult Caution Scheme was approved by the Director of Public Prosecutions and became operational on 1st February, 2006. The group will outline a proposed amendment of the schemes procedures which is the preferred option in terms of developing a non-judicial prosecution policy for use in suitable cases involving persons with mental illness and situational trauma who interact with the criminal justice system through minor offences at the first instance. The existing scheme applies to persons aged 18 years and upwards and involves a schedule of minor offences only.

It is an alternative to the prosecution of certain persons against whom there is evidence of the commission of a scheduled criminal offence where the prosecution of such offence is not required in the public interest. The use of the Adult Caution Scheme is growing year on year resulting in eligible low level is the primary adult diversion policy operating in this jurisdiction and is reviewed annually with the Office of the Director of Public Prosecutions and AGS. The objectives of the HLTF were discussed by the subgroup and it was agreed that the Adult Caution Scheme has diverted persons with mental health difficulties and addiction challenges from the outset of the scheme in 2006 without it being specifically captured in terms of policy or data. The subgroup agreed that the Adult Caution Scheme has been incredibly successful since its introduction but is silent in terms of incorporating language or guidance pertaining to individuals relevant to this subgroups Terms of Reference. The subgroup consulted with the Office of the Director of Public Prosecutions (ODPP) who retain ownership of the scheme. The ODPP was not entirely in favour of changing the Adult Caution Scheme given its success and efficiency but is disposed to an amendment to the procedures document to align the definition of 'public interest' with the definition contained in the DPP Guidelines for Prosecutors. Therefore, it is the view of the subgroup and in particular Crime Legal AGS that language such as 'Amendment to Adult Caution Procedures to expressly take account of mental health difficulties etc.' would more appropriately reflect the situation.

The decision to administer a caution instead of a prosecution is a serious decision to take and before it is taken it must be clear that the offence is of a kind that is appropriate for consideration of a caution and must be one of the schedule of offences attached hereunder, and the offender is deemed to be a person suitable for consideration. As it stands if the offender has previous convictions or previously received a caution they are not eligible for the caution a second time which the subgroup propose to recommend a change that will remedy such a restriction in particular circumstances.

The following matters need to be specifically addressed by Gardaí in making the Adult Caution referral:

i. The decision to caution

ii. The public interest

iii. The views of the victim

and following conditions must be met before a caution can be administered:

- There must be prima facie evidence of the offender's guilt,
- The offender must admit the offence,
- The offender must understand the significance of a caution and,
- The offender must give an informed consent to being cautioned.

The subgroup agreed that the amendment of the Adult Caution Scheme is the most effective and efficient way of implementing a prosecution avoidance policy for use in suitable cases when members come in contact with adults with mental illness, addiction challenges or related situational problems who may have committed a minor offence. The architectural framework and policy document was already in existence and developed over 15 years. The areas of expansion would focus on a) administering cautions on direction from the ODPP where previous convictions and cautions already exist and b) creating a more progressive and inclusionary approach for AGS going forward c) enhancing the terminology and language of the scheme d) aligning the adult scheme with the prosecutor guidelines e) provision of information and signposting to community based support services following a caution or non-prosecution in the public interest.

5. Collaboration with Crime Legal AGS and the Office of the Director of Public Prosecutions

The most significant consultation for the subgroup occasioned when a meeting with representatives from Crime Legal AGS and the directing division of the Office of the Director of Public Prosecutions took place. This was a progressive meeting whereby the work of the subgroup and the taskforce was discussed. As stated the Adult Caution Scheme is afforded to all individuals if they meet the criteria. The ODPP retains ownership of the Adult Caution Scheme and it is clear that they will continue to make the final decision if previous convictions exist on foot of AGS recommendations and any supporting materials.

The ODPP outlined to the subgroup members that there is no possibility of a conditional caution in respect of follow up service and referrals. The caution is an *alternative to prosecution* and is not conditional to the offender partaking is additional commitments. There may be a role for community support teams and mental health services but it is believed that signposting and the provision of information might be the preferred outcome. This is consistent with the report by Working Group to Consider Alternative Approaches to the Possession of Drugs for Personal Use (Sheehan Report) which looks to reducing harm and support recovery through a health diversion scheme.

The ODPP had concerns about capacity and members of AGS making assessments on the level of mental illness or vulnerability at first point of contact. This was further discussed in the context of the nature of minor offences and that no decision would be made without a report submitted to the ODPP for decision, which was welcomed. This report would present all available information (in line with GDPR) to investigating Gardaí and would include the criteria that currently exist within

the scheme that would help with the decision making process. The delegation of decisions to refer to the ODPP for decision should also be unambiguous to front line Gardaí.

The key component of the existing scheme as highlighted by the ODPP and the Executive Director of Crime Legal AGS was the existing use of the public interest to discontinue or a decision not to prosecute. The expanded scheme would have to make amendments to its policy to ensure overlap and consistency between the Guidelines for Prosecutors [5th Edition - December 2019]. It would also be necessary to elaborate on the definition of public interest which has clarity within the Guidelines useful to the subgroups work.

It was agreed that no statutory provisions/changes are required to expand the Adult Caution Scheme as proposed. It is a policy designed to avoid court proceedings in suitable cases that involve episodic offending and is regarded as part of the CJS.

An Garda Síochána will be meeting with the ODPP later in the year to review the Adult Caution Scheme and it is hoped the current proposal will be included and incorporated into future policy documents. It was agreed at the conclusion of the meeting that the proposal is centred on progressive, enhanced thinking by AGS without a fundamental change to the existing process.

6. Person in Crisis guidance definition

On the 2nd of September 2021 Prof Gulati (HSE/University of Limerick) and Dr Alan Cusack (School of Law University of Limerick) presented to the subgroup in respect of definitions and terminology relevant to the proposed expanded Adult Caution Scheme that would appropriate to the subgroups work and strive to be inclusionary and beneficial to those vulnerable persons in Irish Society who could benefit from prosecutorial diversion.

Careful consideration was given to language and terminology for inclusionary consideration. As members of the subgroup are involved in ongoing works pertaining to the implementation of co response Crisis Intervention Teams they have leanings through international collaborations. The Toronto CIT model defines a person in crisis as an *individual experiencing a mental health crisis whether it is due to a diagnosed mental illness or a temporary breakdown in coping skills due to situational trauma.* The group favoured this definition as the starting point for discussions and engagement with additional stakeholders.

Prof Gulati and Dr Cusack agreed with the group and felt that the Toronto model was a common sense definition which was board enough not to tie the hands of front line Gardaí. Dr Cusack outlined that there is a lack of a clear definition for mental disorders and vulnerability in Irish Law. Prof Gulati and Dr Cusack proposed the following *guidance definition/terminology* which has additional wording pertaining to intellectual or developmental disabilities. It was highlighted that this guidance definition avoids labelling in terms of the prerequisite for diagnosis as any individual can experience temporary trauma.

Person in Crisis :an individual experiencing a mental health crisis whether it is due to a diagnosed mental illness, addiction challenge, intellectual or developmental disability or a temporary breakdown in coping skills due to situational trauma

The subgroup agreed that that a diagnosis requirement for inclusion into the diversion policy would be rigid and overly difficult for frontline members of AGS to implement. Secondly, it would place an additional burden on health professionals who are already experiencing huge volumes of cases and referrals. Dr Cusack felt that this definition also widened the eligibility to persons with physical or intellectual disabilities who may experience situational trauma.

It was felt that the definition of 'Person in Crisis' needed to be guidance only and “fit” with the presentation as opposed to “meeting criteria” or establishing actual diagnosis. The draft definition will raises a number of issues in terms of workability for frontline members on the ground but it is felt these issues can be overcome with the provision of training and policy advice from AGS Crime Legal and the ODPP.

The following questions arose:

- What is the extent of a mental illness and where is it defined?
- What is the extent of an intellectual disability and where is it defined?
- What is a developmental disability and where is it defined?
- What is a temporary breakdown?
- What is the meaning of coping skills?
- What is situational trauma?
- How is any of these matters diagnosed?

It is accepted by the subgroup that these terms are ambiguous to the non-trained medic. These are critical matters that will require clarity but it is proposed that the person in crisis definition is to be used as a guidance resource in suitable cases and confirmation of diagnosis is not ultimately required. The training of operational Gardaí will be crucial to the practical implementation of the guidance definition. The benefits and visible impact of the recommendations will be diluted and hinder implementation if overly clinical and forensic in nature. It is proposed that a prosecutorial decision maker in An Garda Síochána will have sufficient operational experience to utilise the Garda Decision Making Model in an informed manner that will lead to a positive outcome for the person in crisis. In respect to many of these cases the Director of Public Prosecutions will also have oversight of the prosecutorial decision that ultimately will have linkage to the public interest

principle. The subgroup recognises the need for further work in this area and a recommendation would be that a short online training module should be designed to assist condition identification which will form part of the CAST project implementation.

The efficiency of the amendments to the adult caution scheme procedure and public interest decision making can be problematic in spontaneous situations where time does not permit a consultation and the member has to take immediate action. In its current form this proposal will restrict immediate action from members where it is necessitated by the circumstances. The subgroup accepts avoidance of prosecution will primarily be an investigative process post offence and in certain cases where arrests were made (public order, theft and criminal damage) the submission of a report/file by the operational member of An Garda Síochána will be required to prevent a court appearance. The subgroup is confident that despite the situation arising where unavoidable arrests take place that a) the appropriate outcome will be determined in a timely manner and b) there will be instances where arrests will be avoided through the guidance and polices emanating from the work of the HLTF and consequential policy materials and awareness training.

7. The Decision to Prosecute Guidelines for Prosecutors [5th Edition] "Public Interest"

There also exists another option that the subgroup highlighted which is the authority of the Superintendent/Inspector acting in the area where the offence occurred to direct no prosecution/unsuitable for Adult Caution in the public interest. At this juncture, a decision may be taken not to prosecute in the public interest where a person was in crisis (as defined, subject to agreement) at the time of the alleged commission of the offence. This authority is obviously open to the ODPP who may also direct no prosecution/unsuitable for Adult Caution in the public interest

During the subgroups consultation with the Office of the Director of Public Prosecutions it was agreed by both sides that the alignment of the prosecutor guidelines with the subgroups work was essential. The decision to prosecute or not to prosecute is of great importance. It can have the most far-reaching consequences for an individual and is preferable to an acquittal in terms the individual and also the agencies within the criminal justice system in respect of resource deployment.

It is therefore essential that the prosecution decision receives careful consideration. As in other common law systems, a fundamental consideration when deciding whether to prosecute is whether to do so would be in the public interest. A prosecution should be initiated or continued, subject to the available evidence disclosing a prima facie case, if it is in the public interest, and not otherwise. As per the Guidelines for Prosecutors [5th Edition 2019] published by the Office of the Director of Public Prosecutions there are many factors which may have to be considered in deciding whether a prosecution is in the public interest. Often the public interest will be clear but in some cases there will be public interest factors both for and against prosecution. There is a clear public interest in ensuring that crime is prosecuted and that the wrongdoer is convicted and punished. It follows from this that it will generally be in the public interest to prosecute a crime where there is sufficient

evidence to justify doing so, unless there is some countervailing public interest reason not to prosecute. In practice, the prosecutor approaches each case first by asking whether the evidence is sufficiently strong to justify prosecuting. If the answer to that question is 'no' then a prosecution will not be pursued. If the answer is 'yes' then before deciding to prosecute the prosecutor will ask whether the public interest favours a prosecution or if there is any public interest reason not to prosecute.

In assessing whether the public interest lies in commencing or continuing with a prosecution, a prosecutor should exercise particular care where there is information to suggest that the suspect is a victim of crime. In a case in which there is credible information that a suspect is also a crime victim, the prosecutor should consider whether the public interest is served by a prosecution of the suspect.

8. Public Interest Considerations not to Prosecute (Mental Health Difficulties and Addiction Challenges)

Once the prosecutor is satisfied that there is sufficient evidence to justify the institution or continuance of a prosecution, the next consideration is whether, in light of the provable facts and the whole of the surrounding circumstances, the public interest requires a prosecution to be pursued. It is not the rule that all offences for which there is sufficient evidence must automatically be prosecuted.

The factors which may properly be taken into account in deciding whether the public interest requires a prosecution will vary from case to case. The interest in seeing the wrongdoer convicted and sentenced and crime punished is itself a public interest consideration. The more serious the offence, and the stronger the evidence to support it, the less likely that some other factor will outweigh that interest therefore the focus on minor offences within this piece of work is favourable. The first factor to consider in assessing where the public interest lies is, therefore, the seriousness of the alleged offence and whether there are any aggravating or mitigating factors. The aggravating factors are outlined clearly within the guidelines and include organised crime, use of weapons, level of violence and vulnerable victims etc.

On the other hand, the following mitigating factors, if present, tend to reduce the seriousness of the offence and hence the likelihood of a prosecution being required in the public interest: a) if the court is likely to impose a very small or nominal penalty; b) where the loss or harm can be described as minor and was the result of a single incident, particularly if it was caused by an error of judgment; c) where the offence is a first offence, if it is not of a serious nature and is unlikely to be repeated. In addition to factors affecting the seriousness of an offence, other matters which may arise when considering whether the public interest requires a prosecution may include the following: a) the availability of any alternatives to prosecution such as the Garda Síochána Adult Caution Scheme and also Youth Diversion; b) the prevalence of offences of the nature of that alleged and the need for deterrence, both generally and in relation to the particular circumstances of the offender; c) the need to maintain the rule of law and public confidence in the criminal justice system.

The area of primary interest to the HLTF in respect to the Prosecutor Guidelines is whether the consequences of a prosecution or a conviction would be disproportionately harsh or oppressive in the particular circumstances of the offender. This can be further focused on whether an offender who has admitted the offence has shown genuine remorse and a willingness to make amends and whether the offender is either very young or elderly or *suffering from significant mental or physical incapacity (p.17 Guidelines for Prosecutors [5th Edition 2019]).*

The criteria for the exercise of the discretion not to prosecute on public interest grounds cannot be reduced to something akin to a mathematical formula; indeed, it would be undesirable to attempt to do so. The breadth of the factors to be considered in exercising this discretion reflects the need to apply general principles to individual cases. Where there are mitigating factors present in a particular case, the prosecutor should consider whether these are factors which should be taken into account by the sentencing court in the event of a conviction rather than factors which should lead to a decision not to prosecute. Nevertheless, where the alleged offence is not as serious as plainly to require prosecution, the prosecutor should consider whether the public interest requires a prosecution. Finally the public interest does not prohibit the administration of an adult caution notwithstanding the existence of a mental illness or addiction and where the person has a previous conviction.

9. Classification of Minor (Summary) v Serious (Indictable) offences

The subgroup considered the offences that should be included within the ambits of the subgroup's work. The IDG Report in 2012 specify that a diversion policy is recommended for adults with mental illnesses who may have committed a minor offence. The subgroup in its engagement examined the nature of minor offences and their district relationship with summary offences which are dealt in the District Court and are classed as minor offences. Minor offences are not defined in the Constitution or in the statute books but generally minor offences are offences which attract a maximum penalty of 12 months imprisonment or less and a fine**.** Outside of minor offences this jurisdiction has indictable offences which are termed hybrid offences and while they carry a sentence of 5 years or more can be tried summarily in certain circumstances.

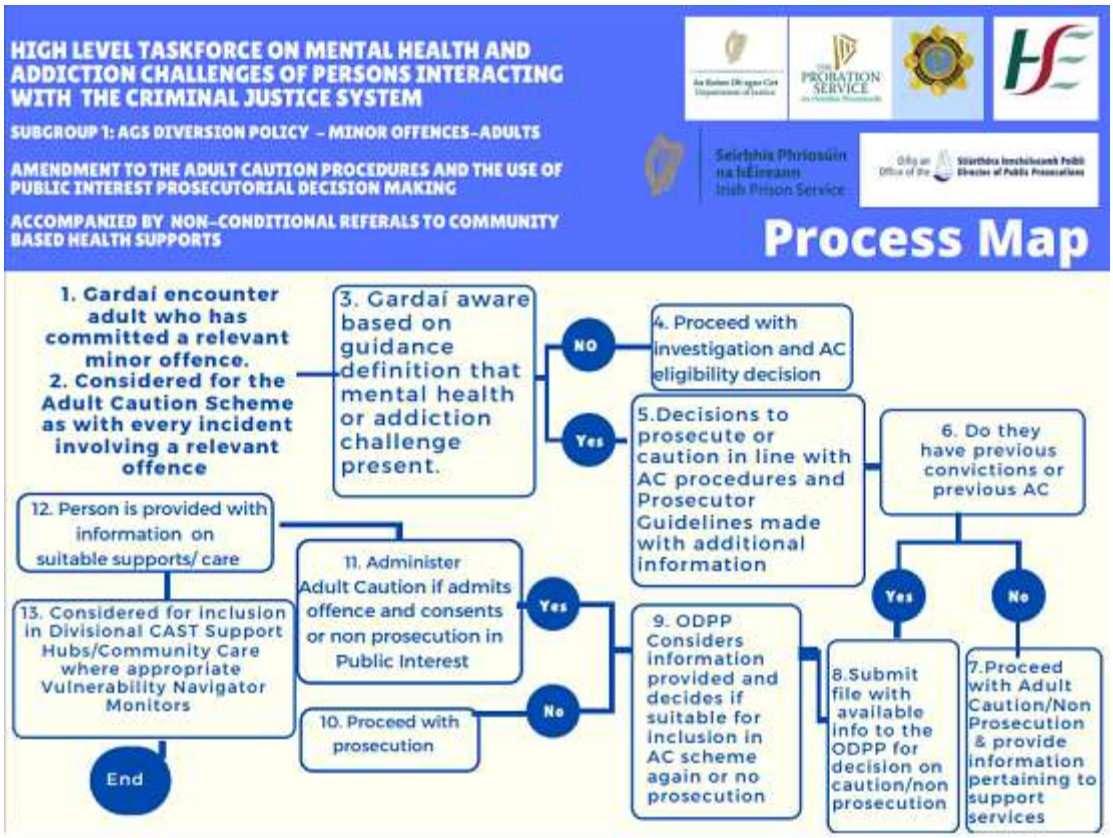
10. Schedule of Eligible Minor Offences

The subgroup agreed that the offences included in the Adult Caution Scheme remain the suitable offences for the proposed amended scheme. The priority of the subgroup is to divert at first instance to reduce re offending in respect of serious offences further down the line. The list of eligible offences are included in (App 3). This schedule is reviewed on a yearly basis.

In terms of other offences which may be considered under the public interest consideration or the DBI approach (discussed later in the approach) no prescribed schedule or formula exists. However serious incidents with harm caused to victims or anything relating to sexual offences would not be appropriate for consideration. The restorative justice referral scheme referred to later in the report would adopt a similar approach in terms of eligible offences for diversion.

11. Process Map for Amended Caution/Public Interest No Prosecution

The subgroup have designed a process map that allows for guidance to members of An Garda Síochána who can consider the non-prosecutorial options available to a person who meets the criteria associated with a mental health difficulty or addiction challenges. The process map has potential linkage to two other taskforce subgroups.



Stage	Explanation
1	The offence committed must be a minor offence as per adult caution offence schedule or of a non-serious nature to justify a non-prosecution as per the prosecutor guidelines.
2	Decision to administer a caution instead of a prosecution is a serious decision to take and before it is taken it must be clear that the offence is of a kind that is appropriate for consideration of a caution and must be one of the schedule of offences attached hereunder, and the offender is deemed to be a person suitable for consideration. Various conditions must be met before a caution can be administered but every individual will be assessed for eligibility regardless of circumstances. It is common

place that persons with mental health difficulties and addiction challenges benefit immediately from the adult caution through immediate eligibility.

3 Gardaí become aware that the individual who offended is a Person in Crisis as per the guidance definition. This could come to light in various ways including evidence through presentation and disclosures by the individual, family members, third party input or simply the nature of the offences itself i.e. theft of basic food consumables not for monetary gain.

4 If no evidence of crisis, mental health difficulty, addiction or situational trauma the investigation continues in the traditional fashion.

5 If evidence of crisis, mental health difficulty, addiction or situational trauma the decision to follow up with caution or non-prosecution in the public interest is made with all the information available to the decision maker.

6 Establish if the individual has previous convictions or was in receipt of an adult caution previously

7 If no previous convictions and first time to be considered for the adult caution scheme proceed with the decision of eligibility and follow up with non-conditional signposting and provision of services pertaining to relevant support service (mental health, addiction etc.)

8 If previous convictions exist or individual previously received an adult caution scheme decision on eligibility or prosecution rests with the Office of the Director of Public Prosecutions following a file submission with all relevant detail.

9 Director of Public Prosecutions reviews the file submitted

10 ODPP decides individual is not eligible for AC and a non-prosecution in the public interest is not merited or justified.

11 ODPP decides individual is eligible for additional AC or a non-prosecution in the public interest is merited.

12 Individual informed and follow up non-conditional signposting and provision of services pertaining to relevant support service (mental health, addiction etc.) is completed.

13 If it is clear that the individual suffers from recurring severe and enduring mental illness or addiction and requires more intensive interventions in line with the on scene co-responder CAST Model this will be escalated using CAST resources or vulnerability navigators. This will assist these individuals in accessing more structured and intensive care through the wider suite of interventions offered through the CAST Support Hub model. The multi-agency wrap around approach that designs positive action plans for

the individual would be more appropriate for severe and enduring cases. Such interventions will be by consent at all times.

The amended Caution model is different from the current Adult Caution model in that as part of the mental health caution is that AGS advises the individual of appropriate local services (as opposed to referring individuals) as the additional layer. At all times the Garda PULSE or investigation management system would record the actions taken and close the incident under the appropriate category and marked detected.

Post-Charge Consideration

If a person who perhaps is suitable for inclusion or consideration in the proposed expanded caution scheme or public interest non prosecution is already charged before the courts the scheme will allow for the prosecution to be withdrawn if deemed suitable following consultation with the ODPP via report and rationale. A similar approach will be taken regarding remand/custody cases however, given the subgroups focus on minor offences and incidents at first instance these decisions will be less frequent and perhaps more suited to other subgroups working within the context of courts and in reach to prisons.

12. Follow up Community Supports – Signposting and Diversion

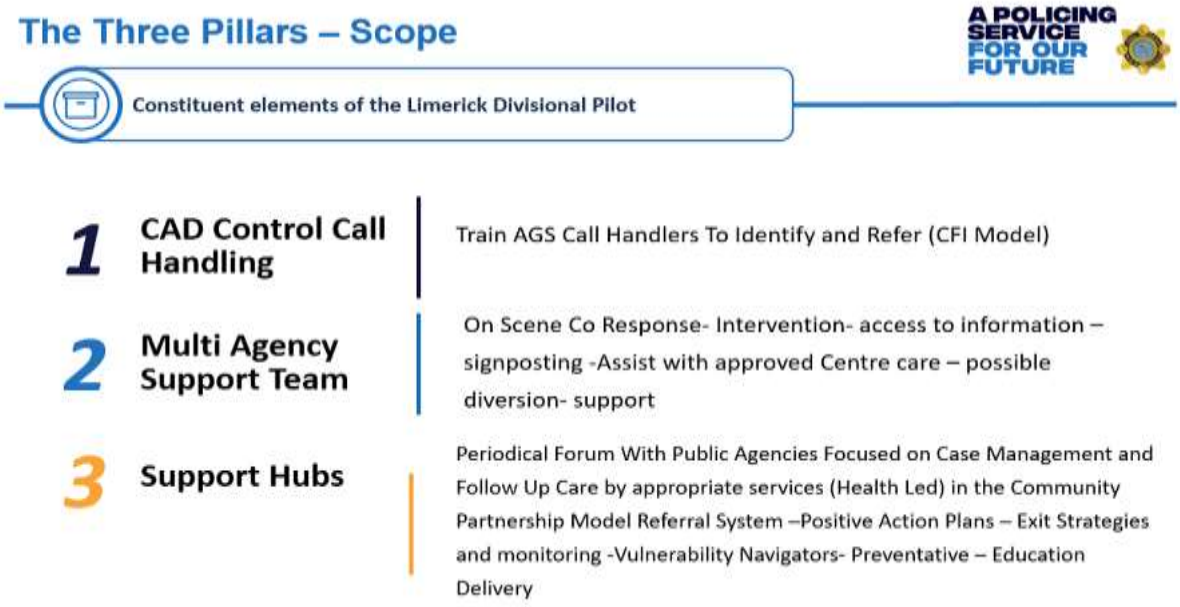
Within the process map reference is made to signposting and supports. It will be noted that An Garda Síochána does not have authority to make referrals and it noted from the meeting with the ODPP, that the consensus was that any follow on services or support must be voluntary on the part of the offender and is non conditional. Signposting and the provision of information should be the extent of the involvement of An Garda Síochána. Referral goes well beyond this position and could be viewed as a conditional approach associated with non-prosecution. As referenced previously the subgroup considered that if an individual is deemed suitable and eligible for consideration under this approach he or she should receive appropriate follow up care beyond the prosecutorial diversion but it must not be inclusive of the process. The approach involving multi agency inputs (social services, housing, community care, health, counselling, homeless services, addiction support, family services, employment etc.) could be described as being aligned to the biopsychosocial model of mental health and its three core elements which be incorporated into the CAST support hub model which is outlined further in the report.

13. Integration with the CIT/CAST Project

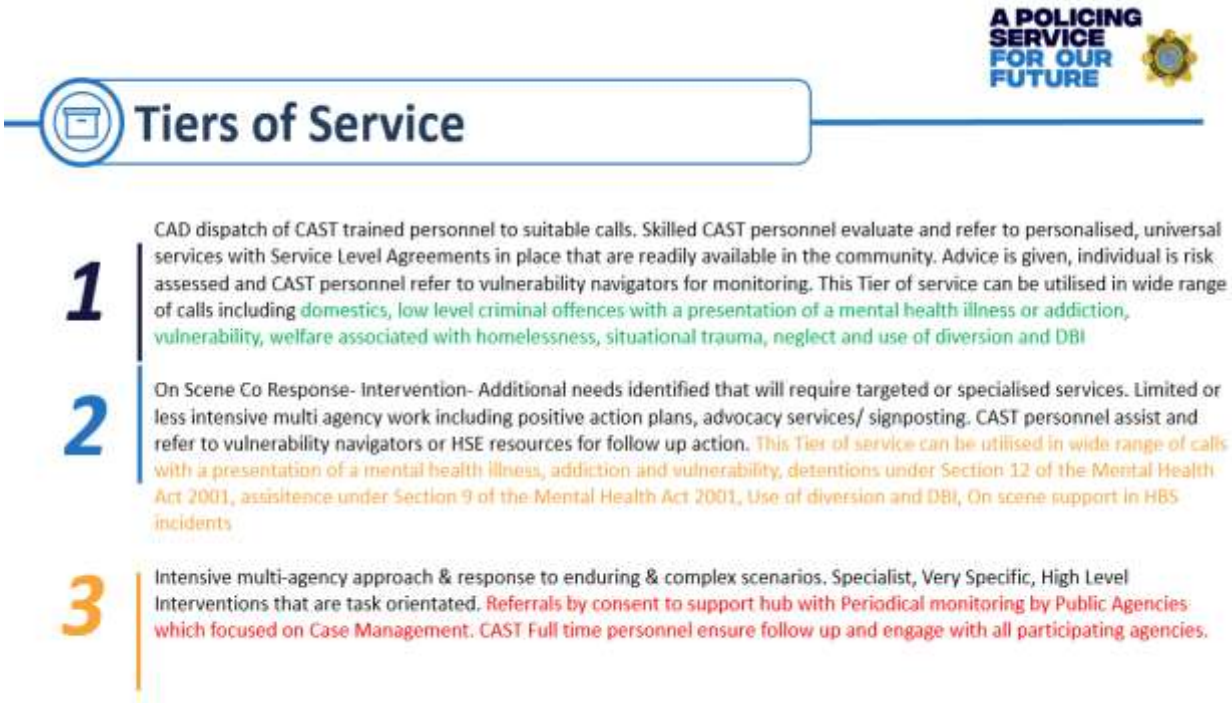
The CIT implementation team based in Limerick and the mid-west heath area who are part of the subgroup have reviewed similar models in other jurisdictions such as Distress Brief Intervention (DBI) in Scotland, which allows for referrals to suitable counselling/support service or the individuals GP. The overarching aim of the DBI programme is to provide a framework for improved inter-agency co-ordination, collaboration and co-operation across a wide range of care settings, interventions and community supports, towards the shared goal of providing a compassionate and

effective response to people in distress improving experience and outcomes for those experiencing distress and those providing support. As confirmed by the ODPP this jurisdiction will not endorse a conditional caution scheme but the subgroup will continue to explore the options available to the agencies involved.

At the core of this project is a desire to explore, identify and operationalise alternatives to arrest for vulnerable persons and to enhance assessments and non-conditional referrals that are more aligned to the community health care model. Where appropriate, diverting suitable persons out of Garda Custody and indeed the criminal justice system, more broadly, is a priority. It is proposed that the team will be co-located with a mental health professional being rotational seconded to a Garda setting for the duration of the pilot programme. The joint proposal for the pilot project was recently submitted for consideration.



The Support Hub is the significant piece on the potential linkage to community based support hubs to provide focused multiagency case management of persons in crisis. The availability of a suitable support Hub will be crucial to developing effective diversionary approaches. Clearly, administering an Adult Caution, in itself, does nothing to deal with mental health difficulties, drugs or other personal issues applying in individual cases. For those whose offending is precipitated by mental health or addiction issues the effect would most likely be to simply delay their entry into the prison system and would not deal with the underlying issues. This would produce little if any benefit for the operation of the Criminal Justice System and absolutely no benefit for society in terms of reduction in crime or more effective responses to mental health difficulties.



It is equally clear that providing a Support Hub will incur costs, which are likely to be significant if the model were rolled out generally. However, the alternative cost – the cost of imprisonment - is currently incurred for those who continue to offend. This can amount to up to €80,000 per person annually. This does not take account of the other Justice Sector costs such as Garda resources in arrest and prosecution processes as well as ODPP costs, legal and Courts costs.

At the very least it is important to quantify what an initial version of a Support Hub would cost, and how the relevant resources could be realised. It would then be possible to consider if the model offers a ready mechanism to support diversion with reference to other issues such as drug addiction, young adults or other issues (e.g. homelessness), so that the resources involved might contribute to a range of solutions arising in the community.

In this context it would be illogical and extremely wasteful of time and resources to proceed with the development of diversion models without progressing further examination and quantification of the resources needed for a community Support Hub.

14. Legislative Position and Observations

Mental Health Act 2001

The first report by the Interdepartmental Group recommended that Department of Health consider whether any amendments to sections 9 and 12 of the Mental Health Act 2001 are required to facilitate the operation of a Garda diversion policy. The subgroup have discussed the Mental Health Act 2001 through various lenses during our work but outside of the provision of statute based conditionality and information sharing the Act is not of huge influence to the diversionary work pertaining to minor offences. The Mental Health Act provisions are used by members of An Garda Síochána as a last report and in majority have no linkage to criminal offences.

The first report by the Interdepartmental Group also recommended that Department of Health consider the implications of any changes to the procedures for involuntary admission to approved centres under the Mental Health Act 2001 for the duration of detention in Garda stations of persons taken into custody under section 12 of the Act. Similarly the subgroup's work focuses on diversionary practices around low level offending and not the procedures associated with acute crisis care. The subgroup through their respective organisational roles have made submissions following consultations pertaining to the General Scheme of a Bill to amend the Mental Health Act. There is concerns from AGS on the practical issues involved with restricting the making of an application under Section 12 of the Mental Health Act 2001 to just Authorised Officers.

The subgroup is aware that the Department of Health has no plans to introduce provisions to allow members of AGS to take a person directly to a mental health facility. The subgroup agrees that providing for this would be a serious curtailment of the rights of the individual, as it would skip not only the application step under the updated Act, but also the examination of the person by a GP. There also is lack of approved centres interim assessment locations for such a move.

The Policing, Security and Community Safety Bill

The Policing, Security and Community Safety Bill will make the prevention of harm and protection of people who are vulnerable or at risk an objective of An Garda Síochána and make the safety of communities a "whole of government" responsibility. The Bill has largely been developed on the basis of the recommendations of the Commission on the Future of Policing in Ireland and the work of the HLTF is an example of the multi-agency community partnership that is aligned to the spirit of the Bill.

The primary legislative concern by the subgroup is the statutory basis for the encouraged practice of sharing information between agencies. The objective of the national strategy will be "to promote multi-disciplinary approaches and inter agency collaboration to enhance community safety". It is agreed that this is a worthy objective, but to implement such works effectively or efficiently will be difficult without addressing the sharing of information between agencies.

Sharing is Caring: Commencement of the Data Sharing and Governance Act 2019

On the 7th of July 2021, provisions of the Data Sharing and Governance Act 2019 (the 'DSGA') carrying implications for the way in which public bodies may exchange data were commenced. The DSGA is intended, among other things, to reduce the burden on individuals who wish to receive public services from having to provide the same information to different public bodies and to facilitate the effective administration of public services. However, it creates strict requirements for the exchange of data between public bodies in specific circumstances and creates a layer of oversight of this data sharing in the form of the Data Governance Board. The requirements can have an impact on data sharing between public bodies.

Section 13 provides a legislative basis for sharing data where there is no other legislative provision that specifically permits it. It requires that the sharing takes place under a data sharing agreement. While the data sharing arrangements may positively benefit individuals receiving personal services

from public bodies, the commencement of these provisions creates additional requirements and restrictions for public bodies that transfer data and marks a new horizon for data sharing in the public sector. The works associated with the HLTF recommendations will have to establish a data sharing arrangement to ensure that they comply with the requirements of the DGSA.

With regard to data sharing generally, these are recurring issues in relation to the development of diversion initiatives across agencies, and with regard to interagency working generally. Experience in relation to Justice sector initiatives such the Joint Agency Response to Crime (JARC), and the Greentown programme to support children under the influence of criminal networks, as well as the Health Diversion initiative (drugs possession) point to similar difficulties. Therefore the need for coordination of efforts, and effective problem solving mechanisms, to support the design of such initiatives across Departments and Agencies is clear. Data can only be shared between State bodies in accordance with existing data protection laws.

Health Information Bill

The proposed Health Information Bill was examined by the subgroup. The General Scheme of the Bill is currently in preparation in the Department of Health. The main purposes of the Health Information Bill are to ensure that health information is provided by those holding such information (for examples, hospitals, GP practices) to enhance (a) patient care and treatment, especially in terms of providing a legislative basis for an online Summary Care Record and (b) support other health service goals (like public health, patient safety and clinical audit, health service management, policy making and research and innovation).

To do so, a planned National Health Information Centre (NHIC) will be established under the Bill and be empowered to require the forwarding to it of specified health information by data controllers. That information may need to relate, in certain scenarios, to identifiable individuals so that necessary and proportionate matching and linking can take place. The NHIC will be able to make information available, subject to safeguards and strong governance rules, to persons (mainly but not exclusively in the health sector) where there is a health-related public interest in doing so. Such information will be anonymised, pseudonymised or aggregated. Only in exceptional cases where there is a compelling reason will the information made available by the Centre be identifiable.

More generally, the Bill will help clarify the rules on the sharing of health information for primary care and secondary purposes to remove uncertainty on when health information can be shared for such purposes. It will also enhance individuals' rights in relation to access to and portability of their health data.

While the above is a positive move in terms of advancing the sharing of information for persons in crisis or experiencing mental health difficulties, it is not clear whether the Bill will permit the sharing of health information in strictly defined cases suitable to the subgroups work and the work of the co response CIT model at the design stage in Limerick.

It would be beneficial to AGS, Probation Services, Irish Prison Service and the HSE in light of ongoing works if the sharing of information between health services in circumstances where the

informing body has a reasonably held belief that the information in question is appropriate and necessary to share with other regulatory bodies to significantly help the data subject and enhance access to appropriate services. While this is something that is already most likely permitted under GDPR, there is a lack of clarity and a related uncertainty among the relevant data controllers about what the legal position actually is. It would therefore be helpful if, consideration could be given in preparing the General Scheme to providing clarity and certainty on necessary and proportionate information sharing to agencies within the criminal justice family where it would help those in need to access services and commence positive action plans with appropriate service providers.

Memorandum of Understanding between An Garda Síochána and the HSE

The subgroup reviewed the current Memorandum of Understanding between An Garda Síochána and the HSE and there is a consensus that it solely relates to the removal to or return of a person to an Approved Centre in accordance with Section 13 & Section 27, and the removal of a person to an Approved Centre in accordance with Section 12, of the Mental Health Ac, 2001. This document is reviewed annually with Crime Legal AGS and the HSE. Through the works of the HLTF and the implementation of CIT through the Limerick pilot project additional MOUs should be included if clarify and consistency is to be achieved.

15. Policy Coherence

The subgroup notes that in addition to Mental Health Diversion there are proposals in development relating to diversion for drugs possession (Health Diversion) and young adults aged 18-24. There is likely to be considerable commonality in relation to the issues that may present in designing each of these new initiatives so it is imperative that they are designed coherently. Therefore there needs to be ongoing coordination between the Department of Health and the Department of Justice to ensure effective development of the new systems. It would be useful if a particular interagency group or forum was identified which would be tasked with ensuring effective coordination. This view also holds firm in respect of the pre court diversionary practices outlines in the next section. Beyond identified pilots there should be consistency across the jurisdiction so one area isn't benefitting from multiple prosecutorial avoidance practices.

16. Restorative Justice in the Community – Pre-Court Diversion Pilot Proposal

The subgroup examined existing Restorative Justice programmes operating in various district court areas that include offender Reparation Programme resulting in proceedings being dismissed. The subgroup was briefed by Restorative Justice in the Community (formerly Nenagh Community Reparation Project) which is a restorative justice project supported and funded by the Probation Service. It currently works with communities across Tipperary, Laois and Offaly. Its restorative justice activities comprise mainly Victim-Offender Mediation, RJ Conferencing and a Reparation Programme.

Head of Service Ms Emily Sheary delivered a presentation the subgroup and expanded on the role and functions of RJS. The main source of funding is through the Probation Service and works with

adults of all ages, but the majority of referrals tend to be those aged 18-25. Unlike the Adult Caution Scheme the RJC deals with a broad range of offences including, but not limited to, assault, theft and related offences, burglary, damage to property, public order and drug related offences. Currently the referrals are solely court-led and come from local District Courts across Tipperary, Offaly and Laois.

In such schemes the Court, provides the offender the option of participation in the Offender Reparation Programme before final sanction is decided. The offender attends meeting with the assigned RJS Case Worker and the Reparation Panel which is made up of one representative from An Garda Síochána, the Probation Service and the Community. The victim is contacted and advised of the case being referred to RJS. Information and options are provided to the victim with regard to level of participation and / or input they might be interested in. Victim participation is completely voluntary. Part of the process involves engagement with supports and services in the community.

The subgroup is recommending that a pilot project run within one of the participating District Court areas whereby the local Gardaí (Inspector or Superintendent Rank) can refer directly to the RJS (Restorative Justice Service) if a suitable case presents and fits the guidance definition of person in crisis as proposed by the subgroup.

The person who would be about to face charges would be invited to meet with a Case Worker from Restorative Justice Services and then attend a Reparation Panel meeting. The Reparation Panel meeting is chaired by a representative of the community. Also in attendance is a Probation Officer and a member of An Garda Síochána. The RJS Case Worker also attends. All the parties present will discuss and agree certain reparative and restorative actions that could be undertaken to try to repair the harm. The actions will be written up on what is called a Reparation Contract. Unlike the current court referrals for Reparation Contract for AGS referrals under the pilot scheme would be non-conditional with the caveat that the individual referred can strictly only avail of the scheme on one occasion.

Reparation Contract Actions include the following

Other actions could include

• letter/s of apology

• meeting with a victim advocate

• voluntary work, charitable donation

• attendance at anger management or alcohol / substance abuse education

Under the pilot a report is then submitted by RJS to AGS, outlining what has been undertaken, achieved, completed and / or requesting more time. The local Garda Superintendent will read and consider the report, which will include a copy of the agreed contract, any letter of apology, record of any meetings attended with the victim and / or others, any written reflective work, confirmation of any charitable donation, and any other agreed actions.

The Garda Superintendent will briefly record the outcome of the process and the matter is closed. In the absence of legislation AGS will not attach any conditionality to the referral but hope that the individual will benefit from the diversionary referral and access more community health led supports and services.

17. Mild and Moderate Vs Severe and Enduring Cases – Diversionary Categories

It is important to acknowledge two broad cohorts of individuals who come to Garda attention due to mental health difficulties and addiction issues. The first cohort consists of individuals who suffer from occasional, mild to moderate mental health difficulties or situational trauma through addiction. This group comes to occasional Garda attention due to temporary breakdowns in their coping skills. The recommendations of the subgroup include the provision of supports and signposting to the majority of these individuals. To achieve this in itself will be preventative measure reducing future presentations and interactions with Gardaí or other blue light services. CAST resources will also utilise proposed non prosecutorial initiatives like DBI (Distress Brief Intervention), use of the public interest and the adult caution will reduce court appearances and potential convictions for this cohort.

The second cohort is of individuals who suffer from recurring severe and enduring mental illness. This cohort requires more intensive interventions in line with the on scene co-responder CAST Model that will assist these individuals accessing appropriate care potentially at the on scene interaction or more likely the wider suite of interventions offered through the CAST Support Hub model. The multi-agency wrap around approach that designs positive action plans for the individual would be more appropriate for severe and enduring cases.

18. Progressive Application of the Probation Offenders Act

The Probation Act allows a Judge to dispose of an offence punishable by the District Court without proceeding to a conviction. The Act specifies particular grounds for the application of the Act and these rules are interpreted differently by different Courts. If a Judge decides to apply the Act after hearing submissions by a Solicitor, he or she may either dismiss the charge, or discharge the offender on certain conditions. For example, in applying the Probation Act to a charge of possession of drugs the Court may request a defendant to pay a sum of money to a local charity or to the Court Poor Box. The Probation of Offenders Act is also regularly applied to Public Order Offences such as drunk and disorderly. According to the Act the Court can have regard to the character, antecedents, age and health, mental condition of the defendant or to the trivial nature of the offence when considering to apply the Probation Act.

The Probation Act is usually considered in the District Court for relatively minor offences especially where the person before the Court has no previous convictions and the offence was more likely a once off offence. The advantage in having the Probation Act applied is that no conviction is recorded against the person before the Court.

The subgroup has discussed the position whereby the Probation Offenders Act is often recorded as a criminal conviction on the Garda PULSE computer system. It is agreed that it should be recorded on the Garda PULSE system that a person has received the Probation Act, however it should not be listed as a conviction when considering eligibility for the adult scheme or used negatively in a non-prosecution public interest decision. It also has the potential to be a barrier to a person in crisis with mental health difficulties or addiction issues to progress within society in terms of employment and housing for example.

The subgroup believes that the appropriate use of the Probation Act in cases of offenders who meet the guidance definition can have a positive outcome for the individual involved. While this observation is perhaps outside the subgroup's terms of reference, which focuses on a diversion policy for An Garda Síochána at first instance, the group feels that the existing statute has potential in the context of the overall work of the Task Force.

19. Service Level Arrangements - Community based support services in Ireland

Statutory responsibility for the provision of services to people with mental health difficulties, addiction challenges and intellectual disability rests with the Health Services Executive (HSE). The HSE either provide services directly or engage with voluntary organisations who can provide the services on their behalf. When a voluntary agency is engaged to provide services on behalf of the HSE, the HSE discharges its responsibility via a Service Level Arrangement (SLA). Access to the voluntary services recognised by the HSE is crucial to the diversionary model outlined by the subgroup. The dissemination of the relative services with SLAs in place across this jurisdiction is critical to the capacity of members of AGS to signpost and provide information to individuals following the non-prosecution decision or caution.

There are numerous procedures, policies, codes of practice and guidance documents required by the HSE in the context of SLAs which ensure that the service delivery is to the required standard.

1. **Distress Brief Intervention (DBI)**

As part of the research behind the CAST project in Limerick the implementation team collaborated with Police Scotland and learned about the improved responses to people in distress. The DBI programme was examined as a diversionary pillar to the CAST Programme and front-line service providers. Since inception the DBI programme in Scotland is building the vision of connected compassionate support, through a large and far reaching national and regional distress collaboration between health and social care, emergency services, and third sector, providing early intervention, and improving outcomes and experience for people experiencing distress and those providing support.

The overarching aim of the DBI programme is to provide a framework for improved inter-agency co-ordination, collaboration and co-operation across a wide range of care settings, interventions and community supports, towards the shared goal of providing a compassionate and effective

response to people in distress improving experience and outcomes for those experiencing distress and those providing support.

The DBI 'ask once get help fast' approach has two levels:

DBI Level 1 is provided by front line staff (Emergency Departments (ED), Police Scotland (PS), Primary Care and Scottish Ambulance Services (SAS)), who have received the DBI Level 1 training, produced by University of Glasgow, who ease the person's distress, provide a compassionate response and involves an offer of a seamless referral, with confidence and clarity to a DBI Level 2 service.

DBI Level 2 is provided by commissioned and trained third sector staff who contact the person within 24-hours of referral and provide compassionate, problem solving support, wellness and distress management planning, supported connections and signposting for a period of up to 14 days – reducing both immediate distress and empowering ability to manage future distress. The person's GP will be notified of the outcome of referral by the DBI service.

Below is a front line policing example of the DBI service in practice

A male in his mid-20s was caught shoplifting (food worth only a few pounds) and the store called Police Scotland. A young police officer who had undertaken DBI training attended and established that the man had in effect been left homeless following a family bereavement. He also had virtually no possessions, knew no-one locally, was struggling financially and felt low and isolated. Without DBI the man may well have been placed in custody and possibly charged. However the Police identified the distress related to the contributing factors above and felt the man might benefit from a referral for DBI support and a referral was made with the man's agreement.

The young man shared with the DBI practitioner that he had been having difficulty sleeping; that his mind kept racing and felt this was exhausting; that his mood was low and that he had experienced suicidal thoughts in the past but not feeling that way now. He explained to the DBI practitioner that there was no money for food, and that he was finding this very distressing. He also stated that he wanted to get support to look for work.

Actions taken were:

- DBI worker supported the young man to complete a Distress Management Plan - making a safety plan and addressing triggers for the hopelessness. DBI worker discussed websites to support the management of anxiety, confidence and how isolated and down the man had been feeling.
- Support was given to register with a GP.
- Supported to receive a food parcel.
- Accompanied for support to appointments with homeless team, and supported to complete forms to apply for housing.

- Support to engage with the Job Centre, where he enrolled in a construction skills certification course that will assist in finding a job.
- Support to contact Addiction services to self-refer for support. Outcomes & Experiences:
- Compassion Level 1 recorded as 10 out of 10 by person in distress.
- Distress level reduced to 3 at end of DBI.

The key linkage to a comparable example in the Irish jurisdiction is linkage to the services with SLAs.

2. Alignment to *Sharing the Vision*

Sharing the Vision, Ireland's national mental health policy, makes several recommendations relevant to diversion schemes seek to ensure that offenders with a mental health difficulty do not get involved needlessly in the criminal justice system. When offending behaviour is clearly related to a mental health difficulty, it is recommended that a diversion scheme can allow offenders to be diverted to the care of the mental health services. While many countries have introduced specific and comprehensive mental health policy change to provide for court diversion, Ireland does not yet have a specific policy to provide for court diversion to community settings or community treatment. The effectiveness of the service depends on ongoing resourcing and access to facilities and services in the community to which individuals can be diverted. There is no doubt that the CAST proposal would allow for the implementation of the *Sharing the Vision* recommendations.

Recommendation 55 states:

''There should be ongoing resourcing of and support for diversion schemes where individuals with mental health difficulties are diverted from the criminal justice system at the earliest possible stage and have their needs met within community and/or non-forensic mental health settings.''

Recommendation 87 states:

''The Department of Justice and the Implementation Monitoring Committee, in consultation with stakeholders, will determine whether legislation needs to be amended to allow for greater diversion of people with mental health difficulties from the criminal justice system.''

The subgroup is cognisant that the government policy is moving away from a model of involuntary treatment. *Sharing the Vision* adopts a human rights-based approach, emphasising the importance of consent, capacity, and a person-centred perspective that focuses on enabling recovery through an emphasis on personal decision-making supported by clinical best practice. Importantly, an individual deemed to have capacity may, in some instances, not adhere to clinical advice. When a person is diverted away from the criminal justice system and towards mental health services, it is important to recognise that no individual that is considered to have capacity can be forced to engage with mental health supports and treatments should they not wish to do so. The trained CAST resources with actively encourage persons who they interact with through crisis or otherwise to actively engage with mental health and support services.

3. Alignment to the Recommendations of the Commission on the Future of Policing in Ireland (CoFPI)

The Commission on the Future of Policing published its report in 2018 outlining a clear vision and roadmap for strengthening An Garda Síochána and the broader national framework for policing, security and community safety. The central finding of the report is that the systems currently in place – the police service itself and the wider national framework for policing, security and community safety – must be strengthened significantly to meet existing challenges, and also to address future demands.

The Second Principle cites that Policing and national security are not the responsibility of the police alone and under Recommendation 5 effective multi-disciplinary approaches must be in place between the police and other public agencies and services, both at national and local level. The proposed pilot project in Limerick travels to the heart of this principle. At local level, this proposed partnership will include health professionals, local authorities, statutory support agencies, approved voluntary organisations, educational partners others who can contribute to community safety and embrace diversionary practices recommended by the subgroup. The recommendation encourages other departments, agencies and bodies with a function in policing, community safety and harm prevention should develop Joint Strategic Plans with An Garda Síochána.

As part of this principle, recommendation 19 cited that the prevention of harm should be explicitly identified as a core objective of policing and that that all non-core duties should be reassigned to other agencies. The recommendation on Crisis Intervention Teams sought that “a specialist uniform unit who will work conjointly with health professionals to provide a rapid and integrated 24/7 response to persons with mental health difficulties. “Previous reports containing sensible and often excellent recommendations have gathered dust on shelves”. The recommendations of the CoFPI and the implementation of this pilot must fare better because too much is at stake in the area of mental health and policing where reform is needed urgently.

20. Subgroup 1 – Diversion Drivers

Success will be based on 7 key areas:

1. First, a strong network of relationships among Gardaí, mental health professionals, mental health advocates with service level agreements, probation services, Director of Public Prosecutions, court services and other community members and leaders.
2. Second, an understanding of the community-wide response to mental health crisis situations, including mental health services, emergency responders, Gardaí and other resources that can help people during a crisis situation.
3. Third, building the infrastructure to strengthen the diversionary system and sustain the programme—including revised policies and procedures and staffing.
4. Fourth, a training programme for those involved in the CJS in particular first responders and those involved in prosecutorial process.

5. Fifth, a robust, proportionate and legally approved data sharing capabilities between the agencies that will work towards achieving the best outcomes for the persons with mental health difficulties or addiction challenges and situational trauma.
6. Sixth, a commitment to providing the required information technology upgrades for the successful implementation of the subgroup recommendations.
7. Finally, a level of patience towards the implementation of the subgroups recommendations. It is clear that there is a strong political will to implement the recommendations of the HLTF which is welcome however the nature of the recommendations work will require significant time to implement in a sustainable manner.

Appendix 1 – Proposed Minor Offences Suitable for Diversion

Adult Caution Scheme – Schedule of Offences

Criminal Justice (Public Order) Act, 1994

Section 4: Intoxication in a public place

Section 5: Disorderly Conduct in a public place

Section 6: Threatening, abusive or insulting behaviour in a public place

Section 8: Failure to comply with direction of a member of An Garda Síochána

Section 9: Wilful Obstruction

Section 11: Entering building etc. with intent to commit an offence

Section 13: Trespass in a manner likely to cause fear*

Section 21: Failure to comply with Garda directions controlling access to certain events*

Section 22: Surrender and seizure of intoxicating liquor

Criminal Justice (Theft and Fraud Offences) Act 2001

Section 4: Theft (where the value of the property concerned is less than €1,000)

Section 8: Making off without payment (where the value of the payment is less than €1,000)

Section 17: Handling stolen property (where the value of the property concerned is less than €1,000)

Section 18: Possession of stolen property (where the value of the property concerned is less than €1,000)

Intoxicating Liquor Act 2003

Section 6: Offences by a drunken person

Section 8: Disorderly conduct

Non-Fatal Offences Against the Person Act 1997

Section 2: Assault (Assaults on a member of An Garda Síochána shall be forwarded to the Director of Public Prosecutions)

Criminal Damage Act 1991

Section 2: Damaging Property (where the value of the property damaged is less than €1,000)

Section 3: Threat to damage property

Dublin Police Act 1842

Section 14(12): Nuisances in Public thoroughfares (applies to Dublin Metropolitan (Court) District Only)

Intoxicating Liquor Act 1927

Section 17: Persons on licensed premises during prohibited hours

Licensing Act 1872

Section 12: Public Drunkenness

Summary Jurisdiction (Ireland) Amendment Act 1871

Section 8: Offensive or riotous conduct in a theatre or other place of public amusement (applies to Dublin Metropolitan (Court) District only)

Misuse of Drugs Act 1977

Section 3: Possession of cannabis or cannabis resin a controlled substance. Commonly referred to as

'simple possession' or possession for personal use*

Casual Trading Act 1995

Section 3: Casual trading without a licence or contrary to the terms of the licence*

*Denotes offences introduced on the 14th December 2020.

Chapter 4: Subgroup 2

1. Introduction

The group considered the issue of increasing the capacity of forensic mental health services across the prison estate and for those who require admission to the CMH as a priority. This involved the development of an evidence base for step down care and exploration of all options to open additional forensic beds. This work involved a robust analysis of current capacity and modelling of future capacity needs. It also considered the use of Approved Centres in support of forensic mental health services and the issue of any legislative requirements to support this.

a. Nominated membership of subgroup 2

Name	Position and Organisation
Chair - John Devlin	Clinical Director, Irish Prison Service
Ben Ryan	Assistant Secretary, Criminal Justice Policy, Department of Justice
Deborah White	Principal Officer, Department of Justice (to 03.09.21)
Mary O'Regan	Principal Officer, Department of Justice (from 06.09.21)
John Dunphy	Asst. Principal Officer, Penal and Policing Policy, Department of Justice
Yvonne Phillips	Higher Executive Officer, Penal and Policing Policy, Department of Justice (to 27.08.21)
Oonagh Ffrench	Higher Executive Officer, Penal and Policing Policy, Department of Justice (from 30.08.21)
Kerrie Keegan	Executive Officer, Project Collaboration, Department of Justice
Colm Desmond	Assistant Secretary, Dept. of Health, Corporate Legislation, Mental Hlth, Drugs Policy and Food Safety Division (to 07.21)
Seamus Hempenstall	Principal Officer, Mental Health Unit, Dept. of Heath
Michael Murchan	Assistant Principal Officer, Mental Health Unit, Dept. of Health

Deirdre O Flaherty	Administrative Officer, Mental Health Unit, Dept. of Health
Prof. Harry Kennedy	Executive Clinical Director, Central Mental Hospital
Patrick Bergin	Head of Service, Forensic Mental Health Service, HSE
Enda Kelly	National Nurse Manager, Irish Prison Service
Dr Narayanan Subramanian	Consultant General Adult Psychiatrist & HSE National Clinical Lead in Dual Diagnosis, HSE

b. Terms of Reference of subgroup 2

This subgroup will consider the identified recommendations as set out below from the IDG Reports by:

- *reviewing the current capacity and sustainability of the National Forensic Mental Health Service, including the CMH, and future requirements*
- *develop a model of clinical care to provide this service in the health and criminal justice systems that is based on international best practice; by*
  - *Considering governance, legislative and resource requirements in support of this model of care.*
  - *ensuring the model of clinical care can be responsive to groups with specific needs; and*
- *Consultation with relevant stakeholders as deemed necessary.*

c. Forensic Mental Health Services in Irish Prisons

The provision of appropriate mental health services to those in custody is one of the major challenges to effective healthcare in prisons. Information on the level of mental health difficulties in the prison population is derived from studies done in 2003 and 2005 which found that drugs and alcohol dependence were by far the most common problems, present in between 61% and 79% of prisoners. Typically, prisoners were using multiple intoxicants, including alcohol, benzodiazepines, opiates, cannabis and stimulants.

For the more severe mental conditions rates of psychosis were 3.9% amongst men committed to prison, 7.6% amongst men on remand and 2.7% amongst sentenced men. Women prisoners had psychosis in 5.4%.

There is evidence, supported by multidisciplinary healthcare staff in all prisons, of an increase in the numbers of persons committed to prison presenting with severe and enduring mental illness. Imprisonment can have a serious impact on people with severe and enduring mental illness as

prisons are not therapeutic environments. In certain situations, there are serious safety concerns for prisoners and staff because access to specialist in-patient forensic mental health services is limited and prisoners must be “managed” in an inappropriate prison environment.

The National Forensic Mental Health Service (NFMHS) at the Central Mental Hospital (CMH) provides a Mental Health Prison In-Reach and Court Diversion Service (PICLS) programme to the Irish Prison Service (IPS). This includes consultant forensic psychiatrists, non-consultant hospital doctors, community forensic psychiatric nurses, social workers and other staff. The Health Service Executive (HSE), through the NFMHS, provides healthcare services to prisoners on the same basis of access and entitlement as it provides to persons in the wider community. The prison in-reach arrangements provided by the NFMHS are an excellent example of partnership working and provide an invaluable service to the significant body of prisoners who suffer from a mental condition.

The IPS has access to a limited number of beds in the CMH for prisoners suffering from a severe mental illness who require residential mental health treatment. The CMH is registered for 94 beds at present and referrals are taken from both the Prison system and Approved Centres and assessed on a clinically prioritised basis. There is currently an average of 20 to 30 persons in custody each week awaiting transfer to the CMH.

A waiting list for the admission of prisoners to the CMH is operated by the NFMHS and is reviewed on a weekly basis. Over the last nine years, the number of prisoners on the waiting list has varied between 5 and 33 prisoners and since 2020 has been between 20-25 patients. It should be noted that all prisoners placed by NFMHS consultants on the waiting list have been clinically assessed as warranting admission to the CMH, which is a tertiary care facility.

The growth in the waiting list numbers represents an increasing risk for the IPS in safely managing prisoners suffering from a severe mental illness. Data on self-harm in prisons is provided from the reports of the Self-Harm Assessment and Data Analysis Project (SADA) which in 2019 reported 203 episodes of self-harm in prisons. The major contributory factor related to mental health difficulties (56%).

At present, prisoners with significant mental health difficulties are managed within the prison estate however this care is not comparable to what is provided in the CMH and represents a significant patient safety issue.

d. Scope of Current Services in Prisons

All prisoners are medically assessed on committal to prison. This includes a mental health assessment which can be employed to develop an individual care plan. The majority of mental health care is provided by IPS primary care teams. Where clinically indicated, the prisoner is referred to a forensic clinician who, subject to his/her findings, may make certain recommendations to the Governor for the care of the prisoner. The NFMHS has confirmed that its current caseload includes up to 250 patients who are ordinarily in the custody of the Irish Prison Service.

The IPS works with the Health Service Executive/NFMHS to ensure the appropriate provision of Psychiatric services to those in custody with mental health needs in all closed prisons. A description of the activity is included in the Table below.

Table 1 : Prison In-reach Service 2019

Prison	New Referrals	Patient Reviews	Transfer to other In-reach teams	Transfer from other In-reach teams	Total discharges
Arbour Hill	4	241	0	0	8
Cork	88	722	28	8	102
Clover Hill	315	1,416	81	6	218
Castlerea	88	274	23	6	42
Dochas	129	704	8	4	121
Midlands	107	677	28	6	85
Mountjoy	69	1,072	10	11	54
Portlaoise					
Shelton Abbey	1	12	0	1	1
Wheatfield Prison	60	467	20	42	59
Oberstown Children Detention Campus	26	88	0	0	25
Total	887	5,673	198	84	715

Subgroup 2 is aware that a Health Needs Assessment across all prisons is currently being finalised and that this report will consider the organisation and capacity of health services including those relating to mental health. It is likely that this report will make recommendations to strengthen mental health services in a number of locations.

In-reach mental health services are available in all Dublin prisons, the Portlaoise Campus and Castlerea Prison with a partial service in Cork prison through collaboration with the NFMHS to provide forensic mental health sessions weekly in these prisons. Thirteen in-reach Community Psychiatric Nurses (CPNs) and two new social workers, attached to the NFMHS, are part of the in-reach multi-disciplinary teams. Since 2016 a consultant forensic psychiatrist has provided a psychiatric service in Castlerea prison with a full consultant led team since 2019.

Consultant Psychiatrist led services are provided to those in custody in Limerick and Cork prisons, by way of an interim agreement with the HSE and do not operate under the governance arrangements that apply in other closed prisons.

The IPS, in collaboration with the NFMHS, has established two dedicated areas where high support is provided to vulnerable prisoners with mental illness – D2 wing in Cloverhill Prison (for remand prisoners) and the High Support Unit in Mountjoy (for sentenced prisoners). Both units provide a dedicated area within the prison where mentally ill and vulnerable prisoners, who present with a risk of harm to self or to others, can be separated from the general prison population and are closely monitored in a safer environment. The High Support Units (HSU) have managed vulnerable and mentally ill prisoners in a more effective and humanitarian environment and have resulted is greater access to care and regular reviews by the prison in-reach team. With the increased resource allocation from the HSE/NFMHS, the establishment of other HSUs is under consideration.

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

D2 in Cloverhill has 22 cells including two Special Observation Cells (SOCs). The maximum capacity of D2 landing is 27 prisoners and can accommodate those presenting with vulnerability to those with severe mental illness.

There is clear evidence of the outcomes to be achieved between focused planning and service design between the IPS and the NFMHS.
This can be seen in the establishment of the HSU and Lower Support Unit (LSU) in Mountjoy prison and the objectives, purpose and outcomes are set out below:-

The main objectives were:-

- to reduce frequency & duration of time spent in Safety Observation Cell by providing an alternative environment with increased observation & interaction
- reduction in self-harm & suicide by providing early intervention & greater clinical input
- All in a structured physical environment, which is NOT a clinical area, secure unit or challenging behaviour unit.

The purpose of the unit is:

- Provide increased observation by prison officers
- Provide increased support & short term targeted interventions by clinical staff
    - For those in an acutely disturbed phase of a serious mental illness
    - For those who require increased observation for a physical illness
    - The unit is designed for short term intervention, however where significant risks present this may be for longer

Access to the HSU:

- Open referral from all staff within the prison
- Self-referral from prisoners
- Responding to concerns from external agencies & families/others
- Assessment & recommendation by healthcare staff
- Clearance sought from Chief Officer for security & safety – before transfer to HSU
- Confidentiality always maintained

Management of stay in the HSU:

- Provision of increased level of supervision & observation in a safe environment
- Supported with increased clinical inputs and daily clinical review – more if required
- Interaction is active and engaging with frequent contacts to assist on-going assessment
- If possible all activities e.g. school, gym, visits, telephone calls should be maintained
- Clinical staff handover to prison officers after each assessment
- Weekly Multi-Agency meeting to review progress and plan interventions for each prisoner
- Special needs managed as clinically indicated

The HSU in Mountjoy prison can accommodate 9 people at any given time with 2 people in transition back to the main prison population in the Low Support Unit. Oversight and throughput is managed by the weekly Multi Agency Meeting.

The IPS has developed a mental health awareness training programme, which is currently being delivered to all staff. Training on Seclusion Policy and Critical Incident Stress Management are also provided by the IPSC.

Further to this, people in custody in all closed prisons have access to the Samaritans Listeners Scheme. The IPS is now developing a standard mental health awareness programme for all those in custody, to be delivered as part of the Red Cross programme in all prisons. There are also a number of multi-disciplinary groups that provide information and support in the area of mental health to prisoners.

In addition to healthcare input, the IPS Psychology Service provide ongoing evidence informed therapeutic approaches to those referred to the service who are suffering from a mental health difficulty.

Conclusion

The Subgroup noted that there should be equitable access to mental health services across the prison estate.

Recommendations

i) In this regard, the subgroup noted the ongoing work of the prison specific mental health HNA recommendations, as well as the recommendations from the acute bed capacity review as set out in the Department of Health policy *Sharing the Vision* and that these should be considered in the reports overall recommendations. The implementation of the HNA recommendations pertaining to the mental health requirements in all prisons should be aligned with the recommendations of the Task Force so that prisoners should have timely access to the full range of specialist forensic mental health services where clinically required.

ii) It is recommended that research be conducted to update information on the prevalence and impact of mental health difficulties and addiction across the prison estate.

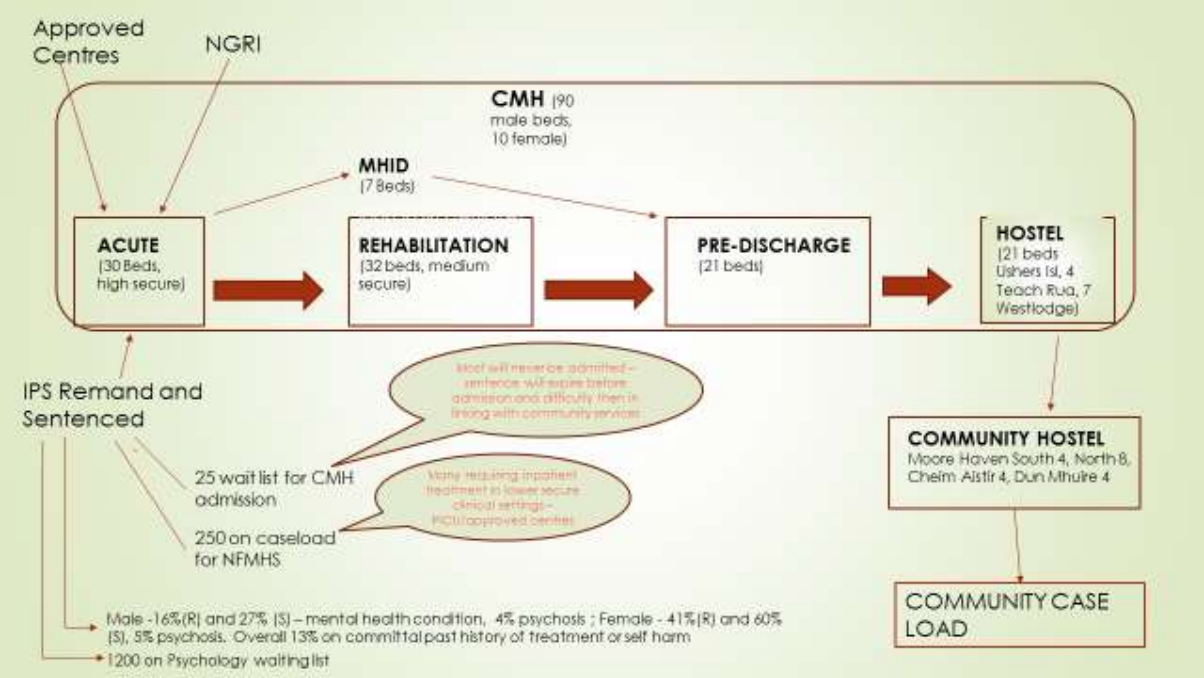
iii) There should be a single system of governance for forensic mental health services across the prison estate. This should be explored further by the HSE and IPS by means of a formal agreement on the provision of a National Forensic Mental Health Service under the aegis of the CMH in all closed prisons and with the collaboration of community mental health services.

2. Central Mental Hospital (CMH)

a. Current Care Pathway

The CMH provides a specialist forensic service for those patients who have been assessed and require admission for further treatment. A description of the care pathways in CMH is provided in Figure 1. A more detailed description of the current CMH in Dundrum is provided in the Appendix 1.

Figure 1 : Current Care Pathway through CMH for patients requiring secure care



The rationale for these therapeutic pathways through secure care is as follows:

The aim of the therapeutically secure hospital model is to admit patients to higher security admission wards, and then move patients forward in a step-wise manner, from ward to ward through a coherent pathway through care.

Each successive ward has a lower staff to patient ratio, and allows increasing freedoms alongside increasing responsibilities for patients.

This ensures that even from admission, patients are moving in a step-wise manner towards the community discharge.

With each new ward, patients are challenged a bit more, expectations for engagement are successively higher and patients need to move in this step-wise manner to ensure the best possible chance of a successful community discharge.

All admissions and referrals for admission will be discussed fully and triaged to the appropriate level of therapeutic security by the NFMHS admission panel. This is a vital step, to ensure judicious use of these beds, which are ultimately a scarce and expensive resource. Admission panels of this nature are standard practice in the NHS (England), Scotland and international forensic hospital settings. They ensure clarity and accountability in terms of admission decisions. Triage will be assisted by the use of the DUNDRUM-triage tools (D1, D2).

However, there are challenges:

The first challenge to the model is when patients need to move to higher dependency wards for varying periods of time, to manage aggression and violent behaviour. However objectively, this must be expected in any forensic mental health service.

A further challenge is where there is an increasing number of patients who require long term low secure care. This means the pathway to stepped down care for patients with community discharge potential becomes very limited. The pathway becomes limited and/or dysfunctional and such patients are delayed in the hospital as they cannot step down in a graded manner.

An analysis conducted by the CMH on men in prison placed on the waiting list for admission to CMH during the years 2015-2019 found that only 17% required admission to the CMH. Positive findings were that 38% of remand prisoners on the waiting list were diverted to Approved Centres and 23% improved following voluntary treatment in prison. However a number of prisoners did not progress from the waiting list and ten per cent were either released while on the waiting list or remained on the list at the end of 2019.

b. CMH Admission and Discharge Patterns

CMH patients are detained either under the Mental Health Act (2001) or the Criminal Law (Insanity) Act 2006. Male patients in the Central Mental Hospital are admitted to a high secure admission ward. From there they progress to a series of medium secure units and finally to low secure and pre-discharge units. Patients are moved from more secure wards to less secure wards along this recovery pathway. This system is patient centred as each patient is placed at an appropriate level of therapeutic security according to their individual need. These placements correspond to levels of risk, symptom severity and the patient's overall level of functioning.

These rankings match the position of each unit on the recovery pathway as patient's progress through the hospital from admission to discharge. The longer term low secure unit and the high secure intensive care units are optional placements according to assessed need, while the "main" pathway through care proceeds from the high secure admission unit through the first and then second medium secure units to the pre-discharge unit then to the hospital hotel ward and on to high support community residence. Patients may however be discharged from any point of

recovery pathway if appropriate or if they come to the end of a fixed sentence. Decisions regarding moves along the recovery pathway are made at clinical transfers and referral meetings.

The DUNDRUM-3 programme completion tool supports an individualised approach to the care and treatment programmes offered to individual patients. It rates progress in domains rather than dictating particular programmes. For example, patients are rated for successful programme completion in domains such as mental health, offending behaviour, substance misuse or education, occupation and creativity. This is designed specifically to allow an individualised approach to patient care and allow the unique needs and strengths of each patient to be the deciding factor for the best care and treatment approach. It also allows clinicians to consider new therapeutic options as they arise.

Regardless of the setting, forensic clinician's take more into account than violence risk alone when moving patients forward on their care pathways – engagement, therapeutic working alliance and recovery in a broad sense are also important. Also important are measures of risk, indication of recovery, programme completion and functioning all of which provide outcome measurements in high secure forensic hospitals and the settings to which patients may be discharged such as community settings or return to the prison environment. Patients are continually assessed using the Dundrum – 4 measure of forensic recovery.

The Executive Clinical Director (ECD) of the NFMHS advised that the number of admissions to the CMH annually has fallen from 57 in 2012 to 28 in 2019; it is understood that the level of admissions was mainly comprised of prisoners. The fall in admissions can be attributed to a number of factors which include, inter alia, patients who are Not Guilty by Reason of Insanity (NGRI), the level of acuity of admissions in the last 18/24 months, the impact of recommendations arising from the McMorrow Commission and perceived deficits in community mental health services.

Table 2: CMH Admissions and Discharges 2007 to 2019 (Source: CMH 2021)

Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
TOTAL Admissions	41	50	61	56	52	57	74	52	45	30	27	23	28
TOTAL Discharges	33	41	52	55	62	61	76	52	47	30	26	18	21

The following section describes the admission/egress routes for patients in CMH.

Figure 2 : Sources of male admissions year by year, 2010 to 2020.

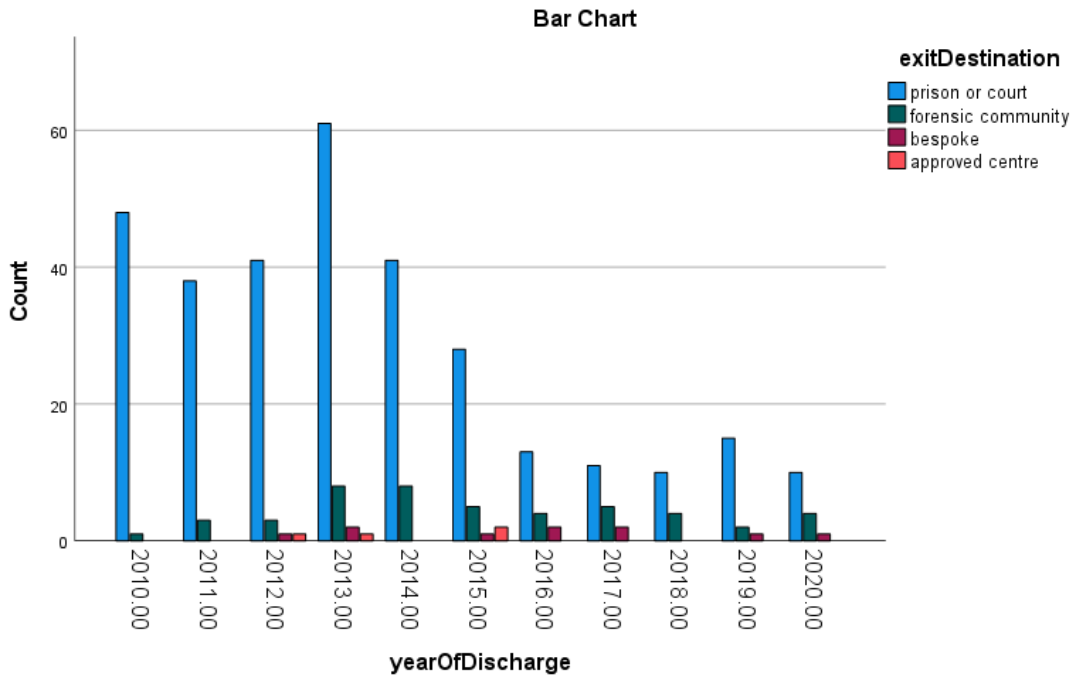


Figure 2 illustrates that admissions from prison peaked in 2013 and reduced significantly in subsequent years. In contrast admissions from other locations remained constant.

In Table 3 the sources of male admissions are described year by year, 2010 to 2020. Admissions peaked in 2013. NGRI admissions peaked in 2014. Note that 2020 – the first Covid year, is not representative.

Table 3: Admission source by year, 2010 to 2020

Count

		Entry Route					
		prison	NGRI	approved centres	Recall NGRI	UTP	Total
yearof admission	2010.00	39	7	2	0	1	49
	2011.00	36	2	1	0	0	39
	2012.00	44	4	1	0	0	49
	2013.00	54	7	4	0	5	70
	2014.00	31	12	0	2	3	48
	2015.00	27	8	0	0	0	35
	2016.00	11	8	1	0	1	21
	2017.00	10	2	1	2	1	16
	2018.00	13	6	0	1	2	22
	2019.00	15	5	3	0	0	23
	2020.00	7	0	0	0	1	8
Total		287	61	13	5	14	380

In Table 4 linking admission source to discharge destination, for males only including those present at the beginning of 2010 and all subsequent admissions 2010-2021, sources of admissions are divided into prison, unfit to stand trial (UTP) & NGRI, approved centres and recalled NGRIs. As expected, almost all prison admissions return to prison;

There were 116 UTP and NGRI patients of whom 48 remain in CMH, with 46 having progressed successfully to forensic community teams and houses; the 22 who returned to court are a mixture elucidated in the next table.

27 admissions from approved centres (section 2(2) MHA) of whom 4 retuned to approved centres, 7 went to bespoke placements and 16 remain in CMH.

Table 4 : Admission Source by Discharge Destination 2010-2021

Count

		exit Destination					
		prison or court	forensic community	bespoke	still in CMH	approved centre	Total
entry Route	prison	299	0	4	20	0	323
	UTP NGRI	22	46	0	48	0	116
	approved centres	0	0	7	16	4	27
	Recall NGRI	0	3	0	3	0	6
Total		321	49	11	87	4	472

In the Table 5, UTP and NGRI patients are separated – this shows that there were

98 NGRI verdicts, of whom 9 went back to court very quickly because they did not have a mental disorder

46 progressed to forensic community teams and houses

43 remain in CMH

18 were admitted as UTP (unfit to stand trial) of whom 13 returned to court when treated to regain fitness and 5 remain in CMH

6 were admitted as NGRI patients recalled from the community for breach of conditional discharge – 3 of these were discharged again to forensic community teams and houses, 3 remain in CMH.

Table 5 : Entry Route / exit Destination Cross tabulation

Count

		exit Destination					
		prison or court	forensic community	bespoke	still in CMH	approved centre	Total
entry Route	prison	299	0	4	20	0	323
	NGRI	9	46	0	43	0	98
	approved centres	0	0	7	16	4	27
	Recall NGRI	0	3	0	3	0	6
	UTP	13	0	0	5	0	18
Total		321	49	11	87	4	472

Patients who are NGRI, Unfit to Stand Trial or Life Sentenced prisoners unable to return to prison occupy most of the beds in the intensively staffed, treatment orientated medium secure wards at the CMH.

Table 6 : NGRI Verdicts (Source: CMH 2021)

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
NGRI	7	4	3	1	2	5	6	5	16	7	6	6	68

Those who have failed to progress to the Rehabilitation and Recovery Cluster (pre-discharge, low secure) within five years of admission or five years of final court disposal are likely to require much longer periods in secure care and benefit only very slowly from intensive treatment programmes. However they remain at significant risk of harm to others, and to themselves, including serious harm.

General length of stay data for patients admitted to the CMH is provided in the Tables below. These indicate that length of stay can amount to several years in a number of patients.

Table 7: Length of Stay (Source: CMH 2021)

Cross-sectional length of stay (years), CMH, September of each year.

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
N	75	83	83	83	93	92	94	92	91	92	94	92	91	97	102
Mean (s.d.)years	9.3 (11.2)	8.0 (10.4)	7.2 (10.4)	6.4 (9.7)	6.4 (9.3)	6.6 (9.3)	7.5 (9.8)	7.2 (9.8)	7.1 (9.3)	7.2 (9.7)	7.1 (8.9)	6.9 (8.8)	6.9 (8.7)	6.8 (8.7)	6.9 (8.8)
Median (years)	5.0	3.5	2.3	2.1	2.6	3.3	4.4	4.8	4.9	3.1	3.7	3.5	3.8	4.1	4.4

Table 8 : Cross-sectional length of stay in bands (Source: CMH 2021)

Length of stay	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
N	93	92	94	92	91	92	94	92	91	97	102
<12 months	29	19	16	22	22	26	18	20	16	17	15
12 to 60 months	31	46	40	28	24	24	35	34	37	44	41
60 + months	38	31	38	42	45	42	41	38	38	36	46

This is the cumulative effect of the change in legislation dating from 2010. As a result much greater numbers of new long stay patients found NGRI have occupied what were formerly acute and sub-acute beds. The CMH currently has 38 patients who have been in the CMH for over 5 years. These can be shown to have reached a treatment impasse and are not benefiting from the mainstream mental illness pathway through the CMH at present. A recent needs assessment examined the short to medium term prospects for these 38 patients. A small number could progress to community bespoke placements at very high cost. However most require a more secure hospital environment which paradoxically could be provided at lower cost. None are considered appropriate to progress either to the HSE “mainstream” community high support services or provided by their partnership organisations DePaul and Hail.

In summary, this has led to an increase in complex cases of a very high number of extremely ill patients in prison who are at risk of self-harm and physical illness resulting from their underlying acute mental health condition. This is a significant patient safety issue. In addition, there are assaults on in-reach NFMHS staff and IPS discipline staff and continuing crises in Courts. The CMH is unable to meet the essential role of providing an accessible and appropriate secure psychiatric service for all those in need. Legal obligations under the Criminal Law (Insanity) Act and Section 21(2) Mental Health Act are also unable to be met in full.

The absence of appropriate access to admission beds in the CMH exacerbates risk for the IPS in managing prisoners with a severe and enduring mental illness, which for a small number is likely to be a prominent influence in offending. The low level of CMH admissions will likely witness a further increase in the IPS waiting list which will place additional strain on IPS healthcare and in-reach NFHMS services.

The opening of the new CMH in Portrane in 2022 is a positive development but it is anticipated that additional specialist forensic mental health in-patient capacity will be required. The work of subgroup 2 is intended to examine current and future capacity requirements of the NFMHS service relating to the needs of individuals who come in contact with the criminal justice system. This is further explored in Section 3 (e).

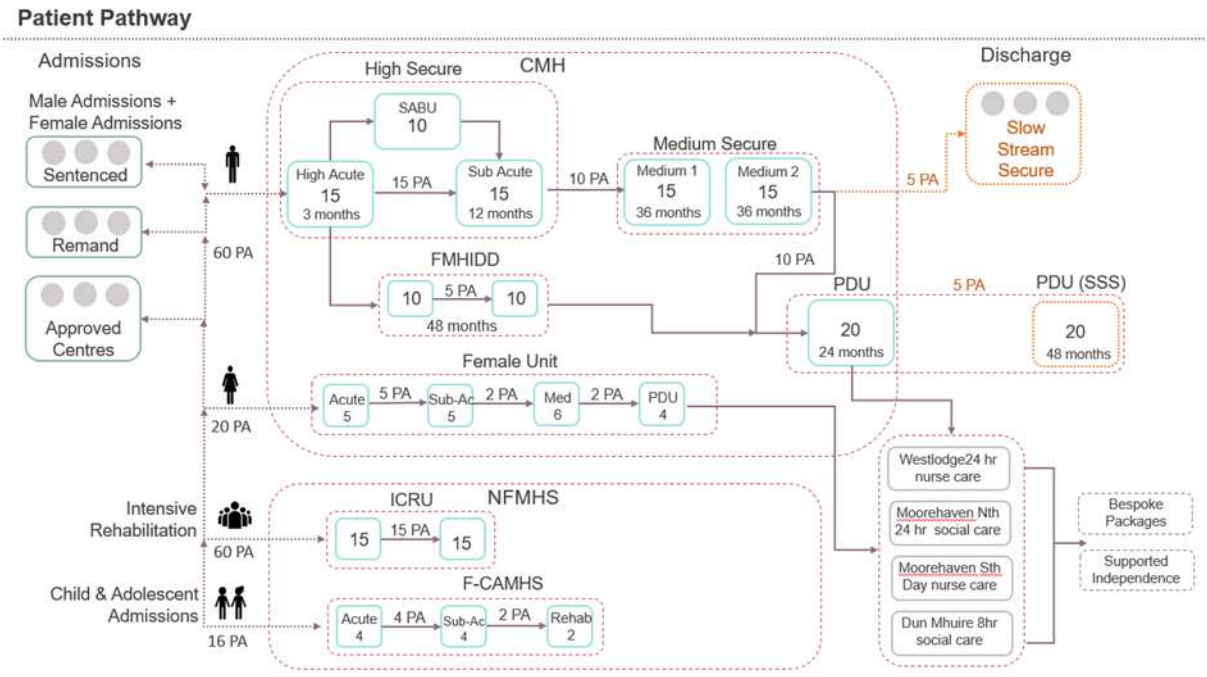
Conclusion

The Group reviewed the current capacity and agreed that there is little throughput through the various units in Dundrum as all Units were at 100% capacity at all times. This has reduced CMH admissions to minimal levels. This has generated a waiting list for admission to the CMH however this option will not be available for the majority of patients.

c. Central Mental Hospital

The subgroup reviewed the future arrangements pertaining to the proposed pathways of care (Figure 3).

Figure 3 : Care Pathways in the proposed Portrane Model of Care



A description of these units is included in the table below.

Table 9 (i), (ii) and (iii):

Portrane Patient Care Pathways

CLUSTER	WARD TYPE	BED NUMBERS	PATIENT COHORT
Acute male	Acute male admissions	15	Newly admitted adult male patients, from prisons generally. Patients will usually be floridly psychotic. Aim is to quickly stabilise mental state, and complete admission assessments including HCR-20, SRAMM and Dundrum tool assessments. Night time confinement is part of risk management and violence prevention. Max length of stay should be 3 months, at which point they either return to prison or move to male sub-acute on their first step of the forensic hospital care pathway.
	Sub-acute male	15	Adult male patients transferred from acute admissions ward. This ward will not accept admissions new to the hospital. Patients are still likely to have high levels of psychosis, and medication titration likely to be ongoing from admissions ward. Some likelihood of incidents due to the unwell mental states on this ward. Night time confinement is part of risk management and violence prevention. This ward will also accept 'backward moves' from the recovery care pathway for patients who were unable to manage on wards further along the care pathway, due to relapse in psychosis, or challenging behaviour issues.

	High dependency male	10	This ward will be the high dependency ward of the new forensic hospital. Very few patients will require this level of care. All patients will be adult males over 18 years. All will present with a combination of treatment resistant psychosis and high rates of violence, even whilst an in-patient. This ward will accept patients from other wards within the CMH when the patient has needed longer periods in seclusion with the aim of managing violence and aiming to reduce the need for restrictive practice, whilst balancing safety and risk issues to patients and staff. Night time confinement is part of risk management and violence prevention. Management of antipsychotic medication for highly treatment resistant psychoses will be key here, and many patients may need 1:1 nursing over and above the high staff to patient ratio on the ward.
Male medium security	Male medium security 1 (MMS1)	15	This ward is the first step on the medium secure part of the therapeutic care pathway. It will accept adult male patients over age 18 years on step-down from sub-acute wards. Patients may still have some psychotic symptoms but should be aiming to be violence free and also beginning 1:1 and group work on psychology, social work and OT, in addition to medical and nursing input.
	Male medium security 2 (MMS2)	15	This ward is the second step on the medium secure part of the therapeutic care pathway. It will offer increasing levels of freedoms in conjunction with increasing responsibilities over MMS1. It will accept adult male patients over age 18 years on step-down from sub-acute wards. Patients should be largely free from psychotic symptoms but should be entirely violence free and

			also well engaged in strong recovery oriented work including 1:1 and group work on psychology, social work and OT, in addition to medical and nursing input.
Male pre-discharge	Pre-discharge unit	20 (18+2)	This ward is the pre-discharge ward for adult men over age 18 years. This sub-divides into an 18 bed pre-discharge unit and a 2 bed rehab unit. Patients should be in remission in terms of their major mental illness, entirely violence free within the secure hospital and completing high level therapeutic work e.g. book of evidence work, relationship work and family / victim work, to prepare for their discharge to the community. It is vital that all patients on this ward are reasonably considered to be suitable for a community direction care pathway, so as to maintain the flow of patients through the hospital. These beds are extremely important to prevent from 'silting up'. Any silting up here, will have a knock on effect back through the MMS2, and MMS1 wards, eventually limiting the hospitals admission capability.
Women's service	Women's acute	10	This ward will provide admission and higher dependency ward care to adult women over age 18 years. Patients will generally be very unwell with Axis I mental illness, often psychosis. MDT care and treatment under a responsible treating consultant will be provided.
	Women's pre-discharge	10 (6+4)	This ward will provide a step-down women's unit to permit transfer of women who are more stable in their mental state from the acute women's unit. This will aim to provide more intensive therapy including 1:1 and group work to prepare female patients for discharge including book of evidence work, insight work and work re: mental illness, substance misuse, and risk and family issues. This unit sub-divides into a 6 bed medium term intensive therapy unit and a 4 bed rehab and pre-

			discharge unit. There is also a super-numerary one-bed high dependency area with flexible use.
Forensic - Mental Health and intellectual disability	F-MHIDD acute	10	Adult male patients with intellectual disability or autistic spectrum disorder. All patients will have been admitted via the male acute admission ward, although they can subsequently be transferred to the F-MHIDD ward from either the male acute ward or elsewhere on the hospital care pathway. Patients on this ward may continue to present with psychotic symptoms or challenging behaviours linked to their intellectual disability or autistic spectrum disorder. Patients are provided with consultant led multidisciplinary input from psychiatry, nursing, SW, OT and psychology.
	F-MHIDD step-down	10	Adult male patients with intellectual disability or autistic spectrum disorder, who have successfully stepped down from F-MHIDD acute ward. Patients are provided with consultant led multidisciplinary input from psychiatry, nursing, SW, OT and psychology and the focus on this ward will be to prepare the patients to return to the community via the appropriate specialist service, given their unique needs. From this unit, patients should progress if possible onto the hospital main pre-discharge unit and from there to the community setting. Again it is vital that only those who are reasonably expected to move to the community in the shorter term are transferred on to the pre-discharge ward to avoid silting the pre-discharge beds.
TOTAL BED NUMBERS		130	

Forensic Intensive Care & Rehabilitation Unit (FICRU)

CLUSTER	WARD TYPE	BED NUMBERS	PATIENT COHORT
Acute male	Acute male admissions	15	Newly admitted adult male patients, from approved centres mainly, but also those not meeting threshold for admission to CMH who may be diverted from courts. Patients will usually be floridly psychotic. Aim is to quickly stabilise mental state, and complete admission assessments including HCR-20, SRAMM and Dundrum tool assessments. Night time confinement is not necessarily part of risk management and violence prevention though high staff to patient ratios are a part of therapeutic management and prevention of violence. Max length of stay should be 3 months, at which point they either return to the local approved centre or to the court or move to male sub-acute on their first step of the forensic hospital care pathway. Patients who have been conditionally discharged to the community from the CMH may from time to time require brief but urgent admissions here, either under the Mental Health Act or as recalls under the Criminal Law (Insanity) Act section 13.
	Sub-acute male	15	Adult male patients transferred from FICRU acute admissions ward. This ward will not accept admissions new to the hospital. Patients are still likely to have high levels of psychosis, and medication titration likely to be ongoing from admissions ward. Some likelihood of incidents due to the unwell mental states on this ward. Night time confinement is not necessarily part of risk management and violence prevention though high levels of staff to patient ratios are.

Total		30	

Forensic Child and Adolescent Mental Health Unit (F-CAMHS)

CLUSTER	WARD TYPE	BED NUMBERS	PATIENT COHORT
Acute	Acute	4	Admissions will be under the Mental Health Act section 25 on transfer from other Approved Centres for Children or under the Criminal Law (Insanity) Act from Oberstown Childrens Detention Campus. Acute admissions will be for up to three months.
	Sub-acute	4	Sub-acute admissions will be for a further twelve months.
	Pre-discharge	2	Some patients may stay until their 18th birthday.

Conclusions

The Group reviewed and agreed with the clinical rationale set out in the Portrane pathway of care and in particular and discussed the requirement to provide appropriate capacity for patients who were clinically fit for discharge but required a lower level of security.

It should be noted that recommendation 56 of *Sharing the Vision* (StV) states that the development of further Intensive Care Rehabilitation Units (ICRUs) should be prioritised following successful evaluation of operation of the new ICRU on the Portrane Campus. The new regional units will then have to be prioritised and approved to go to Design/Planning in the context of competing demands under the HSE Capital Programme. This is considered further in Section 3.

There is also be a requirement to discharge prisoners back to Prison once they have been assessed and treated such that they are no longer in need of care and treatment that can only be given in hospital as defined in section 18 Criminal Law (Insanity) Act 2006.

The possibility of developing this safe area (intoxicant free and violence free) within the prison service estate should be explored. This would afford an opportunity for prisoners returning from inpatient hospital treatment to extend their recovery and rehabilitation period and facilitate a further sustained period of stabilisation before reintegration back

into the general prison population. An appropriate IPS facility is considered further in section 4.

Recommendations

The Group have agreed with the new Portrane model of care as the appropriate clinical pathway to manage patients following admission to the CMH.

The Group did not consider that prisons should be designated under the Criminal Law (Insanity) Act 2006 for the purpose of treating prisoners with a mental health difficulty.

d. Requirement for CMH Step Down Facilities

In several Western countries, the average duration a patient stays in highly secure forensic settings has been rising. This development has consequences. First, an increasing length of stay (LOS) counteracts treatment efficiency. When treatment is prolonged in highly restrictive conditions for longer than necessary, rehabilitation is impeded. Additionally, it is desirable to shorten LOS from a humanitarian point of view. Human rights might be violated when LOS increases unnecessarily, particularly regarding the principle of proportionality according to the Council of Europe. Furthermore, treatment in secure hospitals is expensive and may not be an efficient use of scarce resources. Factors related to a longer LOS include being male, a history of absconding, a need to prevent absconding, public confidence, victim sensitivity, legal process, a younger age at index offense, and a younger age at the first documented delinquency. Clinical factors linked to a longer LOS include previous psychiatric admissions, previous contact with child and adolescent psychiatric services, having a lifetime diagnosis of learning disability, having severe mental illness as diagnosis, making less progress in rehabilitation, persistence of mental state associated with violence, specialist forensic treatment need, complex risk of violence (comorbidity), problematic institutional behaviour and a higher baseline risk of recidivism. All of these factors need to be taken into account when planning a care plan for patients as they transit the forensic mental health system on the pathway to recovery.

The decision to move a forensic mental health patient from conditions of high to medium to low security is one of the most important decisions taken by forensic mental health professionals. Risk assessment has evolved into structured professional judgement instruments which guide decision makers by identifying risk factors for violence or suicide. The Dundrum toolkit is a suite of structured professional judgement instruments developed at the Central Mental Hospital Dundrum.

When making decisions regarding moving a patient from high to medium and on to low levels of therapeutic security or discharging patients to the community, clinicians are likely to take more than risk assessment alone into account. Factors such as mental health, physical health, self-care and activities of daily living, family and social networks, use of leave from the hospital and others such factors are all given strong consideration. These items are often included in clinician's reports

to mental health tribunals and review boards to assist these bodies in their decision making with regard to a patient's readiness for a move to a location with a lower security requirement.

Provision of mental healthcare in the least restrictive setting appropriate to safely manage the patient's risks and needs is a core principle of mental health law in many jurisdictions. Implementing the "least restrictive option" for patient's replacements requires balancing risks and freedoms, rights and responsibilities. Increasingly secure forensic mental health settings are expected to reduce restrictive practices, but at the same time eliminate in-patient violence or violence towards staff. This is a constant challenge. Although most forensic mental health services strive to implement the principle of caring for patients in the least restrictive setting, demonstrating that this is taking place is often very challenging to do.

Within secure forensic hospitals, the care pathway is typically stratified according to risk, with higher staff to patient's ratio present on wards that accommodate individuals with higher levels of symptoms and higher risks and lower staff numbers on rehabilitation wards. The aim of this system of stratification of the care pathways within secure units is to allow patients graded access to increasing freedoms and increasing personal responsibility. Placement on therapeutically secure care pathways should correspond to risk and need for individual patients and should change overtime as patients recover. This system should facilitate patients being placed in the least restrictive hospital setting appropriate to meet their individual risks and needs, but also within those secure hospitals to be placed on the least restrictive unit possible, and when possible to transfer to a community setting.

The provision of longer term care for patients who require lower levels of therapeutic security is recognised as a major challenge. The Group was aware of the potential to use ICRUs and PICUs in this regard. However both ICRUs and PICUs have specific functions. In general PICUs are a part of the hospital that provide short term care for patients in an acute phase of their mental health difficulty and who cannot be safely managed in a general psychiatric ward. The distinctions between these different care settings is set out as follows.

- **Psychiatric Intensive Care Unit (PICU)**

This provides acute, short term treatment (up to three months) in conditions of low therapeutic security for patients with severe mental illness who require this level of care. Typically these are patients who would otherwise abscond placing themselves or others at risk. The risk to others would not be life threatening. Typically these are between 10 and 15 beds and there should be one in each district service – for a population of 200,000 to 500,000.

- **Sub-Acute Psychiatric Intensive Care**

This provides low secure care for periods of up to a year for those who need longer than three months treatment in a low secure setting. For example to initiate Clozapine treatment in a patient with treatment resistant schizophrenia who would otherwise abscond or represent a risk to others though not a life threatening levels. These might also serve a population of 200,000 to 500,000.

- **Intensive Care Rehabilitation Units**

This concept was a new development under AVFC. This consists of two 15 bed wards, one providing PICU service the other providing a sub-acute low secure service. Four of these units were recommended on a regional basis.

- **Long Term Medium Security**

This provides for those with treatment resistant severe mental illnesses who continue to present a serious danger to others after 5 years of treatment in a secure forensic hospital.

- **Long Term Low Security**

This provides for those who cannot safely be discharged from a sub-acute psychiatric intensive care unit after 15 months of treatment; or who have made only limited progress in a secure forensic hospital to the point where they continue to represent a danger to others due to treatment resistant severe mental illness, but no longer represent a risk of life threatening harm to others.

A Matrix Model of Comprehensive Levels of Care / Therapeutic Safety and Security in Psychiatry

Table 10 provides a matrix that includes in outline all parts of a modern service for people with severe mental illnesses. The table cross-references levels of therapeutic security (community, open wards, low secure, medium secure, high secure) against length of stay (short term, sub-acute, medium term, long term) and finally the population catchment areas served.

Table 10 : Mapping whole systems: security, length of stay and population served.

	Community	**Open hospital**	**Low secure**	**Medium secure**	**High secure**
Acute / Short term, under 3 months	crisis house; police station, court and prison liaison/ diversion teams	Generic/ local mental health unit. Admission wards (open)	Locked generic/ local psychiatric intensive care (PICU), forensic intensive care (FICU)	regional medium secure unit admission wards	medium secure unit admission wards, high secure hospital admission wards
Sub-acute / **3 to 12 months**	Intensive Case Management (ICM), Assertive Community Treatment (ACT);	Sub acute open wards	ICRU sub-acute ward	Regional medium secure units sub-acute wards	High secure hospital sub-acute and intensive care wards
Medium term, 12 months to 3 years	ICM, ACT, (CMHT), day hospital, hostel, forensic community teams (integrative model)	Rehabilitation wards.	Long-term low secure	medium term medium secure wards	High secure intensive care or medium term wards
Long term	Core and cluster, day centre, sheltered workshop. Forensic community teams (parallel).	24 hour nursed care, general or forensic.	Long-term low secure	long-term medium secure unit.	High secure long term (typically intensive care)

Population served	Local, 30 – 50,000 or district.	district, 200 - 500,000	Regional or national, 1.5 – 5.0 m.	Regional or national, 1.5 – 5.0 m.	regional/ national 5.0m+

Note: level of therapeutic security required at point of admission is assessed using DUNDRUM-1; step-down is assessed using DUNDRUM-3 and DUNDRUM-4 alongside HCR-20

e. Modelling Future CMH Capacity Requirements

(i) Methodology and Rationale

It is important to consider the new Portrane hospital so that future capacity requirements are sufficient to meet patient needs. This work involved a modelling analysis which provided an estimate of the CMH discharge requirements so that the CMH can continue to provide the acute treatment and rehabilitation service as originally intended. There are a number of potential egress pathways and these depend on the clinical assessments as described above and depend on the therapeutic and security needs of the individuals concerned.

A description of the analysis is provided below.

This modelling exercise was commissioned to provide an understanding of the future capacity requirements of the new National Forensic Mental Health Service (NFMHS), based on CMH admission and discharge trends. A full description of the methodology and outputs of this work is included in an Appendix.

The context includes the implementation of an updated model of care for the service aligned with the move of the NFMHS from Dundrum to Portrane.

The modelling work addressed future demand projections in respect of the NFMHS inpatient service until 2026. In particular they address the question as to the trajectory of demand under two pre-defined possible clinical scenarios.

Outputs included demand/ beds occupied projections analysed by length of stay, patient final legal status as well as type of bed required as well as the profile of expected future discharge volumes and destinations. The analysis included timelines when the capacity limits of the CMH were likely to be exceeded.

It is noted that the provision of a long term medium secure pathway for patients with very long lengths of stay would enable a much more significant volume of admissions.

The first step of the modelling approach was to understand, classify and potentially simplify the type of patients for modelling purposes. Three high level categories of patients were described based on detailed data analysis and validation by senior clinical stakeholders within the NFMHS. These categories were:

IPS – non-NGRI

NGRI

Approved Centre admissions

The second step was to identify potential clinical pathways for each patient type. These clinical pathways were defined with and validated through NFMHS senior clinical stakeholder engagement e.g., High Secure Acute -> High Secure Sub-Acute -> Medium Secure -> Discharge (to IPS) etc.

The proportions of patients allocated to each category and clinical pathway were calculated based on analysis of past data provided by NFMHS.

The average length of stay (LOS) for each part of the clinical pathway was also based on historical analysis as well as the superimposition of the new NFMHS model of care as provided to the modelling team and validated by NFMHS.

Future demand patterns were run through the model based on demand scenarios provided by the NFMHS and IPS engagements. Two agreed scenarios were run through the model – involving annual IPS admissions of 60 males with different NGRI/ non-NGRI proportions.

The modelling work focused on male patients because the provision of 20 beds in the Portrane complex was considered to be adequate to address future demands.

(ii) Modelling CMH Capacity Requirements: Outcomes

The modelling work has addressed the future demand projections of the NFMHS inpatient service until 2026. Under different scenarios, in males, bed capacity will be exceeded in 2023 if the current pattern of admissions from prison, approved centres and as a result of NGRI is maintained. This trend will continue up to 2026 and result in increasing waiting lists for CMH admission. Further modelling work using different admission scenarios was conducted to quantify the CMH discharge destination requirements so that the CMH would be in a position to meet its admission requirements and not exceed capacity. At present, CMH patients are discharged either to prison, forensic community centres or to bespoke packages. It is anticipated that discharges to prison will continue at a level of more than 50 per annum. The demand for bespoke packages and also for discharges to forensic community settings will be low and at a similar level to previous years. There will be however a requirement to discharge patients to a Long Term Medium Secure (LTMS) setting. This requirement will peak in the early phase of the new Portrane development at 42 beds and reduce in subsequent years.

f. LTMS Facilities

In many countries a requirement for long term psychiatric care has been identified. This applies for a small subgroup of patients who have partially responded to the prevailing therapies or care and are not making sufficient progress in the pathway to recovery. In the Netherlands, a centre for long

term forensic care has been developed. Patients can be admitted to this centre after a thorough legal procedure and in which the treatment goals are managing the mental health difficulty, stabilisation of the patient's symptoms, promoting recovery and optimising the quality of life of the individual. As part of its work, the group consulted with Dr Peter Braun who has pioneered the development of LTMS facilities in the Netherlands. This applies to patients who have had more than 6 years of treatment without a satisfactory clinical outcome and there is risk of reoffending. A priority is to manage the facility as a village/community rather than a prison and the residents are seen as people with a handicap and not solely as dangerous people. While there are behavioural rules and responsibilities for residents, they also have rights and can exercise choice in how they conduct their life and where they want to work. Nursing staff and therapists are also perceived as part of the community where the emphasis is on providing a supportive environment through various techniques and "normalising" the daily routine of this vulnerable group. This model of care has changed the outcomes of people who did not respond well to therapy and the expectation was that they continued to live in a long stay ward of a specialist forensic mental health hospital. While a minority of individuals continued to require ongoing care in the LTMS facility, most have been suitable for discharge and follow up treatment in community clinics.

Conclusions

While there is no international accepted standard for length of stay in forensic settings, the European experience illustrates that length of stay across high security forensic facilities is increasing.

Characteristics associated with long stay include an index offence of murder/homicide, overall severity of the index offence, a history of psychiatric treatment and cognitive or organic deficit.

There are alternative models of care other than to manage long stay patients in a long stay ward in a specialist forensic mental health hospital.

In Ireland, the male bed capacity of the new CMH will be exceeded in 2023 if the expectations relating to the required level of admissions are met.

The modelling exercise has set out the requirements for LTMS beds under different admission scenarios to the CMH. This will peak in the early phase of the Portrane development (at 42 beds) and reduce in subsequent years.

Recommendations

(i) The Group recommend the development of a facility that provides a model of care that delivers a supportive environment that "normalises" care and recovery for vulnerable individuals who require LTMS. The LTMS bed requirements will peak in the early phase

of the Portrane development at 42 beds and reduce in subsequent years. These are considered further in Appendix 2.

(ii) It is recommended that planning for this facility should commence at the earliest opportunity in order to meet the male bed capacity requirements for the new CMH in Portrane.

The scope of this planning should include:

-Development of a model of Care for LTMS

-Consideration of Capital requirements

-Development of a Workforce Plan

-Consideration of a broad range of shorter term alternatives including but not exclusive to the use of FICRU (Portrane) and PICUs regionally to provide LTMS accommodation on an interim basis.

3. Use of Approved Centres

Much has been referenced in the past decade or more about the plight of people with a mental health difficulty who are in direct contact with the criminal justice sector.

Typically this engagement ranges from initial contact with An Garda Síochána, through to engagement with the Courts Service, the Irish Prison service and the Probation Service.

This sub group has a focused interest in the engagement at the level of the Irish Prison Service and deliberating on how access to local approved centres may be enhanced.

Not all people in custody who present with a major mental illness require the levels of therapeutic security afforded by the Central Mental Hospital, indeed, not all prisoners with major mental illness require the inputs of a forensic mental health team. There is a significant cohort of people with a major mental health difficulty who are only ever engaged in minor crime, and much of this is as a result of:

- Poor engagement with community mental health services and/or capacity issues at a local or regional level should there be a need for increasing levels of therapeutic security
- Difficulty in accessing community mental health services by virtue of homelessness or dual morbidity
- Self-medicating with drugs and/or alcohol
- Poor family and social supports.
- A requirement to strengthen structured mental health services designed to meet increasing levels of therapeutic security (*Vision for Change (AVFC)*; 2006)

This cohort of prisoner invariably receive short sentences and often present as acutely mentally unwell in the prison environment. Admission to the CMH is highly unlikely, as they do not have the forensic/offending history to require such a level of therapeutic security.

With regards to this challenge, *Sharing the Vision ;* 2020 proposed the following:

‘’A small group of individuals each year who are found not guilty by reason of insanity (NGBRI) must be detained under the Criminal Law Insanity Act in a designated centre under the Act. An intensive care rehabilitation unit (ICRU) will be built [this unit has since been built but is not yet operational] as an adjunct to the new forensic facility on the Portrane campus. This unit will have dual registration as an approved centre under the Mental Health Act 2001 and a designated centre under the Criminal Law (Insanity) Act 2006. It will therefore be available to accept those who have NGBRI status but who do not require the level of care provided in the Central Mental Hospital. The operation of the new ICRU centre will be reviewed to determine the need for and effectiveness of this model of care and the possible location of further ICRUs.’’ (Page 51)

Additionally, StV further recommended the development of Psychiatric Intensive Care Units (PICUs) under recommendations 46 & 47 of the policy, as a means of alleviating the challenges outlined above. A PICU is a tertiary mental health service designed to provide intensive care to service users in an acute phase of a mental disorder.

The PICU in the Phoenix Care Centre is made up of the Oak Ward and Alder Ward, providing 12 beds each for male and female residents respectively. The Oak Ward takes patients from Dublin, Wicklow and the North East Region, and the Alder Ward takes patients from around the country. The Phoenix Care Centre opened in 2013 at a cost of €21 million. It functions as a tertiary mental health service providing a service to Adult Approved Centres. Admissions are from other Approved Centres and not directly from the courts, prisons or the CMH in-reach teams, diversion team or the CMH. The male ward functions at over 90% bed occupancy. Minor capital works are under way to provide additional seclusion facilities.

The Carraig Mór unit in Cork originally provided an 18 bed psychiatric intensive care unit for men (12 beds) and women (8 beds) for the Cork and Kerry area. This unit functions as a tertiary mental health service with a high bed occupancy. It has competing demands for admission from Approved Centres, the FACTS team and in-reach services.

Unlike morbidities of other categories (e.g. cardiac, oncology) being acutely mentally unwell may not attract the same level of response in terms of access to acute inpatient facilities, and prisoners can end up being untreated and clinically deteriorating with their illness until they are released from prison. This is as a result of a number of factors, among them:

There is no reciprocal provision between the Criminal Law legislation and the civil Mental Health Legislation to allow for the transfer of a mentally unwell prisoner to local services (PICU/Approved Centre) other than to a designated centre and be returned to prison. The Central Mental Hospital is the only psychiatric centre designated under the Criminal Law (Insanity) Act 2006. S3(2) of the 2006 Act allows for the designation of further psychiatric centres, but as previously outlined, there

is very little availability of secure places in psychiatric centres outside the CMH. The 30-bed Forensic ICRU in the new NFMHS in Portrane will go some way to meeting this requirement. Prisoners cannot be compulsorily treated for their mental illness while in prison. Involuntary treatment of prisoners in a prison setting in general does not have international support, as prisons are not considered to be appropriate therapeutic environments and they do not have the necessary safeguards in place. STV adopts a human rights-based approach, emphasising the importance of consent, capacity, and a person-centred perspective that focuses on enabling recovery through an emphasis on personal decision-making supported by clinical best practice. This is supported by the Draft Heads of Bill for the revised Mental Health Act 2001 and the Mental Health Commission.

- The Criminal Law (Insanity) Act 2006 does not provide for prisoners to be involuntarily treated for their mental illness in prison, consistent with international human rights practice. An attempt by the Minister for Justice to provide for designated centres in a prison in the 2006 Act was withdrawn by the Minister during the Bill's passage amid concerns about its compliance with international human rights practice and concerns relating to the overall clinical governance. S15 of the 2006 Act does provide for the transfer, either voluntarily or involuntarily, of a prisoner to a designated centre for appropriate care or treatment which they cannot be afforded in the prison. That treatment is regulated by Part 4 of the Mental Health Act 2001, which deals with consent to treatment.
- Local psychiatric centres may be unable to take in prisoners due to a lack of capacity in these centres to manage patients who may require conditions of therapeutic security or supervision. In addition, some prisoners with mental health difficulties may be stigmatised and this can affect the response by local services. Importantly, many psychiatric centres across the country do not have access to a separate high dependency setting for patients with enhanced mental health and behavioural support needs. This places significant restrictions on the capacity of many psychiatric centres to provide appropriate care to complex mental health presentations, including those being referred from prisons.

Although AVFC has supported significant development over the past 13 years, it is recognised that much more is work is required under the new Policy *Sharing the Vision* to develop stronger, more appropriate mental health supports in the area of forensic mental health.

However, the subgroup is aware that the DOH/HSE is undertaking a review of mental health bed capacity. The development of PICUs is under consideration in the Capital Plan. These services as originally described in AVFC would allow for a national response to the stratification of risk, appropriate and timely transfer of people into and discharged from varying levels of mental health service and allow for a throughput of patients mitigating delays in access to services and enhancing recovery and rehabilitation. PICUs, low and medium secure services, typify the services required to maintain a sustainable and responsive mental health service and affording patients access to the required level of care at the time they are needed. These needs relate to short, medium and long term care and treatment. Access to approved centres is only one part of a suite of available resources that characterise a well-organised and sustainable mental health service. They are only part of the solution.

Oversight, gatekeeping, governance and appropriate risk assessment are essential components of developing a responsive pathway for mentally ill prisoners. The development and establishment of a multi-agency shared care approach is a fundamental necessity where shared governance, shared accountability and shared responsibility underpin a robust and well informed and responsive risk assessment process.

StV reinforces the need for ''every person with mental health difficulties coming into contact with the forensic system to have access to a comprehensive stepped (or tiered) mental health service that is recovery-oriented and based on integrated co-produced recovery care plans supported by advocacy services as required.'' (Page 50).

There are several forensic mental health initiatives outlined within StV that relate to the work of this subgroup, including:

- The development of a new 170 bed facility in Portrane to replace the 96 bed CMH, to continue to provide services both in the community and in prisons. The facility will include a forensic intensive care rehabilitation unit (F-ICRU), as well as a forensic child and adolescent mental health service (F-CAMHS) unit the first of their kind in Ireland.

- The 2015 New Connections report set out a series of recommendations for adequately meeting the psychological needs of the prisoner population. These include access to a range of talking therapies and the development of mental health peer supports in prisons. The recommendations of the New Connections report are promoted and endorsed in this policy.
- The national forensic mental health service (NFMHS) began its prison in-reach and court liaison service (PICLS) in 2007. The service aims to identify prisoners with a mental health difficulty as rapidly as possible and put in place practical solutions for appropriate mental healthcare. It provides in-reach clinics at Cloverhill, Mountjoy, Dóchas Centre, Wheatfield, the Midlands, Portlaoise, Arbour Hill and Castlerea Prisons, and also at Oberstown Children's Detention Centre. The service carried out 5,673 patient reviews in 2019.

Table 11 : Recommendations from StV which relate to subgroup 2

	Recommendation	Actions/Tasks
46	An Expert Group should be set up to examine Acute Inpatient (Approved Centre) bed provision (including PICUs) and to make recommendations on capacity reflective of emerging models of care, existing bed resources and future demographic changes, with such recommendations being aligned with Sláintecare.	Set up an Expert Group to examine Acute Inpatient (Approved Centre) bed usage and develop recommendations.
47	Sufficient Psychiatric Intensive Care Units (PICUs) should be developed with appropriate referral and discharge protocols to serve the regions of the country with limited access to this type of service.	Develop Psychiatric Intensive Care Units (PICUs) to meet identified need. Agree updated referral and discharge protocols.
54	Every person with mental health difficulties coming into contact with the forensic system should have access to comprehensive stepped (or tiered) mental health support that is recovery-oriented and based on integrated co-produced recovery care plans supported by advocacy services as required.	Complete mental health needs analysis of the prison population. Develop a comprehensive tiered forensic mental health model of care. Deliver phased implementation of the tiered mental health service.
55	There should be ongoing resourcing of and support for diversion schemes where individuals with mental health difficulties are diverted from the criminal justice system at the earliest possible stage and have their needs met within community and/or non-forensic mental health settings.	Provide ongoing resourcing and support for diversion schemes.
56	The development of further Intensive Care Rehabilitation Units (ICRUs) should be prioritised following successful evaluation of operation of the new ICRU on the Portrane Campus.	Carry out a comprehensive evaluation and review of the ICRU on the Portrane Campus. Develop a national plan for the development of ICRUs. Undertake phased implementation of the national ICRU development plan.

Note: With regard to recommendation 56 of StV, Phase 1 of the HSE NFMHS capital project is the new complex at Portrane. Phase 2 relates to new regional ICRUs in the longer term under the overall HSE Capital Plan.

The Sláintecare Report identifies 2 significant commitments:

Goal 2: Provide high quality, accessible and safe care that meets the needs of the population.

Strategic Action 3: Improve population health-based planning and develop models of care to deliver more effective and integrated care.

Importantly, the overarching principles and approach of the Sláintecare policy overall are reflected, from a Mental Health perspective, in StV. This includes in more appropriate detail agreed policy, objectives, and phased implementation. Implementation of StV will, in practice, be realised by new development funding under the agreed annual HSE Service Plans for Mental Health. Recommendations of StV, including the update of the Mental Health Act, relevant to each subgroup IDG recommendations have been considered in the context of the Final Report.

Additionally, the National Drugs Strategy, Reducing Harm, Supporting Recovery a health-led response to drug and alcohol use in Ireland 2017-2025 recommends:

2.1.24 Improve outcomes for people with co-morbid severe mental illness and substance misuse problems.

2.1.25 In line with Rebuilding Ireland, improve the range of problem substance use services and rehabilitation supports for people with high support needs who are homeless.

2.1.27 Improve the capacity of services to accommodate the needs of people who use drugs and alcohol from specific communities including the traveller community; the lesbian, gay, bisexual, transgender and intersex community; new communities; sex workers and homeless people.

It should be noted that StV also make several recommendations with regards to people with co-morbid severe mental illness and substance misuse problems, namely:

- ‘’A tiered model of integrated service provision for individuals with a dual diagnosis (e.g. substance misuse with mental illness) should be developed to ensure that pathways to care are clear. Similarly, tiered models of support should be available to people with a dual diagnosis of intellectual disability and/or autism and a mental health difficulty.’’ (Page 61)

- ‘’[..] the profile of the mental health needs of the prison population needs to be explored to gather data on the prevalence of autism, intellectual disability and needs relating to addiction and dual diagnosis, often not specifically catered for by an associated model of care in prisons. Such data will allow for a more joined-up approach by all professionals delivering care in a prison setting.’’ (Page 51)

Moreover, the HSE is currently finalising a Model of Care for the National Clinical Programme for Dual Diagnosis, as well as developing pilot sites for the programme. The Model of Care describes the clinical pathway for service users with substance misuse and moderate to severe mental health difficulties, with links to primary care substance misuse, community mental health and acute services.

Furthermore, the Second IDG report considered and commented on:

- the challenges of prisoners returning to the community on release from custody
- the increased risk of morbidity and recidivism at this point
- the requirement for continuity of care
- the risks associated should this (continuity) fail to materialise

- consideration of emerging service improvements

The PICLS Team in Cloverhill and the Pre-release Planning Services (PReP Model) within the Irish Prison Service and NFMHS have made extensive strides in diverting prisoners form custody and planning safe and sustainable releases from custody. A comparable approach has not been possible for sentenced prisoners. It is considered unacceptable for any other physical health morbidity to experience and tolerate the significant delays, and frequent lack of treatment, that is accepted for those in prison with a mental health diagnosis.

Diversion from custody for sentenced prisoners to approved centres is only available to a very small number of potential prisoners as it is contingent on approval of Temporary Release (TR). TR is normally only available in the final 4-6 weeks of a sentence and again this a hugely resource intensive arrangement to put in place as the agreement of the admitting Clinical Director has to be in place as well as an identified available bed in the approved centre.

Conclusions

The Group note the establishment of the Expert Group which is examining the Acute Inpatient (Approved Centre) bed provision including PICUs under the StV policy. Access to local PICU/psychiatric centres would augment these services and should be considered as a priority. The Group also note the StV commitment regarding a National Plan of further Intensive Care Rehabilitation Units (ICRUs).

Imprisonment as and of itself is not an automatic indicator that a person requires the high level of therapeutic security provided by the Central Mental Hospital. All prisoners who require mental health treatment in a clinical setting will be assessed and appropriately referred by NFMHS clinicians to the service which best provides for the level of therapeutic security required. For professional consistency and appropriateness the Dundrum Toolkit will be used in determining the most appropriate level of therapeutic security required. This also supports the recommendation in StV that persons with mental health difficulties will be cared for in the least restrictive and most clinically appropriate environment.

These measures would allow a more comprehensive mental health service provision, including for those with enhanced and significant mental health needs. Additionally, it would allow for a positive and appropriate response to the levels of mental health difficulties, increase the availability of flexible capacity at appropriate levels and prevent stigma and discrimination, as well as improving the response to mental health difficulties, ensuring they are on par with other health morbidities.

Recommendations

i) **Subject to the work of the Expert Group which is considering Inpatient bed provision, the development of PICUs is considered as a priority**
ii) **Work should commence on planning of further ICRUs and a Design Team should be established at the earliest opportunity**

iii) **Sources of funding for what would be a resource intensive development for i) and ii) would need to be identified and considered.**

i) **The Criminal Law (Insanity) Act 2006 provides for the transfer of patients from prison to a mental health treatment facility and that the Minister can designate an Approved Centre for this purpose. In this regard, a small number of Approved Centres should be considered for designation on a regional basis so that this care could be provided for patients who have committed a minor offence, require a low level of security and suffer from a significant mental health difficulty. The use of these centres should be subject to clear clinical risk assessment and security admission criteria as per the Dundrum Toolkit.**

4. A Safer Prison Environment

The numbers of persons committed to prison presenting with severe and enduring mental illness is increasing. Imprisonment itself can impact adversely on mental health and prisons are not therapeutic environments. There are ongoing challenges in maintaining an intoxicant and violence free environment across the prison estate. In certain situations, there are serious safety concerns for prisoners and staff because access to specialist in-patient forensic mental health services is limited and prisoners must be “managed” in an inappropriate prison environment

One of the issues for IPS regarding the provision of care for prisoners with a mental health difficulty is “to explore options to provide care in an intoxicant free and violence free environment”. Under the new Portrane model of care, it is anticipated that CMH/prison transfers are sustained at 50 or more patients per annum. Current IPS facilities do not have the capacity to provide this level of care to the standard required.

It is envisaged that a bespoke facility/unit would provide care for prisoners on their transfer back from CMH/FICRU or an Approved Centre so that they can be stabilised and established on a pathway to recovery before they return to general population across the prison estate. This would complement the other measures we are considering in freeing up CMH capacity and consistent with a previous recommendation from the Inter Departmental Group.

Recommendations

The IPS should establish a Working Group with Terms of Reference to include:

1. **To identify a suitable facility/unit in accordance with the recommendations of the Mental Health Task Force that would provide care and accommodation for prisoners on their transfer back from CMH/FICRU or an Approved Centre in order that they can maintain stability and advance on a pathway to recovery before they return to general population.**
2. **To develop appropriate governance arrangements (including clinical admission/discharge criteria) for this facility**
3. **To identify clinical and operational resource requirements**

This work should commence at an early opportunity with a reporting timeframe of circa 9 months or earlier.

5. Substance Misuse and Dual Diagnosis

(i) Drug Treatment Services

Those in prison are now more likely to have a challenging lifestyle that predisposes to substance misuse. This includes those with a dual diagnosis of addiction and mental health difficulties.

The Irish Prison Service (IPS) continues to review existing drug treatment programmes. Trends in Mountjoy, Portlaoise and other prisons point to a significant number of prisoners currently self-detoxing from methadone resulting in a reduction in the average dose of methadone.

The services available include:

1. Drug Treatment Programme (DTP) which is a nine week programme, has 9 places per programme, and there are up to 6 programmes being facilitated in Mountjoy Prison annually.

   The DTP programmes were significantly curtailed in 2020 as a result of mitigation measures related to covid but are planned to recommence shortly.

2. The Medical Unit (excluding Higher Support Unit & Low Support Unit), at Mountjoy Prison, circa 50 beds, of which 9 beds are being utilised exclusively for the DTP at any one time.

Other services available include Slow Detox and Stabilisation and Relapse Programmes.

The IPS continues to seek to construct a range of programmes, support services and through-care options for prisoners demonstrating a commitment to addressing their substance misuse. This includes clinical addiction services provided by consultant and specialist GP services. In line with Reducing Harm Supporting Recovery, the National Drug Strategy, IPS has an agreed protocol with the HSE for the seamless transition of prisoners established on drug treatment into community drug treatment settings.

Table 12 :Number of prisoners received drug treatment (methadone)

Year	2012	2013	2014	2015	2016	2017	2018	2019
Total Patients	2176	1922	1886	1865	1793	1773	2128	2024

- A snapshot figure for 12 Nov 2020 shows 543 persons were prescribed methadone.
- No. of addiction counselling sessions provided in 2019 was 18,696

Based on 2018 data, approximately 15% of those treated for addiction issues nationally were treated in prison. Merchants Quay Ireland provide Drug Counselling Services across the prison estate. Counsellors provide one to one counselling and group work sessions in each prison with the exception of Arbour Hill.

There are currently 20 WTE addiction counsellors employed across the prison estate.

(ii) Dual Diagnosis

Dual diagnosis is defined in various ways across different countries. Historically, dual diagnosis referred to those with learning disability and co-morbid mental illness. Dual diagnosis is a general term used to describe patients with both severe mental illness and problematic drug and/or alcohol use. Personality disorder may also overlap with psychiatric illness and/or substance misuse. A primary psychiatric illness may precipitate or lead to substance misuse. In addition, substance misuse may worsen the course of a psychiatric illness and can sometimes act as a trigger in those who are susceptible. The range of severe mental illness includes those with schizophrenia, schizotypal disorder, delusional disorders, bipolar disorder, severe depressive disorder with or without psychotic symptoms. This has led to varying levels of services for those with dual diagnosis.

Policy Context:

Sharing the Vision acknowledges that access to primary care addiction services and existing mental health supports when there is a co-existing mental health difficulty/addiction problem remains complicated. It is recognised that there is significant overlap between these conditions and that an individual with an addiction has a right to access relevant mental health supports within primary care. The national policy on substance misuse, Reducing Harm/Supporting Recovery, describes how tiered levels of alcohol addiction supports are needed in order to develop effective mental health services for people with coexisting mental health difficulties and addiction or dual diagnosis. *Sharing the Vision* recommends that this tiered approach should extend to mental health supports within primary care. The HSE Dual Diagnosis Improvement Programme also emphasises the need for integrated services across primary care and specialist mental health services.

Recommendation 57 of *Sharing the Vision* states, A tiered model of integrated service provision for individuals with a dual diagnosis (e.g. substance misuse with mental illness) should be developed to ensure that pathways to care are clear.

The scale of the problem

In general, approximately 70% of prisoners have a substance misuse problem. Typically prisoners were using multiple intoxicants, including alcohol, benzodiazepines, cannabis and stimulants. The increased availability of Novel Psychoactive Substances in recent years has increased the risks to people taking illicit substances in prison.

Challenges in Diagnosis and Treatment

The first challenge in dual diagnosis is the actual diagnoses themselves. As an example the symptoms of depression presenting in the problem drinker do not constitute a separate mental illness but may be the effect of alcohol consumption. In others the feelings of depression are symptomatic of a separate, co-occurring condition.

Treatment aims

There are a number of broad treatment aims as follows:

- Harm reduction: supervised consumption, needle exchanges, looking at wider health needs (eg, hepatitis and HIV exposure).
- Stabilising consumption: establishing treatment programmes (detoxification, substitute prescribing, counselling and psychological treatments).
- Education: improving awareness of risk-taking behaviour, explaining how to find support.
- Addressing social care needs including possible triggers for substance misuse.
- Treatment of mental health difficulties: drug treatment, psychosocial therapy, complementary therapies.

National Clinical Programme for Dual Diagnosis:

The Mental Health Clinical Programmes (NCPs) are a joint initiative between HSE Mental Health Services and the College of Psychiatry of Ireland. The overarching aim of the NCPs is to standardise quality evidence-based practice across the Mental Health Services. The NCPs are clinically led services, designed and implemented to provide and improve better clinical outcomes for service users.

The HSE re-established the National Clinical Programme for Dual Diagnosis in 2021 and the National Clinical Lead took up post in late June 2021. The aim of the National Clinical Programme is to develop a network of Dual Diagnosis Teams nationally, ensuring enhanced working and training between mental health and addiction services staff. A National Working Group has been re-established and this interagency multi-disciplinary team are mandated to develop a Model of Care to support individuals with a Dual Diagnosis. Model of Care is expected to be presented to the Chief Clinical Officer Council in April 2022.

One of the key components of this Model of Care is the establishment of specialist teams throughout the HSE to support individuals with Dual Diagnosis. CHO3 was selected as an initial site for the development of a dual diagnosis team by the National Clinical Programme, which will offer services to the public in CHO3. CHO3 was granted funding for the dual diagnosis team under new development posts in 2021. The team consists of 13 whole time equivalents and the post of Consultant Psychiatrist has already been advertised. The second site is planned in CHO 4 and the third site will be an Adolescent Dual Diagnosis Team based in CHO 9.

Further sites in the future will be implemented as more funding becomes available to the National Clinical Programme.

Dual Diagnosis in Prisons

Not surprisingly, dual diagnosis is often associated with criminal behaviour. In fact, Dual diagnosis has been described to be a major issue in the prison population with up to one in four having a dual diagnosis. The two reports published by the Probation services in 2021 identified the extent of mental health difficulties and substance misuse issues in the prison population and both reports called for a collaboration between the different services to address the complex needs of this population

In the Irish Prison Services, healthcare services are largely provided by professional staff employed by the Irish Prison Services. In the Dublin and Portlaoise prisons, specialist mental health services are provided in-reach by services lead by a Consultant Forensic Psychiatrist associated with the HSE National Forensic Mental Health Services as outlined previously. Cork and Limerick services are provided under the clinical governance arrangements of the HSE Mental Health Services in that Community Health Organisation (CHO).

In the case of provision of addiction services in prisons, this varies across the country, particularly in the prisons outside Dublin. IPS and HSE Clinical Addiction services provide in-reach to the prison population in most of the Dublin prisons. However, outside Dublin, clinical addiction services are provided in a limited manner by those professionals employed by the Irish Prison Service. Support services are provided by staff from Section 39 agencies. The above variation in services creates a challenge in meeting the needs of those with dual diagnosis since the Dual Diagnosis Clinical Programme is envisaged as a tertiary service within the Dual Diagnosis model of care being drafted by the HSE.

As a tertiary service, the provision of Dual Diagnosis services will largely depend on the existing service provision by the mental health and addiction services and the HSE Clinical Programme when established should not be viewed as a solution to manage the gaps in such services.

Hence, the development of a Dual Diagnosis service in prisons must be supported by adequate mental health and addiction services being delivered in advance of such services being provided in the individual prisons. The IPS plan to appoint a Lead in the Irish Prison services to coordinate mental health and addiction services in prisons is a welcome step in that direction and the HSE Clinical Programme anticipates meeting with the IPS to progress the issue of dual diagnosis treatment provision within Irish Prisons.

Conclusions

The coexistence of mental health difficulties and substance misuse is a major challenge for those providing prisoner services. The Group has noted the establishment of the HSE National Clinical Programme for Dual Diagnosis and would strongly support its ongoing development both in the community and prison settings.

Recommendations

i) **The provision of a specialist dual diagnosis service supporting prisoners with a mental health difficulty and substance misuse should be established across the IPS estate.**
ii) **The IPS should appoint a Mental Health and Addiction Lead to support this work.**
iii) **A Pilot Dual Diagnosis programme in a prison should be established at the earliest opportunity. This would provide the basis further learning with the potential for a broader rollout across the prison estate.**

6. Proposed Legislative changes relevant to CMH Capacity

Legislative instruments are designed to ensure equitable and rights based access to essential treatment when necessary. In this context, demand for services should lead capacity while limited capacity should not 'cap' demand. All public services must however operate under conditions of relative shortage. The legislative changed proposed here are intended to ensure that the limited capacity of secure forensic hospital places (designated centres) is used to achieve the goals of accessibility, equitability and proportionality to need in a legally defined rights based modern system.

In view of the requirement to ensure that the new CMH has sufficient capacity to meet patient needs in the coming years, the Group considered legislative issues that impact on the sustainability of the service while having regard to rights and needs. As outlined earlier in this report, admissions to the CMH may originate from prison, Unfit to stand trial, NGRI or from Approved Centres. In general, prison admissions have shorter lengths of stay compared to other sources who may require several years of care in the CMH. On this basis, the Group considered that there may be alternative and clinically appropriate pathways of care if there was legislative provision for this.

The Group recognised that legislative change takes place over time and on this basis must be considered as a longer term initiative. Nevertheless these proposals are considered complementary to the other recommendations of subgroup 2 and are put forward on this basis.

Recommendations

In this regard, the Group recommend that consideration should be given to:

(i) Unfitness to Stand Trial

There should be a delay between the making of an order in Court under Section 4(6) Criminal Law (Insanity) Act and the execution of the order for example two weeks. This would allow the National Forensic Mental Health Service or other Designated Centres to ensure that a bed is available. Ideally it would also allow a consultant from the designated centre to carry out a pre-admission assessment and report on this to the court. An alternative is to review section 4 of the Criminal Law (Insanity) Act with a view to assisted decision making. This would ensure compliance with the UN CRPD and would guarantee the right to a fair trial for all.

(ii) Not Guilty by Reason of Insanity (section 5)

The diagnostic step (requirement of legally defined mental disorder) should be preserved however the three part test of insanity should be narrowed as the capacities referred to are not mutually exclusive. The preservation of any one of them should carry with it preserved some degree of responsibility. The complete negation of responsibility leading to a verdict of Not Guilty by Reason of Insanity should have a high threshold. To be found NGRI should require the presence of mental disorder and all three conditional tests. Those meeting a lesser standard should instead be considered under diminished responsibility. In addition, the term "unable to refrain from committing the act" is difficult to interpret clinically and should be abolished.

(iii) Diminished Responsibility (section 6).

The Diminished Responsibility defence should be made much more accessible in relation to all indictable offences tried in the Circuit Court. It should never be available for offences that are acquisitive or related to fraud or deception.

(iv) Provision of Hybrid orders

These are available under the Mental Health Act for England and Wales whereby a fixed tariff prison sentence is imposed and part of the tariff can be in a secure psychiatric hospital (designated centre and approved centre) for no longer than is necessary for treatment. The remainder of the sentence would be passed in a custodial setting. That custodial setting might be an ordinary prison, a high security prison or an open prison or probation/parole service in the community. The prison setting should be violence free and drug free as outlined earlier in this report.

(v) Provision of community treatment orders (CTO) should be considered

This would enable alternative therapeutic settings to be available for offenders. It would be helpful to involve probation officers in the management of CTOs in a forensic context. However, it is noted that the Expert Group Review of the Mental Health Act did not recommend this in the amendments to the Mental Health Act. This was on the basis that involuntary detention was considered as an option of last resort when it was not possible to treat a person in the community and that this approach was consistent with the commitments to UN CRPD. The alternative is provision of CTOs by means of criminal justice legislation.

(vi) Provision of a Statutory Instrument to ensure therapeutic safety in CMH Portrane and other designated centres

There is a concern regarding the legal basis to inspect CMH as a designated centre and this is under active consideration by the Department of Health so that the Minister for Health can make regulations for designated centres in the General Scheme.

Appendix 1: Current CMH Facilities

CLUSTER	WARD TYPE	BED NUMBERS	PATIENT COHORT
Acute male	Male admissions (Unit B)	12	Male newly admitted patients, over age 18 years. Usually suffering from florid psychotic symptoms. Commonly also have co-morbid PD, and/ or polysubstance misuse. Selected because of a serious mental illness and because of serious violence requiring treatment that can only be given in a therapeutically secure hospital (DUNDRUM-1). Rapid titration of medication usually needed to stabilise mental state and may require periods in seclusion. Main therapeutic aims include assessments and stabilization of mental state, and other baseline assessments including risk of violence and suicide (HCR-20s and SRAMM) and treatment completion and forensic recovery (DUNDRUM programme completion and recovery assessments), and assessments of functioning. Night time confinement is part of risk management and violence prevention.
	Male High dependency (unit 4)	6	Male patients over age 18 years who continue to pose a persistent risk of serious and frequent violence towards others even within the therapeutically secure environment of the CMH. This is intensive care psychiatry and few patients will require this level of care. Patients usually only referred to this ward for ongoing, repeated assaults on staff and peers and

			prolonged periods of seclusion that are difficult to end. Patients usually floridly psychotic, although there are high levels of complex needs co-morbid seen on this ward. Main aim here is titrating antipsychotics for highly treatment resistant presentations. Using high levels of nursing staff interventions to try to minimise seclusion and work towards reducing the need for seclusion and other restrictive practice, whilst maintaining the balance of the need for a safe ward environment. Multiple patients will generally require 1:1 nursing in addition to the high nurse to patient ratio on the ward baseline. Night time confinement is part of risk management and violence prevention.
Male medium security	Medium security – step down from high dependency / slow stream medium ward (unit 5)	10	All patients are adult males. Patients step down from either high dependency or from admissions if they need a slower medium secure pathway. All present with high levels of treatment resistant psychoses but assaults should be less frequent than on high dependency and moving towards violence free. Night time confinement is part of risk management and violence prevention.
	Medium security one (unit 2)	16	All patients are adult males. Patients transfer from either unit 5 or male admissions and are deemed to be progressing on their recovery pathway. Patients may still have some ongoing psychotic symptoms, but assaults should be rare. Safe milieu management (prevention of bullying and exploitation) typically are prevented, treated and managed here. Night time confinement is part of risk management and violence prevention.

			Patients are expected to engage in 1:1 and group talking therapy with OT, Psychology and Social work. . Night time confinement is part of risk management and violence prevention.
	Medium security two (unit 3)	16	Step down from unit 2 and patients are all adult males now moving well on their recovery journey. Should be entirely violence free within the secure hospital and making good progress in terms of understanding insight into mental illness, substance misuse and past offending. Night time confinement is part of risk management and violence prevention. This is the last medium ward prior to transfer to rehab for most patients. . Night time confinement is part of risk management and violence prevention.
	Medium security three (unit A)	4	This is a ward for adult males, on the medium cluster but for a smaller group of men that are deemed vulnerable patients due to risks like bullying from peers etc. Night time confinement is part of risk management and violence prevention.
Male assertive rehabilitation	Rehab ward on-site (unit 7)	15	This is a rehab / pre-discharge ward for adult men. Psychotic symptoms should be in remission. Patients should have active engagement with psychology, social work and OT as well as psychiatry and nursing, and should be working though therapeutic work regarding their index offences, e.g. book of evidence work to a high standard. Pre-discharge work e.g. family or relationship work, and assessments of placement support needs take place on this ward. Night time confinement is not a part of risk management and violence prevention here. At present there are significant numbers of patients on this ward that could be managed in a long term low secure unit, thereby freeing up the care pathway for others who could then progress

			on from Unit 7 beds to the community. . Night time confinement is not part of risk management and violence prevention on this unit.
Forensic Mental Health and Intellectual disability	MHIDD ward (Laurel Lodge)		Adult male patients with intellectual disability or autistic spectrum disorder. All patients will have been admitted via the Unit B male admission ward, although they can subsequently be transferred to the F-MHIDD ward from either Unit B or elsewhere on the hospital care pathway. Patients are provided with consultant led multidisciplinary input from psychiatry, nursing, SW, OT and psychology.
Women's ward	Women's service (one ward)	10	Adult women over aged 18 years. All adult women admitted to the forensic service, are admitted to this ward and it includes admission and higher dependency patients as well as pre-discharge patients. Night time confinement is part of risk management and violence prevention. This is not unusual internationally to have such a mix for women forensic services, and is due to the practicalities of having low female numbers in forensic services, although not the optimal situation. . Night time confinement is part of risk management and violence prevention.
TOTAL BED NUMBERS		96	

Appendix 2 : NFMHS/IPS Demand and Capacity Model

Introduction and background

The NFMHS provides a range of forensic mental health services to its patients. This service is currently in the process of moving to a new site in Portrane.

The new facility will be able to provide care for up to 170 patients in the Portrane facility and will continue to provide community and prison in-reach services. The NFHMS Portrane will also have a Forensic Child and Adolescent Mental Health Service (FCAMHS) Unit and Intensive Care Rehabilitation Unit (ICRU).

The expansion of the service is a great step forward for the provision of mental health services in this country. It is critical to do further analysis to understand to what extent the new services will match projected demand for forensic mental health services in the coming years. As existing patients transition from the old site in Dundrum, existing long-term patients will occupy beds in the new service which will lead to a net reduced supply of beds for new patients in the new service.

The supply and demand equation for this service is of special interest to the Irish Prison Service. A significant proportion of admissions to the NFMHS come from the IPS and any capacity issues within the service have a direct impact on the requirement for clinical service provision within the IPS.

Purpose of document

The purpose of this document is to provide the reader with an overview of the design specification and components of the model solution and to fully understand the model logic and assumptions.

Background

This modelling exercise was commissioned to support an understanding of the dynamics affecting future demand and capacity of the new National Forensic Mental Health Service (NFMHS) – with a focus on demand arising from the Irish Prison Service (IPS).

The context includes the implementation of an updated model of care for the service aligned with the move of the NFMHS from Dundrum to Portrane.

The nature of the service and clinical service modelling more generally is such that a critical enabler of the work is input from senior clinical stakeholders.

The assumptions feeding the modelling are based on analysis of the data supplied in addition to senior stakeholder input and are outlined in the following sections.

Final outputs

The modelling work completed to date has addressed future demand projections in respect of the NFMHS inpatient service until 2026. In particular they address the question as to the trajectory of demand under two pre-defined scenarios (provided by the Clinical Director of the NFMHS). The assumptions to inform the modelling were similarly validated.

Outputs included demand/ beds occupied projections analysed by length of stay, patient final legal status as well as type of bed required as well as the profile of expected future discharge volumes and destinations.

It is noted that should a long term medium secure pathway be provided in respect of these long LOS patients, the admissions scenario profiles would potentially look very different to the above – in particular, a much more significant volume of admissions would be enabled.

Two scenarios have been analysed with the expected admission of 60 male every year:

1. 54 IPS non-NGRI and 6 NGRI admissions

2. 50 IPS non-NGRI and 10 NGRI admissions

As NGRI's have longer lengths of stays we expect scenario 2 to have more beds occupied compared to scenario 1.

Scenario 1: 54 IPS non-NGRI and 6 NGRI admissions

Discharge destination outputs

Based on the model outputs from 2024 onwards approximately 55 prisoners will be discharged from the NFMHS to prison based on their final legal status.

In 2024 6-7 NGRI's will be discharged to Forensic community and on average 4 to 5 NGRI patients would be discharged to Forensic community every year.

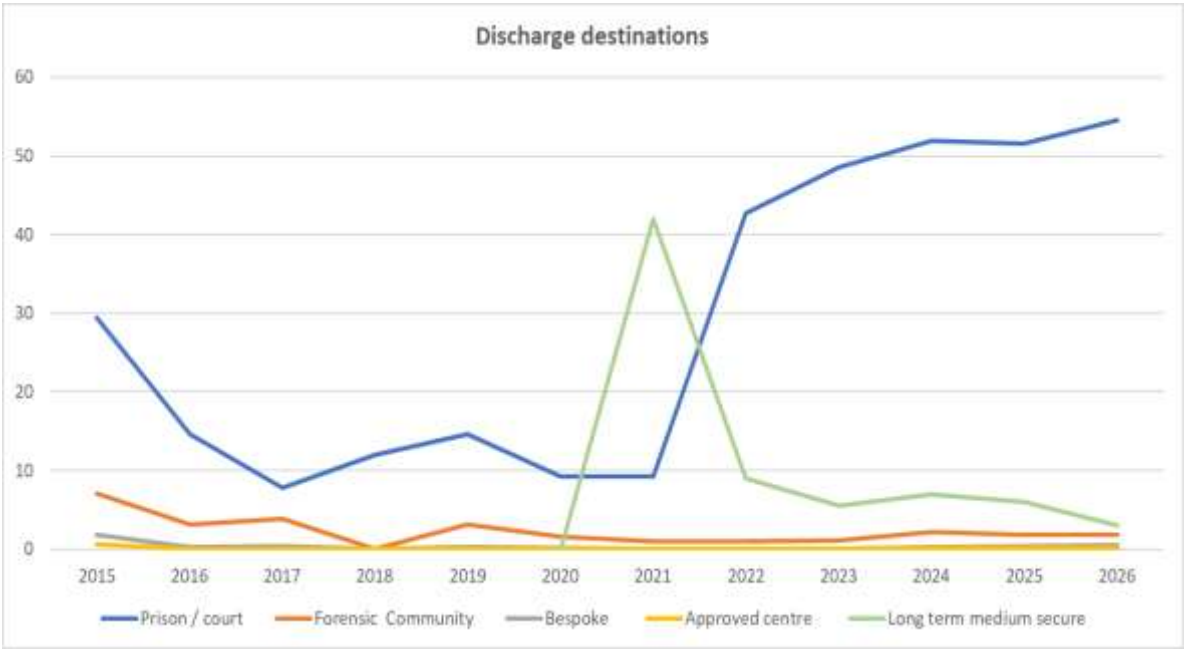


Figure 1: Scenario1 outputs- Patients discharged to different destinations

Year	Prison / court	Forensic Community	Bespoke	Approved centre	Long term medium secure
2015	29	7	2	1	0
2016	15	3	0.3	0	0
2017	8	4	0.3	0	0
2018	12	0	0	0	0
2019	15	3	0.3	0	0
2020	9	2	0.1	0	0
2021	9	1	0.1	0	42
2022	43	1	0.1	0	9

2023	49	1	0.1	0	6
2024	52	2	0.3	0.1	7
2025	52	2	0.4	0.2	6
2026	55	2	0.4	0.2	3

Bed Occupancy outputs

Demand for 1 bespoke package every year will be expected which is in line with historical 11 bespoke in 2010 to 2021 period. Highfield or similar to be offered to patients with “NGRI” as Final legal status. Bespoke package CD WOC offered to mostly patients with “21(2)” or “21(2) WOC” as Final legal status.

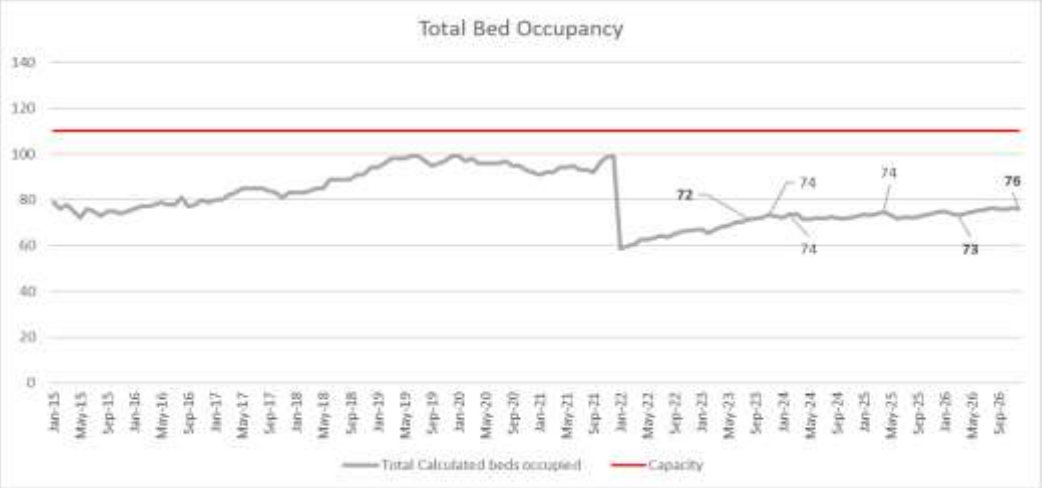


Figure 2: Scenario 1 output – total number beds required at NFMHS

Figure 2 shows the total calculated beds occupied in the NFMHS. It illustrates projected numbers of beds occupied if male IPS non-NGRI admissions increase to 54 admissions per year and NGRI to 6 admissions per year. These admissions are assumed to occur evenly over a year commencing immediately.

72 beds will be occupied by Aug 2023, 73 beds will be occupied by Mar 2026, 76 beds will be occupied by Dec 2026.

The red line in all cases represents total available male beds.

The adjacent visuals show the potential impact on the service and availability of male beds should long term medium secure accommodation become available for the relevant patient group.

Figure 3 shows the beds occupied by the source of admission. The red line shows current male bed capacity. Long term secure beds are the patients leaving the facility hence those patients leaving the NFMHS will add critically needed beds capacity.

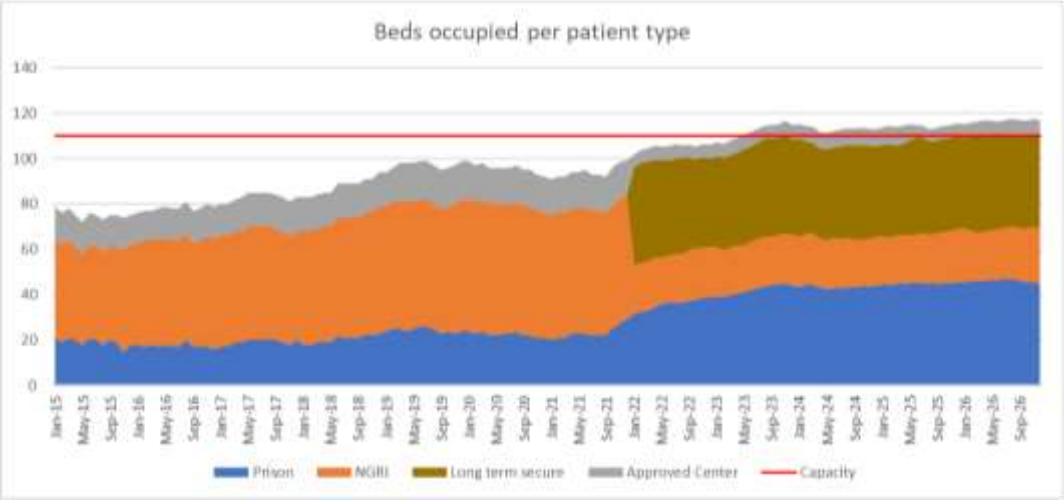


Figure 3: Scenario 1 output - beds occupancy by source of admission

Figure 4 shows the beds occupancy by LOS groups.

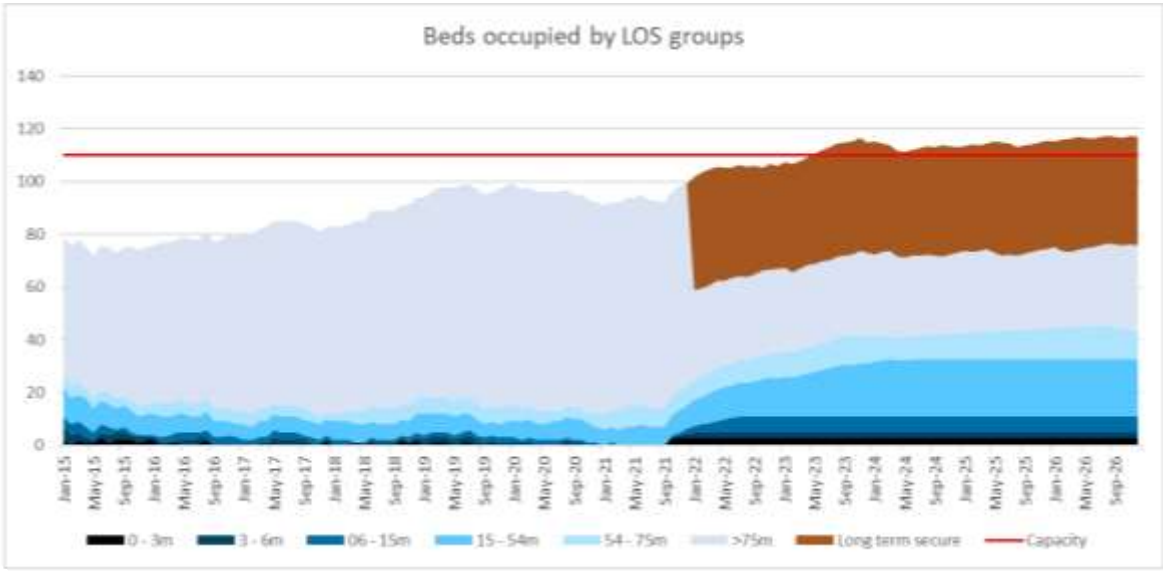


Figure 4: Scenario 1 output - beds occupancy by LOS Groups

Figure 5 shows the beds occupancy by type of care required.

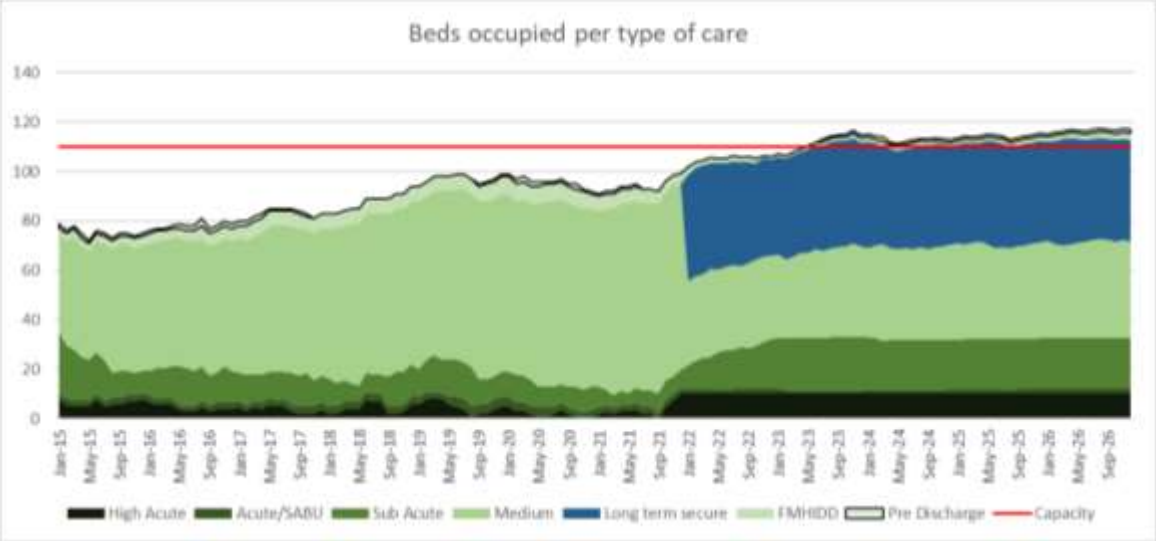


Figure 5: Scenario 1 output - beds occupancy by type of care required.

Scenario 2: 50 IPS non-NGRI and 10 NGRI admissions

Discharge destination outputs

Like scenario 1 the Figure 11 shows a spike in number of patients to be released to long term secure facilities as per new change in policy. Due to increased number of NGRI admissions every year the forensic community and bespoke packages required increased slightly and number of patients returning to prison reduced by 4 patients every year. Based on the model outputs from 2024 onwards approximately 50 prisoners will be discharged from the NFMHS to prison based on their final legal status.

In year 2024, approximately 6-7 NGRI's will be discharged to Forensic community and on average 3 NGRI patients would be discharged to Forensic community every year.

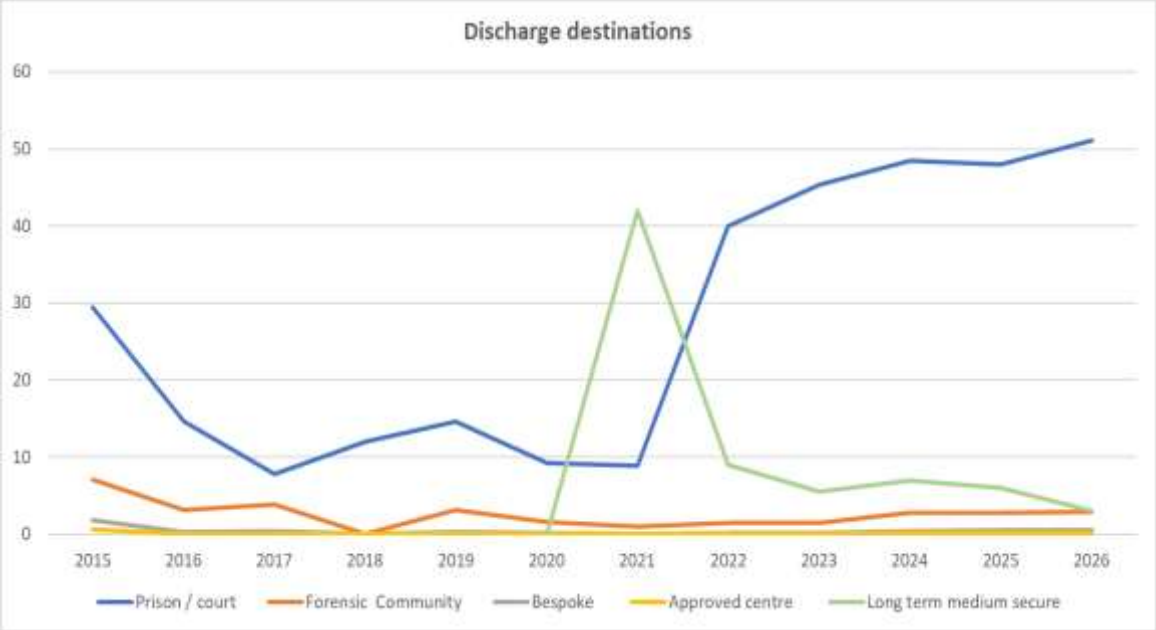


Figure 6: Scenario 2 output - beds occupancy by LOS Groups

Year	Prison / court	Forensic Community	Bespoke	Approved centre	Long term medium secure
2015	29	7	2	1	0
2016	15	3	0.3	0	0
2017	8	4	0.3	0	0
2018	12	0	0	0	0
2019	15	3	0.3	0	0

2020	9	2	0.1	0	0
2021	9	1	0.1	0	42
2022	40	1	0.1	0	9
2023	45	2	0.1	0	6
2024	48	3	0.4	0.1	7
2025	48	3	0.5	0.2	6
2026	51	3	0.5	0.2	3

Bed Occupancy outputs

The output illustrates projected numbers of beds occupied if male IPS non-NGRI admissions increase to 50 admissions per year and NGRI to 10 admissions per year. These admissions are assumed to occur evenly over a year commencing immediately.

76 beds will be occupied by Aug 2023, 85 beds will be occupied by Mar 2026, 89 beds will be occupied by Dec 2026.

The red line in all cases represents total available male beds.

The visuals show the potential impact on the service and availability of male beds should long term medium secure accommodation become available for the relevant patient group.

Of note, initial work suggests that an increase of a single annual NGRI admission leads to a reduction of 3-4 non-NGRI IPS admissions per year.

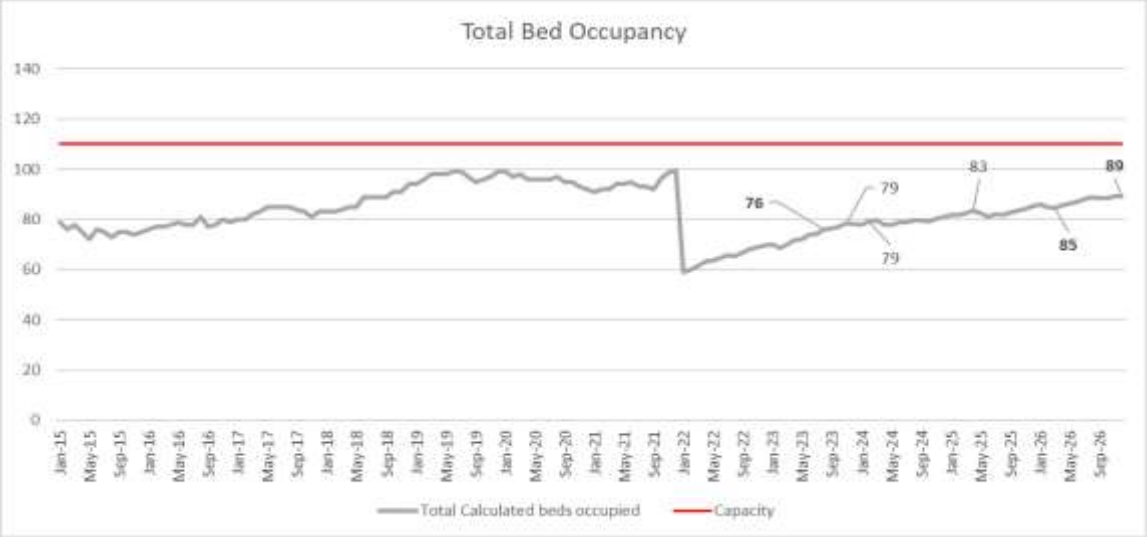


Figure 7: Scenario 2 output - beds occupancy by LOS Groups

Figure 7 shows that without the possibility of long-term secure facility to release the patients the current capacity would not be sufficient after 2023 onwards. Majority of those released to long term secure facility will be from patients spending more than 6.25 years.

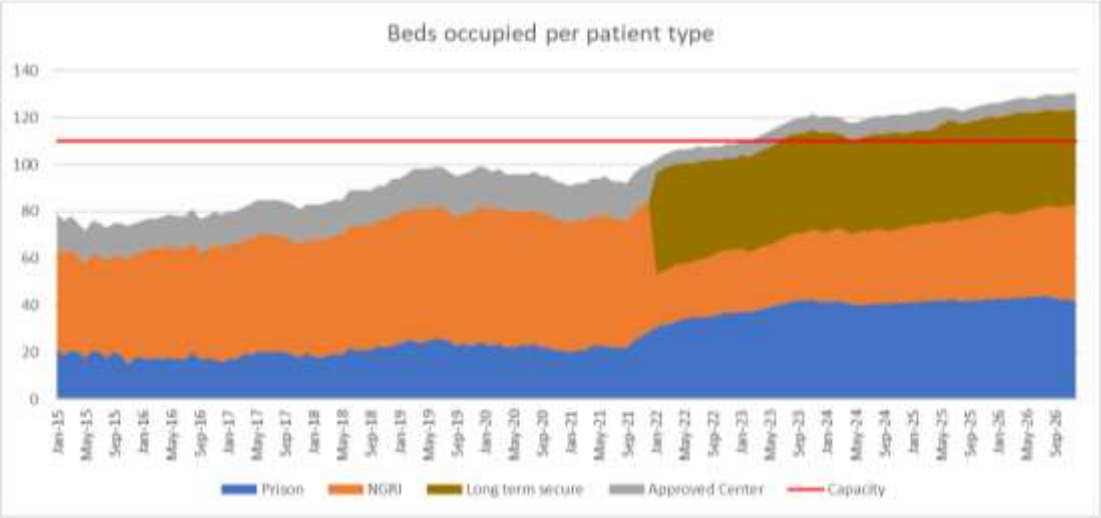


Figure 8: Scenario 2 output - beds occupancy by type of care

Figure 8 shows that long term secure facilities would help reduce the patients occupying the beds in NFMHS which are mostly admitting from NGRI and approved centre.

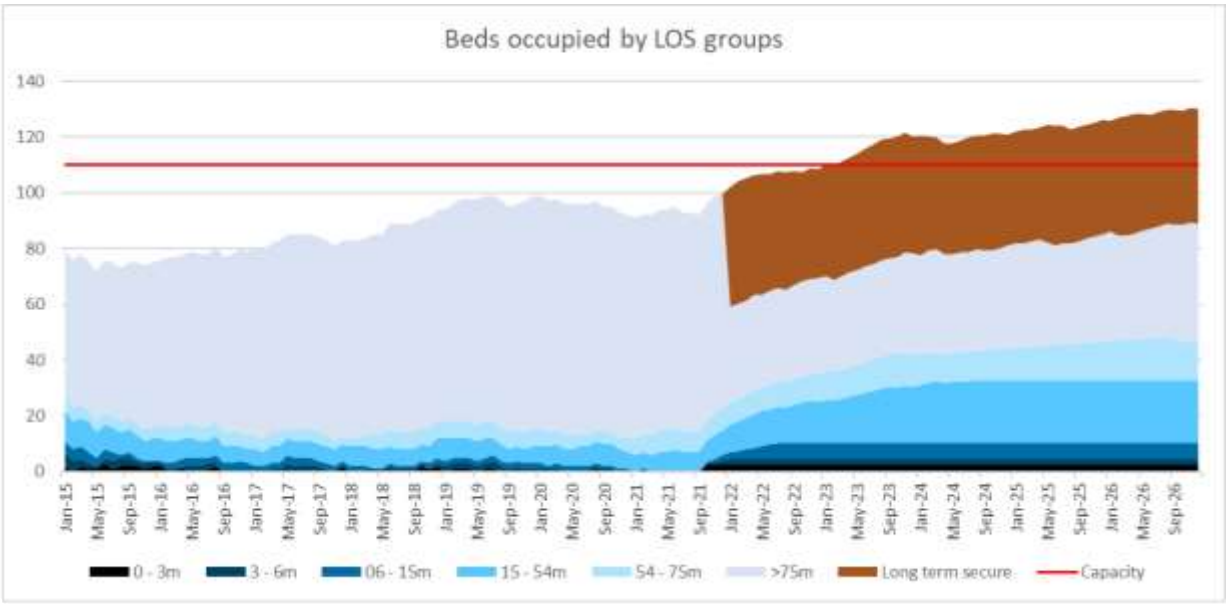


Figure 9: Scenario 1 output - beds occupancy by LOS Groups

Figure 9 if compared to Figure 4 from earlier scenario shows that significant number of long-term patients in which most of them would be NGRIs in case of absence of long-term secure facility to discharge from NFMHS, would have either not get a admission or occupy beds for the other patients who would need facility for shorter length of stay.

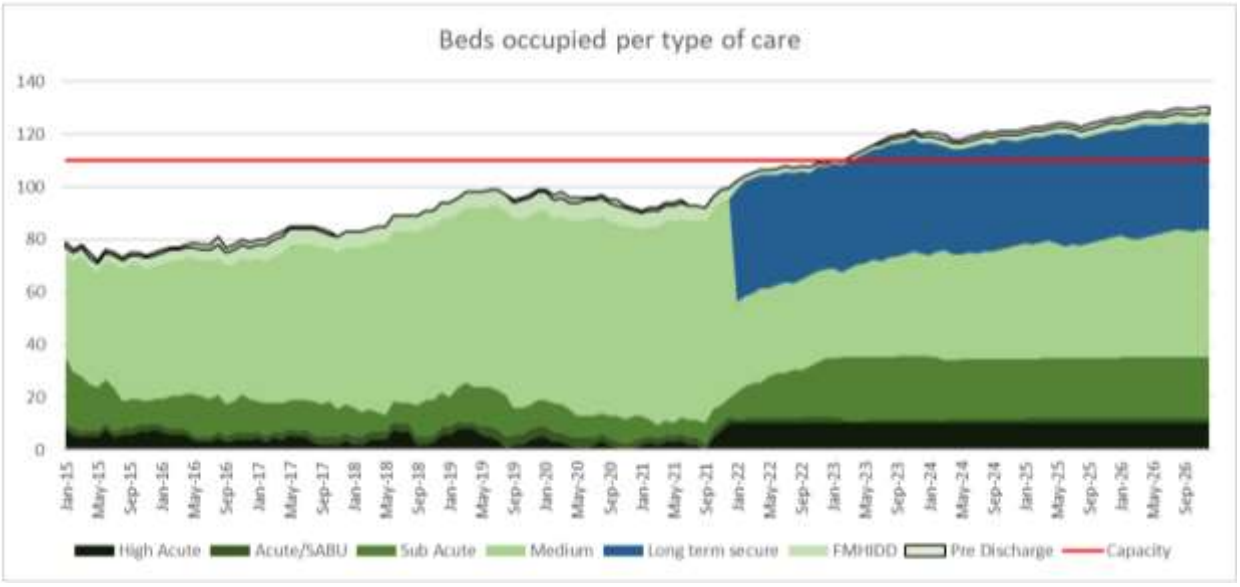


Figure 10: Scenario 1 output - beds occupancy by LOS Groups

Additional what-if scenarios conducted as a part of sensitivity analysis suggests that an increase of a single annual NGRI admission leads to a reduction of 3-4 non-NGRI IPS admissions per year. In other words, due to longer length of stay of a NGRI patients greatly affects the ability of NFMHS to admit from prison or approved centres.

Methodology

Approach

The first step of the modelling approach was to understand, classify and potentially simplify the type of patients for modelling purposes. Three high level categories of patients were described based on detailed data analysis and validation by senior clinical stakeholders within the NFMHS. These categories were:

IPS – non-NGRI

NGRI

Approved Centre admissions

The second step was to identify potential clinical pathways for each patient type. These clinical pathways were defined with and validated through NFMHS senior clinical stakeholder engagement e.g., High Secure Acute -> High Secure Sub-Acute -> Medium Secure -> Discharge (to IPS) etc.

The proportions of patients allocated to each category and clinical pathway were calculated based on analysis of past data provided by NFMHS.

The average length of stay (LOS) for each part of the clinical pathway was also based on historical analysis as well as the superimposition of the new NFMHS model of care as provided to the modelling team and validated by NFMHS.

Future demand patterns were run through the model based on demand scenarios provided by the NFMHS and IPS engagements. Two agreed scenarios were run through the model – involving annual IPS admissions of 60 males with different NGRI/ non-NGRI proportions.

Outputs were created in the form of a time series of the numbers of male beds occupied based on the combination of the above i.e., the application of modelled proportions of clinical pathways applied to the expected numbers of annual admissions by category.

Patients currently admitted to the NFMHS were included in the projections and they form a baseline of beds occupied at the outset of the projections.

Model assumptions

The dataset used to complete the analysis informing the modelling work was provided by the NFMHS and contains anonymised, historical data from 2010 to 2021. This data includes all inpatients as at 1 Jan 2010, all patients admitted from 1 Jan 2010 to 21 Sept 2021 and all patients discharged in the intervening period.

The projections provided are the output resulting from the application of these assumptions to standard predictive modelling techniques. The outputs are sensitive to several factors especially

demand volumes and variability of length of stay (LOS) – particularly as it relates to patients requiring a long LOS.

The projections include a baseline scenario where future demand is assumed directly based on experience. However, it is understood that this does not represent a true representation of demand as it is constrained by historic capacity limits within the service. Therefore, scenarios were developed to show the potential outturn based on “true” hypothesised demand for the service.

The scope of this work includes analysis and modelling of demand for male beds. Engagement with senior NFMHS stakeholders suggests that the future provision of 20 female beds in Portrane will be adequate to address demand for these beds. Notably this assumption does not speak to configuration of the female beds.

The modelling work has addressed future demand projections in respect of the NFMHS inpatient service until 2026. These projections address the question as to the trajectory of demand under two pre-defined scenarios (provided by the Clinical Director of the NFMHS). The assumptions to inform the modelling were similarly validated. Outputs included demand/ beds occupied projections analysed by length of stay, patient final legal status as well as type of bed required.

The outputs presented prompted further questions, and in particular, the following sections address the question as to the profile of expected future discharge volumes and destinations based on the modelling approach and assumptions adopted in the initial phase of the modelling work as well as the addition of a hypothetical extra pathway in respect of patients with a LOS of greater than 6.25 years.

For the following projections, the same scenarios as utilised for the initial phase of modelling were re-deployed – this enables ease of comparison. The scenarios are:

1. 60 annual admissions from IPS – 6 of these to be NGRI
2. 60 annual admissions from IPS – 10 of these to be NGRI

It is noted that, should a long term medium secure pathway be provided in respect of these long LOS patients, the admissions scenario profiles would potentially look very different to the above – in particular, a much more significant volume of admissions would be enabled.

3 broadly homogeneous categories of patients have been modelled:

IPS – non-NGRI (Section 15 & unfit to plead)

NGRI (NGRI & recalled)

Approved Centre Admissions and Wards of Court (WOC)

Each of the above categories, in turn, has a cohort of patients who will experience various routes/ clinical pathways through the NFMHS which have been individually modelled.

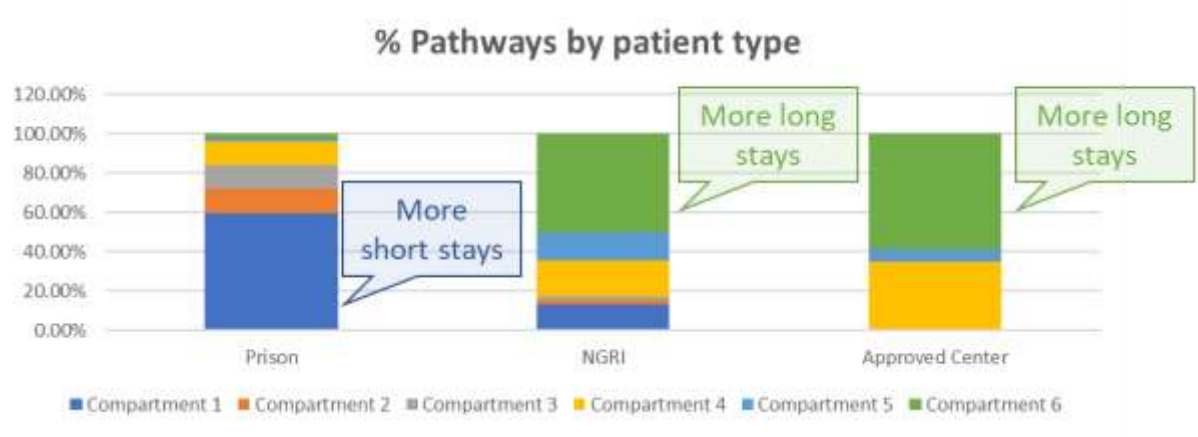


Figure 11: Percentage pathways by patient type

Each of these categories has been split into six compartments with respect to potential LOS (based on analysis of the historical data):

1. Less than 3 months
2. 3-6 months
3. 6-15 months
4. 15 months - 4.5 years
5. 4.5 years – 6.25 years
6. More than 6.25 years

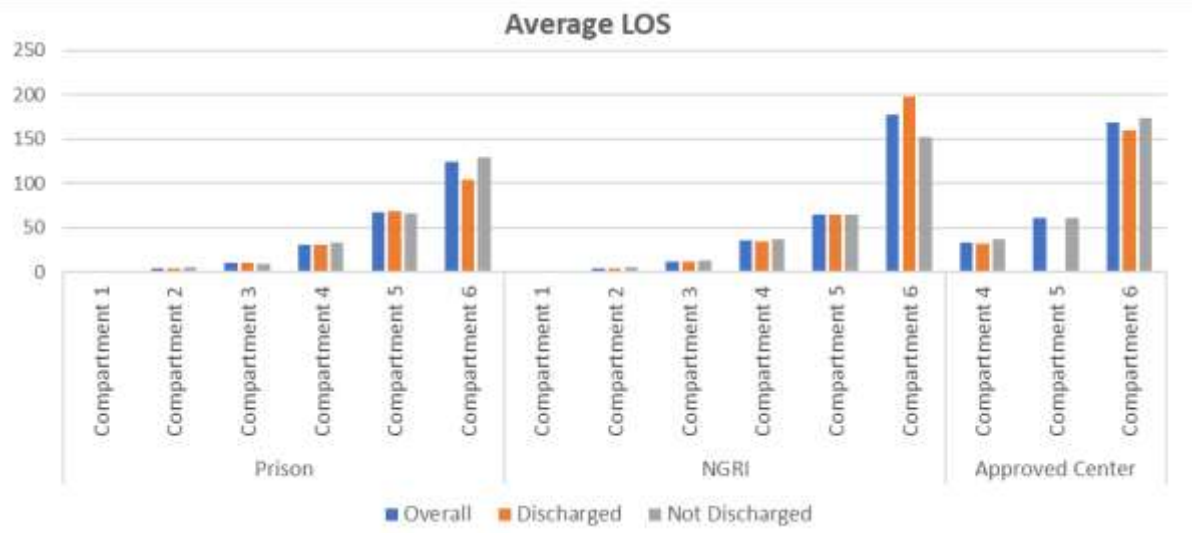


Figure 12: Average length of stays by source of admission and LOS group

No significant difference is observed between discharged and not discharged patient data except where LOS is more than 6.25 years and the non-discharged patient data contain all the extreme long duration admissions.

For second phase of results shared following additional assumptions were added:

All patients who stay longer than 6.25 years are discharged to long term medium secure accommodation. There is no option for patients to stay within the NFMHS in Portrane for more than 6.25 years (previous iteration of the modelling permitted a long length of stay in line with analysis of experience in the past regarding this factor).

It is noted that based on current service configuration that this is a purely hypothetical discharge route.

With respect to the current inpatient cohort, all patients who have completed a LOS of more than 6.25 years will be discharged to the hypothetical discharge destination by the end of 2021. This is for illustrative purposes and shows the extent to which the service is currently impacted by this group of patients in terms of beds occupied.

With effect from January 2022 onwards, every patient who has completed the treatment more than 6.25 years will be released immediately at the point of completion of this LOS.

An updated dataset was provided by the Clinical Director of the NFMHS on 7th Dec for phase 2 analysis. This dataset contained the "Discharged to" field and description. The dataset was analysed, and the results of this analysis are shown on the table below with mapping of existing destination for modelling purposes:

"Discharged to" description	Exit destination type
Prison	Prison or court
Court	
AWOL	
Forensic hostels S14 CD WOC	Forensic community
Bespoke package CD WOC	Bespoke
Highfield or similar	
Still in CMH	Still in CMH
Approved centre	Approved centre

The model is based on "Final legal status". The tables below show:

The number of patients by "Final legal status" mapped to existing discharge destination/ currently in CMH

The resulting proportions for each route and exit destination (with current inpatients removed from these proportions)

Exit destination	Prison or court	Forensic community	Bespoke	Still in CMH	Approved centre	Total
Prison	310	2	0	25	0	337
NGRI	10	47	4	46	0	107
Approved Center	1	0	7	16	4	28
Total	321	49	11	87	4	472

Exit destination	Prison or court	Forensic community	Bespoke	Still in CMH	Approved centre	Total
Prison	99%	1%	0%	0%	0%	100%
NGRI	16%	77%	7%	0%	0%	100%
Approved Center	8%	0%	58%	0%	33%	100%

Figure 13: Number of cases by Exist destination and Source of admission

Prison, NGRI and Approved centre follow 6 Pathways shown in figure.

Pathway stages can be added or removed by specifying LOS in Model of care table.

F-CAMHS pathway (Child & Adolescent) considered out of scope.

Model Overview

An overview of the model such as adaptability and flexibility features and the operations is described in this section.

The workflow of this model utilises MS Excel Office 365 version. To this end, Microsoft Excel has been used to build a simple but powerful solution. The model can be used by decision makers who require an easy to use and adaptable tool with no learning curve. Inputting data is an automated process by using data transformation tools in Excel. The data flow is fed into Excel where much of the input data is combined and transformed.

Adaptability & Flexibility

The model solution should be flexible and able to handle several model variations as outlined below:

Patients types

Pathway timelines

Case Data Flow

At a high level, the model requires the following to produce an output.

Sheet “Inputs 27.10.21” contains the raw data for all the historic case and reference Data and the data extract with preparation steps for modelling is stored in “Modified input” sheet. Following is the list of important columns used for the modelling:

- Date of admission
- Date of discharge
- Gender
- Final legal status
- New confirmed cases data
- Acute cases
- Critical cases
- Local catchment area cases
- Bed capacity for critical care settings

Data Input and Assumptions

The model needs to contain a robust data import process. The configuration excel workbook outside of the model will incorporate all the inputs and proportions, data from this workbook can be pasted in the model. This exercise limits model size and increases efficiency of the model. Data input required are described in this section and outlined in detail in Appendix 1:

- Input Assumptions
- New Cases per Month
- Bed capacity

Modelling & Calculations

Content sheet

The “Content” sheet includes list of all the sheets used in the model and their short description with links to each of those sheets.

Several modelling sheets are used to generate the required outputs. Following is title and description of sheets used for Modelling:

Modified input	Based on “Inputs 27.10.21” with required modifications for modelling
Preload	Creating month on Month demand for model preload plus forecast
MOC	Model of care selected for the model
Modelling	Model calculations
Model1	Model calculations for the selected demand and Model of care Option 1
Model2	Model calculations for the selected demand and Model of care Option 2

Model3 Model calculations for the selected demand and Model of care Option 3

Model of care (MOC)

The MOC sheet calculates the cumulative lengths of stay by patient severity and age group, for use in the offset calculations in the Care Model sheet. The MOC (MOC1, MOC2, or MOC3) is selected as a parameter in the Care Model sheet.

Model of care – IPS - non-NGRI

The following assumptions are applicable to the male patient group who are defined by being ultimately discharged back to the IPS.

The patient LOS since 2011 have been analysed in line with the different pathways through the NFMHS assumed to apply to this group.

The destination within the NFMHS for longer term (LOS > 6.25 years) for this group of patients is assumed to be either MHIDD or the Medium Secure Unit.

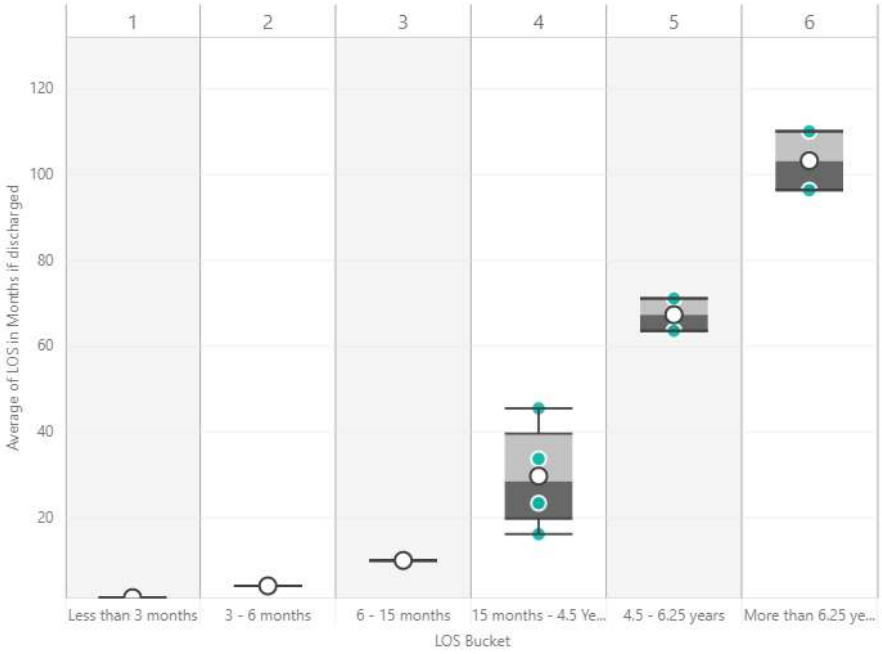


Figure 14: Box plot of non-NGRI LOS in months for discharged cases by LOS groups

Patients with a diagnosis, per the data provided, of ASD, Learning Disability or low IQ (single or combined diagnosis) have been assumed indicators of MHIDD admission.

As patients are all assumed discharged back to the prison service, it was assumed no Pre-Discharge Unit length of stay is required in respect of this cohort.

All patients start with 3 months in the High Secure Acute Unit and subsequently move to High Secure Sub-Acute for 12 months (unless discharged earlier) before moving to the Medium Secure Unit.

Unit for all length of stay is in Months*

Description	Num. of Patients	% Patients	Mean LOS	High Secure Acute	High Secure Sub-Acute	Medium Secure	MHIDD	Discharge step-down destination	Description	Num. of Patients
Less than 3 months	190	56.55%	1.3	1.3				Prison	Less than 3 months	190
3-6 months	44	13.10%	4.1	3	1.1			Prison	3-6 months	44
6-15 months	44	13.10%	10.0	3	7			Prison	6-15 months	44
15 months - 4.5 years	43	12.80%	30.1	3	12	15.1		Prison	15 months - 4.5 years	43
4.5 years – 6.25 years	6	1.79%	69	3	12	54		Prison	4.5 years – 6.25 years	6
More than 6.25 years - FMHIDD	1	0.30%	103.3	3	12		88.3	Prison	More than 6.25 years - FMHIDD	1
More than 6.25 years - Medium	8	2.38%	103.3	3	12	88.3		Prison	More than 6.25 years - Medium	8

Model of care – IPS - NGRI

The following is applicable to the male patient group who have a final legal status of NGRI. For this analysis, those who are recalled after conditional discharge are also included in this group.

The patient LOS since 2011 have been analysed in line with the different pathways through the NFMHS assumed to apply to this group.

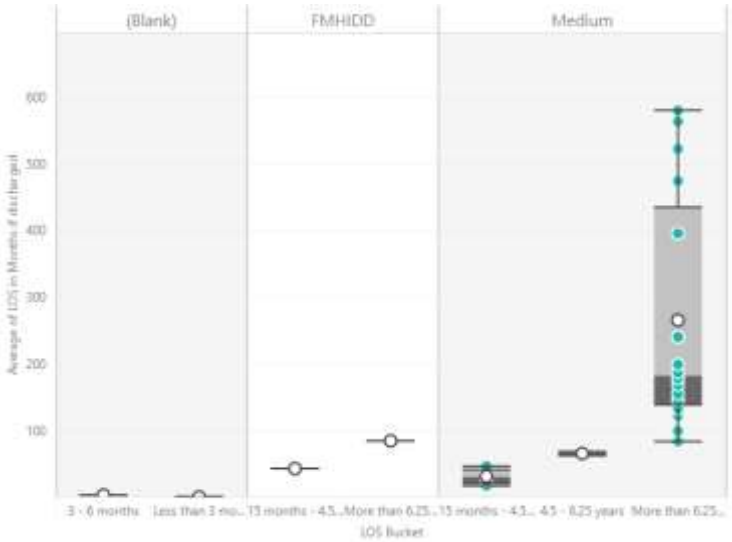


Figure 15; Box plot of NGRI LOS in months for discharged cases by LOS groups

Compartments applying to patients with a LOS greater than 15 months have been split into three cohorts:

- Those who transition to the MHIDD – transferring after 12 months in High Secure Sub-Acute
- SABU – currently assumed to be zero in respect of this group (see next section for relevant pathway).
- Those who transition from High Secure Sub-Acute to the Medium Secure Unit

Diagnoses (single or combined) of ASD, Learning Disability or low IQ are assumed indicators for MHIDD admission.

All patients requiring a LOS of greater than 15 months are assumed to require 9 months in the Pre-Discharge Unit before egress.

Patients with a LOS greater than 6.25 years are assumed long term and will not transition to the “Pre-Discharge Unit”.

Description	Num. of Patients	% Patients	Mean LOS	High Acute	SABU -	Sub Acute	Medium	FMHIDD	Pre - Discharge -	Discharge or 'step down' destination
0-3 months	15	14.02%	1	1						Community houses
3-6 months	2	1.87%	4	3		1				Community houses
6-15 months	0	0.00%	12	3		9				Community houses
15 months - 4.5 years SABU	0	0.00%	33	3	9	12			9	Community houses
15 months - 4.5 years FMHIDD	2	1.87%	44	3		12		20	9	Community houses
15 months - 4.5 years Medium	16	14.95%	34	3		12	10		9	Community houses
4.5 years – 6.25 years SABU	0	0.00%	66	3	18	12	24		9	Community houses
4.5 years – 6.25 years FMHIDD	2	1.87%	65	3		12		41	9	Community houses
4.5 years – 6.25 years Medium	14	13.08%	66	3		12	42		9	Community houses
More than 6.25 years SABU	0	0.00%	211	3	196	12				Long term secure
NGRI More than 6.25 years FMHIDD	4	3.74%	85	3		12		70		Long term secure
NGRI More than 6.25 years Medium	52	48.60%	211.0	3		12	196			Long term secure

Model of care – Approved Centres/ Wards of Court

The following is assumed applicable to the male patient group who are either admitted through an Approved Centre or become Wards of Court at some point during their admission to the NFMHS.

The patient LOS since 2011 have been analysed in line with the different pathways through the NFMHS assumed to apply to this group.

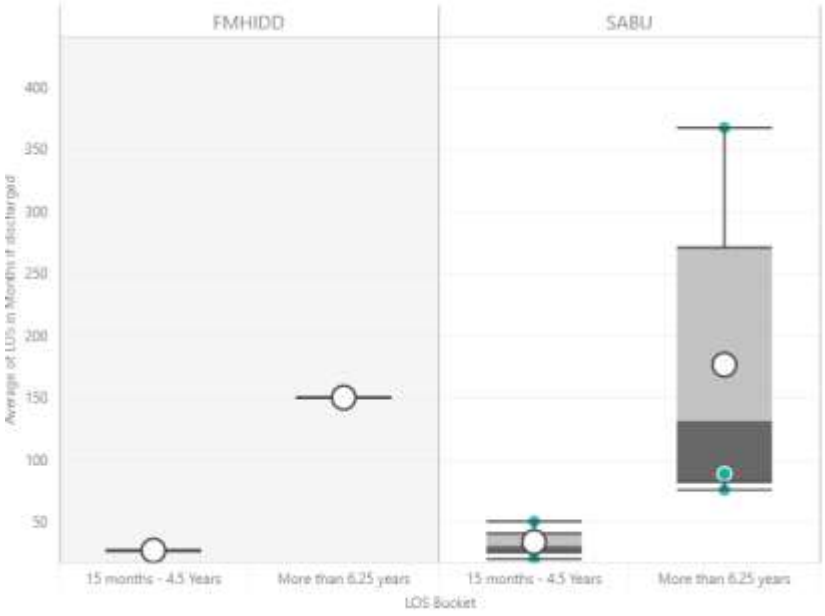


Figure 16: Box plot of Approved centers LOS in months for discharged cases by LOS groups

Shorter admission pathways are not applicable to this group based on historic data.

Pathways applying to patients with a LOS greater than 15 months have been split into three:

- Those who transition to the MHIDD – transferring after 12 months in High Secure Sub-Acute
- Those who transition from High Secure Acute to the SABU and to High Secure Sub-Acute – assumed that the total time in SABU + Medium Secure will be the same as the time spent in Medium Secure for those who do not require a SABU admission
- Those who transition from High Secure Sub-Acute to the Medium Secure Unit

Diagnoses (single or combined) of ASD, Learning Disability or low IQ are assumed indicators for MHIDD admission.

Patients spending over 6.25 years are assumed long term patients who will not transition to the “Pre-Discharge Unit”.

Description	# Patients	% of patients	Mean LOS	High Acute	SABU	Sub Acute	Medium	FMHIDD	Pre - Discharge	Discharge / step down destinations
15 months - 4.5 years SABU	4	14.29%	33	3	10	12			8	Bespoke packages
15 months - 4.5 years FMHIDD	1	3.57%	28	3		12		4	9	Bespoke packages
15 months - 4.5 years Medium	4	14.29%	33	3		12	10		8	Bespoke packages
4.5 years – 6.25 years SABU	0.5	1.79%	55	3	16	12	15		9	Bespoke packages
4.5 years – 6.25 years FMHIDD	1	3.57%	66	3		12		42	9	Bespoke packages
4.5 years – 6.25 years Medium	0.5	1.79%	55	3		12	31		9	Bespoke packages
More than 6.25 years SABU	8	28.57%	177	3	77	12	85			Long term secure
More than 6.25 years FMHIDD	1	3.57%	151	3		12		136		Long term secure
More than 6.25 years Medium	8	28.57%	177	3		12	162			Long term secure

Model pre-load

The model as set up was populated with current patients based on their admission dates as summarised in the table below.

IPS non-NGRI

Current LOS	Patients	Populated LOS
Less than 3 month	1	6-15 months
3-6 months	1	15 months – 4.5 years
6-15 months	1	15 months – 4.5 years
	4	4.5 – 6.25 years
15 months – 4.5 Years	3	15 months – 4.5 years
	3	4.5 -6.25 years
	3	More than 6.25 Year
4.5 -6.25 years	3	More than 6.25 Year
More than 6.25 Year	7 – (1 FMHIDD)	More than 6.25 Year

NGRI

Current LOS	Patients	Populated LOS
3-6 months	1	6-15 months
15 months – 4.5 Years	11- (1 FMHIDD)	More than 6.25 Year
4.5 -6.25 years	9- (2 FMHIDD)	More than 6.25 Year
More than 6.25 Year	26 - (3 FMHIDD)	More than 6.25 Year

Approved centres

Current LOS	Patients	Populated LOS
15 months – 4.5 Years	3	More than 6.25 Year
4.5 -6.25 years	2 - (1 FMHIDD)	More than 6.25 Year
More than 6.25 Year	12	More than 6.25 Year

Model Validation and Quality Assurance

Model validation

Along with Model pre-load the discharged patients were also loaded into the model to support model validation.

Historical hospital occupancy was compared to modelled occupancy to validate the modelling approach.

Analysis of the data shows that the LOS has reduced significantly over the period of the data. To preserve a relatively homogenous dataset, we have focused on the period from 2015 to the current date.

The modelled occupancy is aligned with the actual occupancy and we therefore concluded, appropriate for use for the purpose of occupancy forecast. We note that the model as currently calibrated has a propensity to slightly underestimate occupancy – this factor has been considered in the key messages in earlier section.

Figure 17: Model validation output – Calculated vs Actual of beds occupied by male cases

Version Control

The version control sheet in the model workbook tracks all changes made to the input sheets, to the model sheet. Any modelling changes go through at least two reviews with at least one review from Manager or Senior Technical Lead.

Appendix 1(a) – Input data

Data Extract

Data file was provided by the NFMHS on September 17th 2021 containing anonymised information on all patients admitted to the NFMHS from January 1st 2010 as well as those already in CMH on that data

Figure 18: Power BI Visualization of data (Page1)

- Data was analysed in respect of 490 admissions in total (to include existing admissions at the beginning of 2010 and new admissions since that date).
- This included 398 males and 92 females.
- Age 31-40 showed the highest admission risk followed by age 21-30
- A total of 327 (67%) admissions arose from the prisons
- Schizophrenia was the most common diagnosis – 47% of cases. 22% of cases were recorded as having no diagnosis in the data received

Length of stay

The most common admission duration is 3 months or less representing 43% of the admissions analysed. 12% of admissions have a duration of 3-6 months. Critically, over 10% of admissions exceed 7 years in duration based on the data provided with a further 3% representing admissions of between 5 and 7 years. This pattern provides some evidence that once a threshold of admission of 5 years is reached, it is likely that the patient will continue as a long term inpatient.

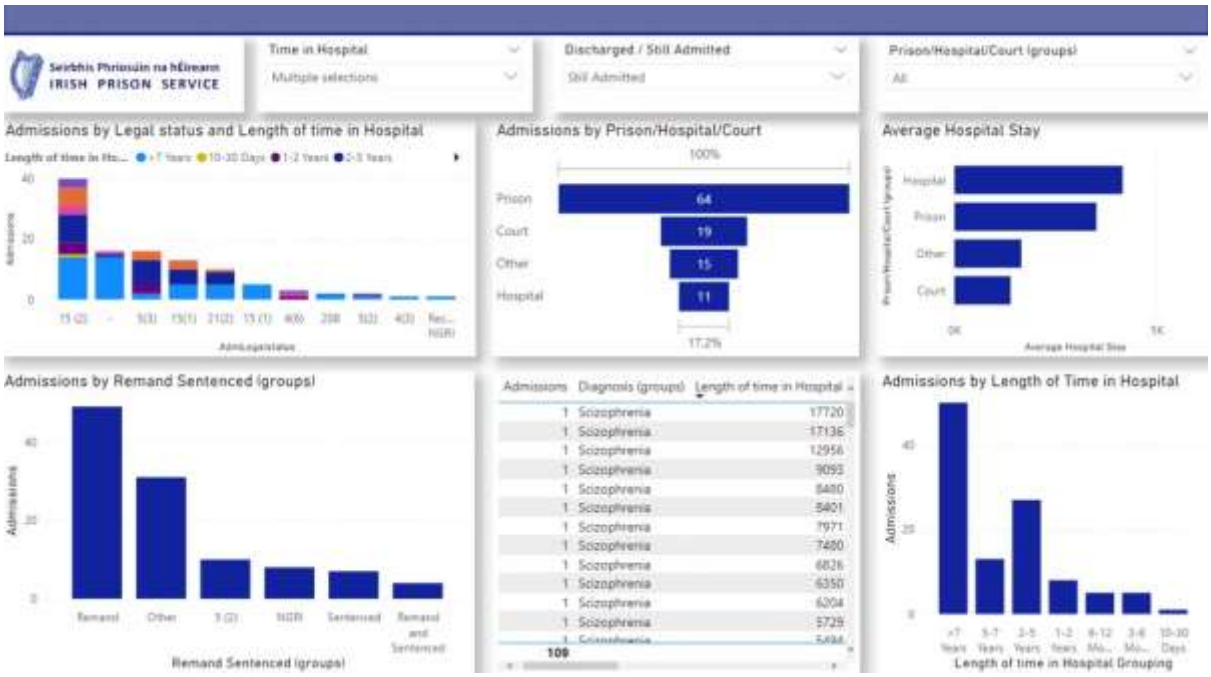


Figure 19: Power BI Visualization of data (Page2)

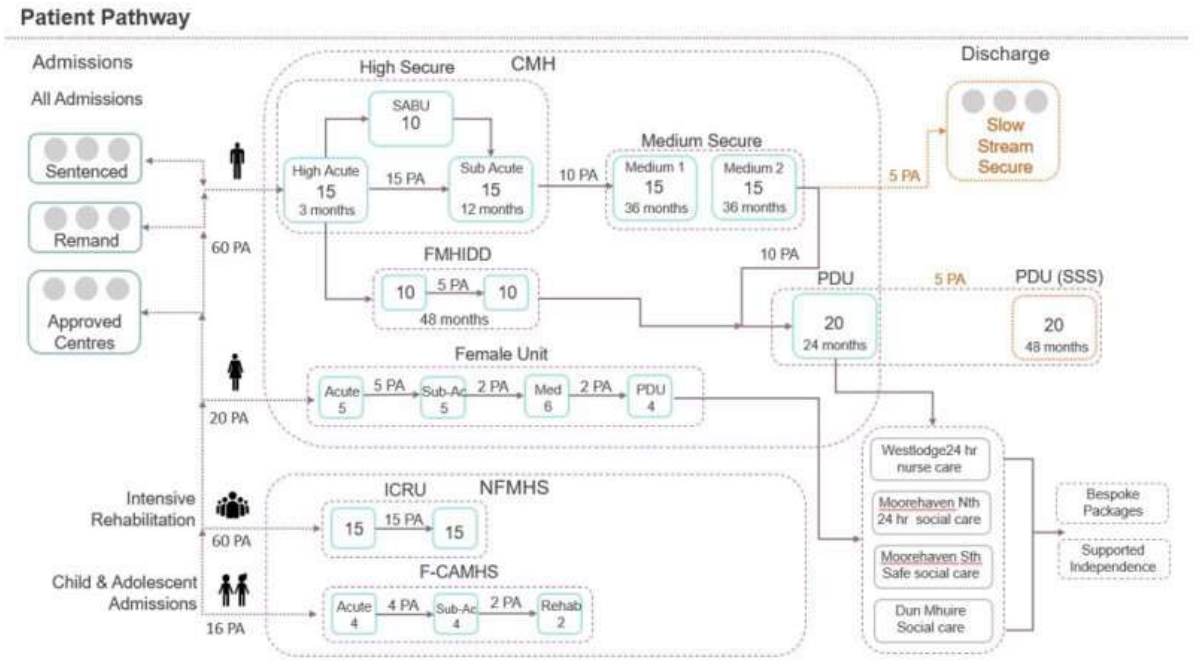


Figure 20: Patient flow process map by each patient pathway

Bed allocation		
Cluster	**Unit**	**Beds**
High Secure Unit	Acute Admission	15
	Sub-Acute	15
	SABU	10
Medium Secure Unit	Medium 1	15
	Medium 2	15
MHIDD	Sub-acute	10
	Rehab	10
Female	Acute/Sub-Acute	10
	Medium	6
	Pre-discharge	4
Pre-Discharge Unit	Rehabilitation	18
	Training flat	2
F-CAMHS	Acute/Sub-Acute	10
F-ICRU	Acute / ICU	15
	Sub-acute	15

Table 4: Unit Bed Numbers

Figure 21: Bed allocation by type of care

Chapter 5: Subgroup 3

Introduction

In considering persons with mental health difficulties and addiction issues, who also come in contact with the criminal justice system, it is acknowledged that being convicted before the courts can have a life restricting impact with regard to personal circumstances, status and employment. It is further acknowledged that loss of liberty can have a further profound impact on the life of the person concerned by removing them from familial, social, health and other protective factors, destabilising health care interventions and potentially compounding their mental health difficulties and addiction issues.

In guiding the Task Force the following principles were therefore at the forefront of our work:

- Persons presenting with mental health difficulties should be diverted from the criminal justice system at the earliest point (where appropriate and possible) with a focus on stratification, mitigation and management of risk.
- Detention should be used as a sanction of last resort (including remand)
- Health interventions should be the primary response (where appropriate and possible), with consideration given to a structured community sanction where appropriate
- Diversion should take place at the earliest point (i.e. pre court, pre conviction, pre detention)
- There should be equivalence of access to services/care for all those engaged with the criminal justice system
- There should be a seamless care pathway for those concerned to ensure continuity of care.

As identified in the Interim Report, subgroup 3 divided its focus between three areas:

(i) Courts
(ii) Community and
(iii) Throughcare

Many of the areas considered, or the findings reported, overlap between the three areas in focus, or indeed overlap with the findings of subgroups 1 and 2. Notwithstanding this, subgroup 3 has included its deliberations in each of the three areas concerned, enabling the reader to consider each either separately or collectively.

Executive summary

Subgroup 3's terms of reference included an examination of service provision in the community and the related processes involved in a prisoner's throughcare from custody to community. The scope of this, inclusive of all contact between persons with mental health difficulties and addiction issues and the criminal justice system is extensive.

That said, in considering its work, subgroup 3 is satisfied that the policy on mental health and forensic mental health as articulated initially in Vision for Change and reaffirmed in *Sharing the Vision* and in both *A Vision for Change* and *Sharing the Vision* reflects best practice. The challenge is the implementation of the specifics of Vision for Change policy and in particular how clarity of service provision, based on the often complex needs of the client, can achieve a reduction in the number of persons with mental health difficulties and addiction issues unnecessarily becoming involved in criminal behaviour, coming into contact with the criminal justice system, receiving inadequate clinical care in prison and potentially having a conviction imposed which limits life opportunities.

The need to consider diversion, at the earliest point, becomes a core aim of the work of the Task Force. While subgroup 1 focused on Garda Diversion, subgroup 3 considered forms of diversion once an individual appears before the court – diversion from conviction, diversion from custody - all within the context of a person accepting responsibility for their actions and the Court determining an appropriate sanction as necessary.

Interventions by Primary Care, Addiction Services, Community and Forensic Mental Health Services and Social Inclusion were noted. So too were the range of services provided by the Irish Prison Service in relation to the physical and mental health and welfare of the prisoner.

In that regard it is noted that much excellent work is evident across the health and justice sectors, with a range of projects operating on a small scale which, with investment, are likely to have significant impact on the challenges faced by the target group.

It is clear that there are a number of identified targets which need to be achieved. It is particularly clear that there is a need for greater alignment of agencies across the health and justice sectors. This includes:

- The assessment of client need
- Establishing agreed pathways into care
- Ensuring alignment during periods where both pillars (health and justice) are engaging with the client
- Enabling memoranda of understanding and data sharing agreements
- Devising and implementing a multi-agency, cross sectoral case management model
- Agreeing points of contact at operational, managerial and policy levels to ensure blocks and gaps are identified (and expeditiously resolved) and that positive outcomes are being achieved

Existing service provision demonstrates the way forward in the context of services to courts, throughcare within and from custody and within Primary Care. The sub group is strongly supportive of expanding these existing initiatives, enabling them have broader reach into critical areas of the justice system, supporting the aims and principles identified in the report.

As such, recommendations highlight where such developments are necessary and what can be expected to be achieved should these recommendations be implemented. Recommendations are prioritised as short, medium or longer term.

There is the temptation to write a significant number of recommendations within this section of the Task Force report. However, mindful of existing strategies, commitments and competing priorities, recommendations within the report have been deliberately kept focused on the smallest number which, if fully implemented, will make the greatest impact.

Oversight of the implementation of the recommendations, within set time frames and against performance measurement focused on outcomes, will be a critical success factor.

Subgroup 3 membership

- Mark Wilson (Chair) Director, Probation Service
- Kim McDonnell, Probation Officer, Probation Service
- Seamus Hempenstall, Principal Officer, Mental Health Unit, Department of Health
- Michael Murchan, Assistant Principal Officer, Mental Health Unit, Department of Health
- Deirdre O'Flaherty, Administrative Officer, Mental Health Unit, Department of Health
- Jim Ryan, Head of Operations for Mental Health Services HSE
- Tom O'Brien, Head of Service Primary Care, Community Healthcare Organisation
- Joseph Doyle, National Lead Social Inclusion; Primary Care, Community Operations, Health Service Executive
- Judge Brendan Toale, District Court
- Enda Kelly, National Nurse Manager, Irish Prison Service
- Ruairi Ferrie, Assistant Principal Officer, Homelessness Policy, Funding and Delivery Section, Department of Housing
- Tony O'Donovan, Principal Officer, Child Welfare Advisor, Children Detention Unit, DCEDIY
- Dr Damien Smith, Consultant Forensic Psychiatrist, National Forensic Mental Health Service (HSE) and visiting psychiatrist to Cloverhill and Mountjoy Prisons
- Professor Conor O'Neill, Consultant Forensic Psychiatrist, HSE NFMHS Prison Inreach and Court Liaison Service, Cloverhill Prison. Clinical Associate Professor in Psychiatry, Trinity College, Dublin
- Chief Supt Gerry Roche, Henry Street Garda Station, AGS
- Brendan O'Connell, Senior Psychologist, Psychology Service, Irish Prison Service
- Mary O'Regan, Principal Officer, Department of Justice
- John Dunphy, Assistant Principal Officer, Department of Justice
- Oonagh Ffrench, Higher Executive Officer, Department of Justice
- Kerrie Keegan, Executive Officer, Department of Justice

Summary of Recommendations

Courts:

(i) **Screening and Assessment**: There is a need for a national service to screen and/or assess for mental ill-health issues or other care requirements eg. HSE Primary Care, Dual Diagnosis etc. amongst those appearing before the Court. The subgroup viewed this as a natural development of the role of the existing Prison Inreach and Court Liaison Service which has operated so effectively to date. The model of service provision and staffing requirement will need to be scoped and resourced appropriately. Consideration should be given to aligning this team with Probation Service Court Liaison teams.

(ii) **Care Pathways:** In providing options to the Court, where it is clear that engagement with mental health services may be required, and in addition to the screening/assessment referred to above, clear pathways for access to primary, community and mental health services, between the HSE and criminal justice agencies, are required. These pathways should be formalised and regularly reviewed against agreed performance metrics to ensure positive client outcomes.

(iii) **Problem Solving Court Framework:** The Department of Justice, in conjunction with the Department of Health, should develop a framework, achieving the aims of a Problem Solving Court (such as the Drugs Court) to enable positive treatment and behavioural outcomes for persons appearing before the court. The framework could potentially involve models of bail supervision, an increased use of community sanctions, a specific mental health court or other such options.

(iv) **The Probation Service:** should be resourced to recruit staff (psychology or nursing) to enable increased competence at a regional and national level in the assessment of mental health within pre-sanction reports prepared for the Criminal Courts and to support effective offender management and clinical treatment options.

(v) **Training:** A training needs analysis and related training programme should be actioned for staff across the criminal justice sector to ensure a relevant degree of understanding of mental health, mental illness and the services available to meet the needs of such persons appearing before the Courts.

(vi) **Research**: Research should be commissioned to:

- establish the extent of persons with mental health and addiction issues (dual diagnosis) appearing before the courts and to establish the broader needs of this cohort (e.g. accommodation, employability etc.).
- track the outcomes of the implementation of the Task Force's recommendations – with a specific focus on social inclusion/marginalised groups.

(vii) **The Judiciary**:

- Department of Justice, working with relevant stakeholders conduct research to assess the impact of the alternative sanctions available under law, any barriers to their utilisation and any opportunities to improve their uptake and effectiveness.
- Where appropriate, the results of this research be utilised to inform a programme of judicial education to ensure that the judiciary are fully supported in the application of such alternatives to imprisonment.

Community:

(i) **Memorandum of Understanding:** A memorandum of understanding between the HSE, criminal justice agencies and other key stakeholders such as Local Authorities is required to deliver a partnership approach that creates easy access to case management services that include counselling, key working, outreach, addiction, mental health assessment, homeless placement and housing advice so that mental health difficulties can be treated within social inclusion/primary care and prison settings.

(ii) **Integrated Multi-agency Model of Case Management:** The HSE Single Integrated Case Management model, which is being piloted to support people experiencing homelessness in Dublin, should be further expanded to align with case management models in place in both the Probation Service and Irish Prison Service.

(iii) **Social Inclusion Case/Key workers :** In keeping with Sláintecare and the Enhanced Community Care Network model, Social Inclusion Case/Key workers should be allocated to each Community Health Network to ensure coordination and access to pathways. Such case managers should work with the Probation Service, homeless services and others, as required, to support offenders in the community and those before, during and after custody.

(iv) **Assertive Outreach Teams**: Such teams should be expanded to make specialist mental health care and housing supports available to people experiencing homelessness, mental illness and severe distress and to divert clients away from entering the criminal justice system.

(v) The potential to establish direct referrals pathways between the Probation Service and CMHSs should be explored, inclusive of screening tools, agreed referral criteria, enhanced bi-lateral liaison and outcome analysis. This should balance the needs of the Probation Service and the Community Mental Health Service.

Throughcare:

(i) **Prison Inreach Services:** The National Forensic Mental Health Service **'**Prison Inreach and Court Liaison Service' should be expanded to enable its services to be fully provided in all committal prisons

(ii) IPS Psychology Service: Should be resourced to at least the levels recommended in the "New Connections" review of the Service (Porporino, 2015). This resourcing should include funding a review to make recommendations to enhance recruitment and retention.

(iii) **Prison Health Care**: Prison health care services should be resourced to fully replicate the range of services available in the community

(iv) **PReP**: The National Forensic Mental Health Service 'Pre-Release Planning Programme' (PReP) should be expanded to have national coverage across the prison estate.

(v) **Case Management:** HSE Social Inclusion Case Managers and relevant NGO's should begin engagement with prisoners at the earliest point prior to release to ensure continuity of care as the prisoner's release date may be brought forward for a number of reasons resulting in an earlier than anticipated release date

(vi) **Reducing Attrition:** Maintaining engagement and motivation at the point of release - Attrition (drop out) from services is higher for homeless individuals with mental health difficulties who are in contact with Community Mental Health Teams due to this population being highly transient. Attrition would be reduced if all prisoners had a

community agreed discharge plan in place with an identified case manager prior to release.

(vii) **Research and Data Analytics**: Limited information is collected about the profile of those involved with the criminal justice system. As part of its data holdings, the CSO has access to and use of other administrative datasets such as those of the Department of Employment and Social Protection, Revenue, Education and other agencies and departments. Other information which would be useful in predicting the risk of recidivism include; age at first offence, prior arrests, family status, health status (including mental health and addiction), accommodation status, ethnicity and education level. The addition of these variables could be used to enrich the existing prison and probation datasets to provide a better understanding of the underlying factors that lead offenders to reoffend or conversely, desist from criminality and to lead a crime-free life.

Courts

(i) Defining the problem:

The *Access to Mental Health Services for People in the Criminal Justice System* Report stated that people who are mentally ill and who have been accused or convicted of a criminal offence have unequal access to mental health services compared to those who have not offended. The overarching problem from the perspective of courts is that there are large numbers of people with mental illness and particularly with severe mental illness (e.g. schizophrenia) coming in contact with the criminal justice system (Gardaí, courts and prisons), often repeatedly and at times when they are acutely unwell. The downstream impact of this inequality of access to mental health services is evidenced in the finding that there are a disproportionately high number of persons with major active mental illness in prison or subject to Probation Service supervision in the community following sentencing in Court. For example, the Moving Forward Together: Mental Health Among Persons Supervised by the Probation Service study in 2021 reported that 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 difficulty. Approximately 50% of all people supervised by the Probation Service in the community who present with mental health difficulties also present with one or more of the following issues as well: alcohol and drug misuse, difficult family relationships, and accommodation instability.

A Vision for Change in 2006 recommended that every person with serious mental health difficulties coming into contact with the forensic system should be accorded the right of mental health care in a non-forensic mental health services unless there are cogent and legal reasons why this should not be done. Unfortunately this has not been fully achieved as envisaged. There has been significant investment of over €450m by Government across HSE Mental Health over last decade or so.

The findings and attendant problems are compounded by the Courts having limited options, including:

- no or very limited support to identify these individuals, particularly at first court appearance
- no, or very limited options to direct them to risk-appropriate healthcare
- limited powers of disposal of cases in a manner that may incorporate diversion out of the criminal justice system altogether or incorporate appropriate treatment or therapeutic elements within any criminal sanction imposed.

Those acutely psychotic are disproportionately homeless and impoverished and very often have difficulty in meeting standard bail conditions, resulting in frequent and possibly prolonged periods in custody, even when charged with relatively minor offences. Courts should not be expected, without assistance, to identify those requiring assessment or treatment. Substance misuse and co-occurring mental health difficulties are highly prevalent and problematic among persons appearing before Courts. There is an urgent need for improved access to specialist services offering assessment and care through multi-disciplinary assessment and intervention for those presenting with co-occurring mental health difficulties and addiction issues. These issues cannot be addressed in isolation where there are complex overlapping needs.

Where the person is assessed as “unfit to be tried” [which is a high threshold rarely reached] an order can be made for assessment in a designated centre under Section 4 of the Criminal Law (Insanity) Act 2006. In practice this has rarely been possible at first instance due to a lack of available “designated” beds at the CMH. To date, such beds may be appropriately used for those with major mental illness charged with serious offences or posing a high risk to others.

Judges can request that the individual receive assessment and treatment in a remand setting. Of those, 95% remanded are males, mostly young men. Judges cannot order assessments by or at community healthcare facilities regarding need for admission or other treatment. In practice, even when persons are identified who are acutely and severely mentally ill and require urgent admission in locations other than the CMH, and are granted bail to enable this, organisational obstacles are often encountered which delay and prevent such admissions, especially for those currently homeless. These obstacles include the lack of a clear operational process within the HSE to make decisions regarding catchment area responsibility in a timely manner.

Courts need responsive solutions with access to mental healthcare workers to:

- Identify those with mental illness, particularly major mental illness at the earliest stage and obtain an objective assessment on whether their mental illness was a contributory factor in their offending behaviour.
- Distinguish persons with major mental illness from those with minor/no mental illness, and intoxication/withdrawal.
- Obtain structured, standardised mental health reports in a timely manner, to include solutions to accessing healthcare in appropriate (forensic, community inpatient and community outpatient) settings, in accordance with longstanding government policy. “Timely” is in the context of court proceedings, in respect of which it is widely recognised that it is in the interests of victims of crime and the public interest and the interests of accused persons that court proceedings conclude as quickly as possible. The potential ‘up-front’ cost of a properly resourced reporting structure could be balanced in part if not in full by reduction in delay and by more appropriate disposal.
- Maintain oversight of such persons where diversion is achieved to community settings, with feedback from healthcare agencies in collaboration with the Probation Service and feedback from the HSE regarding reasons for delays in implementing such solutions.

(ii) Scoping requirements for the solution

There are significant and unmet psychological and psychiatric needs among persons appearing before Courts. Many are currently not engaged with health services having disengaged from services or been excluded. There is a need for improved access and engagement routes to mental health services including cross-agency and multi-disciplinary working. There is a need for a focused cross-government approach to ensure this gap can be addressed.

There is a need to identify standardised approaches to the identification, diversion and maintenance of mentally ill and particularly severely mentally ill defendants.

It is also appropriate to determine whether potential savings could be made by exploring the current cost of 'revolving door' prisoners with major mental illness (largely acutely psychotic, homeless young men who abuse substances, in inner city areas) on the criminal justice system, in comparison to that of providing 'wrap around' Housing First (synergistic mental health, housing, addiction) supports for such individuals.

Following concerns raised by inspection bodies (e.g. Committee for the Prevention of Torture and Inhumane Treatment), there are clear benefits to the consideration of conducting a root cause analysis to determine 'barriers to care' for those remand prisoners with the most extended delays in accessing community based hospital treatment where courts have granted bail to enable such options.

A research project should be considered aiming to identify the number, profile and, if possible, related issues of concern regarding persons with mental health difficulties appearing before Courts.

(iii) Considering alignment with existing activity/initiatives

The Prison Inreach and Court Liaison Service (PICLS) model as discussed in detail in the Task Force Interim Report, does provide for court liaison/diversion from Ireland's busiest remand court at Cloverhill, and to a lesser extent to other courts remanding to Cloverhill Prison. This model should be provided and resourced at a national level to provide a service to regional courts remanding to all prisons.

There is a clear need for enhanced co-ordination and improved access routes to appropriate mental health services for individuals presenting with a range of mental health difficulties and possible co-occurring needs. It highlights the need for increased and integrated cross-agency, inter-disciplinary and joint working by the services and professionals. Prison and court-based diversion services should be directed mainly at persons with severe mental illness and those requiring comprehensive assessment. This is in an addition to the welcome initiative of Garda Station Diversion, which may initially deal with people with less severe illnesses and is likely to have a significant lead-in phase before national roll-out in all Garda Districts.

There is a gap in assessment and service provision for persons with perceived lesser mental health and trauma conditions that do have significant impact on behaviour, coping and self-management. There is a need to identify appropriate assessment, engagement and treatment service referral processes for this population. There has been very significant funding for forensic mental health services in Ireland in recent years. It is important that this investment be directed at patients requiring forensic care. Those repeatedly coming in contact with the criminal justice system when charged with minor offences may be more effectively helped through close alignment with homeless psychiatry services, Housing First initiatives, inclusion health initiatives and mental health services providing 'assertive outreach', particularly in inner-city areas.

There should be strengthened co-working between probation, mental health and other services including accommodation and training/employment providers, for persons with mental health difficulties, and particularly major mental illness, appearing before the courts, including regarding access to residential rehabilitation facilities. There should be mental health staff available to busier district courts.

There should be exploratory discussions with the mental health services to address the barriers between forensic and mainstream mental health services in the community to improve service provision, access and co-ordination for persons in the criminal justice system particularly in areas where specialist forensic services are not available.

Consideration should be given to the inclusion of mental health staffing and provision in the Probation Service to support work with people with mental health difficulties, provide guidance in supervision and to provide specialist expertise in assessment for Courts.

(iv) Developing proposals

Liaison/Diversion services aim to assist the mentally ill through helping multiple agencies to provide coordinated and appropriate support to these individuals, bearing in mind public safety concerns. Liaison services thus aim to assist Gardai, Courts, prisons (including for those subsequently sentenced), community psychiatry services, the HSE National Forensic Mental Health Service (NFMHS), housing services and other agencies in providing comprehensive assessments and arranging "joined up care" for those with greatest need in appropriate environments. Liaison/Diversion services are required at all points in the offender pathway, including Garda Stations, District Courts and Prisons.

Key to this is early identification through systematic screening. Multistage screening has been in place for persons remanded in custody at Cloverhill Remand Prison since 2006, through the PICLS service, but not in remand prisons elsewhere. This can be implemented rapidly for persons remanded in custody nationally, given provision of relatively limited resources.

The aim should be to have a similar specialist screening process in District Courts on a daily and national basis. This exists in some other jurisdictions (e.g. NSW, Australia), which have pragmatic legislation for diversion of those requiring immediate admission to forensic and non-forensic beds, as well as legislation providing for oversight of community outpatient treatment options by courts. It is however difficult to justify the resourcing of screening in all courts nationally at this point, in the absence of legislation to translate identification into healthcare solutions and/or disposal that may incorporate diversion out of the criminal justice system altogether or incorporate appropriate treatment or therapeutic elements within any criminal sanction imposed. There is scope however for this screening to be provided in certain busier courts currently provided with Probation Court Liaison teams, and for daily specialist healthcare keyworker input to "remand courts" so timeframes for reports (current median 13 days for the PICLS service) can be reduced.

There is a need to improve and strengthen the alignment of mainstream primary care and forensic and community mental health service providers with the Probation Service, the Courts and other interests for the development of joined-up strategies and interventions for persons in the criminal justice system with mental health difficulties and related issues.

<u>In the short to medium term:</u>

- There is a need to adequately resource the current integrated PICLS service such that it can provide both its prison Inreach and court liaison model to courts remanding to custody. This would include sufficient staffing to allow regular attendance at the busier district courts.

- There is a need for similar services at all remand prisons nationally and the courts remanding to those centres.
- There is a need to strengthen the knowledge and develop skills-based training in mental health for the Probation Service, An Garda Síochána, the Irish Prison Service and other relevant personnel to aid recognition of mental health difficulties and where identified, ensure that the appropriate services are involved at assessment and/or intervention.
- There is a need to improve and strengthen the Courts, Probation Service, Irish Prison Service and An Garda Síochána engagement with mainstream primary care and forensic and community mental health service providers and the development of joined-up strategies and interventions.
- A Housing First model with 'wrap around services' from point of contact with the criminal justice system is required. Housing Support Workers (as part of PICLS teams, providing support for people on release from court and prisons) can assist with handovers to such services in a cost-effective way.
- The homeless mentally ill mainly accumulate in inner-city areas. Inner-city HSE services, such as homeless services and assertive outreach services, who are tasked with working with mentally ill and particularly severely mentally ill individuals should be funded and staffed appropriately to address the needs of those currently repeatedly presenting through courts and prisons following minor offences, with support from PICLS and the Probation Service. Community based services from HSE and other services should be available to such individuals on the basis of contact with the CJS rather than on location or catchment area.
- Consideration may be given to "designating" centres other than the CMH with regard to people "unfit to plead" but not requiring such a high level of therapeutic security. The ICRU in the new CMH is such a setting, and should be opened as a priority in line with the planned phased operation of the overall NFMHS facility at Portrane.
- There should be closer liaison with Probation Services, with regard to needs and risk assessment for persons with severe mental illness, to enable the implementation of conditional supervised sanctions, feedback to courts and access to substance misuse treatment services, particularly residential rehabilitation.
- There is an urgent need for a national HSE process enabling immediate decisions regarding catchment area responsibility for severely mentally ill people requiring hospital admission.
- The Mental Health Act explicitly excludes people who have a personality disorder without a co-existing 'mental disorder' as sole grounds for involuntary detention under the Act. This exclusion is because people with personality disorders without a co-existing 'mental disorder' generally do not see an improvement in their condition following involuntary detention and treatment; this aligns with practice in other jurisdictions including the UK (see https://www.nice.org.uk/guidance/conditions-and-diseases/mental-health-and-behavioural-conditions/personality-disorders/products?ProductType=Guidance&Status=Published) The 2015 Expert Group to review the Mental Health Act considered the exclusion of personality disorders and recommended that it should remain in place. The Personality Disorder category diagnosis and classification is difficult to address and manage in mental services in Ireland due to differing interpretations and policy approaches when compared to neighbouring jurisdictions. Internationally, there remains a paucity of evidence based treatments for the key personality disorders; the HSE has developed significant DBT services for the evidence based treatment of people with Borderline Personality Disorder. This may indicate that personality disorders are largely unaddressed and under

diagnosed. This can contribute to difficulties in assessment, management and intervention and requires further attention. There is also a need for a multi-dimensional focus to include the full range of psychiatric/psycho-social/neurological issues, including neurodiversity. The implementation of relevant recommendations of STV in relation to improved inter-agency co-operation would be key in this regard.

Medium Term:

- Consideration should be given to a "Mental Health Court" framework with the aim of appropriate disposal primarily focussed on treatment and rehabilitation and reduction of recidivism, with capacity for accused people to enter into agreements regarding appropriate conditions with the court. This could be assisted by a team based in the court including psychiatry, social work, housing support, addiction counselling, probation and other supports, or be based on support from services currently providing such supports. This could perhaps initially be targeted at persons based in inner city areas.
- International research has found promising results indicating that participation in a Mental Health Court was able to reduce re-offending regardless of varying severity of criminal history. The impact of MHC was so great that length of participation reduced severity of offense type after 3 years even for those who ultimately did not complete the requirements. (The Effectiveness of One Mental Health Court: Overcoming Criminal History Julie S. Costopoulos & Bethany L. Wellman Psychol. Inj. and Law 2017 DOI 10.1007/s12207-017-9290-x)
- This would require offering accused people the opportunity to engage with certain conditions, including engagement with recommended treatment and other supports for a defined period, with the assumption that this would be associated with non-custodial disposal (and in some circumstances eventual discontinuation of prosecution). The person would have the option to decline such an approach or revert to the normal court process at any time.
- This framework could be achieved through a more focused use of 'adjourned supervision', again as outlined in the Task Force Interim Report, where the Probation Service supervise an individual under strict conditions as imposed by the Court.
- Again, given the patient group (people with conditions such as schizophrenia which may relapse), there would need to be clarity regarding catchment area responsibility for such patients were admission to be required in the event of an acute relapse of their illness.
- Extending the range of available verdicts to include possible recognition of reduced culpability due to mental illness, (such as 'diminished responsibility', which currently applies only to fatal offences), to offences more generally, for persons with conditions which may temporarily impair decision-making capacity and capacity for intent. This may facilitate decision making regarding future hospital orders and/or community treatment orders and allow defendants to decide (when fit to enter such a plea), whether they are prepared to enter into agreements regarding engagement with treatment, and provide for a balance between rights and responsibilities.

In the longer term:

- There is a need to modernise legislation, in keeping with international norms, to enable diversion (i.e diversion out of the criminal justice system altogether or by incorporating appropriate treatment or therapeutic elements within any criminal sanction imposed),

hospital orders and maintenance in the community. New South Wales, England and Wales and parts of Canada may provide examples of good practice.

- Daily input by mental health staff to district courts nationally to provide daily screening and 'on the day reports' regarding immediate diversion options (with legislation to provide for this) and to advise regarding timeframes for assessments which may take longer, in remand prison and 'designated' facilities.
- Explore the options for integrated/comprehensive mental health assessments for Courts and structured care and treatment supervision interventions.

(v) Considering limiting factors

- There is a lack of legislation to provide for rapid assessment in an appropriate clinical setting of severely mentally ill people appearing before the courts. The existing legislation[2] allowing for such assessment under fitness legislation has not worked.
- While the very substantial investment by the state in the new HSE NFMHS, Portrane will allow for better access to some such assessments, if this reaches full capacity as a result of large numbers of such referrals for people not requiring this costly process, there is a risk that we will rapidly return to the current untenable situation unless all associated care options are maximised to best address this.
- In practice, almost all mental health assessments for courts of those severely ill and remanded into custody are provided by mental health Inreach teams which are minimally resourced.
- There is a lack of clear commissioning arrangements for psychiatric reports prepared at the request of Courts for those remanded in custody and for those not remanded in custody.
- When directed, HSE staff including consultants, attend court. There is a need however for co-ordinated & improved liaison services within HSE including specific staff to attend courts on these issues. One Advanced Nurse Practitioner role has recently been authorised.
- Such support is currently provided by prison Inreach workers as an adjunct role to their key duties. This 'integrated approach' can be very effective, (and cost effective) while avoiding duplication of work, but to date has not been provided with adequate resources at PICLS Cloverhill or elsewhere.
- The 120 ICRU beds across 4 regional locations recommended in *Sharing the Vision* over 15 years ago have not been provided. It is unclear when the 30 ICRU beds in the new NFMHS Portrane is to open on a phased basis but it is expected by end 2022. There are systemic barriers to access to local PICU and general psychiatry beds under the Mental Health Act 2001, particularly 'catchment area' issues for people homeless at the time they appear before courts.
- The issue has been raised that previous offending should not be disclosed in psychiatric reports provided for use by judges prior to trial/conviction. However, it is noted that a healthcare worker cannot provide a useful risk assessment without reference to previous offending, and particularly violent offending.
- In many jurisdictions persons with a major mental illness are treated under a community treatment order (CTO). CTOs are legal statutes that require individuals, who suffer severe mental illness, to attend clinical services and comply with a plan of treatment, when living in the community. CTOs in one form or other are now available in more than

[2] Section 4 Criminal Law Insanity Act

75 international jurisdictions, including Australia, Canada, England and Wales, New Zealand, Scotland, and the United States. The possibilities and attendant issues involved in the use of CTOs or Mental Treatment Orders should be explored and assessed.

- It is unhelpful that legislation provides mainly for “unfitness” (which is often temporary and readily remediable with treatment) and the defence of “not guilty by reason of insanity”, an absolute acquittal for any offence, while “diminished responsibility” is only available for homicide.
- At a practical level, many people with schizophrenia will stay well for extended periods if they remain compliant with medication (especially depot medication) and do not use intoxicants. When not acutely psychotic, such people are capable of appreciating this, and capable of entering into agreements with courts regarding future behaviour.
- Most people with personality disorders and/or who abuse substances do not suffer from major mental illnesses such as to impair their capacity to distinguish between legal and illegal acts. These constitute the great majority of people in prisons internationally. It is important that this Task Force determine if its intention is to improve conditions for prisoners generally through a rehabilitation model, or focus attention on those who have severe illness. If the former, those with severe illness will continue to flow through and accumulate in our prisons, and agencies such as the CPT will continue to describe them as subject to “inhuman and degrading treatment” while awaiting hospital admission.
- It is hoped that the new and expanded CMH will be able to address these admission needs. Most such admissions from prisons generally and remand prisons in recent years have not been to the CMH, but arranged through the courts by the PICLS service from Cloverhill. While other limiting factors as summarised above remain, it would be helpful were the PICLS service to be appropriately resourced and expanded to optimise this ‘release valve’ and mitigate demand for costly CMH beds.
- The Recommendations of the *The Access to Mental Health Services For People in the Criminal Justice System Report* and the *Moving Forward Together: Mental Health Among Persons Supervised by the Probation Service* should be reviewed to identify cross-cutting and common issues, factors and changes to be addressed in the context of mental health among persons appearing before courts.

Recommendations - Courts

(i) Screening and Assessment:

In the context of the administration of justice and to assist the judiciary, there is a need for a national service to screen and/or assess for mental health difficulties amongst those appearing before the Court. The subgroup viewed this as a natural extension of the role of the existing Prison Inreach and Court Liaison Service which has operated so effectively to date. The model of service provision and staffing requirement will need to be scoped and resourced. Consideration should be given to aligning this team with Probation Service Court Liaison teams.

(ii) Care Pathways:

In providing options to the Court, where it is clear that engagement with mental health services may be required, and in addition to the screening/assessment referred to above, clear

pathways for access to primary, community and mental health services, between the HSE and criminal justice agencies, are required. These pathways should be formalised and regularly reviewed against agreed performance metrics to ensure positive client outcomes.

(iii) Problem Solving Court Framework:

The Departments of Justice, in conjunction with the Department of Health, should develop a framework, achieving the aims of a Problem Solving Court (such as the Drugs Court) to enable positive treatment and behavioural outcomes for persons appearing before the court. The framework could potentially involve models of bail supervision, an increased use of community sanctions, a specific mental health court or other such options.

(iv) The Probation Service:

should be resourced to recruit staff (psychology or nursing) to enable increased competence at a regional and national level in the assessment of mental health within pre-sanction reports prepared for the Criminal Courts and to support effective offender management.

(v) Training:

A training needs analysis and related training programme should be actioned for staff across the criminal justice sector to ensure a relevant degree of understanding of mental health, mental illness and the services available to meet the needs of such persons appearing before the courts.

(vi) Research:

Research should be commissioned to:

establish the extent of persons with mental health and addiction issues (dual diagnosis) appearing before the courts and to establish the broader needs of this cohort (e.g. accommodation, employability etc.).

(vii) Track the outcomes of the implementation of the Task Force's recommendations – with a specific reference on social inclusion/marginalised groups.

(viii) Further Supporting the Judiciary:

The judiciary play an indispensable role in the administration of justice. Earlier recommendations in this report are aimed at ensuring that the judiciary are adequately supported when dealing with individuals before the court who are or appear to be facing mental health and dual diagnosis issues particularly in respect of assessment. The judiciary and their confidence in the alternatives to imprisonment will be a critical factor in the success of these alternatives and achieving the long term objectives of the HLTF. To this end, and mindful of the importance of judicial discretion it is recommended that the Department of

Justice, working with relevant stakeholders conduct research to assess the impact of the alternative sanctions available under law, any barriers to their utilisation and any opportunities to improve their uptake and effectiveness. It is further recommended that, where appropriate, the results of this research be utilised to inform a programme of judicial education to ensure that the judiciary are fully supported in the application of such alternatives to imprisonment.

Community

(i) Defining the Problem

Every day members of An Garda Síochána interact with persons presenting with challenging behaviour, mental health difficulties and mental illness. Earlier in this report we outlined a formal model for Diversion which will support effective referral to treatment for appropriate persons coming in contact with the Gardaí, thereby minimising their contact with the criminal justice system. Additionally, as outlined in the Task Force Interim Report, many such incidents occur at night, when few health services are available to assist Gardaí in managing such persons. A model of Critical Intervention was identified and will be elaborated on later in this report. The recent report from the Garda Inspectorate again reflects on the challenges for persons detained within Garda stations, and for the Gardaí themselves, and the need for improvements to this practice.

Additionally, in 2006, *A Vision for Change* called for linkages between the Probation Service and the relevant mental health services to ensure continuity of care. Fifteen years later, however, individuals on Probation supervision living with poor mental health continue to encounter challenges engaging with mental health services.

"There are significant unmet psychological and psychiatric needs among those persons subject to Probation Supervision and limited Mental Health Service engagement." (Power, 2021:6)

"There is a need to improve and strengthen Probation Service engagement with mainstream primary care and forensic and community mental health service providers and the development of joined up strategies and interventions." (Power 2021:6)

For people supervised by the Probation Service in the community, there is a high level of co-morbidity with:

- Alcohol and Drug Misuse (51%)
- Difficult family relationships (49%)
- Accommodation Instability (47%) (Power 2021)

A significant number of individuals who come into contact with the criminal justice system experience homelessness. These individuals encounter obstacles accessing support services that are usually provided based on a person's address or catchment. This causes many difficulties for those trying to access homeless, health and social services. A stepped approach to providing health care and access to specialist mental health services for people who are homeless is required.

Not every individual who has contact with the criminal justice system will have served a prison sentence. Issues faced by individuals with mental health difficulties, involved in the criminal justice system in the community also include:

- Lack of availability of a Community Forensic Mental Health service
- Lack of statutory arrangements for interagency working (shared responsibility)
- Lack of Assertive Community Outreach mental health services and an out of hours service. This is especially problematic for homeless mentally ill clients
- As with clients in prison setting (subgroup 2) there is a lack of access to Psychiatric Intensive Care Unit (PICU) beds for acutely mental ill patients requiring admissions.
- Lack of access to Intensive Care Rehabilitation Unit (ICRU) beds for clients requiring longer term (to months) admission with a focus on rehabilitation and community reintegration
- Lack of access to GPs and Community Mental Health Services for clients with dual diagnosis
- Difficulty for these persons with dual diagnosis accessing information to any form of residential rehabilitation
- The Criminal Justice strand of Housing First was not available nationally
- Lack of access to GP and/or medical card
- Clients may only access healthcare during crises (usually by way of arrest or through Emergency Department)
- There can be other co-morbid issues (intellectual, developmental disabilities and acquired brain injury)
- Personality Disorder alone is not a mental disorder within its meaning under the Mental Health Act 2001
- No representation of Probation Officers in Primary Care settings or Community Mental Health Teams or embedded with the National Forensic Mental Health Service in terms of case conferences, care planning of clients engaging with these services.
- There is a need to improve and strengthen Probation Service engagement with mainstream Primary Care and Forensic and Community Mental Health service providers and the development of joined up strategies and interventions.
- Members of the Travelling Community are over represented within the criminal justice system and may require a bespoke response in this area.

Without any or ongoing treatment in the community, the danger of a relapse is high, posing a threat to the individual's health and increasing the possibility that they will again come into contact with the criminal justice system.

"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." (Finnerty, 2021: 5 MHC)

"The National Forensic Mental Health Service does not have the 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." (Finnerty 2021:33)

(ii) Scoping requirements for the solution

As has been mentioned in previous section, examining Courts, there is a need for enhanced, multi-agency coordination both within the HSE and between the HSE and justice agencies. In that regard, it may be useful to explore the roll out of the Case Management model within Social Inclusion services that aims to ensure that each complex service user has access to a case manager who will navigate their journey in partnership with the service user. At present the NEIC, Homeless and Addiction services (including NGOs), all led by HSE Social Inclusion operate this model in Dublin as referenced in the HSE National Service Plan 2021. Such a model may assist cooperation, coordination and enhanced outcomes if it can be aligned across HSE services and with existing criminal justice practice.

There is also a need to strengthen Assertive Community Outreach Mental Health services for homeless mentally ill patients with Social Inclusion and Housing First reintegration roles.

There is potential benefit in mapping access pathways for clients with mental health difficulties and addiction issues, differentiating between those with severe and enduring illness and who are mild/moderate, to identify where access issues are breaking down.

Equally, there is merit in conducting a scoping exercise with Community Mental Health teams and Community Forensic Mental Health teams to identify:

- challenges they encounter engaging with individuals involved in the criminal justice system (at both micro and macro levels)
- gaps in service provision
- potential solutions.

Further research is also required in the cohort of individuals presenting with mild to moderate (and/or occasional) mental health difficulties as to:

- Why they have difficulties in accessing primary or secondary care
- Why do they not engage or sustain engagement with the community services
- Identify barriers to service provision for those with dual diagnosis seeking access to treatment.

"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." (Finnerty 2021).

As highlighted in the Expert Report in 2015, an update of Mental Health Act 2001 is now underway, those deemed to have Capacity and Consent sometimes make choices that is not in their best interest, despite best professional advice. This can be a significant hindrance to sustained engagement with services. A scoping exercise should be conducted to establish the confidence and competence of Probation Officers working with individuals with mental health difficulties, with the aim of identifying gaps in training of Probation Service staff. In this regard there may be merit in identifying a standard Mental Health Training Programme for Probation Officers (at Induction and as part of continuous professional development).

(iii) Considering alignment with existing activity/initiatives

Primary Care and Social Inclusion are central to the coordination and delivery of a wide range of integrated services in collaboration with other providers and partner organisations. Primary Care serves as the foundation for the enhancement and reform of community services, which will deliver a greater range and volume of integrated care resulting in reduced hospital admissions

while enabling people to live healthier lives in their community. Primary Care encompasses services provided in social inclusion, including supporting homeless individuals and those with an addiction or mental health condition. Primary Care also provides services for migrant communities, Traveller and Roma communities and other priority groups such as LGBTQ+ groups.

It is acknowledged that primary care services in prisons are more complex because there is a higher likelihood that individuals in prison will have more health issues, including substance misuse and mental health difficulties. Therefore, building better synergies with community primary care services where access to post release clinical, pharmacological and dental Care (where medically appropriate) is essential.

Enhancing community services is a fundamental reform priority for HSE Primary Care Services. The new Enhanced Community Care programme (ECC) allows for community health networks in Primary Care, focusing on populations of 50,000 per network. Networks will provide multi-disciplinary teams to produce coordinated Care for individuals accessing services. Networks will engage with other care groups in older people, mental health and disabilities in an integrated way. Networks will manage and deliver local services to a defined population in alignment with the principles of Sláintecare, where community-based Care is delivered in the right place at the right time. This new way of working enhances more significant partnerships with hospitals and the voluntary sector to create better Care in the community. This approach augments the HSE national model of care for the health of people experiencing homelessness in Ireland and is informed by learning and developments from the Dublin Homeless COVID19 response.

The ECC approach described above aligns with the proposed development of a single integrated case management model to support people experiencing homelessness in the Dublin region as referenced in the HSE National Service Plan 2021. The pilot aims to provide continuity and coordination of person-centred health and social services for people experiencing homelessness or marginalization affecting some individuals in the prison population.

Positive synergies exist in this new model to support individuals who engage with the criminal justice system. Primary Care incorporates social inclusion services and has existing service level agreements with Homeless/Addiction/Traveller/LGBTQI/ HIV/ Roma/Migrant agencies. Each community health network will have key workers that link service users into various services and coordinate service delivery following an agreed care plan. In addition, this key worker role will signpost the client to all other services such as mental health, disabilities, primary care, and HSE funded voluntary services.

It is recognised that no single service can cater to the diverse needs of an individual with mental health difficulties or dual diagnosis, and there is a need for a multi-sectoral, multi-stakeholder approach. This approach will enable individuals to access most supports and services as close to home as possible and at the level of complexity that corresponds best to their needs and circumstances. This way of working may benefit people in their communities before they engage with the criminal justice system and enhance healthy relationships with probation services to support individuals prior to and upon release from prison.

To improve the partnership process required to achieve positive outcomes for marginalised groups, it is important to have a system in place to assist with the coordination of care required. A central Case Management structure made up of a dedicated team of Social Inclusion case

managers should be resourced to engage with Community Health Networks and external agencies so that each service user will have a holistic needs care plan prior to leaving prison inclusive of Health, justice, housing, employment, training & education, finance, mental health using a common assessment methodology.

The case management teams are positioned in the system as a team that manage complex cases in partnership with NGO's and Health links for Homeless teams. NGO's currently provide key working services and should refer to the case management service when more complex case management and support is required. In order to achieve this, a key focus will be to shape a system in which local voluntary groups have a recognised role and where primary care supports are closely linked to specialist mental health services and acute hospital services across the lifespan in an integrated and coordinated manner.

Forging better relationships between primary care services and the voluntary sector will allow for better resourced teams to provide additional in-reach and outreach services to offenders/prisoners using the social prescribing model of care. Case management teams will be better placed to support clients prior to, during and following release from prison. In addition, greater integration with Probation and Social Inclusion services within the Community Network Structure will support aftercare and increase knowledge of services locally so that clients can be signposted to services as appropriate.

Housing First for those engaged with the Criminal Justice System

Persons with high and complex support needs may engage in behaviour which results in their appearance before the criminal courts. The challenges faced by such individuals is often compounded by an absence of suitable and stable accommodation, often resulting in the person becoming entrenched in emergency homeless services. A number of voluntary organisations currently work with the Justice agencies, providing housing responses for those with medium support needs. However, some of those with more complex needs, including health, mental health difficulties and addiction problems, remain difficult to place. It is widely recognised that a targeted intervention is needed for this group.

In major city and urban areas (Dublin, Cork, Limerick, Galway) voluntary agencies are working effectively with those engaged with criminal justice services – multiple types of accommodation available e.g. emergency hostels, hub and spoke models, group residential, single units. However outside these areas there is overreliance on emergency B&B accommodation which certain clients are often excluded from because of difficult history with local councils, offending records, mental health difficulties and substance misuse histories. Work collaboratively with all the stakeholders in relation to providing appropriate accommodation for individuals with these issues (e.g. AGS, HSE, Local Authorities, IPS, CBOs etc.)

Work closely with other linked services and projects which are currently developing, implementing and evaluating their trauma informed practice. This is consistent with the Service Delivery Principles identified in *Sharing the Vision.* The Principles require co-ordination and effective communication between services and organisations.

Work with the HSE and local authorities to move from a strict catchment area for homeless service users to a model that is more reflective of their homeless status and their mental health

needs (e.g. service provision should follow the individual) has been initiated within Dublin region to rollout nationally.

A key focus is to shape a system in which local voluntary groups have a recognised role, where primary care supports are closely linked to specialist mental health services and where mental health services across the lifespan are integrated and coordinated.

By utilising the existing good relations that exist between primary care services and the voluntary sector, there is a possibility to create additional in-reach and outreach services to prisoners through use of social prescribing. GPs, nurses and other primary care professionals can refer people to a range of local, non-clinical services provided by voluntary and community sector organisations.

The need for a revised co-ordinated approach between HSE & CJS services in a memorandum of understanding to access Social Inclusion case management services, that include counselling, keyworking, outreach, addiction, homeless placement and housing advice so as to ensure that minor mental health difficulties can be treated within social inclusion/primary care.
It is also important to note that there is ongoing active participation from the criminal justice sector in Regional Homeless structures (i.e. Statutory Management Groups, Homelessness Consultative Forums – set out in s38 and s39 of the Housing (Miscellaneous Provisions) Act 2009).

There is a sub-set of people who find themselves within the Criminal Justice System who require a more targeted housing response. This has been provided by a pilot scheme that has been in operation in the Dublin region since October 2020. Housing for All committed the Housing First National Implementation Plan 2022-2026 to build upon the existing pilot scheme by expanding the scheme nationally. The National Implementation Group will now oversee this expansion of the criminal justice strand of Housing First over the lifetime of the Plan. The new tenancy targets include provision for this sector. Progress and delivery under this strand will be reported on and monitored as a distinct element.

Community:

(i) Memorandum of Understanding:

A memorandum of understanding between the HSE, criminal justice agencies and other key stakeholders such as Local Authorities is required to deliver a partnership approach that creates easy access to case management services that include counselling, key working, outreach, addiction, mental health assessment, homeless placement and housing advice so that mental health difficulties can be treated within social inclusion/primary care and prison settings.

(ii) Integrated Multi-agency Model of Case Management:

The HSE Single Integrated Case Management model, which is being piloted to support people experiencing homelessness in Dublin, should be further expanded to align with case management models in place in both the Probation Service and Irish Prison Service.

(iii) Social Inclusion Case/Key workers :

In keeping with Sláintecare and the Enhanced Community Care Network model, Social Inclusion Case/Key workers should be allocated to each Community Health Network to ensure coordination and access to pathways. Such case managers

should work with the Probation Service, homeless services and others, as required, to support offenders in the community and those before, during and after custody.

(iv) Assertive Outreach Teams:

Such teams should be expanded to make specialist mental health care and housing supports available to people experiencing homelessness, mental illness and severe distress and to divert clients away from entering the criminal justice system.

(v) The potential to establish direct referrals pathways between the Probation Service and CMHSs should be explored, inclusive of screening tools, agreed referral criteria, enhanced bi-lateral liaison and outcome analysis.

Throughcare

(i) Defining the Problem

As was highlighted in the Task Force Interim Report, the Irish Prison Service has a prison population of 4,000 prisoners and released 4,000 prisoners to date in 2021 (end of August) of this population, at any one time. Approximately 250 people are engaged with the NFMHS and approximately 1960, or 49% with the IPS Psychology Service. In relation to throughcare from custody, the Probation Service is managing 1,500 post-release supervision orders in the community. The value of effective pathways for the Probation Service and Irish Prison Service with Primary Care and Mental Health Services is therefore well established.

Of the almost half of the prison population accessing the IPS Psychology Service, the vast majority have significant (including chronic and enduring) mental health difficulties. The ratio of Psychologists: People in custody, at 1:250, remains significantly divergent from the internationally recognised minimum of 1:150 recommended in the 2015 external review of the Service (New Connections: Porporino, 2015). This can adversely impact timely access to the Service – a critical factor in prognosis and recovery. It should be resourced to at least the levels recommended in the "New Connections" review of the Service (Porporino, 2015). This resourcing should include funding a review to make recommendations to enhance recruitment and retention.

The critical issue for prisoners on release from custody is to ensure that their needs are met and there is a seamless provision of necessary supports or interventions. The need for somewhere to sleep/live and the need for continuity of health care provision (mental health, addiction or other) are central to this. In many cases this seamless continuity of care is disrupted by a range of factors, both those personal to the individual or through some form of systems failure (no medical card, lack of address, relapse into addiction, failure to sustain engagement etc.).

In remand prisons there are large numbers of people, generally well-known to local psychiatric service, who have severe mental illnesses, such as schizophrenia and also mild/moderate illnesses such as depression. They are often charged with minor offences and pose risks such as could be managed in local low-secure or general adult approved centres or community services, such as primary care, dual diagnosis or social inclusion. Many (almost 50%) of those with severe and enduring illness are homeless. This can lead to difficulty and delay in re-engaging with local services, particularly when admission beds are needed.

Similarly there are higher rates of severe mental illness among sentenced prison populations than in the general population. Unlike remand settings, by virtue of receiving a custodial sentence this population are more likely to be charged with more serious or violent offences. There is a correlation between the length of sentence and the nature of the criminal offence. Local services may have concerns when such persons are released to the community. Problems are similar to those for remand prisoners, other than having to liaise with the Courts. Barriers to throughcare for more serious offenders with severe and enduring mental illness which are more common in sentenced prisons include the following:

- Lack of statutory arrangements for interagency shared responsibility
- Lack of access to PICU and ICRU beds can be particularly challenging in achieving throughcare for released sentenced prisoners
- Lack of legislative provision for transfer to admission beds in approved centres other than the Central Mental Hospital, upon release from prison.
- Ratios of Psychologist : to Persons in Custody not meeting the minimum level set out in the 2015 service review (New Connections, Porporino, 2015)
- Lack of Community Forensic Mental Health Service provision to support community mental health teams in managing released mentally ill prisoners
- Difficulty in accessing residential rehabilitation placements for released prisoners with dual diagnosis of mental illness and substance use disorders.

Service planning should reflect the fact that males constitute over 95% of the prison population, while the much smaller number of female prisoners have pro-rata greater levels of psychiatric and broader mental health difficulties and more complex needs. As such similar but bespoke trauma informed services are required for women.

Where people with severe and enduring mental illness exhibit behavioural difficulties not directly linked to such illnesses, there is a need for support and supervision from criminal justice agencies such as the Probation Service.

(ii) Considering alignment with existing activity/initiatives

The Task Force Interim Report provided detail of a range of existing high value services of note in this area including:

- The National Forensic Mental Health Service ‘Prison Inreach and Court Liaison Service’ (PICLS) was established at Cloverhill remand prison. This service has addressed healthcare, diversion, housing and other needs of large numbers of mentally ill prisoners annually, using a clearly described and highly effective model. Unfortunately the PICLS model is not currently available in all remand prisons nationally, despite evidence of efficacy since 2006.
- The National Forensic Mental Health Service multidisciplinary ‘Pre-Release Planning Programme’ (PReP) which was established in 2015 to liaise with and complement existing internal and external supports in assisting mentally ill sentenced prisoners in accessing healthcare and other supports in the post release period.
- The HSE and Irish Prison Service arrangements to supply medical cards for prisoners
- The Offender Management Governance and Strategy Group, established by the Department of Justice, to oversee a range of offender ‘pillars’, each of which drives multi-agency offender management activity. The Interim Report referenced the proposed new pillar targeting ‘Life Sentenced Prisoners and Complex Prisoner Releases’. Such a

structure would provide a vehicle to support effective linkages between Justice and HSE services, including primary care and mental health, enabling higher levels of alignment, shared case management and mechanisms to resolve systemic blocks and gaps.

- The NEIC 12 month pilot project to meet the health and social care needs of offenders upon release from prison in which a dedicated case manager is recruited to support recently released prisoners to access medical and social care and to reduce the risks associated with prison release. The focus is on the initial release period (initial four weeks). This team engages and works specifically with recently released prisoners and their families and assist the main streaming of medical and social care for this vulnerable population.

The HSE and NEIC have developed a pilot Community Aftercare Programme in which residents of the NEIC who are leaving prison will be supported to navigate and engage with health services. The programme aims to improve the physical and mental health outcomes of vulnerable adults who reside in the NEIC by bridging the gap between prison and community services. Through goal oriented support, service users will be empowered to advocate for themselves and manage their health and social care needs.

Prior to being released from custody service users will work with a dedicated Care Navigator to complete a focused health and social care needs assessment and develop an individualised care plan. The Care Navigator will meet Service Users at the gate when leaving custody and initiate their care plan. The first stages of support will be intensive but increasingly the Care Navigator will work towards empowering service users to manage their own health care needs and engagement with services. Once the Service User and Care Navigator have completed the post-release care plan a qualified peer Mentor from Care After Prison will continue to work with the service user to continue to support them as needed.

The Community Aftercare Programme will support men and women who have a connection to the NEIC. The programme will start while the service user is in custody and bridge the gap between custody and community support. Based on the individualised care plan, the Care Navigator will establish strong working relationships with existing services in the NEIC and support service users to engage by arranging and attending appointments and advocating on the service user's behalf where necessary. Prior to release from custody the Care Navigator will identify any personal obstacles which have previously prevented someone engaging and include some level of pre-engagement work with them.

The Care Navigator will act as a link between the service user and the services which exist within the prison and community. They will establish strong relationships with existing services to enhance the efficacy of these services by supporting service users who are harder to engage. They will establish a referral system between services within the prison and community services, such as Probation Services, IASIO, Irish Prison Services and Release.

In addition to those listed, the IPS Psychology Service's development of pro-active referral policies for 18-24 year olds and those sentenced to more than two years for violent offending has further enhanced access to that Service. Furthermore a wealth of NGOs provide inreach services to prisoners, each aiming to meet the needs of those engaged with. There is the potential to further consider the coordination of such inreach services at local prison level to maximise outcomes, in a similar manner to the social prescribing model referred to in the Community section of this report..

(iii) Developing proposals

Strengthening and the mainstreaming of the models detailed above will greatly enhance existing Irish Prison Service throughcare processes. This, coupled with the Social Inclusion referenced Case Manager model under Sláintecare Enhanced Community Care Network model will provide a strong structure to enhance outcomes, dependent of course on the availability of those services to the prisoner in the community at the point of release.

In addition:

- Since 2014, PICLS and some of the prison inreach mental health teams have had a Housing Support Worker (Hail Housing) who assists in accessing improved accommodation for homeless mentally ill remand prisoners. This approach should become an integral component of both the PICLS/PREP teams nationwide.
- There is a lack of information on the profile of the mental health/Dual Diagnosis needs of the prison population. The prevalence of autism, intellectual disability and needs relating to addiction are often unmet in the prison system. A collaborative approach is required to design services for individuals with specific needs as provided for in *Sharing the Vision*. There is also a need to improve access to admission facilities for people with dual diagnosis to residential rehabilitation.
- There is a need for the provision of a centralised decision maker to resolve catchment area issues within HSE particularly for homeless mentally ill individuals.
- Finally, there remains the need to develop Community Forensic mental health services to support Community Mental Health teams in managing released mentally ill prisoners.

Recommendations - Throughcare

In addition to those recommendations made in the Courts and Community sections:

(i) Prison Inreach Services:

The National Forensic Mental Health Service 'Prison Inreach and Court Liaison Service' should be expanded to enable its services to be fully provided in all committal prisons

(ii) IPS Psychology Service:

Should be resourced to at least the levels recommended in the "New Connections" review of the Service (Porporino, 2015). This resourcing should include funding a review to make recommendations to enhance recruitment and retention.

(iii) Prison Health Care:

Prison health care services should be resourced to fully replicate the range of services available in the community. Taking account of this report and the Health Needs Assessment report.

(iv) PReP:

The National Forensic Mental Health Service 'Pre-Release Planning Programme' (PReP) should be expanded to have national coverage across the prisons estate.

(v) Case Management:

HSE Social Inclusion Case Managers should begin engagement with prisoners at the earliest point prior to release to ensure continuity of care as the prisoner's release date may be brought forward for a number of reasons resulting in an earlier than anticipated release date.

(vi) Reducing Attrition:

Maintaining engagement and motivation at the point of release - Attrition (drop out) from services is higher for homeless individuals with mental health difficulties who are in contact with Community Mental Health Teams due to this population being highly transient. Attrition would be reduced if all prisoners had a community agreed discharge plan in place with an identified case manager prior to release.

(vii) Research and Data Analytics:

Limited information is collected about the profile of those involved with the criminal justice system. As part of its data holdings, the CSO has access to and use of other administrative datasets such as those of the Department of Employment and Social Protection, Revenue, Education and other agencies and departments. Other information which would be useful in predicting the risk of recidivism include; age at first offence, prior arrests, family status, health status (including mental health and addiction), accommodation status, ethnicity and education level. The addition of these variables could be used to enrich the existing prison and probation datasets to provide a better understanding of the underlying factors that lead offenders to reoffend or conversely, to lead a crime free life.

(viii) Research on the intersection of homelessness and criminality:

Conduct research into the scale of overlap between the homeless and criminal justice sectors to develop a more informed response to the throughcare needs of those existing custody, inclusive of the needs of minority groups, young persons and women.' (DoH, DOJ, IPS, PS.

Appendices :

Appendix I : Inspector of Prisons

Anonymised examples of deaths in prison custody where the deceased suffered from mental illness

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Mr A

Mr A was a dedicated father of two children. He had held a senior position in a business until he was involved in a serious road accident. As a consequences of the accident he became addicted to soft medication and started to suffer chronic depression and had suicidal ideations.

This led to misuse of class A drugs and violent episodes. He was eventually arrested by Gardaí and following a number of incidents he was committed to prison.

Whilst in custody of An Garda Síochána he attempted self-harm by strangulation. On the Irish Prison Service Prisoner Information Management System it showed this man as having had a history of attempting self-harm and was a risk.

On admission to prison he was distressed and the family telephoned the committal prison and informed prison staff of his mental illness. This man was in need of safety and treatment for his mental illness. Unfortunately his condition deteriorated in prison and despite it being agreed that he should not be left alone and he should be placed in a shared cell, this man was left alone in a cell. This man was found by a prison officer with a ligature suspended by his neck within a week of committal.

Despite medical intervention in the prison and on removal to hospital this young man was in his late twenties when he died.

Ms A

Ms A was a mother in her mid-thirties. This lady suffered with mental illness since childhood and had many episodes of self-harm from the age of 12 or 13. Ms A had been treated as both an inpatient and outpatient for schizophrenia including in the months up to her death.

Ms A was arrested for minor public order offences when she was found intoxicated in a public place. An additional offence was added for her conduct in the Garda Station and she was charged to attend court. Ms A failed to appear at court and a warrant was issued for which she was subsequently arrested. Between the time of the alleged offences and the execution of the warrant Ms A had been admitted to a Psychiatric Hospital, was also treated as an outpatient, had Gardaí called to her home by her support worker due to concerns for her mental health and had been rescued from an attempt to take her own life. These circumstances were known to different State agencies.

On appearance at court on foot of the warrant she was given conditional bail requiring that Ms A surrender €100 to the court as recognisance for her re-attendance 5 days later. Unable to secure these funds Ms A was detained in the court cells for transfer to Prison.

Whilst in detention at court cells Ms A self-harmed necessitating hospital treatment including assessment and dressing for her wounds following which she was transported to prison by An Garda Síochána.

On arrival to the prison Ms A intimated in the presence of Gardaí that she would self-harm, the Irish Prison Service personnel present stated that they did not hear these comments.

Ms A was assessed by a prison nurse on the night of her arrival in prison and a doctor the following morning. Ms A informed those assessing her both of her history of self-harm since childhood and her actions whilst in the cells at court. Ms A denied any suicidal ideation and this was accepted. The medical staff recommended that Ms A should not be left alone in a cell and she was initially placed in shared accommodation. Ms A was referred for assessment to the prison in house psychiatric team, but with it being a Friday the earliest this could take place was the following Monday.

Still unable to raise the bail the following day Ms A had to remain in custody until funds were secured or until her case was again before the courts. The other two occupants of her three person cell were moved to the general population of the prison on the Friday afternoon. Within four hours of Ms A being locked back in the cell alone she was found suspended from a ligature. Despite medical intervention by prison medical staff and subsequently hospital staff Ms A died not regain consciousness and died in hospital.

Personnel at her community support service advised the Inspectorate that Ms A should never have been in the criminal justice system as she needed supported for her mental illness and not punishment in prison. This view was echoed by members of An Garda Síochána and the Irish Prison Service personnel.

It is worthy of note the Irish Prison Service Self-harm Assessment and Data Analysis report stated that circa 20 per cent of women committed to prison self-harm, and this percentage increases for those on remand.

Mr B

Mr B was in his fifties when he was committed to prison. He had previous terms of imprisonment. The family representative informed the Inspectorate that Mr B was a very vulnerable person advising that he rapid cycle bi-polar and could be hypomanic or manic. He could behave oddly, do things that would come into his head for no reason such as damaging property, drinking excessively and being disorderly, they stated that there was no rational reasoning to his behaviour.

The Inspectorate was advised that Mr B could go without sleep for days during a hypomanic episode. They stated that his condition was controlled to a certain degree by medication without supervision he, at times, failed to take his medication. The family spent years seeking community support for Mr B. They held the firm view that with his condition Mr B required supported community accommodation when his parents could no longer provide the support and supervision he required for his mental illness. Mr B's family expressed the view that the State failed Mr B, they stated that they spent years pleading for mental health and housing support for Mr B but without success.

They stated that prison was not the place for Mr B. His last committal was during the Covid-19 restrictions which resulted in Mr B being subjected to quarantine on committal, he was locked in his cell for 23 hours a day and advised his family that he was finding the experience extremely difficult from a mental health perspective.

Mr B died alone in a prison cell. The family had not seen Mr B for over 12 months as visits were not permitted during Covid-19 restrictions. They knew from the phone calls that he was finding prison difficult, particularly the long hours of lock back. They are angry with the system and the State's lack of response to provide adequate supports for those suffering from mental health stating that there is still a stigma around mental health in Ireland.

The family and Irish Prison Service personnel are of the view that prison is not an appropriate environment for people who have mental illness who commit offences of a minor nature such as public order offences.

Appendix II : Mental Health Survey and Addiction

Overview

In collaboration with the High-Level Task Force on Mental Health, the Probation Service surveyed Community Based Organisations (CBOs) to ascertain the views of individuals with mental health and addiction issues with experience interacting with the Criminal Justice System and their families. The Mental Health Survey was sent to all the Community Based Organisations funded by the Probation Service to complete in consultation with service users. The Probation Service received twenty-nine responses which are included in *Table 1 (Section 1.* **Community Diversion)** and *Table 2* **(***Section 2.* **Post-release from prison).** The responses incorporated both individual and group submissions that were submitted.

Summary

Section 1. Community Diversion

Twenty-eight responses outlined that mental health or addiction issues had contributed to the participants becoming involved in crime. This was due to several factors, including stress levels, peer group, and lack of appropriate support from DSP (difficulty obtaining habitual residency, thus not entitled to any allowance, etc.). It was mentioned that mental health and addiction go hand in hand, and drug habits can help block out early or adult trauma. Addiction also led to service users getting involved with money lenders and organised criminal gangs to feed their habit.

There was a mixed response in relation to experiences with mental health or addiction services. Several responses indicated that mental health & addiction services received while attending different Probation Service Funded Projects were more suitable. Some respondents indicated negative experiences attending addiction services. It was mentioned that there were not enough drug counsellors in prison. Some service users also found it a long process and had anxiety speaking with professionals.

In response to what help or assistance service users would want for a person today who is experiencing mental health or addiction problems, included

- a safe space to be taken out of their situation (family and community) to give them a chance to develop coping skills,
- early access to treatment.
- one to one addiction supports to start while in prison and continue after release.
- In relation to young persons, the type of safe space was emphasised as being important.

In relation to the experience of Garda/Court diversion scheme, some service users indicated that they had experienced it and that it was positive. The diversionary activities kept them off the streets and night and kept them away from negative peer groups. Other respondents found themselves directed to the court system and felt that it might have been too late for involvement from Garda Youth Diversion.

Section 2. Post-release from prison

There was mixed experience of linking in with medical GPs post release and if it was helpful. Several responses outlined it was generally good while others indicated that there was difficulty finding a GP, getting a medical card with long waiting lists. In addition, it was

difficult to get an appointment with a doctor and no guidance post-release was offered to them. Having good treatment in prison but accessing methadone in the community was also mentioned.

The responses to experiences in getting help to find somewhere to live included difficulty getting housing, sleeping rough after coming out of prison, living at home, delays and no support to organisations that assisted services users in getting housing. Thirteen responses mentioned difficulty getting access to health or accommodation when they were released from prison.

The responses to what worked well included linking to the linkage worker in Probation and also to the Community Based Organisation. In addition, the Enhanced Prisoner Programme, staff who followed up with the service users and sports. In addition homeless services engaging with us in prison and having direct contact with someone working in homeless services in the community on release.

The responses as to how services could be improved, included

- **a need for more understanding of the difficulties after release,**
- **increased access to supports and services that are more streamlined.**
- **supports in place when the person leaves prison (payments set up/medical card, housing list and a GP in place),**
- **obtaining employment, and**
- **Housing support/homeless services meetings before release.**

Section 1. Community Diversion			
Q1.Do you feel mental health or addiction issues contributed to you getting involved with crime? If so, how?	**Q2. If you went for help to mental health or addiction services, what was your experience?**	**Q3. For someone with a mental health or addiction problem, what help/or assistance would you want for that person today?**	**Q4. Have you had any experience of Garda/Court diversion schemes? Do you think that they might have been helpful in your particular circumstances if they were available?**

Yes I do feel that mental health or addiction issues can contribute to young people getting involved with crime. Young people with addiction issues face a higher risk of co-occurring mental health difficulties which in turn can effect behaviours, relationships and increased social problems. Many young people in these circumstances find themselves being isolated by older friends and tend to seek out alternative peer groups. In many cases leading to a negative peer group can influence their decision making etc. leading to crime. Other factors may also include entering into crime as a necessity to feed their addiction issues. Feedback from service indicates that mental health or addiction issues does contribute to getting involved in crime due to some of the following indicated factors: Stress Levels Peer Group Lack of appropriate supports from DSP (as indicated by a service user finding difficulty in obtaining habitual residency, thus not entitled to any allowance etc.).	The experience of mental health or addiction services was quite mixed, some felt being referred to addiction services too early and when not ready has little affect. Some felt that the service where not needs led and not tailored to the individual circumstance of service user (not stage or age appropriate) having a negative effect on engagement. Some service users experience in residential addiction services were quiet negative highlighting that they felt a difference in treatment between those referred by Probation Service to those privately paying for treatment. Some service users indicated that the mental health & addiction service received while attending the Probation Service Funded Project (C a C) was much more suitable as the services came to them and counsellor took the time to develop relationships etc. Addiction services also attend the centre weekly.	A safe environment, where mental health and addiction problems are discussed openly in a non-judgemental manner. An environment where young people can access someone that can advocate for them in a time of need and offer practical solutions and supports to the issues that impact their day to day life. An environment that offers therapeutic and practical supports in relation to addiction and mental health. Young people indicated that the type of space is important - a quiet, comfortable room with options of meditation, and having a friendly person supporting you. Young people in our service have indicated that they get good experience and personal learning from the counselling service offered. "One to one community based support as we receive here". It was highlighted that the type of environment and how it is perceived is crucial for young people - having a sense of welcoming and genuine care in the people meet make a difference on how open young are to engage.	Service users indicated that they had experience, it was available and did help and learnt much from it. The diversionary activities kept them off the streets and night and kept them away from negative peer groups. Others however found themselves directed to the court system and felt that it might have been too late for involvement from Garda Youth Diversion.

Yes	It's not a person centred service. They don't show a lot of compassion. It's a very negative environment. Feels like we're being put into a factory conveyer belt.	Empathy, Compassion. Quality time.	No
Yes had no guidance or anywhere to turn for help	Atrocious absolutely shocking until I found Coolmine	Someone to treat me with compassion and no stigma	Yes
Yes. It alters personality. Substance takes priority in life. Substances helped manage the stress but also certain things you would only do if you were under the influence	When I went to addiction services I did not do it for myself. I did it for court	Someone to remove them from situations- Family/friends/community. Give a person a chance to develop coping skills and give them hope	JLO many years ago. Never robbed a car after this again
Yes. Gambling addiction got me into debt and therefore into crime	I didn't get help. Getting arrested was the motivation to stop	Best thing is awareness. Not much info on gambling addiction-.	No
Yes. Someone close to me passing away and not being able to cope	In recent times I have found that groups help me	Communication- Men were not encouraged to talk about feelings so to see this changed even more	No
Yes, addiction related. I would commit crime feed my addiction	My GP helped with mental health and addiction issues.	More campaigns around the reality of addiction aimed at younger people.	none

Mental Health Yes, addiction started later while in Prison. I came from an abusive family, my dad was physically abusive to us all. I didn't have anyone to talk to about what was going on. I wanted to spend as little time at home and ended up spending more and more time with my friends.	Nothing before prison. Even in prison in took time before I would trust the psychological services. I only looked for help with my addiction towards the end of my time in prison.	These services are already more available these days, but it's not always easy to access the services.	Yes, they may have been helpful. If I was getting support before my offences got serious then maybe I would be on a different path.
Yes, drugs helped me get away from my mind and using drugs caused me to have illegal behaviour	Not everyone understands what it's like	Understanding and real support, not just once per week	I don't know if it helps. It's hard to trust Gardaí
No	Drug counselling in jail yes but there was a big waiting list you have to constantly ask about it.	Everyone should be asked when they come in if they have addiction issues and should be approached by drug counsellors.	Just one JLO officer seen me once and that was it.
Yes robbing to fund a drug habit from a young ages taking drugs and also to gain acceptance.	Not enough drug councillors in jail. The ones that are there are good but there is not enough of them. Big waiting lists also.	Psychiatry help and drug counsellor and therapy. There's more sex offenders getting help from what I've seen that criminal offenders.	No I will be having probation.
Yes, mental health difficulties can leave you vulnerable and addictions issues can lead to crime as it is expensive to have addiction issues.	It is difficult to get wrap around support, services seem to be working independent of each other.	For mental health more day programmes / training supports. For addiction issues residential support.	
Yes committing robberies to fund my habit.	Big waiting lists then you lose interest	More therapy counselling and reduce the waiting lists.	I did but the guard that looked after me hit me

Yes all my sentences are to do with addiction, it was committing crime to fund my drug habit.	I done counselling. I couldn't get support for coming off methadone they put your dose up so the experience wasn't good.	Should be proper medication and more counsellors.	No
Yes. Funding your drug habit.	Not great in prison I feel they take on too many people more councillors needed.	Counselling medical attention and therapy. A 24 hour service available to them where they can go to.	All I have is a probation officer
Yes, looking for drugs committing crime to fund it.	Good experience I've got positive change good foundation to move forward and have my family back in my life. Turn into a positive role model.	Same4 as I got addiction counsellor through jail and support and referrals to go to treatment to get them stable and ready for treatment.	No
Yes, from not talking about issues effecting you and then you use drugs and break the law.	A bit of relief and I felt it helped prevent me from reoffending.	To see a therapist and express issues and problems.	No
Yes. Committing offences to fund drug habit	Long waiting lists.	One to one addiction supports. To start while in prison and continue after release	Don't know what this is
Yes	It helped at the time but relapsed.	advise them to seek help	no

Yes. Because I always needed money to fund my habit.	Not good, takes too long to get an appointment and even longer to actually get to see someone.	Immediate access to the proper care depending on what is needed. Also follow up care is very important.	Yes, Have had good experience of engaging with the Garda Diversion project. They were very helpful in giving me options to and organisations to seek help from.
Having to steal to feed my drug use	Not good with HSE but very good with Cornmarket Project	Easy to access treatment and non-judgemental	I think so
Yes because I couldn't cope in my own head it took me away from myself committing crime.	I went to Coolmine it has shown me how to manage my emotions and thus helped me cope with my addiction.	To admit they need help and getting into treatment and talking about the issues effecting them.	no experience
My Mental health suffered from using drugs. I committed offences due to needing money to buy drugs or I was out of it when I shoplifted.	Addiction services were nice people and tried to put me in the right direction.	I found that it was hard during Covid to talk over the phone as one to one always worked better for me.	N/A
Yes - more drugs using need resources to fund addiction	A lot of services don't really listen and can be long processes	Help early more counselling services	No
Yes and in my area lot of mental health and addiction	Good in end but hard to get seen	more money so more availability of therapists that do talking - was easy get prescriptions hard get therapy and counselling	not in my time

Yes. Mental health and addiction go hand in hand. -The group agree that taking drugs starts off as having fun / buzz with those around you. -Everybody is doing it. -Don't want to be left out. -Then turns to block out things that we have done, people that we have hurt or early child/adult trauma -In turn become addicted. -Individual get involved with money lenders and organised criminal gangs to feed their habit. In turn they end up before the courts.	1. The group would agree that it was difficult to know who to ask for help. 2. Anxiety with speaking to professionals 3. Long waiting lists.	Early intervention by a professional and for that profession to be able to sign posted the individual to the appropriate services.	Yes. Treo Portlairge where we attend has links within the community to support us to engage with appropriate services.
Individual A - Yes, the mental health difficulty encourages the use of drink or drugs for reality escape and then leads to crime. Individual B - Yes. The drugs help ease the mental health difficulties, and then to petty crime.	Individual A - Very good - very positive Individual B - Good and positive	Individual A - A listening ear with no judgement Individual B - Good addiction counsellor	Individual A - No experience of diversion schemes, through personal referral into services. Garda/Court diversion would have been appreciated if offered Individual B - Yes the SWAY project from age 15 - 18. Very helpful

Yes, anti-social behaviours and need funds to access substances	I went to a service that provided dual diagnosis service - excellent addiction counselling in Bushypark helped me to look at my childhood issues	Definitely to speak with an addiction counsellor and to be taken out of my family and community for a month to have a look at myself and for my family to see me in a different way as they learnt a lot also with me being away and they got support too	n/a
If people were not suffering mental health difficulties they wouldn't be involved in crime!!! growing up in poverty causes mental health difficulties, getting involved in alcohol and drugs makes you forget for a while, only when you come round or sober up , you are in more trouble and probably debt as well, vicious circle	Depends on your age, it would seem to be young unexperienced people you see first who don't have a clue what's it like in your shoes, they promise they will help and get this or this, but when it comes to it, it's not available or shut down or you have to wait 6 months or you can't afford it.	Safe space and for a plan to go forward that can actually be followed up	Yes and they are very good at diversion but the underlying issues have to be dealt with before you can appreciate what they are doing

Section 2. Post Release From Prison					
Q1. What was your experience of linking in with medical/GP services before or after you were released?	**Did you find them helpful?**	**Q3. What was your experience in getting help to find somewhere to live?**	**Q4. Were those services (health or accommodation) available immediately on release or were there delays or problems in accessing same?**	**Q5. What worked well?**	**Q6. What could be improved?**
Generally good	Yes	Not good, but understand that housing is a general issue in Ireland at the moment	Yes	Linking to the linkage worker in Probation and also to the Community based organisation who helped me with everything I needed to get done	Access to appropriate accommodation
I have a great GP who is always trying to help me but it's out of his hands when I'm in the mental health service.	My GP is very compassionate and always gives me quality time and attention and does his best to help me with my mental	Fine	No I had to wait very long periods of time to be seen by any professionals and it was very rare that I was given appointments	Still working on it. Haven't found much help	Everything

	health however I do not receive the same quality of care when I am in mental health services				
NA	NA	I moved back to family home	Straight into a job	TR- Got out early as I had a Job offer. Enhanced Prisoner Programme worked really well for me- Away from drugs and gangs was a huge part of changing my life.	Job on release- Routine
Experience has been fine- GP took me on quite easily as I had no health difficulties	Yes	Living back at home	NA	NA	Would be very helpful to have Payments set up/Medical card and housing list when leaving prison
It took quite a while to get a GP, a lot of paperwork difficult to access medical card services	Yes	I am currently living in Emergency accommodation. I have help looking for permanent but I cannot get anywhere I can afford	Delays- I have moved hostels several times.	Key workers in services I linked into. Probation Officer	To have a doctor before you leave, Housing support/homeless services meetings before release.

No issues, I have been with the same doctor for a long time.	Yes	Always had somewhere to live, no issues here. I was homeless during addiction but that was my choice.	N/A	Everything was in place for me already... I did it myself	
Impossible. Could not find a GP and the medical card people are impossible to deal with. 1 year now after release I still don't have a GP or a medical card.	Not at all, in fact the opposite.	I had somewhere to live. No issues.	1 year now after release I still don't have a GP or a medical card.	Nothing. No support really with regards to medical / GP. Don't know about accommodation	That the people in the HSE have more understanding about the difficulties in life after release from prison. That they should be more understanding.
It doesn't always happen, sometimes there is a referral made but no follow up	If you meet them they are nice but there is not usually a follow up to check it went ahead	very difficult, nowhere safe to go when trying not to use drugs but not yet drug free	Very difficult to access and not very safe when accessed	staff who consistently followed up with me to make sure I got help	Safe accommodation is just not a reality and this impacts on everything else badly
Doctor yes	No help at all.	I done that by myself.	No	Drug counsellor helped me get to treatment.	Drug counsellor could improve, welfare could improve and plans been put in place for people being released like careers and education support.
It would have been good I received help through probation and drug counsellor to get to treatment.	Very helpful it can take a while at the start of sentencing but towards the end they were helpful.	I got regestere4d with the council in jail and I'm now in treatment waiting on housing	No delays I came to treatment off a prison van	Getting to treatment went well. You have to follow up yourself. Getting housing going well currently also. There has been improvements in last 10 years.	More probation and more drug counsellors. More staff needed.

experience is fine once released however during the incarceration can be difficult to get the GP appointment	Yes,	Quite difficult to get permanent home.	Homeless supports can be available. However, to get support that doesn't involve some level of drug taking is difficult.	GP service, no longer had to wait for GP to sign off on medical card application	Homeless housing especially for those who are drug / alcohol free
I was released from the gates with money to get home no further support.	No	I had to go through probation to get a place with trail homeless se4rvice.	Yes	I got my own place from it.	Give me people more support before you get released more plans put in place. referrals to treatment etc.
Back to a clinic and back using drugs, revolving door system.	No	no help	No	I received help getting to treatment but that was through the courts.	The whole system welfare more councillors 90 percent of prisoners are addiction so better addiction services.
Not before but after there is an awful lot of running around to do and you lose interest in it quickly.	No	Non existent	non existent	Coming to Coolmine I received help from Eamonn O Regan in Mountjoy.	More services in the prison, welfare, mental and probation. More therapists more medical staff fully qualified in drug addiction.
They always told me false promises saying they would get me treatment. I essentially asserted myself to get in to Coolmine.	No soon as I was finished with probation I had to do it myself. I was 18 months seeing probation.	No help or support I had to do it all myself.	Always delays and problems and you would be lucky to even get them.	The only thing that worked well was that I didn't break my probation.	Rehabilitation and more services for addiction and mental health and help with job and education progress. and family support.
I've seen a GP before and after being to prison and was prescribed anti-depressants.	I did find them helpful towards my mental health.	Very helpful I got linked in with Father McVerry in order to get housing.	No I dint receive any support until I sought help myself.	Sports helped me a lot with regards my mental health and wellbeing.	More counselling in the jail or being offered by probation I think sometimes people need to talk

Very difficult to get the same medication I was on prison outside. Trying to get doctors in prison to forward my medical files over to new GP	Somewhat	Trail supported me I was very thankful	Major delays	Accommodation	Access to supports
both good and supportive	Found them helpful	Does not apply.	Depression help available fairly quickly.	medication worked well	Better access to counselling services.
Always good. Never had a problem.	Yes. They were always able to give me help line numbers and point me in the right direction to access services.	Always found this a very long drawn out procedure. Sometimes accommodation was not acceptable, or too far away.	Always problems in accessing these. Not enough staffing in these departments. Had to wait a while for an appointment.	To keep at them. Regularly contacting them and using other state agencies to plead my case.	A more streamlined approach to accessing these services. Realistic timely appointments and follow up's. Access to information and even a step by step how to access all ones entitlements and benefits.
It was hard to get seen by a GP	Eventually when you get linked in	Very bad I slept rough for a long time after coming back from prison	It was very hard to even get on the list for a flat	Having a place to go to where they could talk on my behalf	Easier ways to get a flat
It is difficult to speak to a doctor in jail and no guidance post release offered to me.	No	No support	NA	NA	Bit of direction in how to become a more productive member of society.

I found almost impossible to get a G.P when I was released from prison as they had all been at capacity. I had to get letters for the HSE showing that I was turned down by three GPs so as they could assign a GP to me.	I did not find some GPs helpful at the time as I feel they did not want to know.	The programme I am attending Stepping out really helped me with getting on the housing list and helped me find suitable accommodation.	I found the housing department impossible to deal with as I became homeless and they kept telling me I could not get a B&B through them.	I found relaying on my course boss and the staff on the course really supported me.	More joined up thinking by agencies in helping a person leaving prison to avail of a GP and housing if required as well as assisting on signing on, I found dealing with INTREO and trying to get money very hard.
			Problems if medical card had expired.		More joined up services rather than disjointed
ok back to own GP from before	Yes	back to family home	Back to home so ok	Support I get now from probation officer and my therapist in Kerry Adolescent Counselling	keep on with therapy for as long as needed
1. Important to have your medical card renewed before you leave prison. 2. If you don't have a valid medical card it can be difficult to access services. 3. A long waiting time to receive your medical card in the post.	Not all of the time.	1. Waiting list to get into the hostel. 2. Have to travel from one side of the county to the other to access services. 3. Lack of services outside of the city. 4. Drug use is high in hostels. 5. Slow process to get	No. 1. Waiting lists 2 Poor communication from the prison back to services in the community. 3. In some prisons homeless services would come into speak to us. Was a different experience	1. Homeless services engaging with us in the prison 2. Having direct contact with someone working in homeless services in the community on release.	1. More homeless services to meet individuals in the prisons. 2. Smaller waiting lists. 3. Easier to access services. 4. More available accommodation. 5. Cheaper rents.

4. Doctors think that we want certain prescriptions because we are addicts. 5. Not believed or listened to by medical professionals 6. Good medical treatment in prison. There can be a gap between coming out of prison on methadone to accessing methadone in the community.		referred into services but once linked in with a service and you engage with them, it starts to speed up.	around the country?		
Individual A - N/A Individual B - N/A	Individual A - N/A Individual B - N/A	Individual A - Not a good experience Individual B - N/A	Individual A - N/A Individual B - N/A	Individual A - U-Cased Individual B - U-Casadh and being kept busy	Individual A - If the staff we meet were more personable and more understanding of our problem. If there were more options other than hostels Individual B - Awareness of the services at my level and more personable staff

Difficult but as part of my assessment at Bushypark I was seen by a Psychiatrist before I went in and every week while I was there. I reduced all the meds I was on and can't believe the difference as was on them for years	n/a	I went home to my family			if I got support in the prison to get counselling - so many of us in there had addiction issues but that wasn't addressed with us at all so you just go out and do the same thing - dealing with real trauma and understanding why I am like I am was vital to help me to change
Just linked in with my own doctor	As helpful (or not) as they were before I went to prison	there is a housing crisis and we are bottom of the list, we were found housing but in centres that are full of people who have addictions so you are moved straight back into that world	Doctor I could see straight away, accommodation took a bit longer so was in hostels one night a t a time		The old fashioned half way house with an on call GP and services available on site. if you have to back to where you came from you just go straight back into what you were doing and that lifestyle

Appendix III : Dillons cross Family Resource Centre presentation to HLTF Plenary

- Every person entering the prison has left behind family and community. Upon completion of their sentence, they will reenter society and reclaim the place they lost.
- Working with persons in custody on issues of mental health and addiction is worthwhile, however, with a strong and stable family/community to return to, the ex-prisoner increases the likelihood of maintaining his recovery.
- Education and continuous support can provide stability for families of prisoners
- Education increases self-confidence and feelings of self-worth, while also offering structure, routine, and purpose.
- Importantly, it can also lead to further/ higher education or employment, which provides stability, inspiring children of these families to do the same.
- Prisoners returning to these families have positive role models and with this mindset will likely continue with their own recovery
- Counteracting social disadvantage and negative experiences with education has proved important for many who have entered the prison system.
- Projects such as the Dillons cross project can put systems in place to support families while loved ones are in prison while also supporting the prisoner post release.

Appendix IV : Bedford Row Family Resource Centre, Limerick presentation to HLTF Plenary

The following was discussed:

- The levels of mental health that their clients experience in prison, such as anxiety and depression.
- How some people may fantasize of having a perfect life upon release and reality is far from their expectations.
- Bi polar, schizophrenia and addiction and when dual diagnosis is an issue, families do not know where to turn as the medical profession can't serve people effectively while they are inactive addiction.

There was a general discussion on how Bedford Row ease the distress of families which led to the importance of the following:

- Inter agency work and how putting a plan in place for an individual can maximise the supports available
- The availability of secure psychiatric care for people in addiction
- Community orders and their success in Scotland. An example given of a client who moved to Scotland and hasn't returned to prison because of his care in the community
- How the medical profession and NGOs such as Bedford Row could work together more effectively

Appendix V : Table of Recommendations

Subgroup number	No.	Recommendation	Lead Department responsible	Agency/Body of Department	Timeframe for achieving ie. Short/medium/long term
1	1.1	Amendment to Adult Caution Scheme	ODPP AGS	AGS Crime Legal	Short Term
1	1.2	Aligning the operation of the Adult Caution Scheme with the prosecutor guidelines	ODPP AGS	AGS Crime Legal	Short Term
1	1.3	Consideration for expanding the offences under the Adult Caution Scheme	ODPP AGS	AGS Crime Legal	Medium -Long term
1	1.4	Use of the Public interest principle from the Prosecutor Guidelines	AGS	AGS	Short Term
1	1.5	Diversionary Elements An Garda Síochána – Knowledge and Awareness of services in the community	AGS	Community Engagement	Short Term
1	1.6	Progressive and Empathic approach by An Garda Síochána	AGS	Community Engagement Garda College	Short-Medium Term

1	1.7	Guidance Definition to be integrated into the relevant policies of An Garda Síochána and agencies with the Criminal Justice family	AGS HSE	AGS Crime Legal Human Rights	Short-Medium Term
1	1.8	Mental Health and Addiction Awareness Training in An Garda Síochána	AGS	Garda College HSE Assist Mental Health Addiction Services	Short-Medium Term
1	1.9	Cross-agency collaboration – CAST Pilot Limerick	AGS HSE	Limerick Division HSE Mid-West	Short-Medium Term
1	1.10	Development of a pilot DBI programme in conjunction with the Limerick CAST project and one other AGS Division/HSE Health area is to provide a framework for improved inter-agency co-ordination, collaboration and co-operation across a wide range of care settings, interventions and community supports	AGS HSE		Short-Medium Term
1	1.11	Develop legislation around Diversion and Mental Health legislation	Department of Health Department of Justice		Long Term

1	1.12	Expand the Health Information Bill to include information sharing with additional state agencies	Department of Health		Medium-Long Term
1	1.13	Expansion of the Spent Convictions Act	Department of Justice		Medium-Long Term
1	1.14	The Probation Act should not be recorded as a conviction or used as a barrier to diversion	Department of Justice	Probation Services	Medium Term
1	1.15	Progressive use of The Probation Act – a catalyst to services and services	Department of Justice	Probation Services	Short-Medium Term
1	1.16	Ensure that problems relating to Data Sharing and Legal issues can be resolved with reference to all relevant proposals and initiatives.	Department of Justice		Medium-Long Term
1	1.17	Ensure Linkage and Collaboration between Diversion Programmes Nationally	Department of Justice Department of Health		Medium Term
1	1.18	The Department of Health and the Department of Justice should agree on appropriate mechanisms to coordinate the work.	Department of Justice Department of Health		Medium-Long Term

1	1.19	Development of Pilot Pre Charge Offender Reparation Referral –RJS (Restorative Justice Service)	AGS Probation Services		Short-Medium Term
1	1.20	Details of all voluntary services recognised by the HSE through Service Level Arrangements (SLA) made available to AGS via mobility devices to enable diversionary practices and signposting	Department of Health	HSE Identify SLAs	Short Term
1.	1.21	Rollout of Dual Diagnosis Services nationally to assist Diversionary Practices	Department of Health HSE	Mental Health Services Addiction Services	Medium-Long Term
1	1.22	Establishment of Criminal Justice Secure email domain between the partner agencies to facilitate diversion and safe sharing of information.	Department of Justice	AGS HSE Probation Tusla	Medium-Long Term

1	1.23	Provision for a Standardised Assessment Form	Department of Health HSE		Short-Medium-Long Term
1	1.24	Provide High Spec Technological upgrades to enable implementation of recommendations.	Department of Justice Department of Health	AGS IT HSE IT	Short-Medium-Long Term
2	2.1	The implementation of the Health Needs Assessment (HNA) recommendations pertaining to the mental health requirements in all prisons should be aligned with the recommendations of the Task Force so that prisoners should have timely access to the full range of specialist forensic mental health services where clinically required.	Department of Justice	IPS	Medium Term
2	2.2	Further research on mental health and addiction be conducted to update information on the prevalence and impact of	Department of Health	CMH/HSE	Medium Term

		mental health difficulties and addiction across the prison estate.			
2	2.3	A single system of governance for forensic mental health services across the prison estate. This should be explored further by the HSE and IPS by means of a formal agreement on the provision of a National Forensic Mental Health Service under the aegis of the CMH in all closed prisons and with the collaboration of community mental health services.	Departments of Health & Justice	HSE with IPS support	Short Term
2	2.4	The Group have agreed with the new CMH Portrane Model of Care as the appropriate clinical pathway to manage patients following admission to the CMH.	Department of Health and HSE	CMH/HSE	Short Term
2	2.5	The Group did not consider that prisons should be designated under the Criminal Law (Insanity) Act 2006 for the purpose of treating prisoners with a mental health difficulty.	Department of Justice	IPS	Short Term
2	2.6	It is recommended to develop a facility that provides a model of care that delivers a supportive environment that “normalises”	Department of Health and HSE	HSE with support IPS	Short Term

		care and recovery for vulnerable individuals who require LTMS. The modelling analysis indicates that these LTMS bed requirements will peak in the early phase of the Portrane development at 42 beds and reduce in subsequent years. Planning for this facility should commence at the earliest opportunity in order to meet the male bed capacity requirements for the new CMH in Portrane.			
2	2.7	Every person with mental health difficulties coming into contact with the forensic system should have access to comprehensive stepped (or tiered) mental health support that is recovery-orientated and based on integrated co-produced recovery care plans supported by advocacy services as required.	Department of Health	HSE with support from IPS	Medium Term
2	2.8	Subject to the work of the NIMC Expert Group which is considering Inpatient bed provision, the development of PICUs is considered as a priority as envisaged by the *Sharing the Vision* policy. In this regard, sufficient Psychiatric Intensive Care Units (PICUs) should be developed with	Department of Health	HSE	Short Term

		appropriate referral and discharge protocols to serve the regions of the country with limited access to this type of service.			
2	2.9	The development of further Intensive Care Rehabilitation Units should be prioritised following successful evaluation of operation of the new ICRU on the Portrane Campus. Work should commence on planning of further ICRUs and a Design Team should be established at the earliest opportunity.	Department of Health	HSE	Short Term
2	2.10	Sources of funding for what would be a resource intensive development for the development of PICUs and on planning further ICRUs would need to be identified and considered.	Department of Health	HSE	Short Term
2	2.11	A small number of Approved Centres should be considered for designation on a regional basis so that care could be provided for patients who have committed a minor offence, require a low level of security and suffer from a severe and enduring mental health condition. The use of these centres should be subject to clear clinical risk	Department of Health	HSE	Short Term

		assessment and security admission criteria as per the Dundrum Toolkit.			
2	2.12	The IPS should establish a Working Group with Terms of Reference to include: - To identify a suitable facility/unit in accordance with the recommendations of the Mental Health Task Force that would provide care and accommodation for prisoners on their transfer back from CMH/FICRU or an Approved Centre in order that they can maintain stability and advance on a pathway to recovery before they return to general population. - To develop appropriate governance arrangements (including clinical admission/discharge criteria) for this facility. - To identify clinical and operational resource requirements.	Department of Justice	IPS with support from CMH/HSE	Short Term

		This work should commence at an early opportunity with a reporting timeframe of circa 9 months or earlier.			
2	2.13	A Pilot Dual Diagnosis programme in a prison should be established at the earliest opportunity. This would provide the basis further learning with the potential for a broader rollout across the prison estate.	Department of Health	HSE with IPS support	Short Term
2	2.14	The provision of a specialist dual diagnosis service supporting prisoners with a mental health condition and substance misuse should be established across the IPS estate.	Department of Health	HSE with IPS support	Medium Term
2	2.15	The IPS should appoint a Mental Health and Addiction Lead to support this work.	Department of Justice	IPS	Short Term
2	2.16	In addition to the above Recommendations consideration should be given to the following legislative amendments: I. Unfitness to Stand Trial II. Not Guilty by Reason of Insanity (section 5)	Department of Justice and Department of Health		Long Term

		III. Diminished Responsibility (section 6) IV. Provision of Hybrid orders V. Provision of community treatment orders (CTO) should be considered VI. Provision of a Statutory Instrument to ensure therapeutic safety in CMH Portrane and other designated centres			
3	3.1	Screening and Assessment: need for a national service to screen and/or assess for mental health difficulties amongst those appearing before the Court.	Department of Health	HSE	Short Term
3	3.2	Care Pathways: clear pathways for access to primary, community and mental health services, between the HSE and criminal justice agencies, are required.	Department of Justice and Department of Health	HSE with The Probation Service and Irish Prison Service	Short Term
3	3.3	Problem Solving Court Framework: should be developed, achieving the aims of a Problem Solving Court (such as the Drugs Court) to enable positive treatment and	Department of Justice and Department of Health	Justice with support from Health	Medium Term

		behavioural outcomes for persons appearing before the Court.			
3	3.4	The Probation Service: should be resourced to recruit staff (psychology or nursing) to enable increased competence at a regional and national level in the assessment of mental health within pre-sanction reports prepared for the Criminal Courts and to support effective offender management.	Department of Justice	Justice and The Probation Service	Short Term
3	3.5	Training: A training needs analysis and related training programme should be actioned for staff across the criminal justice sector to ensure a relevant degree of understanding of mental health, mental illness and the services available to meet the needs of such persons appearing before the Courts.	Department of Justice and Department of Health	HSE with The Probation Service, Irish Prison Service and An Garda Síochána	Short Term
3	3.6	Research: commissioned to: ○ establish the extent of persons with mental health difficulties and addiction issues (dual diagnosis) appearing before the courts and to establish the broader	Department of Justice and Department of Health	Health and Justice	Short-Medium Term

		needs of this cohort (e.g. accommodation, employability etc.).			
3	3.7	Track the outcomes of the implementation of the Task Force's recommendations – with a specific reference on social inclusion/marginalised groups.	Department of Justice and Department of Health	Health and Justice	Short-Medium Term
3	3.8	It is recommended that the Department of Justice, working with relevant stakeholders conduct research to assess the impact of the alternative sanctions available under law, any barriers to their utilisation and any opportunities to improve their uptake and effectiveness. It is further recommended that, where appropriate, the results of this research be utilised to inform a programme of judicial education to ensure that the judiciary are fully supported in the application of such alternatives to imprisonment.	Department of Justice	Probation Service Courts Service	Short-Medium Term
3	3.9	Memorandum of Understanding: required to deliver a partnership approach that creates easy access to case management services that include counselling, key working, outreach, addiction, mental health	Department of Justice and Department of Health	HSE, The Probation Service, Irish Prison Service,	Short-Medium Term

		assessment, homeless placement and housing advice so that mental health difficulties can be treated within social inclusion/primary care and prison settings.		and Local Authorities	
3	3.10	Integrated Multi-agency Model of Case Management: should be further expanded to align with case management models in place in both the Probation Service and Irish Prison Service.	Department of Health	HSE with The Probation Service and Irish Prison Service	Short Term
3	3.11	Social Inclusion Case/Key workers : should be allocated to each Community Health Network to ensure coordination and access to pathways. Such case managers should work with the Probation Service, homeless services and others, as required, to support offenders in the community and those before, during and after custody.	Department of Health	HSE	Short-Medium Term
3	3.12	Assertive Outreach Teams: should be expanded to make specialist mental health care and housing supports available to people experiencing homelessness, mental health difficulties and severe distress and to	Department of Health	HSE	Short Term

		divert clients away from entering the criminal justice system.			
3	3.13	The potential to establish direct referrals pathways between the Probation Service and CMHSs should be explored, inclusive of screening tools, agreed referral criteria, enhanced bi-lateral liaison and outcome analysis.	Department of Justice and Department of Health	HSE and The Probation Service	Short Term
3	3.14	Prison Inreach Services (PICLS): should be expanded to enable its services to be fully provided in all committal prisons.	Department of Health	HSE	Short Term
3	3.15	IPS Psychology Service: should be resourced to at least the levels recommended in the "New Connections" review of the Service (Porporino, 2015).	Department of Justice	Justice with Irish Prison Service	Short Term
3	3.16	Prison Health Care: should be resourced to fully replicate the range of services available in the community.	Department of Justice	Justice with Irish Prison Service	Short-Medium Term
3	3.17	PReP: should be expanded to have national coverage across the prisons estate.	Department of Health	HSE	Short Term

3	3.18	Case Management: HSE Social Inclusion Case Managers should begin engagement with prisoners at the earliest point prior to release to ensure continuity of care as the prisoner's release date may be brought forward for a number of reasons resulting in an earlier than anticipated release date.	Department of Health	HSE	Short-Medium Term
3	3.19	Reducing Attrition: Maintaining engagement and motivation at the point of release. Attrition would be reduced if all prisoners had a community agreed discharge plan in place with an identified case manager prior to release.	Department of Justice and Department of Health	HSE and Irish Prison Service	Short-Medium Term
3	3.20	Research and Data Analytics: As part of its data holdings, the CSO has access to and use of other administrative datasets such as those of the Department of Employment and Social Protection, Revenue, Education and other agencies and departments. Other information which would be useful in predicting the risk of recidivism include; age at first offence, prior arrests, family status, health status (including mental health and	Department of Justice	Justice with CSO	Short-Medium Term

		addiction), accommodation status, ethnicity and education level.			
3	3.21	Research on the intersection between homelessness and criminality Conduct research into the scale of overlap between the homeless and criminal justice sectors to develop a more informed response to the throughcare needs of those existing custody, inclusive of the needs of minority groups, young persons and women.' (DoH, DOJ, IPS, PS	Department of Housing, Local Government and Heritage Department of Justice	Irish Prison Services Probation Services	Short-Medium term

Legislative Changes

A number of proposed changes to legislation relating to the future CMH capacity are recommended to be considered. These proposals are complementary to the other recommendations and considered as a longer term action:

(i)		**Unfitness to Stand Trial** There should be a delay between the making of an order in Court under Section 4(6) Criminal Law (Insanity) Act and the execution of the order for example two weeks. This would allow the National Forensic Mental Health Service or other Designated Centres to ensure that a bed is available. Ideally it would also allow a consultant from the designated centre to carry out a pre-admission assessment and report on this to the court. An alternative is to review section 4 of the Criminal Law (Insanity) Act with a view to assisted decision making. This would ensure compliance with the UN CRPD and would guarantee the right to a fair trial for all.	Department of Justice		Long Term
(ii)		**Not Guilty by Reason of Insanity (section 5, CLIA**) The diagnostic step (requirement of legally defined mental disorder) should be	Department of Justice		Long Term

		preserved however the three part test of insanity should be narrowed as the capacities referred to are not mutually exclusive. The preservation of any one of them should carry with it preserved some degree of responsibility. The complete negation of responsibility leading to a verdict of Not Guilty by Reason of Insanity should have a high threshold. To be found NGRI should require the presence of mental disorder and all three conditional tests. Those meeting a lesser standard should instead be considered under diminished responsibility. In addition, the term "unable to refrain from committing the act" is difficult to interpret clinically and should be abolished.			
(iii)		**Diminished Responsibility (section 6, CLIA)** The Diminished Responsibility defence should be made much more accessible in relation to all indictable offences tried in the Circuit Court. It should never be available for	Department of Justice		Long Term

		offences that are acquisitive or related to fraud or deception.			
(iv)		**Provision of Hybrid orders to be considered** These are available under the Mental Health Act for England and Wales whereby a fixed tariff prison sentence is imposed and part of the tariff can be in a secure psychiatric hospital (designated centre and approved centre) for no longer than is necessary for treatment. The remainder of the sentence would be passed in a custodial setting. That custodial setting might be an ordinary prison, a high security prison or an open prison or probation/parole service in the community. The prison setting should be violence free and drug free as outlined.	Department of Justice		Long Term
(v)		**Provision of community treatment orders (CTO) should be considered** This would enable alternative therapeutic settings to be available for offenders. It would be helpful to involve probation officers in the management of CTOs in a forensic	Department of Justice		Long Term

		context. However, it is noted that the Expert Group Review of the Mental Health Act did not recommend this in the amendments to the Mental Health Act. This was on the basis that involuntary detention was considered as an option of last resort when it was not possible to treat a person in the community and that this approach was consistent with the commitments to UN CRPD. The alternative is provision of CTOs by means of criminal Justice legislation.			
(vi)		**Provision of a Statutory Instrument to ensure therapeutic safety in CMH Portrane and other designated centres** There is a concern regarding the legal basis to inspect CMH as a designated centre and this is under consideration by the Department of Health. The General Scheme of a Bill to amend the Mental Health Act provided for the Minister for Health to make regulations for designated centres and it is intended to retain this provision in the Mental Health Bill.	Department of Justice and Department of Health		Long Term

Glossary of Terms:

ACS: Adult Caution Scheme

ACT: Assertive Community Treatment

AGS: An Garda Síochána

CBO: Community Based Organisation

CHO: Community Health Organisation

CIT: Crisis Intervention Team

CJSM: Criminal Justice Secure Mail

CMH: Central Mental Hospital

CSO: Central Statistics Office

CTO: Community Treatment Order

DBI: Distress Brief Intervention

DSGA: Data Sharing and Governance Act, 2019

ECC: Enhanced Community Care programme

FCAMHS: Forensic Child and Adolescent Mental Health Service

FICU: Forensic Intensive Care Unit

HLTF: High Level Taskforce

HNA: Health Needs Assessment

ICM: Intensive Care Management

ICRU: Intensive Care and Rehabilitative Unit

IDG: Interdepartmental Group

IPS: Irish Prison Service

JARC: Joint Agency Response to Crime

LOS: Length of Stay

LTMS: Long Term Medium Secure

MHC: Mental Health Commission

MOC: Model of Care

MOU: Memorandum of Understanding

NEIC: North Eastern Inner City of Dublin

NFMHS: National Forensic Mental Health Service

NGO: Non Governmental Organisation

NGRI: Not Guilty by Reason of Insanity

NIHC: National Health Information Centre

ODPP: Office of the Director of Public Prosecutions

PICLS: Prison Inreach and Court Liaison Service

PICUs: Psychiatric Intensive Care Units

PReP: Pre-release Planning Programme

RJS: Restorative Justice System

SG: Subgroup

StV: Sharing the Vision

UTP: Unfit to Stand Trial

WOC: Ward of Court