Report of the Group to Review the Structure and Organisation of Prison Health Care Services

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Acknowledgements

We are grateful to all the individuals, groups and organisations who responded to our public invitation to provide views and recommendations.

Members of the Review Group visited all of the prisons and places of detention administered by the Irish Prisons Service and had useful discussions with governors, health care, administrative and custodial staff. We are pleased to be able to record that everywhere and at all levels there was a common desire to provide a completely satisfactory health care service and a readiness to accept change in order to achieve it. We were very much encouraged by that fact.

We wish, in particular, to thank the Prison Authorities of Denmark, Northern Ireland and Scotland, each of which responded readily and, indeed, enthusiastically to our request that they receive delegations of our members to examine the manner in which health care in prisons is delivered in their respective jurisdictions and to discuss common problems. In each case, senior staff at central administration and prison level made themselves available for discussion and volunteered valuable information. We also wish to thank them for their generous hospitality.

Finally, it is a pleasant duty to record our appreciation of and sincere gratitude for the excellent work of our Secretary, Mr Denis Griffin of the Prisons Transition Team. His hard work and excellent judgement made our task very much easier than it might have been. The minutes and records he kept were a model and all arrangements for meetings and travel were made with efficiency and little fuss. His contribution to the preparation of this Report has been invaluable. We recommend that his efforts be recorded and rewarded as being outstanding for an officer of his relatively junior rank.

Recommendations

1. The Group endorses the concept that there should be equivalence of care between the prison population and the general population (Chapter 1.2).

2. The Group recommends that the overall objective should be the creation of a healthy environment in each prison and place of detention (Chapter 2.0).

3. The Group recommends that a multidisciplinary approach should be adopted for the delivery of Prison Health Care Services (Chapter 2.1).

4. The Group recommends that there should be a formal partnership between the Department of Justice, Equality and Law Reform, Irish Prisons Service and the Department of Health and Children and / or the statutory health boards. A working party should be established to examine the specifics of such a partnership (Chapter 2.2).

5. The Group recommends that, in the interests of overall consistency, a clear and defined set of health care standards be introduced (Chapter 2.3).

6. The Group recommends that prisons and places of detention should actively support and participate in achieving the various aims and objectives outlined in the National Health Promotion Strategy and related national policy documents (Chapter 2.4).

7. The Group recommends that in any National Health Strategy proposed by the Department of Health and Children, prisoners should be designated as a special needs group in terms of meeting their health requirements (Chapter 2.4).

8. The Group recommends that arrangements be put in place for the monitoring of the performance of all prison health care staff (Chapter 2.5).

9. The Group recommends co-operation with the health care services by the Psychology Service and the Probation and Welfare Service in the delivery of therapeutic care throughout the prison system (Chapter 2.6).

10. The Group recommends that provision should be made to enable prison health care practitioners to participate in continuing professional development activities (Chapter 2.7).

11. The Group recommends that the present post of Director of Prison Medical Services should be retitled the Director of Prison Health Care Services with the role of this Director being essentially strategic. Appropriate professional and administrative support should

be provided to this post holder. The Director should also be facilitated in engaging in some clinical work to ensure continuing qualification to fill the position (Chapter 3.1 and 3.2).

12. The Group recommends that a condition of any future contracts for prison doctor posts should be that the policy to be pursued in any prison health care area is primarily a matter for the Director of Prison Health Care Services (Chapter 3.2).

13. The Group recommends that the Common Contract for prison doctors should undergo fundamental review (Chapter 4.2).

14. The Group recommends that, in the context of a prisoner's right to see the prison doctor, any new Prison Rules should be drafted to take into account current health care practices and norms (Chapter 4.2).

15. The Group recommends that doctors recruited in the future to work in the prison system should hold appropriate specialist registration (Chapter 4.3).

16. The Group recommends that the Medical Training Schools and the Irish College of General Practitioners should be invited to incorporate a course in prison medicine in their programmes (Chapter 4.3).

17. The Group recommends that consideration should be given to the development and introduction of a Diploma in Prison Medicine (Chapter 4.4).

18. The Group recommends that prison nurses should not have any duties of a custodial or non nursing nature (Chapter 5.3).

19. The Group recommends that a new nursing grade, Nursing Manager, should be established at institutional level (Chapter 5.4).

20. The Group recommends that a special induction course in prison practice should be developed for newly recruited nurses and that the training of nurses should be completely separated from the training of discipline staff (Chapter 5.5).

21. The Group recommends the establishment of a Postgraduate Diploma in Prison Nursing (Chapter 5.5).

22. The Group recommends that the conditions of employment of visiting dentists should be as uniform as possible as well as being subject to ongoing review (Chapter 6.3).

23. The Group recommends that a training programme in special needs dentistry be developed in consultation with the dental profession, the Dental Council and the dental training bodies (Chapter 6.4).

24. The Group recognises that visiting dentists must have the services of appropriately trained auxiliary dental staff including dental nurses and dental hygienists (Chapter 6.5).

25. The Group recommends that adequate pharmacy supervision should be put in place at institutional level. This could be either full time or part time pharmacy input dependent on the size of the institution (Chapter 7.4).

26. The Group recommends that measures should be put in place for the external monitoring of compliance with pharmaceutical regulations (Chapter 7.5).

27. The Group recommends that consideration should be given to the feasibility of community psychiatric teams having direct involvement in the psychiatric care of prisoners* (Chapter 8.3).

28. The Group recommends that, where possible, the preparation of court reports should be on a non custodial basis and that suitable and appropriate resources should be put in place to facilitate this end (Chapter 8.4).

29. The Group recommends that mental health legislation should be introduced in a way that would facilitate diversion of mentally disordered individuals from the criminal justice system to an alternative treatment, supervision and care service (Chapter 8.5).

30. The Group recommends that the Medical Unit in Mountjoy Prison be entirely dedicated for drug treatment related purposes (Chapter 9.1).

31. The Group recommends that, in general, the development of prison psychiatric units and prison hospitals should be avoided* (Chapter 9.2).

32. The Group recommends that appropriate therapeutic units, which could be used to treat prisoners as well as other persons from the community, be made available or established, if necessary, by the statutory health authorities in local psychiatric units* (Chapter 9.2).

33. The Group recommends that as a method of limiting the spread of communicable diseases, disinfectant tablets should be introduced in the Irish prison system without further delay (Chapter 10.2).

34. The Group recommends that a new designated post of Health Care Manager be created at institutional level (Chapter 11.0).

35. The Group recommends that prison health care facilities should mirror equivalent facilities in well run community primary care facilities as much as possible. In the planning of new prisons and the renovation of existing prisons, the needs of health care staff ought to be considered from the first planning stage (Chapter 11.1).

36. The Group recommends that to allow for the more productive use of scarce health care staff time, all appropriate steps be taken to minimise the proportion of time spent by such staff on the preparation and administration of medicines (Chapter 11.2).

37. The Group recommends that in relation to aftercare for prisoners, appropriate arrangements are put in place where possible with community health care resources (Chapter 11.4).

38. The Group recommends that in order to improve the general throughcare / aftercare for prisoners, civilian medical secretaries must be assigned to all institutions as soon as possible (Chapter 11.5).

39. The Group recommends that more structured arrangements are put in place at central level in regard to the granting of access to non governmental organisations seeking to provide therapeutic services in the prison system (Chapter 11.6).

40. The Group recommends that special prisoner groups should receive special attention from health care staff. Women and Juveniles detained in the prison system should be a high priority for any health promotion initiatives (Chapter 12.0, 12.1, 12.2, 12.4).

41. The Group recommends that the use of padded or strip cells for reasons of self protection should be kept to an absolute minimum (Chapter 12.3).

42. The Group recommends that the Prisons Service, Department of Health and Children and local health boards should ensure that proper structures and protocols are in place to ensure a consistent and equivalent approach to the issue of infectious diseases (Chapter 12.5).

43. The Group recommends the creation of an occupational health service designated entirely to the Prisons Service (Chapter 13.0).

*The Department of Health and Children disagreed with the formulation of Recommendations 27, 31 and 32 and proposed the following formulation in place of those Recommendations: — the working party referred to in Recommendation 4 should consider further how psychiatric services can be most effectively and efficiently provided to the prison population and make proposals in that regard to Government.

CHAPTER 1

Introduction

1.0 Establishment of the Group

The Minister for Justice, Equality and Law Reform announced in November, 1999, the establishment of a Group to Review the Structure and Organisation of Prison Health Care Services. The terms of reference of the Group included:

- To consider and make recommendations regarding the structure and organisation of primary medical and nursing services within the prison environment in light of the development of health care services generally and the needs of the prison population.
- To consider and make recommendations regarding the provision of psychiatric services to prisoners (taking into account changes in service provision generally and the potential ramification of possible new mental health legislation).
- To consider the appropriate need and level of in-house provision of specialist medical services and make recommendations accordingly.
- To consider structures for the legal and professionally appropriate control of pharmaceutical products within the prison system.
- To consider the present organisation of prison dental services and make any appropriate recommendations.
- To consult with all relevant professional and representative bodies in this connection.

1.1 Membership of the Group

The membership of the Group was as follows:

Mr John Olden, Member of the Council of Europe Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, and former Secretary of Roinn na Gaeltachta (Chairman);
Mr Jimmy Duggan, Principal Officer, Department of Health and Children;
Dr Enda Dooley, Director of Prison Medical Services;
Governor Edward Whelan, Place of Detention, Wheatfield (replaced Governor John O'Sullivan during the course of the Review);
Dr Ronan Ryder, Nominee of the Irish College of General Practitioners;
Dr Johnston Calvert / Dr Charles Smith, Nominees of the Royal College of Psychiatrists;
Ms Catherine Mc Tiernan, Assistant Director of Nursing, Nominee of An Bord Altranais;
Mr Dermot Mc Dermott, MPSI, Nominee of the Pharmaceutical Society of Ireland (until April, 2001);
Dr Barry Harrington, Nominee of the Irish Dental Association;
Ms Patsy Purtill, Higher Executive Officer, Department of Finance (Observer);
Mr Denis Griffin, Prisons Transition Team (Secretary to the Group).

1.2 Background to the Review of the Structure and Organisation of Prison Health Care Services

This Review has been undertaken in the context of long-term under resourcing of prison health care services. This has led to increasing difficulties in both maintaining the existing levels of service and responding to the increasing expectations of prisoners and other interested parties in regard to the standards and provisions of prisons health care. The Annual Report of the Director of Prison Medical Services for 1998[1] identified a range of urgent health care issues and strongly recommended a comprehensive review of the organisation of prison health care services.

Those services have attracted a considerable amount of attention both within Ireland and internationally and many deficiencies and shortcomings have been recognised. The Whitaker Report in 1985[2] stated that the medical services to prisoners required reorganisation and development and made a number of recommendations in this regard, some of which were implemented. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on a visit to two Irish Prisons in 1998 reported concern at the absence of qualified nursing staff and the number of hours for which prison doctors were present. A report by the Department of Justice in 1994[3] acknowledged that the present organisation and structure of the provision of medical services had failed to keep up with developments in both medical and ethical standards. The Department of Justice, Equality and Law Reform, professional bodies and informed individuals, including those who made submissions to the Group, have stated that a basic principle widely acknowledged is that there should be equivalence of care between the prison population and the general population. It has been repeatedly pointed out moreover that prison populations have a disproportionately large number of persons who have special health needs arising in particular from a high level of psychiatric and drug related problems. A report on the general health of the Irish prisoner population[4] indicated that all the mental health indicators were much worse for prisoners than the general population. The CPT (1998) also noted that in comparison with the general population, there was a high incidence of psychiatric symptoms among prisoners.

It should be noted that the various health care issues and problems referred to above are by no means unique to the Irish prison system. A recent report published by the British Medical Association[5] dealing with the prison system in England and Wales outlines various resource and other difficulties affecting that system. It is apparent from that report that many of the health care issues affecting the Irish prison system are shared by other jurisdictions.

1.3 Consultations

The Group consulted widely in preparing this report. Submissions were invited from all prisoners, relevant staff organisations and professional bodies as well as prison doctors, visiting prison psychiatrists and other relevant bodies. A public advertisement outlining the terms of reference of the Group and inviting submissions from interested parties was published

[1]Annual Report on Medical and Therapeutic Facilities within Prison Establishments 1998.
[2]Report of the Committee of Inquiry into the Penal System (1985) — Ch. 2.24.
[3]The Management of Offenders — A Five Year Plan, Department of Justice (1994) — Ch. 7.4.
[4]General Healthcare Study of the Irish Prisoner Population, National University of Ireland Galway (2000) — Page 5.
[5]Prison medicine: A crisis waiting to break, British Medical Association (2001).

in the national newspapers on 8 February, 2000. Sixty four submissions were received by the Review Group as a result of these invitations.

The Review Group met with representatives of the Department of Health and Children (Mental Health Services) and the Director General of the Irish Prisons Services in December, 2000, on the issue of psychiatric services for prisoners.

Delegations from the Group visited all custodial institutions administered by the Irish Prisons Service during the course of this Review. During these visits, they met and discussed issues pertaining to prisons health care with prison governors, senior prison staff, prison doctors, visiting psychiatrists, prison nurses and medical orderlies. A delegation from the Group travelled to the Scottish Prison Service Headquarters in November, 2000, where meetings were held with senior prisons health care management to ascertain the structures and developments which had taken place in the prison system in Scotland. The delegation also visited the H.M.P. and Young Offenders' Institute at Glenochil to view the health care structures and facilities in place for prisoners detained there. Delegations from the Group also visited the Danish Prison Service and the Northern Ireland Prison Service in February, 2001. The visit to Denmark included discussions with the Director General of the Department of Prisons and Probation, and meetings with relevant officials and health care practitioners in Copenhagen Prisons, Herstedevester Institution and Roskilde Local Prison. The trip to the Northern Ireland Prison Service involved a visit to the health care unit in the main prison there, H.M.P. Maghaberry.

The Review Group did not specifically examine issues such as the provision of chiropody or optometry in the prison system since it understands that these services are generally being provided in a satisfactory manner. It is recommended, however, that these matters should be kept under ongoing review.

CHAPTER 2

General Features

2.0 Overall Objective

The overall objective should be the creation of a healthy environment in each prison and place of detention and consequently the task of the health care services, in the Review Group's opinion, ought to be focused on creating such an environment rather than simply reacting to health problems as they arise.

2.1 Multidisciplinary Approach to Prisons Health Care

The First Report of the Steering Group on Prison Based Drug Treatment Services[6] has recommended a multidisciplinary approach in providing drug treatment services to prisoners. The Review Group endorses those recommendations and believes that this multidisciplinary approach should also be adopted for the wider prison health care setting. The Group noted from their visit to the Scottish Prison Service that a multidisciplinary approach had been established at institutional level and this appeared to be working satisfactorily. Such an approach will require considerable co-ordination at both central and local level.

2.2 Formal Partnership between the Irish Prisons Service and the Statutory Health Bodies

The Group are of the opinion that there should be a formal partnership between the Department of Justice, Equality and Law Reform, the Irish Prisons Service and the Department of Health and Children and / or the statutory health boards. The health boards are responsible for providing health care to the community and the Review Group endorses the view that prison is, in effect, an extension of the community. The Review Group noted that a joint report by the H.M. Prison Service and the National Health Service[7] recommended that a substantial programme of change be initiated in prison health care in England and Wales on the basis of a formal partnership between the H.M. Prison Service and the National Health Service. It is the view of the Group that both the Department of Health and Children and the health boards in Ireland should work in partnership with the Department of Justice, Equality and Law Reform and the Irish Prisons Service in relation to the development and delivery of prisons health care.

The Review Group considers that the establishment of a partnership arrangement, both centrally and at local level, between the Department of Justice, Equality and Law Reform, Irish Prisons Service and the statutory health bodies (Department of Health and Children and/or

[6]First Report of the Steering Group on Prison Based Drug Treatment Services (2000).
[7]The Future Organisation of Prison Health Care — Report by the joint H.M. Prison Service and National Health Service Executive Working Group (March, 1999) — Page i.

the health boards) is essential in order to ensure equivalence of health care between the prisons and the general community. The present situation whereby prison health care is funded and organised separately from general health care in the community has contributed to an inequitable situation. Difficulties have been encountered in attracting and retaining health care staff for both financial and career reasons and this may be due, in part, to the Prisons Service being outside the national health authority structures. More importantly, the constraints on the Prisons Service in the matter of conditions of employment, specifically remuneration, have made health care posts in the Prisons Service less attractive than comparable posts elsewhere. Partnership arrangements in relation to the management and provision of a range of health care services to prisoners should lessen, if not eliminate, discrepancies related to the relative under-resourcing of health care within the prison environment. As a first step, a working party might be established between the Department of Justice, Equality and Law Reform, the Irish Prisons Service and the Department of Health and Children to examine the specifics of such a partnership. The Review Group recognises the strength of the recommendations made by many concerned parties that the prison health services should be taken over completely by the general health services. This is the case in some other European countries such as Norway and is the kind of approach that has been urged by the CPT and others. At the very least there ought to be a formal arrangement between the relevant authorities with a view to ensuring a fully adequate health care service in the prisons. The issue of a formal partnership in regard to the provision of prison psychiatric services to prisoners is dealt with in more detail in Chapter 8.6.

2.3 Formal Prison Health Care Standards

In the interests of overall consistency, a clear and defined set of health care standards is required to guide staff and management and to inform prisoners of their entitlements in regard to health care while in prison. These standards should cover initial committal of a person to prison, transfer to hospital, appropriate throughcare, etc.. The Group noted from the visit to the Scottish Prison Service that health care standards had been set out in a formal document which could be regarded as a guide. Protocols need to be established for all prison health care staff and reviewed as appropriate.

2.4 Integration with National Health Policy

Prisons, and their resident populations, form part of their surrounding community albeit with differences in the age profile and overall health status from the general community norms. In this context, it is considered that overall national health policy should be applicable to prisons and resources should be provided on a partnership basis by both the Departments of Health and Children and Justice, Equality and Law Reform and the Irish Prisons Service and Health Boards to facilitate integration of prison health care on an equivalent basis into the overall framework of national health care policy. Special additional funding should be ring fenced at Department of Finance level for this purpose. Prisons and places of detention should actively support and participate in achieving the various aims and objectives outlined in the National Health Promotion Strategy[8] and related national policy documents dealing with issues such as suicide, alcohol abuse, etc.. In any National Health Strategy proposed by the Department

[8]The National Health Promotion Strategy 2000-2005, Department of Health and Children (2000).

of Health and Children, it is recommended that prisoners should be designated as a special needs group in terms of meeting their health care requirements.

2.5 Monitoring of Prison Health Care Services

There needs to be arrangements for the monitoring of the performance of all health care staff and appropriate arrangements should be put in place in consultation with the professional bodies involved. The proposed Inspector of Prisons should ensure that there is a strong health care presence on his/her team to enable the Inspector to evaluate effectively the total health care provision in each institution visited.

2.6 Co-operation with Other Services

The Group has noted with approval the reports by Review Groups on the Psychology Service[9] and the Probation and Welfare Service[10]. It trusts that these recommendations will be progressively implemented and that both services will be in a position to co-operate with the health care services in the delivery of therapeutic care throughout the prison system.

2.7 Continuing Professional Development

In recent years there has been increasing demands (arising to some degree from public concern regarding issues of ongoing competence) that all medical practitioners undergo periodic revalidation or, at minimum, be able to provide assurance of competence and awareness of new therapeutic developments relevant to individual areas of practice. It is likely that, in the near future, this process of Continuing Professional Development (CPD) will be obligatory not only for doctors but for other health care practitioners (nurses, pharmacists, etc.). To ensure that the Prisons Service continues to attract and retain well trained and motivated health care staff, it will be essential that provision is made in terms of staffing allocations, training budgets, etc., to facilitate participation in ongoing professional development activities.

2.8 Central Management Structure

The Group recommends the establishment of a central management structure to oversee the development of strategy and policy with the overall aim to ensure the provision of a comprehensive health care service. Prisons health care services including policy and development should be led centrally by a Director of Prison Health Care Services. This post is dealt specifically with in Chapter 3. In addition, both a Co-ordinator of Nursing Services (Chapter 5.4) and a Co-ordinator of Pharmacy Services (Chapter 7.4) based at headquarters level with a reporting relationship to the Director of Prison Health Care Services are considered essential by the Group. Adequate administrative support for these professionals, which has been totally lacking, is also considered necessary. The proposal is diagrammatically produced at Figure 1.

[9]Report of the Group Established to Review the Psychology Service of the Department of Justice, Equality and Law Reform (1999).

[10]Reports of the Expert Group on the Probation and Welfare Service (1998 and 1999).

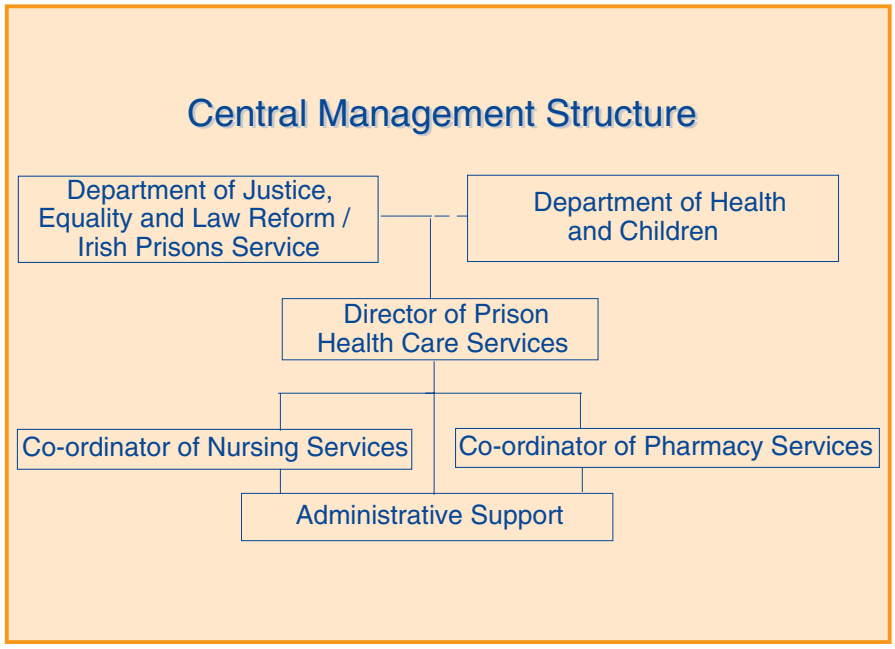
Central Management Structure
Department of Justice, Equality and Law Reform / Irish Prisons Service
Department of Health and Children
Director of Prison Health Care Services
Co-ordinator of Nursing Services
Co-ordinator of Pharmacy Services
Administrative Support

Figure 1

CHAPTER 3

Director of Prison Health Care Services

3.0 Introduction including Historical Background

The post of Director of Prison Medical Services (DPMS) emerged from the recommendations of the Whitaker Report[11]. This need was further emphasised by escalating health related problems which emerged in the prisons during the latter part of the 1980's, particularly those associated with suicide and HIV/AIDS. Two unsuccessful competitions were held in 1986 and 1987 in an attempt to fill the position. A further competition was held in 1990 and it was as a result of this that the present post holder was recruited on an initial two year contract.

3.1 Current Situation

While a very general job specification had been provided (which was basically a re-statement of the broad description outlined in the Whitaker Report)[12], this did not in any way deal with specific matters such as relationships to other disciplines within the prison system and more particularly to the relationship between the Director and the doctors in the various prisons. The failure to do so has led to a situation where some doctors have maintained that they were in no way accountable to the DPMS or that they had never accepted that the holder of the position had any medical management control. This, in turn, placed the DPMS in an invidious position in seeking to respond to demands from within the Department, from prison governors, etc., that medical and therapeutic problems should be resolved since he did not have the authority or resources to do so.

Both the Department and the prisons function on a fairly explicit hierarchical structure with superior grades in clearly defined management relationships with other staff. There is a perception that the DPMS should, similarly, have a defined management relationship with the doctors and other health care staff. Critical comments from various sources (particularly from the Mountjoy Prison Visiting Committee) highlight the problem of having a defined manager who is not in a position to bring about desirable changes.

The role difficulties outlined above typify what could be referred to as a rather complacent attitude to prison health care. The absence of any defined health care management structure had led to a situation where, in the context of rapidly expanding numbers and problems during the 1970s and 80s, any difficulties of staffing, service input, etc., were dealt with on a generally reactive adhoc basis without proper long term planning.

[11]Report of the Committee of Inquiry into the Penal System (1985) — Ch. 7.15-7.21.
[12]Report of the Committee of Inquiry into the Penal System (1985) — Ch. 7.20.

While it has always been accepted that the Director's role would be predominantly administrative, it is becoming increasingly apparent that the continuing registration of health care practitioners, particularly as specialists in any field, is likely to become increasingly dependent on the maintenance of competence in the particular field (see Chapter 2.7).

3.2 Future Role of the Director of Prison Health Care Services

The role of the DPMS should be essentially strategic, i.e. the formulation of prison medical policy, the evaluation of services as well as recommendations for improvement and re-organisation. The lack of any direct support (either administrative or professional) has allowed a situation to develop whereby not only is it necessary to deal with the broad area of health care strategy but also to be involved in day to day operational matters, for example, personally gathering and collating financial information, responding directly to complaints from prisoners, drafting health information leaflets, etc. This involvement means that the DPMS is less able to focus on strategy or to exercise his clinical skills.

As highlighted in Chapter 3.1, any holder of the position in question will have to engage in more direct clinical work (as was, in fact, advised in the Whitaker Report recommendations) to ensure continuing qualification to fill the position. While this aspect is referred to in the present job specification its importance needs to be reinforced. As highlighted in Chapter 2.8 , there is a need for adequate support resources to enable the Director to undertake not only the management aspects of the role but also to facilitate him/her in engaging in appropriate clinical work.

The Group considers that it ought to be a condition of any future contracts for prison doctor posts that the policy to be pursued in any prison health care area will be a matter for the Director of Prison Health Care Services who, of course, would be expected to consult with local practitioners on an ongoing basis.

CHAPTER 4

Primary Care (G.P.) Services

4.0 Introduction

Prison doctors are central to the prison health care area in that they are responsible for the primary medical care of all prisoners. The current providers of this service in the Irish prison system are general practitioners, mostly working on a part time basis. Since late 2000, a full time doctor has been appointed to the new prison at Cloverhill. All prison doctors must be on the General Register of the Medical Council.

4.1 Historical Background including General Features

It would appear that a full-time resident doctor was attached to Mountjoy Prison up to about 1972. It seems that there had been difficulties with pay and conditions for the prison doctor since the mid 1960's. When the full-time doctor retired in 1971/2 it would appear that it was impossible to recruit a satisfactory full-time replacement. An unsatisfactory adhoc arrangement seems to have obtained during the remainder of the 1970's with on-going difficulties in recruiting and retaining doctors.

As prisons were opened throughout the country during the 1970s and 1980s, local doctors were recruited under a variety of employment and remuneration arrangements. The Whitaker Report[13] noted that the Department of Justice had been unhappy with the medical services provided by the part time doctors for some time and that the doctors had been dissatisfied with their conditions of employment. The Report also advised that prisons presented special problems for doctors in providing a satisfactory service. Difficulties encountered by prison doctors which were highlighted by the Whitaker Report included prisoner overcrowding, inadequate surgery accommodation and an excessive prevalence of minor neurotic disorders among prisoners due to the pressures of imprisonment. It also noted that other particular problems for doctors were that they may not have always had the full confidence of the prison authorities and, on the other hand, were seen by prisoners as agents of the authorities.

In an attempt to standardise conditions of employment and resolve the doctors dissatisfaction with their pay and conditions, negotiations were initiated by the Department of Justice in 1992 with the Irish Medical Organisation. The aim of agreeing a common contract of employment for all prison doctors was eventually achieved in 1998 after lengthy negotiations.

[13]Report of the Committee of Inquiry into the Penal System (1985) — Ch 7.16-7.20.

4.2 Current Situation

Prison doctors encounter difficulties of both a professional and organisational nature in carrying out their duties. They have to provide the primary health care services to a population which has a disproportionately higher incidence of mental illness, substance abuse, infectious diseases and social inadequacies than the general community. Necessary security measures within the prisons also impinge on medical consultations with the result that the medical profession runs the risk of being perceived by prisoners as being part of the establishment and not a separate entity that deals with their medical needs. Professional isolation in a culture where custody and security is of prime importance is also a significant problem for prison doctors.

The Common Contract (referred to in Chapter 4.1), while an improvement on the previous arrangements, is regarded by both prison management and the prison doctors as being fundamentally flawed. On the one hand, it is considered to undervalue what is onerous medical work while, at the same time, management perceive that accountability and actual observance of various contractual stipulations remains unsatisfactory.

In a number of locations, a major problem is that a single prison doctor is expected to be available to the prison on a twenty four hour, three hundred and sixty five day basis. This is clearly unrealistic and it would appear that there is a need for structures to facilitate the provision of primary care by group practice or other suitable arrangements.

To ensure the continuance of medical provision to a number of prisons, it was considered necessary to incorporate the concept of 'notional' hours. This was both to take into account work items which were outside the doctor's regular duties such as meetings, reports, etc. and also, to achieve a remuneration figure which would be acceptable to the existing service providers. In theory, actual service input up to the notional maximum could be requested. However, there is no procedure to accurately monitor input.

The net result is that the present contract, while an improvement on the plethora of previous arrangements, cannot be seen as solving the long-term difficulties. It is recommended that in an effort to place the provision of this core aspect of health care on a satisfactory footing which is both accountable and provides a rewarding work experience, the present Common Contract should undergo fundamental review. One suggestion to deal with the twenty four hour commitment would be the establishment of a roster for out of hours cover in the larger prison complexes (Mountjoy, Cloverhill/Wheatfield, Portlaoise/Midlands), for example. If the partnership arrangements proposed in Chapter 2.2 are developed, consideration should be given to including prisons in local community structures for out of hours primary medical cover (GPs).

A number of submissions, particularly from prison doctors, made reference to the existing 1947 Prison Rules in the context of access to a doctor by prisoners. In particular, it was stated that some prisoners made repeated requests (quoting their right under rule 174 (2) of the 1947 Prison Rules) to see the doctor often for trivial or non-medical reasons. This placed significant demands on scarce medical time to the detriment of more pressing clinical issues.

It was felt that with the increasing access to a range of other health care staff, particularly nursing staff, any new Prison Rules should be drafted to take into account current practices and norms. In this context, it was suggested that where a prisoner previously could demand to see the doctor (historically there was no other qualified health resource available within the prison) this should now be amended to state that a prisoner could request to see a member of the health care team (most likely a prison nurse). Many minor issues can be appropriately addressed through this initial interaction to the satisfaction of the prisoner with more significant clinical issues being referred on to the doctor. While this would serve to improve the efficiency of health care provision, good practice would indicate that where a problem remains unresolved ready access should be provided to the prison doctor who has clinical responsibility for the prisoner.

4.3 Recruitment

Prison doctor posts are advertised through the national newspapers as vacancies arise. There have been significant difficulties in recruiting prison doctors in recent years. A number of posts are currently vacant and this situation is likely to worsen in the immediate future. This is probably due in part to the poor image of prison medicine and the prison system as a working environment as well as to the general shortage of doctors in the labour market. Other significant disincentives for potential candidates include remuneration, lack of professional supports and the twenty four hour commitment required. The remuneration on offer, in particular, has been consistently cited as contributing to the failure to attract candidates in recent years.

The Group recommends that in keeping with the principle of equivalence of care, doctors recruited in the future to work in the prison system should hold appropriate specialist registration (MICGP or equivalent and be enrolled on the Medical Council Specialist Register for GPs). Given the particular difficulties faced by prison doctors, it is essential that particular care is taken in the selection of such doctors.

As most doctors, like the majority of the population, have never been in a prison or a place of detention, it is likely that they have an inaccurate impression of the system. The Group considers that the problem could be addressed in a number of ways, for instance, the Medical Training Schools could be invited to incorporate a course in prison medicine in their programmes as could the Irish College of General Practitioners. Prison doctors might be encouraged to make themselves available for courses conducted by the Schools and the College and arrangements could be made for students to undergo part of their training in the prison system.

4.4 Training and Continuing Professional Development

In addition to the training proposed above in order to boost recruitment, it is essential that serving prison doctors receive continuing professional development in order to develop and update their skills. This should improve morale, enhance competence and improve prisoner care. The Review Group understands that the Irish College of General Practitioners is prepared to take a more active role in continuing medical education of prison doctors through meetings and workshops and by the possible development of a Diploma in Prison Medicine.

CHAPTER 5

Nursing Services

5.0 Introduction

Nursing Services are vital in a prison system particularly in the areas of primary health care, mental disorder and health promotion. They form a key element of the professional health care teams working in prisons.

5.1 Historical Background

Until recently, no nurses were employed as such within the prison system. First aid, dispensing of medication, and associated care was provided by medical orderlies who, essentially, were prison officers who had received a six-week first aid course, and paramedical training. It was unarguable that there was a significant qualification and skills deficit between health care staff providing similar services in the general community compared to those in the prison system. With the increasing scrutiny of prison standards together with the development of health and safety legislation (with definitions of required competencies, qualifications, etc., in relation to the provision of various services) it was apparent that any health care services provided within a prison would have to be provided by staff with equivalent qualification and training to those in the general community. In this context, it was considered that existing practice was in possible breach of the Misuse of Drugs Regulations, 1988 and 1993, and the Medicinal Products (Prescription and Control of Supply) Regulations, 1996-2000. Attempts were made to remedy these deficiencies by the recruitment of a prisons pharmacist (see Chapter 7) and by the replacement of medical orderlies with qualified nurses on a phased basis throughout the prison system. Furthermore, controls over the administration of medicines did not meet the professional requirements outlined in the Guidance to Nurses and Midwives on the administration of medicinal preparations published by An Bord Altranais in 1999.

Following negotiation with the Prison Officers Association, it was agreed that nurses should be recruited as prison officer nurses (a Prisons Service grade) rather than as health service staff (on equivalent terms as nurses in the health service). It should be noted that this development was against advice from the Director of Prison Medical Services and prison doctors and the wishes of both the Irish Nurses Organisation and the Psychiatric Nurses Association. This matter was subsequently subject to clarification by the Irish Congress of Trade Unions.

The first nurse officers were introduced into the prison system in March, 1999. By 29 May, 2001, there were 53 serving prison nurse officers.

5.2 Recruitment

Nurse officers are recruited to the Prisons Service by the Civil Service Commission. Candidates must be registered or eligible to be so, on the General or the Psychiatric Register of Nurses maintained by An Bord Altranais and have at least three years post registration experience. Competitive interviews are held and successful interviewees are placed on a panel, from which vacancies are filled. Nurse officers undergo basic prison officer training in the Prison Service Training Centre as well as a short placement in a general hospital before being assigned to an institution. There is currently no promotion outlet for nurses in the Prisons Service.

The possibility of work placements in the prison system for student nurses was considered by the Review Group. The Group considers that the prison environment would provide a unique and valuable training experience for nurses. However, it would be essential that nursing structures be established and the nursing service, which is still in its infancy, be allowed to develop further before any moves are made in this regard.

5.3 Current Situation

The number of nurse officers serving on 29 May, 2001, was as follows:

Institution	Number of Nurse Officers
Mountjoy Prison (Male)	3
Dochas Centre	4
Arbour Hill Prison	1
Castlerea Prison	6
Curragh Place of Detention	6
Cloverhill Prison	14
Midlands Prison	16
St. Patrick's Institution	2
Wheatfield	1
Total	**53**

From a nursing perspective, difficulties encountered in prisons include different value systems, role conflict and professional isolation. The current duties of the nurse officer include not only general nursing and health care duties but may also include duties which are more security orientated and which would generally be carried out by the discipline grades. A significant number of the submissions received by the Group emphasised this point and many commentators have pointed out that foisting a dual role on nurses suggests that nursing is not valued in its own right and could be perceived as a sort of hybrid position.

The practice of nursing is based on a caring philosophy and this remains the same regardless of the context within which it is practised. The Group noted from the visit to Scotland that the Prison Service there had completely separated the role of nurses from those of custodial staff in recent years. During the visit to the Danish Prison System, head prison nurses there argued strongly against any discipline duties for prison nursing staff. The Group recommends that prison nurses should not have any duties of a custodial or non nursing nature but recognises

that they have the same responsibility in regard to security as other prison health care practitioners have.

5.4 Nursing Structure in the Prisons Service

The establishment of a proper reporting and career structure for nurses was a major issue for the Group. While nurses form part of a multidisciplinary team with relationships with other health care professionals, there is still a need for support and clinical supervision within the nursing profession and a number of submissions made this point. To date, the introduction of nurses has been undertaken in the complete absence of any dedicated local or central management structure. With the presence of an increasing number of nursing staff at establishment level, this has led to an inadequate adhoc response to the variety of recruitment, training, industrial relations, and professional issues which are emerging on an increasingly regular basis. The filling of the sanctioned post of Co-ordinator of Nursing Services at headquarters level would appear to be the most appropriate starting point in addressing these requirements and during the course of the Review, the position was in the process of being filled. This post should have overall management responsibility for the growing number of nurses being employed in the Irish prison system. It is envisaged that the Co-ordinator of Prison Nursing Services would, as a manager, report directly to the Director of Prison Health Care Services.

The Group consider that, in addition to the Co-ordinator post, there is a case for other promotional posts, particularly in the larger institutions. A new grade, Nursing Manager, would provide for a clear level of accountability for the performance of nurses and the maintenance of standards of nursing care at local level. It was noted by the Group during the visit to Scotland that the Prison Service there had introduced such a grade for this very reason. The establishment of these posts should act as an incentive to attracting and retaining nurses to prisons work.

5.5 Training and Continuing Professional Development

As mentioned in Chapter 5.2, all nurse officers receive basic training for a number of weeks in the Prison Service Training Centre as well as a short placement in a general hospital before being assigned to an institution. This course covers a number of topics including health care matters (communicable diseases, suicide awareness, drug addiction, etc.) as well as more custodial based subjects (searching, the role of the prison officer and class officer duties).

The Group considers that the training of prison nurses should be completely separated from that of discipline staff. A special induction course in prison practice should be developed for newly recruited prison nurses. Such a course could also be utilised by other health care professionals who are new to the prison system. The precise nature of induction and training for prison nurses should be reviewed. This matter should be a priority for the proposed Co-ordinator of Nursing Services.

It is recognised that prison nurses may have difficulties in the long term in keeping their skills up to date. It is therefore essential that prison nurses are exposed to ongoing professional development to develop their skills base, particularly in dealing with the difficulties they encounter in the prison system. Additionally, they should work with local nursing initiatives to

keep themselves up to date with new developments. The establishment of a Postgraduate Diploma in Prison Nursing with links to a recognised third level institution would be a significant development in meeting the educational needs of prison nurses as well as specialising the role of the prison nurse further. The Group noted that the National Health Service and H.M. Prison Service in England and Wales had recently announced the creation of a National Vocational Qualification (NVQ) in prison health care based on the core skills demanded by prison nursing. Such a programme, which is based on skills in three broad areas — general health nursing, mental health nursing and "jailcraft", could be considered for adaptation for nurses working in the Irish prison system.

5.6 Continuing Involvement of Medical Orderlies in Prisons Health Care

Given the reservoir of experience of medical orderlies and the interest expressed by many of them in continuing to work in the health care area, consideration should be given to an appropriate role for existing medical orderlies in the multidisciplinary provision of health care in the prison system. Such a role could involve them being key workers as proposed in the First Report of the Steering Group on Prison Based Drug Treatment Services.

The Group also noted that there was an agreement in place whereby a number of existing prison staff may, if suitable, be seconded to train as nurses.

CHAPTER 6

Dental Services

6.0 Introduction and General Description of Chapter

It is accepted that a dental service must be made available to prisoners who are a special needs group. This service should be similar to that which would be available to them by the public dental service in the community at large. This service is and should be a basic primary care dental service.

6.1 General Features including Historical Review of Chapter

Until the 1980's dental services in the various prisons were provided on an adhoc basis, usually by local general dental practitioners. Payments were made on a fee per item basis under similar terms to those which were employed under the Department of Social Welfare dental benefits scheme. In that scheme, the contribution normally paid by patients was paid directly by the Prisons Service. With the onset of HIV and associated communicable diseases in the mid 80's problems arose, in Mountjoy Prison in particular. Consequently, the Department of Justice requested the Dublin Dental Hospital to provide a basic dental service to prisoners in the Dublin area. This was initially confined to the Training Unit and Arbour Hill Prison. Subsequently as space and equipment became available, the service was extended to Mountjoy Prison and Wheatfield Place of Detention. From these newly equipped units, services were and still are provided to prisoners in the Dochas Centre and St Patrick's Institution.

Following the reopening of the Curragh as a place of detention, prisoners from there are transferred to Arbour Hill Prison for dental treatment. The fact that the Curragh has a current population of about 100 inmates serving medium to long term sentences would warrant a separate session per week in a dedicated dental surgery in the Place of Detention.

This service in Dublin is a consultant led service where all the personnel are direct employees of the Dublin Dental Hospital at various grades. They provide this service under agreement between the Dublin Dental Hospital and the Department of Justice, Equality and Law Reform. In addition, the consultant supervising the service also has acted as an administrator to the existing service and an advisor to the Prisons Service when requested. In addition, all of the consultants in the various other dental specialities are available to back up the service as part of the service agreement. The level of service provided is similar to that provided by a community health board clinic. The treatment services are provided on a sessional basis. However, the expansion of the prison system recently, in particular the opening of Cloverhill Remand Prison, has placed pressures on the provision of this service with the result that occasional gaps have developed.

The dental service is provided by general dental practitioners in Limerick Prison, Cork Prison, Fort Mitchel, Castlerea Prison, Loughan House and Portlaoise Prison. Dental services for prisoners located in Shanganagh Castle and Shelton Abbey are normally provided by a local dental practitioner in their own practice.

6.2 Recruitment

The recruitment of part-time dentists throughout the country is initiated by placing an advertisement in the national newspapers. Dental practitioners have not been over enthusiastic about volunteering to provide this service. One of the reasons is the inconvenience of relocation to another clinical area during a busy day/week. The lack of back up services is a problem, for example, the supply of, and payment to dental nurses.

Because of the overall shortage of dentists, the possibility of recruiting personnel from the public dental service to provide a similar service for prisons while ideal from a general operational point of view is, in fact, not realistic.

The provision of secondary services such as oral surgery is relatively easy in the Dublin area where prisoners can be transferred to the Mater Hospital under the care of one of the Dublin Dental Hospital's own Maxillo-Facial Consultants. In other parts of the country, oral surgical facilities are only available in the Cork, Limerick and Midlands regions.

6.3 Conditions

The conditions of service in the institutions vary. The dental service provided by the Dental Hospital is on a contract basis. As part of the service contract

- A number of sessions are provided to prisoners
- An emergency service is provided at all times to prisoners
- The full resources of the Dental Hospital including all the other expertise in the various disciplines are available on demand to the consultant led service if required.

The conditions of employment of general dental practitioners around the country are different in relation to tenure and period of contract. Other conditions such as the supply of dental materials to be used in prisons and the employment of a dental nurse vary considerably. The Review Group consider that these employment conditions should be as uniform as possible as well as being subject to ongoing review.

A general problem as far as the dentists are concerned is that the security requirements create difficulties in relation to the flow of patients to and from the surgeries. This results in a situation where the utilisation of the dentists time is inefficient compared to the situation in a community clinic or private practice.

6.4 Training and Continuing Professional Development

There has not been for the general dental practitioner around the country any form of training not to mention on-going training for work in the prisons. However, the Group understands that

the Department of Health and Children has commissioned a review of Secondary Care Dental Service requirements for the country and special needs dentistry is under review. The Department is funding an Academic chair in special care dentistry at Trinity College, Dublin and the Dublin Dental Hospital. The aims of the chair include the development of appropriate training in Special Care Dentistry for dental care professionals providing dental care to special needs groups. In light of this and the fact that the dental service for prisoners is a special needs dentistry service, the Group recommends that a training programme in special needs dentistry be developed in consultation with the dental profession, the Dental Council and the dental training bodies.

6.5 Support Service

A dentist when working in a prison or place of detention ought to have the support of appropriately trained auxiliary dental staff on the basis of the amount of work he or she performs and the recognised best practice. Specifically, the services of dental nurses are indispensable. In addition, the services of a dental hygienist should be available, where justified on the basis of the clinical needs of the particular prisoner group.

CHAPTER 7

Pharmacy Services

7.0 Introduction

The provision and supply of medicines and controlled drugs to prisoners must be under the professional and legal supervision of a registered pharmacist in order to comply with legal and professional requirements. Modern pharmaceutical practice extends far beyond the simple procurement and distribution of medicines and pharmacists can form part of multidisciplinary health care teams both in the community and in prison.

7.1 Historical Background

Medicines are prescribed by prison doctors and are administered either by nurses or medical orderlies. The situation pertaining within the prison system in regard to medicines has been in breach of both legal and professional requirements. A Prison Pharmacist was recruited in 1993 both to monitor the cost effectiveness of drug purchase and to advise on steps to adequately meet legal and professional requirements. Some progress had been made in this respect up to the time the Pharmacist resigned in 1997. Unfortunately, in spite of a number of attempts to recruit, the Pharmacist position remained vacant with the legal and professional deficits outlined above being unresolved. However, during the course of the Review, the position (with an improved salary scale) was in the process of being filled with a Pharmacist taking up duty on 8 May, 2001. There have been no pharmacists employed at local level.

7.2 Recruitment

The vacant post at headquarters level has been advertised in the national press on a number of occasions in the last few years, without success (this situation changed towards the end of the review as highlighted in Chapter 7.1). There appears, like in many health care professions, to be a serious shortage of qualified pharmacists in all areas of practice and this has been the subject of a special report commissioned by the Higher Education Authority.

7.3 Current Situation

In the ongoing absence of any professional pharmacy input, it is long-standing practice that prescribed medicines are ordered from wholesalers or other suppliers and stored under the control of prison medical orderlies. Medicines which have been prescribed by a doctor are dispensed and administered by medical orderlies or, in certain locations, by prison nurse officers. In the absence of any pharmacy control, it would appear that the supply of medicines to the Prisons Service is in contravention of the Medicinal Products (Prescription and Control of Supply) Regulations, 1996 to 2000 and the Misuse of Drugs Regulations 1988 as amended by the Misuse of Drugs Regulations 1993. Serious concerns have been expressed about this

situation by bodies such as the Pharmaceutical Society of Ireland and the Irish Pharmaceutical Union, among others.

Quite apart from the legislative breaches occasioned by inadequate supervision there are serious deficienies in the procurement, storage, handling and supply of medicines within the prison system. The fact that pharmacy services within the prisons are provided by unqualified staff places patients at risk arising from accident or error. Furthermore, inadequate supervision means that access to medicines is not properly controlled and there is a concomitant risk of their diversion via unauthorised routes. Finally, the fact that the prison pharmacies are under the control of custodial staff is unacceptable. In order that prisoners have access to health care services equivalent to those of the general public, it is necessary that a properly supervised, managed and delivered pharmacy service is provided.

7.4 Pharmaceutical Structure in the Prisons Service

The appointment of a Co-ordinator of Pharmacy Services is considered vital for the Prisons Service to ensure compliance with the relevant legislation and professional requirements. This Pharmacist would have executive authority over all the prison pharmacy services and the main role of the post would be to co-ordinate service delivery across the prison system as a whole. The Group noted that the Steering Group on Prison Based Drug Treatment Services[14] made a request that the Department of Finance should review the situation with a view to sanctioning appropriate levels of pay to attract suitable candidates to the post. The Mountjoy Prison Visiting Committee has stated that this post should be filled as a matter of urgency.

The Post of Co-ordinator of Pharmacy Services should have a direct reporting relationship with the Director of Prison Medical Services. In addition to the overall pharmacy control and input at headquarters level, there is an on-going need for adequate pharmacy supervision at establishment level. To a certain degree this input will vary from prison to prison depending on the number of prisoners, level and complexity of prescribing, etc.. In larger complexes (Mountjoy, Wheatfield/Cloverhill, Midlands/Portlaoise) the workload might justify full-time pharmacist input, possibly supervising smaller geographically local prisons on a satellite basis. For other prisons, pharmacist input might be on a part-time basis. The precise organisation of this aspect of the service should be undertaken by the Co-ordinator of Pharmacy Services. The Group noted that in Scotland, the large prison at Barlinnie had a pharmacist on site every day and that other prisons would generally have a pharmacist visiting relating to the size of the prison population.

The possibility of employing pharmaceutical technicians, working under the supervision of a pharmacist, in the larger prison complexes should also be explored.

7.5 External Monitoring of Compliance with Pharmaceutical Regulations

The Group noted that the Pharmaceutical Society of Ireland has, in the general community, a statutory role in enforcing the provisions of these Regulations, and other Acts and Regulations governing the supply of medicines to the public. In the United Kingdom, Inspectors of the

[14]First Report of the Steering Group on Prison Based Drug Services (2000).

Royal Pharmaceutical Society of Great Britain accompany medical inspectors of prisons on their inspection visits. Such a development in Ireland would help to ensure that pharmacy control in the prison system would comply with legal and professional requirements as well as match the pharmacy control in the community and thus ensuring the equivalence of care principle in this regard.

CHAPTER 8

Psychiatric Services

8.0 Introduction

As stated in Chapter 1.2, research has shown that there is a very high incidence of mental health problems among prisoners resulting in major morbidity. These difficulties are further exacerbated by the problem of substance misuse among prisoners. It is clear that for one reason or another, there is a significant and apparently growing number of persons who are not benefiting from the services available to a varying degree under the aegis of the health boards. The Prisons Service believes strongly that this situation has led to a continuing increase in the number of persons with psychiatric problems who end up in prison and, as far as prisons management are concerned, they are a serious management problem. The issue of in-patient psychiatric treatment for prisoners is dealt with in Chapter 9.2. The use of special cells for the containment of disturbed prisoners is addressed in Chapter 12.3 where recommendations are made in regard to the general use of these cells.

8.1 Historical Background

Historically, psychiatric services were concentrated in the main committal prisons. In the Dublin area, a practice has been in place whereby the various prisons are serviced on a sessional basis by non-consultant doctors based at the Central Mental Hospital. In view of their full-time commitment to their health board employment, clinics were often undertaken in the evenings. This was generally unsatisfactory as it required increased staff supervision and limited opportunities for liaison with management and other health care staff. With the increasing turnover and daily population of prisoners together with the increasing numbers of prisons, this adhoc input has been increasingly unsatisfactory in recent years and the maintenance of even an inadequate service has been increasingly problematic.

Following negotiation initiated by the Department of Justice in 1993, an initial consultant psychiatrist position within the Eastern region which would have a specified input to the prisons was created in 1999 and has been in operation since April, 2000. It was intended that this arrangement would both improve the co-ordination of psychiatric input to the prisons involved and place the provision of service on a more satisfactory professional and career basis than had existed heretofore.

Outside the Dublin area, psychiatric services have been provided by local psychiatrists on a sessional basis. In most cases, the doctors involved are either retired or currently employed by a local health board. In recent years, development and expansion of prisons in relatively isolated locations without any significant local pool of scarce health care resources has presented major problems in providing access to specialist services such as psychiatry.

8.2 Current Situation

A study published by the Central Mental Hospital in 1996[15] indicated that ten of two hundred and thirty five prisoners examined had a substantial or disabling psychiatric diagnosis. Staff at the Central Mental Hospital and in the Prisons Service have noted that more mentally ill prisoners are being admitted than previously. A number of submissions from both professional and administrative sources contended that the high levels of mental illness in the prison system are attributable, at least in part, to the policy of treating psychiatric illnesses in the community rather than in the traditional psychiatric hospital. While a majority of patients have been well served by this change, an important minority have been disadvantaged by it. The lack of acute psychiatric beds and facilities for ongoing treatment has resulted in many persons with psychiatric illnesses ending up in the prison system rather than in the mental health system as before. However, both the Inspector of Mental Hospitals and the Department of Health and Children do not accept this view. The Inspector contends that the increases in prisoners suffering from mental illness were not necessarily attributable to the policy of community based care and that many other changes in Irish society over recent years have had a bearing on the issue.

A real problem encountered by visiting prison psychiatrists is that of inappropriate referral. It has been suggested that a large number of prisoners are referred simply for advice in regard to sedation and that no general practitioner would look for specialist help in a similar situation in the community. On the other hand, it seems clear that there a number of prisoners, in particular long term prisoners, who are in need of structured psychiatric / psychological therapy and these persons ought to be of particular concern in the context of the health care structures proposed in this Report.

8.3 Suitability of Prison as a Place of Treatment for Psychiatric Illnesses

While it has been suggested that prison is a suitable location to seek to address a variety of mental health issues affecting those incarcerated, a cursory review of the nature of custody will expose the deficits in such an argument. Modern psychiatric health care is based on the active and co-operative involvement of the various parties involved — patients, families, health care staff, other agencies as appropriate, etc., and is geared towards providing the patient with the greatest degree of autonomy possible, whether in terms of direct treatment or in relation to associated aspects of social functioning. Coercive treatment, particularly under conditions of restricted freedom is avoided if at all possible and only initiated as a measure of last resort for the minimum period necessary. Modern psychiatric care is less and less hospital based and occurs to a greater degree through community based teams providing a variety of medical, nursing, occupational therapy, and related services. Where greater support is required, this is often on the basis of day-hospital attendance rather than full in-patient admission. Treatment is on the basis of a positive, co-operative interaction between the various parties involved.

This scenario contrasts fundamentally with conditions encountered in prison where autonomy and decision making are severely curtailed. Furthermore, the range of facilities outlined above,

[15]Criminal Behaviour and Mental Health (1996).

which are all fundamental to contemporary psychiatric treatment, are lacking in a prison environment. By reason of its coercive nature, the very co-operative ethos which is fundamental to successfully addressing mental health problems on a long-term basis is absent from the prison environment. Notwithstanding the dedicated efforts of various prison based staff, psychiatric treatment provided in a prison environment falls far less than what would, in community terms, be perceived as adequate, not to mind ideal.

Consideration should be given to the feasibility of community psychiatric teams having direct involvement in the psychiatric care of prisoners. This would, of course, also facilitate the admission of prisoners requiring in patient care to local psychiatric facilities, where appropriate. However, the Department of Health and Children favoured the establishment of specific consultant led forensic psychiatric teams with a specialist commitment to prisons. They recommend that this matter should be considered further by the working party referred to in Chapter 2.2 , and that proposals for an effective and efficient psychiatric service for the prison population should be prepared by the working party and submitted to Government as soon as possible.

8.4 Remand for the Preparation of Court Reports

Concern was expressed on a number of occasions by persons interviewed by the Review Group that a significant number of prisoners were remanded in custody (at huge expense) for the sole purpose of having court reports (often psychiatric reports) prepared for the court. The Group understand that, in many cases, remand in custody is precipitated by the inability of an accused to give a fixed address while in other instances it was claimed that remand in custody was an (understandable) attempt on the part of the court to ensure that some treatment was provided, albeit in an inappropriate environment, for a readily evident mental disorder which, for whatever reason, was not being addressed by community mental health services. The Group would suggest that where possible such reports should be prepared on a non-custodial basis and that suitable and appropriate resources should be put in place to facilitate this end.

8.5 Diversion of Persons from the Criminal Justice System

Following on from Chapter 8.4, it is also the opinion of the Group and a number of the visiting prison psychiatrists that a not inconsiderable number of persons committed to prison by the courts could have been diverted to therapeutic facilities if that option was open to the judiciary. The Group consider that mental health legislation should be drafted in a way that would facilitate diversion of mentally disordered individuals (particularly those who are mentally ill) from the criminal justice system, including the courts and the prisons, to an alternative treatment, supervision and care service. It was noted from the visit to the Northern Ireland Prison Service that persons could be diverted to the health services at court stage.

8.6 Formal Partnership between the Irish Prisons Service and the Statutory Health Bodies for the Provision of Prison Psychiatric Services

The Review Group welcomed the recent appointment by the Eastern Regional Health Authority of a consultant forensic psychiatrist with specific sessional allocation to the Dublin

prisons. It was considered that this format of appointment (of health service staff with specific commitment to the Prisons Service) is in line with the general approach suggested in Chapter 2.2 of this report. The Review Group understands that further such appointments are envisaged within the Eastern Regional Health Authority area and that discussion has occurred between the Prisons Service and the Midland Health Board to explore the feasibility of one or more shared psychiatric appointments to provide a service to the prisons in that region. The Review Group would recommend that this type of approach, i.e. partnership between the prison and local community health services, should be pursued in other locations. The overall aim should be to integrate the prisons within their local health care structures and provision rather than treating them as a distinct and separate community.

CHAPTER 9

Secondary Medical Care

9.0 Introduction and General Description

There are no hospital facilities in any Irish Prison. Where a prisoner requires secondary care (surgical, medical, or other specialist) on either an emergency or routine basis, it is practice for the prisoner to be referred to a local appropriate general hospital unit either on an out-patient or in-patient basis. The issue of any necessary or appropriate escort for such prisoners is a matter for local prison management in consultation with the Prison Operations section at headquarters. Any decision to lessen or remove an escort on a prisoner in an outside hospital is usually taken in consultation with the hospital authorities.

To facilitate the efficient control of prisoners who may be referred to external hospitals, it might be appropriate to consider the development (possibly funded by the Prisons Service) of appropriate secure facilities within these hospitals which could be used for prisoners when required. Such facilities (varying from a single room to a small ward unit depending on the average number of prisoners being referred to the particular hospital) should help to lessen the number and cost of prison staff escorts and also facilitate the hospital by minimising any disruption caused by the presence of prisoners and their escorting staff. Furthermore, the management of prisoners in such discrete facilities should help to lessen any stigma attaching to a prisoner through his/her identity as such on a general medical or surgical ward. The general approach throughout Europe in recent times is that prison is not a suitable place for providing secondary medical care. The Group also noted from the visit to the Scottish Prison Service that prison hospital beds had been drastically reduced and it was proposed there to phase them out altogether.

9.1 Medical Unit in Mountjoy Prison

A number of years ago a so called 'Medical' unit was built within Mountjoy Prison. It would appear that this unit was designed to house H.I.V. positive prisoners in more humane (but segregated) conditions than heretofore. In the opinion of the Review Group, the design and structure of this facility is unsuitable for most medical purposes. It would be wrong to perpetrate any impression among external health care staff/resources that there was any form of 'hospital' facility within the prison system. This is patently not the case. The Group understands that in view of the need to improve and re-structure resources devoted to addressing the specific problems of drug misusers within the prison system, consideration is currently being given to concentrating initial resource intensive prison-based drug treatment strategies in this unit. For some time, a detoxification and counselling facility for a small number of appropriate prisoners has functioned on the top floor of the unit. It would appear reasonable to dedicate the whole of this facility for drug treatment related purposes.

9.2 In-patient Psychiatric Treatment

Specialist psychiatric care is provided in all the main prisons on an out-patient sessional basis. Where it is considered that a prisoner requires in-patient psychiatric care it is long-standing practice that arrangements are made for the prisoner to be transferred to the Central Mental Hospital in Dublin for treatment. The Whitaker Report[16] recommended that a small psychiatric unit should be established in Portlaoise Prison to accommodate high security risk prisoners suffering from psychiatric problems. It is understood that this recommendation was taken in an era where subversives prisoners posed very significant problems and in the context that it would be difficult to provide the security required for such prisoners in the Central Mental Hospital given the fact that they were under military as well as civilian guard in Portlaoise Prison. The Group believe that, in general, such in-house units and prison hospitals should be avoided and this view concurs with many of the submissions received. It should be clearly indicated that there is no legal requirement that a prisoner should receive in-patient psychiatric care in the Central Mental Hospital alone. However, partly due to the unwillingness of local health services on the grounds of lack of adequate security, a practice has developed over the last 20-30 years where (unlike the situation applying to medical or surgical needs) prisoners requiring psychiatric care are not treated locally but are transferred to the Central Mental Hospital with significant attendant inconvenience and disruption. There appears to be an automatic assumption that all prisoners suffering from psychiatric illnesses are dangerous. However, from visiting the prisons and discussing the matter with relevant parties, it was clear that this was not the situation in most cases and that the majority of such prisoners only required low to medium security levels. The Review Group consider that the best way forward in this regard is for appropriate therapeutic units, which could be used to treat prisoners as well as other persons from the community, to be made available or established, if necessary, by the statutory health authorities in local psychiatric units. The Group noted that the statutory health authorities in Scotland were building a number of medium secure units for this purpose throughout the country. In their submission to the Group, the Irish College of General Practitioners and the Royal College of Psychiatrists supported this approach. However, the Department of Health and Children and the Inspector of Mental Hospitals do not endorse this approach, favouring instead the further development of consultant led psychiatric teams within the prisons and the establishment of small observation units in prisons for the care of prisoners experiencing short term mental health crises. They consider that the provision of appropriate in-patient psychiatric care for prisoners should be considered further by the working party referred to in Chapter 2.2, which should agree a partnership approach to the development of these services. The Review Group are of the view that the Department of Health and Children and the statutory health authorities must attend to this matter.

[16]Report of the Committee of Inquiry into the Penal System (1985) — Ch 10.8.

CHAPTER 10

Drug Treatment Services

10.0 Introduction

Substance misuse among prisoners has been a significant ongoing problem for the prison authorities over the past twenty years. This problem has been one the main issues highlighted by political commentators in relation to prisons over this time and has portrayed the Irish Prison System in a particularly negative light.

10.1 Historical Background

Drugs first emerged in the Irish prison system in the early 1980's in line with the growth of heroin abuse in the general community. Despite the best efforts of individuals at local level, the first real co-ordinated attempt at drug treatment did not occur until 1996, when a structured programme was introduced where detoxification and counselling were combined together in Mountjoy Prison with the option of a transfer to the Training Unit which had become a drug free institution. However, the lack of resources for the project has meant that this programme has only achieved limited success. In 1999, a draft action plan to deal with substance misuse and drug treatment in the prison system was agreed between the Department of Justice, Equality and Law Reform and the Eastern Health Board. This plan envisaged developments such as drug free areas, the introduction of disinfectant tablets as a harm reduction measure, and the continuation of methadone treatment for prisoners who were already on same in the community, among others. A Steering Group on Prison Based Treatment Services was then established to implement the draft action plan and their First Report was published in July, 2000. The Report has recommended a multidisciplinary approach to drug treatment with substantial Eastern Regional Health Authority input and has outlined the professional resources required to deal with the problem in the institutions most affected. The implementation of the recommendations of the Steering Group's First Report was approved by Government on 18 October, 2000, on the basis that there would be further negotiations involving the Prisons Service, Health Authorities and the Department of Finance.

10.2 Current Situation

Despite the fact that many of the difficulties have still to be resolved, there have been significant developments over the past year or so in relation to the drug problem in prisons. A new drug free wing was opened in St. Patrick's Institution on 22 November, 2000, with places for 76 inmates, and this appears to be working successfully. All prisoners in the new Remand Prison at Cloverhill who have been on a methadone maintenance course in the community are continued on this course. This practice was extended to Mountjoy Prison in October, 2000, for new committals and to those transferring from Cloverhill Prison. However, there are difficulties in placing prisoners on methadone programmes in prison who have not been on

such a programme in the community as there is no guarantee from the Health Authorities that prisoners could be continued on these programmes on their release. The Group noted that the First Report of the Steering Group on Prison Based Drug Treatment Services envisaged that prisoners with a drug dependency could apply for treatment within the prison to be commenced in a similar way as would apply in the community and with similar waiting times applying.

Disinfectant tablets were to be introduced on a trial basis in the Medical Unit of Mountjoy Prison in April, 2000, but this development was suspended due to industrial relations difficulties with the Prison Officers Association. The Group is of the opinion that these should be reintroduced as soon as possible as they are a far less contentious method of limiting the spread of communicable diseases than the introduction of a syringe exchange programme. The Group noted that the use of disinfectant tablets was widespread in the Prison Services in Denmark and Scotland, for example. A report[17] commissioned by the H.M. Prison Service in England and Wales on a disinfecting tablets pilot project recommended that these tablets should be introduced across the prison estate there. Some countries in Europe have gone as far as introducing needle exchange programmes into their prison systems and the effects of these were the subject of presentations and debates at a recent European conference in Hamburg on prison drugs[18]. The introduction of a syringe exchange programme in Irish prisons was considered by the Group but the risk of attacks on staff and prisoners with syringes supplied by the state would appear to be unacceptable. The Group noted from the visits to Scotland, Denmark and Northern Ireland that no needle exchange programmes were in place in the prison systems there.

[17]Public Health Measures : Disinfecting Tablets Pilot Project 1998 — An Evaluation by the Health Promotion Research Unit, London School of Hygiene and Tropical Medicine.

[18]Encouraging Health Promotion for Drug Users within the Criminal Justice System Conference incorporating the 4th European Conference of Drug and HIV / AIDS Services in Prison.

CHAPTER 11

General Health Care at Institutional Level

11.0 Health Care Manager

Within all prisons, but particularly in the larger prisons which may have inputs from a variety of health staff both internal and external, there is a need for a designated Health Care Manager (HCM). This role should essentially be a management and co-ordination role involving both clinical and senior management oversight. It is not specific to any designated professional or management group though, in practice, it is likely to be filled by a senior nurse with appropriate management experience. The remit would be to co-ordinate and ensure the local effectiveness of the various clinical service provisions within the prison. In addition, the HCM would represent the views of health care staff on various local groups (Suicide Review, Communicable Disease, etc.) under the aegis of the local governor. It might well be the case that for various purposes a designated HCM might assume various responsibilities in relation to smaller (satellite) prison establishments in addition to the core prison. The Group noted from the trip to the H.M.P. and Young Offenders' Institute at Glenochil, Scotland, that a dedicated Health Care Manager who carried out these duties was assigned to the health care unit there and this arrangement appeared to work very successfully.

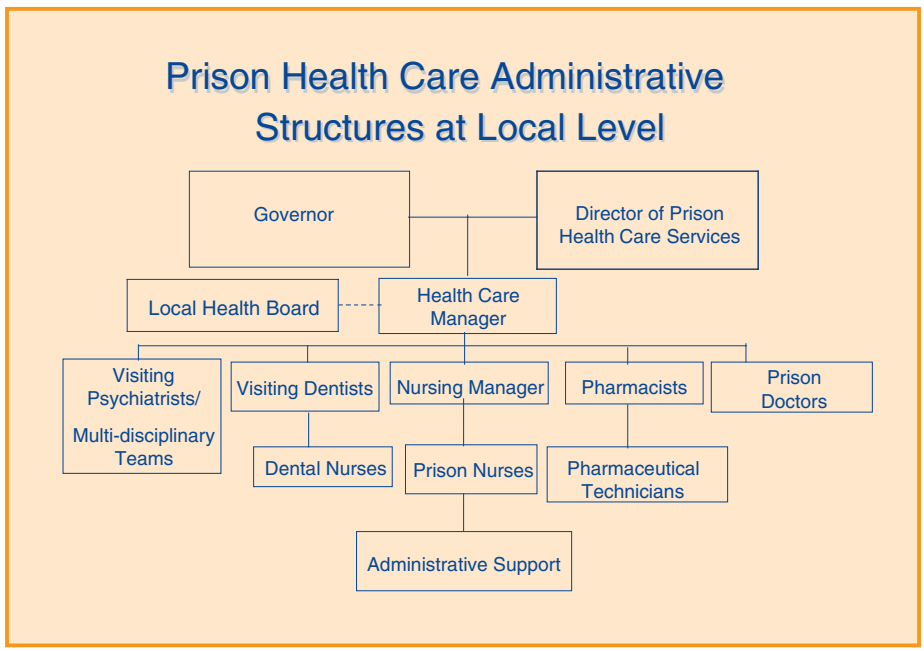

Figure 2

11.1 Structural Issues

In order to facilitate the provision of adequate levels of health care it is essential that the physical facilities available be adequate. Ideally, in terms of space available, standards of decor, medical equipment, etc., they should mirror equivalent facilities in a well run community primary care facility. While a number of locations, particularly those newly built or renovated, meet this expectation elsewhere the facilities available to health care staff are deficient in terms of space, privacy, equipment, etc.. In certain prisons such as Arbour Hill, Cork, Limerick and Loughan House, the surgeries are located in areas which did not allow for easy access and would present problems for persons with limited mobility. Some of the surgeries such as those in the Curragh and Shanganagh are very limited in terms of space and this poses problems for health care staff in providing an appropriate standard of health care. The existence of such inadequacies would tend to foster the impression that health care is considered of low priority within the prison environment and this is all the more serious given the prevalence of health care problems among the Irish prisoner population as identified in a recent report[19]. In the planning of new prisons and the renovation of existing prisons, the needs of health care staff ought to be considered from the first planning stage which has not been the case heretofore. The requirements of older (see Chapter 12.2) and disabled prisoners should also be given some consideration in any such developments.

Bearing in mind the detrimental effect on health of direct or indirect exposure to smoking and the increasing requirement that public buildings should not permit cigarette smoking on the premises except in designated areas, consideration needs to be given to providing adequate smoke-free facilities within any new prisons and taking this need into account in the renovation of existing facilities. In addition to structural provision, resources need to be devoted to health education in relation to the detrimental effects of smoking.

11.2 Efficiency of Medicine Administration

While concerns have been expressed elsewhere in this report regarding the adequacy of professional control over the purchase, dispensing, and administration of prescribed medicines, it would appear that, historically, a significant proportion of the work time of medical orderlies (and more recently, nurses) has been taken up with the preparation and administration of medicines to prisoners. To allow for the more productive use of scarce health care staff time, all possible steps should be taken to minimise the proportion of time spent in this task, possibly by rationalising the number of administration times during the day and, furthermore, consideration ought to be given in certain locations to putting in place structures which would allow prisoners to safely keep custody of their medication (as they would in the general community). Given the range of identified health care problems among the prisoner population, it would appear evident that a more constructive and rewarding use of staff time would be in the area of positive health promotion rather than spending considerable amounts of time on the preparation and administration of medication on a reactive basis.

11.3 Confidentiality / Information Technology (IT)

Prisoners are no different to any other patients in that they are entitled to have personal medical information safeguarded with the same degree of confidentiality as any other patient.

[19]General Healthcare Study of the Irish Prisoner Population, National University of Ireland Galway (2000).

In this regard, the professional responsibilities of doctors and other designated health care staff are no different to what obtains elsewhere. Unfortunately, whether justified or not, prisoners do not generally have confidence in prison health care services in this regard.

The introduction of an IT based prisoner health care record system, planned for the summer of 2001, ought to significantly improve the privacy and confidentiality of prison medical records. Access to health care records will be limited by system security to authorised users and any one accessing the system will be identifiable. Like all such systems, the successful implementation of this record system will require the active support and participation of doctors and other prison health care staff in all locations.

11.4 Co-ordination of Aftercare

Where possible prison health care services should seek to ensure appropriate arrangements are made to ensure that, following release, necessary follow-up arrangements are in place with community health care resources. This may vary from providing a discharge summary to a nominated G.P. to arranging relevant specialist follow-up where this is required. It should be the responsibility of the proposed Health Care Managers (Chapter 11.0) to ensure, as far as possible, these arrangements with particular regard to those suffering from mental illnesses. It should be borne in mind, however, that the consent of a prisoner should be sought for any such arrangement and, furthermore, steps should be taken to avoid unnecessary identification of prisoner status, particularly following release.

11.5 Administrative Support

One issue the Group identified during the course of the Review, particularly from visiting the custodial institutions, was the need to assign dedicated clerical assistance to support the health care services in the prisons. In some instances, Prisons Service Clerks were undertaking duties in regard to health care which were more appropriate to that of a medical secretary. The Group noted from the visit to the H.M.P. / Young Offender's Institute in Glenochil, Scotland, that a full time, civilian, medical secretary was assigned to the health care unit there and this arrangement appeared to be working very satisfactorily. The recent report on drug treatment services[20] recommended that a number of medical secretaries be recruited to institutions in Dublin to help co-ordinate the drug treatment services. The Group concur with this recommendation and are of the opinion that in order to improve the general throughcare / aftercare for prisoners (Chapter 11.4), civilian medical secretaries must be assigned to all institutions as soon as possible. Given the need to safeguard medical confidentiality, it is essential that these staff be clearly identified as members of the health care team. It was felt that this end would be achieved if they were identified by prisoners as being separate and independent from custodial prison staff. These staff who could be employed on a full time or part time basis, depending on the size of the institution, should have a reporting relationship with the Health Care Manager in the institution. In the larger institutions, it is likely that there will be a requirement for more than one full time medical secretary.

[20]First Report of the Steering Group on Prison Based Drug Treatment Services (2000).

11.6 Visits by Non Statutory Bodies to the Prison System

Many non governmental organisations have, on a voluntary basis, provided a welcome and consistent service to the prison system over the years. There does, however, appear to be an increase in recent times in the number and diversity of groups who wish to offer various therapeutic services to prisoners, particularly in relation to counselling. While many of these Groups have the best of intentions, concern has been expressed about the inability of the prison authorities to audit the services provided as well as the level of qualifications of their members who visit prisoners, particularly in regard to counselling services. There also appears to be a general lack of central control and policy over the granting of access to these groups with such decisions often being taken locally. In order that the welfare of prisoners is protected fully, the Review Group are of the opinion that more structured arrangements need to be put in place at central level for the granting of access to such organisations to the prison system.

CHAPTER 12

Health Care Needs of Special Prisoner Groups

12.0 Women Prisoners

At any one time there are up to 100 women detained in Irish Prisons. This comprises approximately 3% of the prison population and this proportion is similar to that in various comparable European jurisdictions. The majority of women prisoners are located in the Dochas Centre at Mountjoy while a small number (mainly from the Munster area) are housed in Limerick Prison.

While female prisoners are a small minority of the total prison population, they present a variety of health care issues which are disproportionate to the actual number of prisoners. In particular, there is a very high prevalence of both substance abuse (with the associated health issues) and mental health problems among this group. In comparison to the male prisoner population, they present as an even more deprived and marginalised group and this, in turn, presents an increased demand on health care services. In general, the overall health care requirements of women prisoners exceeds that of a comparable male group by a factor of two to three.

In regard to obstetric needs which arise occasionally, there has been a long-standing relationship between the Dochas Centre and one of the main maternity hospitals in the city for the provision of necessary ante-natal and/or post-natal care. Any pregnant prisoner who goes into labour is transferred to this hospital for delivery and no child born to an imprisoned mother has any reference to prison in his/her birth certificate, etc.. The Group considers it desirable that a prison nurse with midwifery qualifications is assigned to each of the female prisons. Consideration should also be given to the introduction of formal guidelines for the care of pregnant prisoners with a Royal College of Midwives document on the subject[21] being suggested as a possible template.

The Group noted that phase one of the National Cervical Screening Programme commenced in the Mid Western Health Board area in October, 2000, and a decision whether to extend this programme to the rest of the country is being considered by the Department of Health and Children at present. It is important that any arrangements to introduce cervical (or breast) screening into the female prisons should link in with the national programme to ensure equivalence of care.

In view of the overall poor health of this population, it is considered that the female prison population should be a high priority for any health promotion initiatives developed within the

[21]Caring for Pregnant Prisoners — Position Paper Number 8, The Royal College of Midwives, London (March, 1996).

prisons. In particular, smoking and substance abuse are particularly prevalent problems within this group. In conjunction with other health promotion activities, consideration should also be given to providing courses in parenting skills to both male and female parents of small children. In addition to general matters, such courses might focus on the emotional and material effects on small children of the imprisonment of a parent and so seek to lessen these detrimental effects.

12.1 Juvenile Inmates / Prisoners

While pending legislative changes may alter the minimum age at which some one may be incarcerated in prison, the situation to date has been that people as young as 15 years old have been placed in prison. It has been practice to regard the 16-21 year age cohort as 'juvenile' and certain prison establishments (St. Patrick's Institution and Shanganagh Castle) are specifically designated to deal with this age group. In general, the physical health of this group is good though in view of the high prevalence of substance abuse and associated health issues, adequate and appropriate resources (given the age group involved) are required to address these specific problems within the prison system. It would appear reasonable to target this group for health education and health promotion initiatives given that unhealthy lifestyle behaviours have had less time to become entrenched. Juveniles detained in the Prison System should also be a high priority for immunisation programmes such as Menigococcal C which is aimed at this age group in the general community.

12.2 Older Prisoners

Traditionally, it has been a rarity for the prison system to contain older prisoners in any significant numbers. In recent years, however, there has been a marked increase in the number of older people being sentenced by the courts. In particular, this applies in the area of sex offences (specifically child abuse) where, in recent years, a number of older offenders have received sentences running to years. Because of the nature of the offences, these prisoners have tended to be concentrated in certain establishments. For the first time, the prison health care system is having to respond to the health needs of an older population. As in the general community, this population requires significant health care input both at a primary care and secondary (hospital) level. It is recommended that in those establishments containing significant numbers of older prisoners, consideration should be given to augmenting the health care team to ensure that the health needs of this group are adequately addressed.

12.3 Use of Padded and Strip Cells in the Prison System

A report published on 19 April, 2001 by the Irish Penal Reform Trust on the Solitary Confinement of Mentally Ill Prisoners[22] was brought to the attention of the Group during the course of the Review. While the Group did not necessarily endorse everything in this report, it confirmed the view held by the Review Group and which is widely accepted internationally, that solitary confinement, particularly with sensory deprivation, can be harmful even for short periods.

[22]Irish Penal Reform Trust Ltd: *Out of Mind, Out of Sight* — Solitary Confinement of Mentally Ill Prisoners (2001).

The Group takes note of the guidelines on seclusion and restraint in a policy document by the Department of Health and Children[23] and considers that, if practical, the practice in relation to disturbed persons in the prison system in this regard should be aligned with the policy enshrined in this document.

The Department of Health and Children considers that in the longer term, padded and strip cells should be replaced by observation wards for prisoners experiencing short term mental crises. But as will be seen from Chapter 9.2, the Review Group generally consider that these should be avoided.

The Group considers that the use of padded cells or strip cells, for reasons of self protection, should be kept to an absolute minimum and thus that the duration of confinement in such a facility should not exceed twenty fours hours, the aim being to keep to a period considerably shorter than this. This approach would necessitate the availability of appropriate and adequate medical attention and in many cases, the transfer of prisoners to a therapeutic environment outside the prison system.

12.4 Traveller and Non-National Prisoners

While comprising only a tiny minority of the national population it has been an unfortunate fact that members of the travelling community have been disproportionately represented among the prison population. As well as the normal range of physical health problems associated with a variety of social deprivations, members of this community cope poorly with the stresses associated with close confinement. To some degree attempts have been made to alleviate this distress by facilitating members of the travelling community in sharing cell accommodation, where possible. Given the nomadic existence of this group, a primary aim of prison health care should be to seek to remedy existing health deficits and, if possible, to link members of this group with health care structures in the general community.

Historically, the prison system contained almost uniquely Irish nationals with occasional small numbers of other (generally English speaking) nationalities. In recent years, however, the increased number of non-national (often non-English speaking) people entering the country has brought about an increase in the number of such individuals entering the prison system. While the number may not be great, the problem posed by difficulties in communication, lack of access to past medical information, etc., in individual situations presents a significant burden on existing health care resources. These potential demands need to be taken into consideration in any assessment of the health care requirements of individual institutions.

12.5 Infectious Diseases

Given the fact that prisons are recognised as a conduit for the spread of various infectious diseases, it is important that existing policy aimed at detecting and limiting disease spread be reinforced. In particular, it is recommended that the Prisons Service, Department of Health and Children, and local health boards ensure that proper structures and protocols are in place

[23]Guidelines on Good Practice and Quality Assurance in Mental Health Services, Department of Health and Children — Chapter 4.6 (Seclusion and Restraint).

to ensure an equivalent and consistent approach towards the diagnosis, treatment, and, in particular, curtailing any possible spread of such conditions both within densely populated, high turnover prison establishments and from prison to the general community.

CHAPTER 13

Occupational Health Service for Prison Staff

13.0 General Background

While not actually part of the terms of reference of the Review, the Group considered that as the health of prison staff was of equal importance to the health of prisoners, it should be commented on briefly. It has been long recognised that law enforcement is a very stressful occupation and the Prisons Service is no different in this respect. The high level of absenteeism in the Prisons Service has been highlighted over recent times, particularly in relation to issues such as overtime. At present, the Chief Medical Officer for the Civil Service administers the occupational health service for prison staff. This situation, despite the best efforts of the Chief Medical Officer, is not satisfactory from both the point of view of management and staff. Given the fact that there is almost three thousand staff working in the prison system and taking into account the unique environment, it would appear that the creation of an occupational health service designated entirely to the Prisons Service would be an appropriate development.

13.1 Structure for Occupational Health Service for Prison Staff

A possible staffing structure for such a Service would be an occupational health physician who would fulfil a role similar to Director of Medical Services in the Garda Síochána, as well as an occupational health nurse and an administrative assistant.

Figure 3

APPENDIX 1

Current Health Care Services in Each Institution

Details of each of the institutions (including the health care resources) currently (as at 23 April, 2001) administered by the Irish Prisons Service is as follows:

Institution	General Practitioners	Nurse Officers	Medical Orderlies	Psychiatry	Dental
Mountjoy Committal Prison for male prisoners. Aged 17 years and over. North Circular Road, Dublin 7. Capacity = 602	four (all part time)		six to eight (by day) three (by night)	four and a half sessions per week	five sessions per week
Mountjoy Womens Prison for female prisoners. Aged 17 years and over. North Circular Rd, Dublin 7. Capacity = 70	one (part time)	two (by day) one (by night)		two and a half sessions per week	one session per week
Limerick Committal Prison for male and female prisoners. Aged 17 years and over. Mulgrave St, Limerick. Capacity = 200 (male) and 12 (female)	one (part time)		two (by day) one (by night)	one session per week	one session per week
Cork Committal Prison for male prisoners. Aged 17 years and over. Rathmore Rd, Cork. Capacity = 270	one (part time)		two (by day) one (by night)	three sessions per week	one session per week
Arbour Hill Prison for male prisoners. Aged 17 years and over. Arbour Hill, Dublin 7. Capacity = 139	one (part time)		two (by day) one (by night)	one session per week	one session per week
Portlaoise Committal Prison for male prisoners. Aged 17 years and over, including the detention of high security prisoners. Portlaoise, Co. Laois. Capacity = 203	one (part time)		two (by day) one (by night)	one session per week	one session per week
Training Unit. A semi-open centre for the detention of male adults. Aged 18 years and over. Glengarriff Parade, Dublin 7, for industrial training. Capacity = 94	two (part time shared)		one (by day) night cover provided by Mountjoy	no direct cover at present	two sessions per week
Shelton Abbey. An open centre for male adults. Aged 19 years and over. Arklow, Co. Wicklow. Capacity = 30	one (part time)		one (from 8am to 5pm)	no regular service	inmates attend local dentist as required

Institution	General Practitioners	Nurse Officers	Medical Orderlies	Psychiatry	Dental
St Patrick's Institution. A place of detention for male juveniles. Aged 16 to 21 years. North Circular Rd, Dublin 7. Capacity = 239	one (part time)		three (by day) one (by night)	three sessions per week	two sessions per week (in Mountjoy Prison Clinic)
Shanganagh Castle. An open centre for the detention of male juveniles. Aged 16 to 21 years. Shankill, Co. Dublin. Capacity = 60	two (part time shared)		one (from 8am to 5pm) (nursing sister)	no service	referred to Mountjoy Prison Clinic
Loughan House. An open centre for the detention of male adults. Aged 18 years and over. Blacklion, Co. Cavan. Capacity = 85	one (part time)		one (from 8am to 5pm)	no regular service	one session per week
Fort Mitchel. A place for the detention of male adults. Aged 16 years and over. Spike Island, Co. Cork. Capacity = 102	two (part time shared)		two (by day) one (by night)	one session per fortnight	one session per month
Wheatfield. A place for the detention of male adults and juveniles. Aged 15 years and over. Cloverhill Rd, Clondalkin. Capacity = 368	one (part time)		four (by day) one (by night)	one to two sessions per week	three sessions per week
The Curragh. A place for the detention of male adults and juveniles. Not less than 15 years of age. The Curragh, Co. Kildare. Capacity = 94	two (part time shared)	two (by day) one (by night)		one session per week	one session per week (in Arbour Hill Prison)
Castlerea Committal Prison for male prisoners. Aged 17 years and over. Castlerea, Co. Roscommon. Capacity = 182	one (part time)	two (by day) one (by night)		one session per week	one session per week
Cloverhill Committal Prison. For male remand prisoners only. Aged 17 years and over. Cloverhill Road, Clondalkin. Capacity = 406	three (one full time and two part time)	six (by day) two (by night)		five sessions per week	one session per week (in Wheatfield)
Midlands Prison for male prisoners. Aged 17 years and over. Portlaoise, Co. Laois. Capacity = 515	one (part time)	four (by day) two (by night)		no direct cover at present	one session per week (in Portlaoise Prison

APPENDIX 2

Staffing Structures by Establishment or Complex

The following proposals concerning the appropriate structure and level of health care staffing in various prison establishments or complexes are based on a combination of existing experience, submissions made to the Health Care Review, and proposals arising from the deliberations of the Review Group. The proposals, however, are very tentative and the situation in each individual institution needs to be examined in closer detail by the Prisons Service.

It will be apparent that certain aspects of the proposals outlined below will have either resource and / or industrial relations implications. These aspects should be considered as a second phase of this overall review as opposed to the present initial phase which is focussed on recommending a structure which will ensure that equivalent professional standards of service are available to prisoners given the range of health related problems in the population. The responsible statutory agencies need to insist that appropriate resources be ring fenced to ensure that the recommendations in the report can be implemented. In addition, any potential industrial relations issues which are foreseen should be addressed and resolved at the earliest stage.

In as much as possible, estimates are based on existing or proposed prisoner numbers or workload patterns (for example: committal prisons have a greater workload than non-committal prisons with a similar population; female prisoners have significantly greater health deficits and requirements than males). Should these change significantly then the staffing or service requirements will need to be adjusted accordingly. Establishments or complexes are dealt with on a discipline by discipline basis. In the ongoing absence of either a Co-ordinator of Nursing Services or headquarters pharmacist, the estimates in these areas are based on either existing numbers or on the basis of submissions to the Group. **It should be noted that the proposals (particularly primary medical) relate to actual on-site presence as opposed to 'notional hours'.**

The proposals seek to make allowance not merely for a reactive, illness based health care system but for a more proactive, health promoting and preventative one.

For certain purposes (particularly medical out-of-hours cover, possible staff sharing, pharmacy management, etc.) it is proposed to group certain prisons as follows:—

1. Mountjoy complex — consisting of Mountjoy Male Prison, Mountjoy Womens Prison, St. Patrick's Institution, Training Unit, and possibly Arbour Hill Prison (circa 1,000 prisoners).

2. Cloverhill complex — consisting of Cloverhill Prison, Wheatfield, and possibly the Curragh (circa 800 prisoners).

3. Midlands complex — consisting of Portlaoise and the Midlands Prisons (circa 700 prisoners).

The remaining prisons will be treated as stand-alone units.

1. Mountjoy Complex

Institution	General Practitioners (including drug treatment)	Nursing (including drug treatment)	Psychiatry	Psychiatry (substance misuse)	Dental
Mountjoy Male Prison	2.0 whole time equivalents	Circa 7 by day 2 by night	3 to 4 sessions per week	1 session per week	5 sessions per week
Mountjoy Womens Prison	0.5 whole time equivalents	Circa 3 by day 1 by night	2 sessions per week	1 session per week	1 session per week
St. Patrick's Institution	0.5 whole time equivalents	Circa 3 by day 1 by night	2 sessions per week	1 session per week	2 sessions per week
Training Unit	0.25 whole time equivalents	1 by day 1 by night	0.5 sessions per week		1 session per week
Arbour Hill Prison	0.25 whole time equivalents	1 by day 1 by night	2 sessions per week		1 session per week

In terms of pharmacy input, it is proposed that the Mountjoy complex should be serviced by a whole time pharmacist who would also manage Arbour Hill Prison as a satellite to the complex. Alternatively, Arbour Hill Prison could be managed by means of a contract with an external service provider (either local community pharmacy or other hospital or independent contractor).

In terms of the requirement for medical out-of-hours cover and the present dissatisfaction regarding the demand for individual doctors to be available on a 365 day basis, it would appear more reasonable to seek to combine the prisons outlined above and to establish a satisfactory roster for the doctors involved.

Similarly, to cover leave, sickness, etc., it would appear reasonable to incorporate some nursing flexibility to allow movement of nurses between the various prisons in the complex.

Dental services to the complex are presently provided by Dublin Dental Hospital staff on a contract basis. While the present provision and organisation is considered satisfactory, the increase in both the number of prisons and overall number of prisoners within the Dublin area is placing increasing pressure on the existing allocation of Dublin Dental Hospital staff.

2. Cloverhill Complex

Institution	General Practitioners (including drug treatment)	Nursing (including drug treatment)	Psychiatry	Psychiatry (substance misuse)	Dental
Cloverhill Prison	2.0 whole time equivalents	Circa 6 by day 2 by night	3 to 4 sessions per week	1 session per week	1 to 2 sessions per week
Wheatfield	0.5 whole time equivalents	Circa 3 by day 1 by night	2 to 3 sessions per week	1 session per week	3 sessions per week
The Curragh	0.25 whole time equivalents	1 by day 1 by night	1 to 2 sessions per week		1 session per week (provided elsewhere)

In terms of pharmacy input, it is proposed that the Cloverhill complex should be serviced by a whole time pharmacist who would also manage the Curragh as a satellite to the complex. Alternatively, the Curragh could be managed either as a satellite of the Midlands complex or by means of a contract with an external service provider (either local community pharmacy or other hospital or independent contractor).

The medical input to the two main prisons should be combined to organise a satisfactory out-of-hours roster and facilitate locum or other cover.

As is proposed in relation to the Mountjoy complex, it would appear reasonable to consider organising prison nursing services in such a way to allow staffing interchange between the two main prisons (and possibly also the Curragh) so as to cover any shortages arising from leave, illness, etc..

Dental Services are presently provided by Dublin Dental Hospital staff on a contract basis. The opening of Cloverhill Prison has placed pressure on the provision of dental services to this complex.

3. Midlands Complex

Institution	General Practitioners (including drug treatment)	Nursing (including drug treatment)	Psychiatry	Dental
Midlands Prison	2.0 whole time equivalents	Circa 4 by day 2 by night	3 to 4 sessions per week	Circa 3 sessions per week
Portlaoise Prison	0.5 whole time equivalents	Circa 2 by day 1 by night	1 to 2 sessions per week	1 session per week

In terms of pharmacy input, it is proposed that the complex should be serviced by a whole time pharmacist (who might also manage the Curragh as a satellite to the complex).

Alternatively, the complex could be managed by means of a contract with an external service provider (either local community pharmacy or other hospital or independent contractor). In this case, the Curragh would have services provided on a similar basis or, as outlined above, be managed as a satellite of the Cloverhill complex.

It is recommended that, in relation to the provision of psychiatric services to the complex, the possibility of developing a formal service agreement with the Midland Health Board (along the lines of that in the Eastern Regional Health Authority area) should be pursued. This would be in keeping with the proposal (outlined in Chapters 2.2 and 8.6) for formal partnership between the Prisons Service and Statutory Health Bodies aimed at ensuring that prisoners are able to access equivalent health care standards as citizens in the general community.

Out of hours cover to the two prisons should be combined so as to provide a satisfactory roster for the doctors involved.

4. Limerick Prison

Institution	General Practitioners	Nursing	Psychiatry	Dental
Limerick Prison	0.4 whole time equivalents	Circa 2 by day 1 by night	2 sessions per week	1 session per week

Pharmacy services should be provided by means of a contract with an external service provider (either local community pharmacy or other hospital or independent contractor).

5. Cork Prison / Fort Mitchel

Institution	General Practitioners	Nursing	Psychiatry	Dental
Cork Prison	0.5 whole time equivalents	Circa 3 by day 1 by night	3 sessions per week	Circa 1 to 2 sessions per week
Fort Mitchel	0.25 whole time equivalents	1 by day 1 by night	1 session per week	1 session per fortnight

Pharmacy services to both Cork Prison and Fort Mitchel should be provided by means of a contract with an external service provider (either local community pharmacy or other hospital or independent contractor).

As has been recommended elsewhere the possibility of developing a formal agreement for the provision of psychiatric services to both Cork Prison and Fort Mitchel with the Southern Health Board (along the lines of that in the Eastern Regional Health Authority area) should be pursued. This would be in keeping with the proposal (outlined in Chapters 2.2 and 8.6) for formal partnership between the Prisons Service and Statutory Health Bodies aimed at

ensuring that prisoners are able to access equivalent health care standards as citizens in the general community.

6. Castlerea Prison

Institution	General Practitioners	Nursing	Psychiatry	Dental
Castlerea Prison	0.4 whole time equivalents	Circa 2 by day 1 by night	1 to 2 sessions per week	1 session per week

Pharmacy services to Castlerea Prison should be provided by means of a contract with an external service provider (either local community pharmacy or other hospital or independent contractor).

7. Open Centres

Institution	General Practitioners	Nursing	Psychiatry	Dental
Loughan House	0.25 whole time equivalents	1 by day (8am to 8pm)	Occasional session	1 session per week
Shelton Abbey	0.2 whole time equivalents	1 by day (8am to 8pm)	Occasional session	Seen locally as required
Shanganagh Castle	0.2 whole time equivalents	1 by day (8am to 8pm)	Occasional session	Seen locally as required

In view of their size, etc., the most reasonable way to provide pharmacy services for these open centres would appear to be by means of a contract with an external service provider (either local community pharmacy or other hospital or independent contractor).

Similarly, given the relatively limited need for any regular psychiatric input the practicality of having a service agreement with local health board could be explored. Any such agreement would, essentially, seek to negotiate the occasional referral to or assessment by a locally based psychiatrist.

In relation to those prisons which are geographically separate (all except the three complexes outlined above) and which are medically serviced by either one or two individual doctors, consideration should be given to examining the feasibility of having the prison incorporated in community on-call arrangements. This would have the dual benefit of lessening the requirement for one doctor to be on-call on a more or less constant basis and would, to a certain degree, promote the perception of the prison as being part of the overall (health care) community rather than as something separate and isolated. Such arrangements would go a significant way towards overcoming one of the factors which has been identified in various submissions to the Review as being a deterrent to medical involvement in prisons, i.e., the requirement to partake in onerous on-call arrangements.

APPENDIX 3

Submissions Received from Organisations

Submissions to the Review Group were received from the following organisations:

An Bord Altranais
Association of Psychiatric Nurse Managers
Central Mental Hospital
Clinical Psychology Service, Department of Justice, Equality and Law Reform
Comhairle na nOspidéal
Department of Health and Children (Psychiatric Services)
Dochas Centre (Multidisciplinary Team)
Health Promotion Officers Group of the Health Boards
Irish Association of Speech and Language Therapists
Irish College of General Practitioners
Irish Dental Association
Irish National Council of Attention Deficit Disorder Support Groups
Irish Nurses Organisation
Irish Penal Reform Trust
Irish Pharmaceutical Union
Irish Prison Doctors Association
Midland Health Board
National Steering Group on Deaths in Prisons
Pharmaceutical Society of Ireland
Prison Officers Association
Prison Survey Team, Department of Community Health & General Practice, Trinity College
Psychiatric Nurses Association
Royal College of Psychiatrists Irish Division
Royal College of Physicians of Ireland
Southern Health Board
Visiting Committee, Cork Prison
Visiting Committee, Limerick Prison
Visiting Committee, Portlaoise Prison
Western Health Board