



Oifig An Chigire Príosún
Office of the Inspector of Prisons

Thematic Inspection: An Evaluation of the Provision of Psychiatric Care in the Irish Prison System

February – March 2023

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LETTER TRANSMITTING THE REPORT TO THE MINISTER FOR JUSTICE



Oifig An Chigire Príosún
Office of the Inspector of Prisons

Ms Helen McEntee TD
Minister for Justice
Department of Justice
51 St Stephen's Green
Dublin 2

21 August 2023

Re: Thematic Inspection Report: An Evaluation of the Provision of Psychiatric Care in the Irish Prison System

Dear Minister,

As I mentioned when we met recently, please find enclosed a **Thematic Inspection Report on the Provision of Psychiatric Care in the Irish Prison System**. This inspection was carried out in February and March 2023, by a team including two international experts in forensic psychiatry. The provision of care was assessed in seven of the thirteen prisons in the State, and many of the Inspectorate's recommendations refer to systemic issues arising across the prison estate.

The report presents pragmatic recommendations designed to directly address the factors that are currently undermining the quality of treatment, safety and dignity of prisoner-patients, including critically low numbers of specialist mental healthcare staff; inadequate environmental conditions in some prisons, including overcrowding and dilapidation; deficiencies in mental health treatment in prison, as well as a gross lack of system-wide clinical care pathways to access necessary treatment outside prison, including in the Central Mental Hospital.

The Irish Prison Service (IPS) has verified the factual accuracy of the report, and has provided the enclosed Action Plan in response to the Inspectorate's recommendations. You will see that the IPS has accepted all of the recommendations that it considers fall within the scope of its authority. However, the IPS has also indicated that it agrees with, but cannot accept or implement, a number of other recommendations due to their "ownership resting with another body" namely, the Department of Health. In this regard, I welcome the recent establishment of the Joint Steering Committee between the Department of Justice and Department of Health on the Implementation of the *Final Report of the High Level Task Force to Consider the Mental Health and Addiction Challenges of Those Who Come into Contact with the Criminal Justice Sector*. I would be grateful if the enclosed Thematic Report and IPS Action Plan could also be placed on the agenda of the Joint Steering Committee, with a view to considering how best to implement those recommendations that fall within the authority of the Department of Health.

More generally, greater engagement between the Department of Justice and the Department of Health will be critical if the fundamental problems identified in this report are to be tackled effectively. As ever, the Inspectorate of Prisons stands ready to work closely with all relevant stakeholders to advise on the implementation of its recommendations.

Lastly, having regard to section 31(3) of the Prisons Act 2007, I should be most grateful if you could agree to publish this Thematic Report, together with the IPS Action Plan, as soon as practicable.

Yours sincerely,

Mark Kelly
Chief Inspector of Prisons

EXECUTIVE SUMMARY

There are large numbers of prisoners in the Irish prison system with serious mental illness, some of whom present significant behavioural and management difficulties. There have been commentaries at international, national, and service-wide levels that many such prisoner-patients are not receiving the high quality and effective care and treatment they deserve within prison, and often cannot access prompt transfer to a psychiatric hospital.

This deficit in care can place such prisoners and others, including staff, at risk of harm and is disruptive to the required good order within the prison system. Further, such a neglect in treatment provision, with the resultant potential human suffering, could, on occasion, be construed as ill-treatment.

Within Irish prisons, despite the best efforts of many dedicated prison and clinical staff, prisoner-patients frequently experience sub-optimal clinical treatment, due to the environment being inappropriate to their needs and a widespread lack of clinical staff which prevents the delivery of the necessary range of psychiatric treatments. Further, some prisoner-patients experiencing serious mental illness refuse the anti-psychotic medication prescribed for them and, as such medication cannot be legally compulsorily administered to them in a non-hospital setting, they then languish suffering and untreated in custody.

Prisoner-patients whose condition is so severe as to require transfer to hospital (and who are accepted onto hospital transfer waiting lists), can face long delays, left waiting for very many months on end in dilapidated and sometimes overcrowded prison cells - and on occasion in conditions which could be considered degrading - prior to their transfer. Indeed, many prisoners whom clinicians in prison deem to require transfer, never actually make it to a psychiatric hospital, either because it is thought fruitless to even refer them, due to a lack of any realistic possibility that they will be accepted, or an absence of any appropriate hospital facility or bed offer. Some of these vulnerable and untreated individuals, on release from custody at the expiry of their detention, are then at high risk of falling through the net of community follow-up, sometimes returning to marginal existences with high risk of homelessness and substance misuse, their cycle of re-offending, re-imprisonment and lack of clinical care starting all over again.

Based upon documentary evidence, a high-level consultation meeting with IPS staff and announced on-site visits to seven out of the thirteen prisons in Ireland, which allowed widespread discussion with staff of all types, and interviews with many prisoners, this report evaluates the provision of psychiatric care within the Irish prison system, particularly the care offered to prisoners with serious mental illness. It identifies the key issues which appear to be hindering the provision of high quality and effective psychiatric care and treatment for prisoners, and offers recommendations for improvements, across four main themes. The report is intended to be a clarion call for action, to facilitate further discussion and catalyse much needed improvement, for the benefit of prisoners, prison staff and the prison system, as well as the wider community across Ireland.

Key findings, resulting in recommendations ([Chapter 4](#)), which appear to be adversely impacting upon the provision of good quality mental health care and treatment for Irish prisoners relate to:

- **Low staffing numbers** of specialist mental healthcare staff, sometimes critically low, resulting, on occasion, in neglectful care. Urgent action is required to improve access to in-reach psychiatrists and specialist mental health nurses (and in one prison, IPS general nurses), psychologists, occupational therapy staff and other relevant staff. There should also be further staff training for prison officers and a wider system of staff supervision and support.

- **Inadequate environmental conditions** in some prisons, including overcrowding and material dilapidation, is affecting the privacy and dignity of prisoners, can be harmful to the general mental well-being of prisoners and can cause further deterioration in mental state for some mentally disordered prisoner-patients. The material deficiencies require rectification by the IPS; tackling overcrowding will require a system-wide approach.
- **Deficiencies in treatment within prison**, such as a widespread lack of the full range of required psychological, occupational and social-rehabilitative therapies, results in prisoner-patients often depending solely on pharmacotherapy to ameliorate their condition, should they have enough insight to consent to receive such medication. The further development of special units could improve care and system integration.
- **A gross lack of system-wide clinical care pathways** results in prisoner-patients often not receiving the right care in the right environment at the right time, in particular accessing treatment in an external psychiatric hospital when necessary. Better diversion and easier access to the CMH and civil psychiatric hospitals is needed. This will require systemic changes, led by the HSE, with more beds opening at CMH, a clinical culture change, the opening of long-awaited regional secure hospital units, new designation of hospital units other than the CMH, and the possible use of the independent sector. Further, the proper care and treatment of prisoner-patients who are homeless must finally be effectively addressed.

Underpinning all the above-listed problems, there appears to be a long-standing **under resourcing of mental healthcare services for prisoners within prison and in HSE civil psychiatric hospital mental healthcare services**, as well as an apparent lack of consistent system-wide political will, prioritisation, accountability, and governmental drive to fundamentally address the relevant failings effectively and assertively.

However, providing safe and effective psychiatric treatment to prisoners must now be an urgent priority; many states are judged on their human rights records concerning their most vulnerable citizens. There are high expectations, at national and international level, that improvements will be made, despite the resistance to change so often found within systems (especially where risks are involved). The time for working groups and reports alone must draw to a close, action is now required.

GLOSSARY OF ACRONYMS

CAMHS = Child & Adolescent Mental Health Service

CBT = Cognitive Behavioural Therapy

CBU = Challenging Behaviour Unit

CMH = Central Mental Hospital

CPT = European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment

CSC = Close Supervision Cell

DBT = Dialectical Behavioural Therapy

ECHR = European Convention on Human Rights

GP = General Practitioner

HLTF = High Level Task Force

HSE = Health Service Executive

HSU = High Support Unit

IPS = Irish Prison Service

LSU = Low Support Unit

MAM = Multi Agency Meeting

MHC = Mental Health Commission

NFMHS = National Forensic Mental Health Service (Portrane)

NVRU = National Violence Reduction Unit

PICLS = Psychiatric In Reach & Court Liaison Service

PICU = Psychiatric Intensive Care Unit

SOC = Special Observation Cell

VDP = Violent & Disruptive Prisoner

VPU = Vulnerable Prisoners Unit

WTE = Whole Time Equivalent

1 INTRODUCTION

- 1.1** It is internationally well recognised that persons with mental disorder are overrepresented in prison populations, and Ireland is no exception. Persons with major mental illness, such as schizophrenia or affective disorders, as well as those with personality disorders, intellectual disability, substance misuse disorders, and neurocognitive disorders can all be found within Ireland's prisons. Some are not benefitting from the level of mental healthcare which they deserve.
- 1.2** This thematic report is based upon documentary evidence, consultations with senior IPS staff and on-site announced visits to seven prison establishments in the Republic of Ireland, where facilities for mentally disordered prisoners were inspected and many staff and prisoners were interviewed. It depicts and evaluates the provision of mental healthcare for adult prisoners within the Irish prison system. The report concentrates on the treatments available to those prisoners diagnosed as suffering from severe mental illness, including their access to hospital treatment when that is indicated. Despite co-morbidities, the thematic inspection did not seek to examine the treatment of substance misuse nor personality disorder in any detail, or the specific direct management of self-harm, although some references are made to these matters.
- 1.3** The report identifies key issues which are hindering the provision of high quality and effective psychiatric care and treatment for prisoners with serious mental illness and offers a range of recommendations. It is hoped that the report will encourage further discussion between government departments, and catalyse action to provide much needed improvements, for the benefit of the prisoners, prison staff, the prison system, and the wider community nationally.
- 1.4** The report's recommendations, whilst at times aspirational, are nonetheless pragmatic and grounded, rather than unachievable theoretical goals; they reflect a need for progressive improvement over time, even though improvements in some areas are required urgently. As it is recognised that financial and human resources are currently limited, providing basic acceptable standards should be the immediate aim, with later improvements leading to the excellent care and treatment hoped for by prisoner-patients and staff alike.

A. Expertise & Sources of Information

- 1.5** The inspection team consisted of:
- Mr Mark Kelly, Chief Inspector
 - Ms Helen Casey, Deputy Chief Inspector
 - Dr Ciara O'Connell, Senior Inspector
 - Ms Fiona O'Dea, Inspector

To enhance the clinical assessment and interpretation of data and other information, and best facilitate on-site meetings with IPS clinical staff and HSE in-reach clinical staff within the prisons visited, as well as with prisoners experiencing mental illness, two international experts assisted the team:

- Dr Clive Meux, Consultant Forensic Psychiatrist
- Mr Andy Flynn, Registered Mental Health Nurse

These experts utilised their wide experience of mental healthcare in prisons and those establishment's interface with forensic and civil psychiatric hospitals and community-based forensic psychiatric systems, to add valuable insights; their brief biographies are included in the Appendix.

1.6 The Inspectorate team selected seven of the thirteen prisons in Ireland for on-site thematic inspection. These were Mountjoy Men's Prison, the Dóchas Centre, and Cloverhill Prison in Dublin (visited 15 - 17 February 2023), and Cork, Limerick, Portlaoise and Midlands Prisons (visited 7 - 10 March 2023). This cross section of prisons, accommodating more than 3,100 prisoners (over two-thirds of the total prison population) at the time of the visits, was identified because these establishments were known to have particular challenges in managing prisoners with serious mental illness. The selection allowed the Inspection Team to examine provision in different geographical areas, for men and women in prison, for those held in newer and older-style accommodation, for those on remand and serving a sentence, and for persons who had committed more minor and serious offences. The selection included the only high security prison, the largest prison and the only two prisons accommodating women. Further it allowed the Inspectorate Team to visit several special prison units which catered for prisoners with mental disorders, including the HSU and LSU (and CBU) at Mountjoy Men's Prison, D2 Wing at Cloverhill Prison, the VPU at Cork Prison, and C1 Left Wing and the NVRU at Midlands Prison.

1.7 In reaching their conclusions, the Inspection team considered:

Written documentation: Including information from the IPS (data on prisoner numbers, mental disorder in prison, prison establishments, minutes from MAMs etc.); recent reports by the HSE, MHC and HLTF; CPT country reports on Ireland (and the Irish government's responses to those reports); and previous Inspectorate of Prison reports, including reports on deaths in custody.

Information from IPS Staff: A high level IPS overview was provided during a lengthy meeting with Irish Prison Service senior officials including the Director of Care & Rehabilitation; Executive Clinical Lead Head of Psychological Services and National Operational Nurse Manager. Further, at the seven prisons visited, Inspectorate team members met with each prison's Governor and IPS Chief Nurse, as well as certain Deputy Governors responsible for security, general practitioners (GPs), psychologists, chaplains, and many prison officers of varying seniority.

Information from National Forensic Mental Health Service Staff working on an in reach basis in Prisons: At the seven prisons visited, the Inspectorate team met many HSE in-reach clinical staff, including consultant psychiatrists, a trainee psychiatrist, forensic mental health nurses of various grades, and a social worker. Some in-reach staff were from the CMH, others from HSE Mid-West and HSE South.

Information from Prisoners: The Inspectorate team met with many prisoners diagnosed with serious mental illness, at all of the prisons visited. All such prisoners were interviewed in confidence and with their consent.

B. Background Context

- 1.8** Over the last 25 years, there has been much data and many reports expressing concern about the treatment of mentally disordered prisoners in Ireland. The purpose of this thematic inspection report is not to review and summarise them, rather it is to (i) describe the current situation regarding the treatment of mentally disordered adults, particularly with serious mental illness, in prison in Ireland, (ii) identify issues of concern, and (iii) make recommendations to address those. However, to add some background and context:
- 1.9** Regarding the levels of mental disorder in the prisons of Ireland, in 2005 a survey¹ of the mental health of prisoners (remand and convicted) in Irish prisons found that over 60% of prisoners evidenced dependence or harmful use of drugs or alcohol (often multiple substances) and that for men, between 16% (remand) and 27% (convicted), and for women between 41% (remand) and 60% (sentenced females), had some form of mental illness. For the more severe forms of mental illness, rates of psychosis were 3.9% of men and 5.4% of women. Although contemporaneous data is apparently still being gathered, there is no evidence to suggest that this situation has improved in the last 17 years.
- 1.10** With regard to the provision of mental health services (and their funding) in Ireland, a 2019 report² by the HSE describes service provision. It is noted that the State spends 5.1% of its healthcare budget on mental health services, lower than international comparisons, with a related shortfall in human resources for mental health services.
- 1.11** Taking an international perspective on the treatment of mentally ill prisoners in Ireland, a report published by the CPT following their most recent visit to Irish prisons in 2019³ (including some of the special units) expressed concerns about environmental conditions, the use of SOCs, and that prisoners were sometimes sleeping on mattresses on the floor. The CPT commented upon the lack of structured activities for mentally ill prisoners and raised issues surrounding systems for the transfer to hospital of prisoners with mental illness. The CPT plans to return to Ireland in 2024 to review progress.⁴
- 1.12** At national level, in its most recent report⁵ considering mental health services for people in the criminal justice system, the Mental Health Commission highlighted a range of serious systemic concerns, including unequal access to services for prisoners, gaps in nationwide service provision and the very poor resourcing of some HSE prison in-reach mental health teams.
- 1.13** Regarding governmental reaction, as part of its response⁶ to the CPT report, the Irish government established a taskforce to address the concerns. In 2022 the High-Level Task Force to consider the mental health and addiction challenges of those who interact with the criminal justice system, published its 228-page report⁷.

¹ H Kennedy et al. (2005). National Forensic Mental Health Service: Mental Illness in Irish Prisoners: Psychiatric Morbidity in Sentenced, Remanded and Newly Committed Prisoners.

² HSE (2019) Mental Health Service Delivering Specialist Mental Health Services.

³ CPT (2020) Report to the Government of Ireland.

⁴ CPT (29 March 2023) The Council of Europe Anti-Torture Committee Announces Periodic Visits to Eight Countries in 2024.

⁵ Mental Health Commission (2021) Access to Mental Health Services for People in the Criminal Justice System.

⁶ CPT (2020) Response to the Report to the Government of Ireland.

⁷ Department of Justice (September 2022) Final Report of the High Level Task Force to Consider the Mental Health and Addiction Challenges of Those Who Come into Contact with the Criminal Justice Sector. Following the publication of the final High-Level Taskforce (HLTF) report, a joint Steering Committee between the Department of Health and the Department of Justice was established to provide an overarching monitoring mechanism and structure. The Steering Committee is jointly chaired at Assistant Secretary level within both the Department of Health and Department of Justice and reports regularly to Ministers.

1.14 With regard to the provision of forensic mental health services, a new Central Mental Hospital, which monopolizes designated mental health beds nationally (i.e., sentenced prisoners cannot be treated anywhere else), was opened in Portrane in November 2022. This was intended to address the shortage of high & medium security mental health beds; however, the anticipated significant increase in bed numbers and easing of waiting times for the admission of prisoners has stalled due to staff shortages and unopened beds. Concerns are again building about delayed admission to psychiatric hospital for prisoners with severe mental health problems. As prisoner numbers relentlessly increase (including those with severe mental health needs), these concerns are unlikely to diminish, certainly in the shorter term.

Additionally, although the approach towards the provision of mental health services for prisoners in Ireland was set out 17 years ago in the 2006 policy document “A Vision for Change”⁸, there is still no tiered network of secure in-patient services across the State, and the NFMHS has two secure forensic beds per 100,000 population, whilst most other European Union states have more than 10 secure forensic beds per 100,000⁹.

1.15 Following consideration of the above reports and recent further concerns being expressed regarding the treatment of mentally disordered persons in prison, particularly those with serious mental illness, the Chief Inspector of Prisons decided that the Inspectorate should thematically examine this issue, in order to determine what progress is actually being made for the prisoner-patients concerned, and the staff attempting to care for them.

⁸ HSE (2006) A Vision for Change: Report of the Expert Group on Mental Health Policy.

⁹ Oireachtas Library & Research Service (December 2020) Central Mental Hospital (Relocation) Bill 2020.

2 CURRENT PROVISION OF SERVICES FOR PRISONERS WITH MENTAL DISORDER

A. General Assessment & Treatment within Prison

- 2.1** As part of their committal to prison, all prisoners are screened for mental disorder, initially by an IPS nurse and then by a GP and, in due course, if necessary, by an HSE in-reach forensic mental health nurse and/or a psychiatrist.
- 2.2** If, at any time during their imprisonment, a prisoner is deemed to require specific treatment(s) for a mental disorder, this is offered within an established working framework. If a prisoner requires psychotropic medication, this may be prescribed (by a GP or psychiatrist), although, unlike in a psychiatric hospital, it cannot be administered without the prisoner's consent. If a prisoner requires psychological treatment, following psychological assessment, a prisoner may be offered individual or group therapy, provided by an IPS psychologist. Additionally, support can be offered by IPS nurses, HSE in-reach forensic mental health nurses and social workers, prison officers and the prison's chaplain. There is also a prisoner Listener service and telephone access to the Samaritans.
- 2.3** If, following a risk assessment, a prisoner is deemed to be especially vulnerable and require additional observation because of their mental state and the risk that they present to themselves or others, they may be placed within a Safety Observation Cell (SOC) for medical reasons or transferred to the prison's medical or special unit (if the latter is available).

B. Medical & Other Special Units for Mentally Disordered Challenging Prisoners

- 2.4** Many prisoners who are experiencing less serious mental health problems can remain in the general population and receive care and treatment under the supervision of the prison GP, IPS nurses and psychologists, sometimes supplemented by an occasional appointment with a psychiatrist if required, just as if they were in the community and were receiving support from home on an out-patient basis.
- 2.5** However, if a prisoner with mental disorder cannot be safely managed in the general population and requires more intensive supervision and input on an ongoing basis, for example due to the severity of their mental disorder, related behavioural challenges and vulnerabilities, or are awaiting transfer to an external psychiatric hospital, in some prisons they may be placed in a medical/special unit. These units endeavour to offer a more protective environment, with more clinical input, and aim to avoid the overuse of SOCs. Such units are also more likely to be substance free. Behavioural disturbance within such units is often dealt with from a clinical perspective, rather than via the use of disciplinary sanctions. There was no such special unit in Limerick and Portlaoise Prisons, and the Dóchas Centre operated a "multi-purpose" healthcare/committal unit in one area of the prison. The following special units were visited:

The High & Low Support Units (HSU & LSU) & Challenging Behaviour Unit (CBU), Mountjoy Men's Prison

- 2.6** The HSU, which commenced operation in 2010, has nine single cells (plus one SOC), and the associated LSU has six single cells in relatively narrow corridors. Both the HSU and LSU (situated in F1 and F2 Wings respectively) are within the "New Medical Unit". Although the facilities are for prisoners with enhanced medical needs (somatic and psychiatric), at the time of the visit, all the prisoners in the HSU and LSU had some form of mental disorder requiring additional supervision and care, all being deemed too vulnerable to cope in the general population.

The CBU (situated in C Base Wing) has six single cells (plus two SOCs); although a basement segregation unit for prisoners with behavioural disturbance, at the time of the visit was being utilised as an area to accommodate the most disturbed mentally disordered prisoners who could not be managed in the HSU.

Decisions on the placement of prisoners with mental disorder in one of these special medical units required the involvement of the visiting psychiatrist. The prison's in-reach mental health team and IPS psychologists provided input to the units on weekdays, with clinical input at other times being from IPS nurses and the prison GP.

D2 Wing, Cloverhill Prison

- 2.7** D2 wing occupies the landing above the prison's clinical base and disciplinary wing (D1). It has eight ordinary single cells, two health isolation cells, two SOCs and four CSCs set within two main light and airy accommodation areas, with a central staff control room. The unit has a dedicated exercise yard to which prisoners have relatively free access during daytime.

Although the unit is for prisoners with enhanced medical needs (somatic and psychiatric), at the time of the visit, all but one of the prisoners there had some form of mental disorder requiring additional supervision and care, with all the prisoners on the unit being deemed too vulnerable to cope on in the general population.

Prisoners with mental disorder are triaged for admission to the unit by the PICLS (Psychiatric In-Reach & Court Liaison Service) team, who also provided input during weekday working hours (from Monday afternoon to Friday morning), clinical input at other times being from IPS nurses and the prison GP.

The Vulnerable Prisoners Unit (VPU), Cork Prison

- 2.8** The VPU occupies B1 landing on B Wing. It has seven ordinary single cells of modern design and two SOCs, plus an adjacent exercise yard with wall murals. When the unit is full, prisoners who should be placed therein overspill to the adjacent Challenging Behaviour Unit (CBU; six regular single cells + two CSCs) or even onto the Committal Unit (ten cells).

Although the VPU is for prisoners with enhanced medical needs (somatic and psychiatric), at the time of the visit, all had mental illnesses which required additional supervision and care, with all prisoners on the unit being deemed too vulnerable to cope in the general population.

The prison's in-reach mental health team provided input to the units on weekdays, clinical input at other times being from IPS nurses and the prison GP.

C1 Left Wing, Midlands Prison

- 2.9** C1 Left Wing was described by senior managers at the prison as a “de facto HSU”. The wing, effectively a corridor, has 11 ordinary single cells, plus one SOC and one CSC. It has its own small gym and exercise yards, the latter of a cage-like nature.

Although C1 Left Wing is designed to take prisoners who are deemed too vulnerable to cope, or who are too disruptive, in the general population, and is not specifically for prisoners with mental disorder, at the time of the visit, most of the prisoners there had mental illness and required additional supervision. When the unit is full, prisoners who would benefit from being placed therein have to remain with the general population.

The prison’s in-reach mental health team provided input to the units on weekdays, clinical input at other times being from IPS nurses and the prison GP. Just under half of those on C1 Left were waiting to see an IPS Psychologist.

National Violence Reduction Unit (NVRU), Midlands Prison

- 2.10** The NVRU, which opened in 2018, occupies C1 Right Wing and has ten single cells plus one SOC and one CSC, set along a relatively narrow single corridor. The unit had its own dedicated visiting area, two exercise yards, a small gym, and a multipurpose activity room, with prisoners theoretically able to associate approximately five hours per day, subject to risk assessment and an individual’s willingness to engage with others.

Clinically, the unit is psychologically informed and jointly managed by a Senior Psychologist and Assistant Governor. A total of 18 prison officers are allocated to the unit, with usually seven to eight officers on duty. Although the presence of mental illness is an exclusion criterion for admission, the unit was deemed a useful resource for a small number of prisoners who have a serious personality disorder and are very challenging. Therapy offered uses a trauma led model of care, deploying CBT, mentalisation and schema-based therapy approaches, amongst others.

Since inception the NVRU has treated the current six residents (two returning after violent assaults) and three other prisoners who have departed the facility.

C. Transfer of Prisoners to an External Psychiatric Hospital

- 2.11** If, following an assessment by a psychiatric clinician, a prisoner is deemed to require psychiatric treatment that cannot be legally, safely, or satisfactorily provided within prison, they are referred to an external psychiatric hospital with a view to their transfer for treatment there.
- 2.12** When a prisoner is on remand and has committed a relatively minor offence, such a referral may be made to a local civil psychiatric hospital, with a view to the prisoner being diverted there, including being bailed to the hospital with the condition that they reside/receive treatment there (their ultimate diversion from custody then sometimes being successfully achieved, subject to a voluntary or statutory report being supplied to the court and the court’s agreement).
- 2.13** However, for all sentenced prisoners and remand prisoners who have committed a more serious offence, the only hospital designated to treat such persons is the CMH.

- 2.14** Ireland, unlike some other European states, does not have a spectrum of regional forensic (or locked, designated) psychiatric units. There is only one central psychiatric hospital to which the great majority of prisoners could be transferred, their transfer there then being dependent not only upon their acceptance by that hospital but also upon the availability of an appropriate bed there.
- 2.15** The replacement of the old Central Mental Hospital at Dundrum with the new and larger hospital in Portrane, which opened in 2022, is noted. However, the team was informed by HSE in-reach staff from the CMH whom they met in the prisons visited, that, of the 170 beds at the CMH, only 99 were occupied at the time of the inspection, with approximately 20 acute and intellectual disability beds, 30 rehabilitation beds and ten CAMHS beds still to open; the delays relating to the inability to recruit staff of all clinical disciplines, especially mental health nurses. There were also, apparently, an insufficiency of available ITU/seclusion facilities to meet the needs of potentially numerous disturbed prisoners.
- 2.16** Furthermore, as the CMH is currently the only designated psychiatric hospital in Ireland, prisoner-patients in the CMH cannot step down from there to regional secure units closer to home. This has resulted in beds becoming blocked at the CMH. Plans to develop regional PICUs have not yet come to fruition.

3 KEY FINDINGS

- 3.1** Throughout the entire thematic inspection, in all the establishments visited, the Inspection Team received excellent cooperation from all staff.

Although there is a theoretical framework and pathway for the treatment of mentally disordered prisoners in place, and no unlawful practices were found, the thematic inspection did demonstrate that there are various areas of concern regarding the treatment of such prisoners. These are discussed below, within the following four key areas of focus: staffing; environment; assessment/treatment; and system wide clinical pathways.

A. Staffing

- 3.2** In all prisons visited, the IPS clinical and regime staff and HSE in-reach clinical staff met by the Inspection Team appeared to be dedicated to their work. Although they were sometimes working within challenging environmental conditions and, at times, with disturbed and distressed prisoners who presented potential risks to themselves and others, the staff appeared to be taking a team approach and trying their best to obtain, or provide, safe care to mentally disordered prisoners. This is commendable.

Prison Officers

- 3.3** Although a detailed analysis was not made of prison officer staffing, in the areas visited, the numbers of prison officers on duty did not appear to be unduly low. Considering the challenging and sometimes disturbed nature of the prisoner-patients that staff had to contain, their relaxed approach with such prisoners was notable and admirable, as was their relatively rare use of protective equipment. Nearly without exception, prisoners interviewed by the team reported that they felt safe. Although a personal officer system was not offered on the special units (except the NVRU where it is available and utilised), clinical staff commented that officers in general were often astute in noticing changes in individual prisoners' mental states and worked well with the clinical teams; one senior clinician described the officers they worked with on a special unit as "incredible".
- 3.4** It was noted that prison officers rotated between areas about every two to three years, which assisted in the avoidance of burnout, an important consideration due to the psychologically demanding nature of their work. However, regarding maintaining resilience, some officers on the special units described their work as especially "challenging and unpredictable", and some reported that they did not receive regular psychological support, stating "no one comes to see us after a serious incident". Although some mental health training was offered to officers on some special units, and annual training was provided in Cork Prison, some prison staff elsewhere said that they were "screaming" for more training; one stated "I've only had mental health training twice in 23 years".
- 3.5** Prison staff also clearly expressed that there were insufficient numbers of clinical staff, one stating "we can do security and solve practical problems, but we need more care-type people to do the other stuff". Another officer, commenting upon the number of prisoners with mental disorder, stated "it's clear that prison is not the place for some of them, they shouldn't be here".

Clinical Staff

- 3.6** Despite the great need for clinical staff, in many of the prisons visited, the numbers of clinical staff were insufficient (as shown in **Table 1** below), and sometimes grossly inadequate to meet the clinical needs of mentally disordered prisoners. Not only did this hamper the safe care of prisoners but it also significantly contributed to the obvious symptoms of burnout of some clinical staff interviewed.

Table 1 – Prisoner Numbers & Clinical Staffing Numbers (WTE, present and in post) in the prisons visited

Prison	Prisoners ¹⁰	IPS Clinical Staff			HSE In-Reach Team Staff		
		GPs	Nurses	Psychologists	Consultant Psychiatrists	Psychiatric Nurses	Social Workers
Cloverhill	452	2	7.0 ¹¹	1.0 ¹²	1.0 ¹³	4.0	0.0
Cork	284	1	11.0 ¹⁴	2.0 ¹⁵	0.3 ¹⁶	1.3 ¹⁷	0.6 ¹⁸
Dóchas	171	1	8.0	1.6 ¹⁹	0.2 ²⁰	1.0	0.2 ²¹
Limerick	309	1	12.0 ²²	1.0 ²³	0.2 ²⁴	0.1	0.0
Midlands	891	2	21.0 ²⁵	2.8 ²⁶	0.6	2.0	0.0
Mountjoy	780	2	23.0 ²⁷	2.0 ²⁸	0.3	2.0	0.6
Portlaoise	217	1	8.0 ²⁹	2 ³⁰	0.2	0.0	0.0 ³¹

IPS Nursing Staff

- 3.7** The Chief Nursing Officers in all prisons visited were all highly experienced clinicians and demonstrated impressive dedication to their work. IPS nursing staff under their management worked 12-hour shifts.

¹⁰ On day of visit.

¹¹ Although all provided general nursing services, 3 had additional mental health qualification.

¹² Supported by 1.0 WTE Assistant Psychologist & 0.2 WTE psychologist.

¹³ Supported by 0.6 WTE senior and 1-2 full-time junior trainee psychiatrists (a 0.5 WTE consultant psychiatrist post is currently vacant).

¹⁴ 1 had additional mental health qualification.

¹⁵ Supported by 1.0 WTE Assistant Psychologist.

¹⁶ Supported by a 0.6 WTE senior trainee psychiatrist.

¹⁷ A further 0.5 WTE of nurse time was soon to be added.

¹⁸ Supported by a trainee social worker.

¹⁹ Supported by 0.6 WTE Assistant Psychologist.

²⁰ However, the psychiatrist must provide 0.4+ to meet demand; he is also supported by a trainee psychiatrist.

²¹ There is funding for 1.0 WTE.

²² Although all provided general nursing services, 3 had additional mental health qualification and 1 in addictions The Chief Nursing Officer post was vacant.

²³ Supported by 1.0 WTE Assistant Psychologist & 0.3 WTE trainee psychologist.

²⁴ Further, no trainee psychiatrist support was available.

²⁵ Although all provided general nursing services, 2 had additional mental health qualification and 1 in addictions.

²⁶ Supported by 3.0 WTE Assistant Psychologists. 1 WTE qualified psychologist is dedicated to the NVRU.

²⁷ Although all provided general nursing services, 2 had additional mental health qualification and 2 in addictions.

²⁸ Plus 2 full-time and 1 part-time Assistant Psychologists.

²⁹ Although all provided general nursing services, 2 had additional mental health qualification.

³⁰ Supported by 1 WTE Assistant Psychologist.

³¹ However, a probation officer offered social work input.

- 3.8** In Cloverhill Prison there were seven IPS nurses (of 18 posts) available, with seven vacancies, plus other nurses on long-term sick leave or shorter-term leaves. Further, there were two nurses who were not available to work night shifts. Despite the use of agency nurses, with only two to four nurses on duty in the daytime (rather than the expected seven), serious understaffing was placing great pressures on the nurses, with symptoms of burnout apparent, and nurses being described as “exhausted”.
- 3.9** The dearth of nurses in Cloverhill Prison was impacting upon the provision of safe healthcare to prisoners. The Inspection Team was informed that, apart from medicine dispensation rounds occurring late and ulcer care being delayed, there were occasions when there was no nurse on duty at all in the prison during the night shift. For example, for three nights – Saturday, Sunday and Monday - during the preceding week, five prisoners had received no health screening on arrival at the prison (including urine drug screening) due to the nursing absence. This can only heighten the risks to the health and welfare of mentally ill or vulnerable, physically ill or substance dependent new arrivals. On other recent nights, there was just one nurse on duty for 450 or more prisoners.
- 3.10** If the nursing complement were complete, there should be two IPS nurses specifically allocated to D2 Wing (HSE in-reach staff only being present eight sessions/week (on weekdays) but, as a result of the shortage of IPS nurses, there was said “often” to be no allocated IPS nurse on the wing.
- 3.11** However, it was positive that there were Healthcare Assistants in Cloverhill Prison (on D2 Unit), whose role assisting nurses with prisoner care there was highly valued. However, elsewhere, this grade of staff was not to be found in other locations housing prisoner-patients visited during the inspection³².

IPS Psychology Staff

- 3.12** IPS psychology staff work with prisoners who experience a wide spectrum of mental health difficulties ranging from mental illness through personality disorders, neurocognitive conditions, post-traumatic states, and addictive behaviours. Approximately 2,000 prisoners (about half of the prison population) are engaged with, or waiting to see, a psychologist.
- 3.13** IPS psychology understaffing is of major concern, with 38% of psychology posts across the prison service vacant. Even if these were all filled, it would be unlikely to meet current needs.
- 3.14** Examples of the serious psychology staff shortages were found at the prisons visited. At Mountjoy Men’s Prison it was reported that three of the five psychologist posts were vacant, leaving the Senior Psychologist and one Staff Grade Psychologist (supported by two full-time and one part-time Assistant Psychologists) to cater for the needs of 780 prisoners. In Cloverhill Prison, one of the Staff Grade posts was long-term vacant, the other vacancy owing to the psychologist being temporarily promoted to cover a statutory leave (leaving a seconded acting - Senior Psychologist and one Assistant Psychologist to cover the entire prison). In the Dóchas Centre, psychologists were struggling to come close to meeting clinical demand and in Limerick Prison, where only one of the three psychologist posts was filled, there were 140 prisoners (45% of the prison’s population) on the psychology waiting list, a psychologist there admitting that “many of these may never get seen”. In Midlands Prison, three of the four Staff Grade psychologist posts were vacant and prisoners needing therapy were waiting six months for group therapy and two and a half – to three years for individual therapy. Psychology staff reported this as a “desperately stressful” situation, with one member of psychology staff saying, “I just have to look prisoners in the eye and say I’m sorry”.

³² A single healthcare assistant at Cork Prison had recently departed and it was unclear if they would be replaced.

HSE In-Reach Multidisciplinary Mental Healthcare Clinical Staff

- 3.15** HSE in-reach clinical mental health staff worked in all the prisons visited. It was reported that in Limerick Prison such staff were funded by HSE Mid-West, by HSE South in Cork Prison (plus some in-reach staff from the National Forensic Mental Health Service (NFMHS)), and in all other prisons visited the HSE in-reach staff were from the CMH. Such staff work predominantly with prisoners with serious mental illness.
- 3.16** The NFMHS has apparently confirmed that its current caseload includes up to 250 patients who are ordinarily in the custody of the IPS (i.e. approximately 6.5% of the total prison population). Indeed, the caseloads for the mental health teams in some of the prisons visited were notably high (e.g., 58 in Mountjoy Men’s Prison; 50 in Cloverhill Prison; 70 in Midlands Prison).
- 3.17** At Cork Prison, the quantity of multidisciplinary in-reach clinical staff, and the breadth of disciplines, were broadly sufficient to cope with demand. This was the best situation found in any of the prisons visited; in other establishments, the level of provision was often insufficient to safely and satisfactorily meet legitimate needs.
- 3.18** In Limerick Prison, the scant psychiatric nurse and consultant psychiatrist input, and absence of any other in-reach multidisciplinary clinical staff, were of particular concern. Although the current consultant forensic psychiatrist was doing their absolute best to provide a service to the prison during just one day per week (whilst also providing a service elsewhere to a large catchment area³³), they were only assisted by a psychiatric nurse for one half-day per week. For a prison of 309 prisoners (men and women, remand and sentenced) this mental health service provision was totally inadequate. Further, it is understood that the current in-reach provision is worse than 15 years ago, with no improvement at all in recent years. Additionally, when the in-reach staff took annual leave there was no replacement, sometimes leaving the prison without psychiatrist or psychiatric nurse input for periods of weeks. A member of the clinical staff at the prison stated that “such a thin psychiatric team can only deal with the tip of the iceberg, the very psychotic and dangerous ones”, suggesting all others had to be neglected.
- 3.19** An additional major concern was the total absence of any HSE in-reach psychiatric nursing input to Portlaoise Prison, a situation that has persisted for the last five years. This, for the highest security prison in the State, with 217 high-risk serious prisoners, some with mental disorders (a usual caseload of 20–35), is unacceptable. With only 0.2 WTE consultant psychiatrist, psychiatric input to the prison, the situation was the most deficient of any of the prisons visited, with staff there describing how mental health assessment and support of prisoners, psychotropic medication response monitoring and psychiatric discharge planning were seriously hampered. Indeed, during the four to six weeks each year when the psychiatrist was on annual leave, there was no formal psychiatric input to the prison at all. As a senior IPS nurse there said, “someone really needs to come and manage the caseload”.
- 3.20** An additional concern was that, in a number of the prisons visited, it was reported that HSE in-reach nursing staff from the NFMHS were, on occasion, recalled to the CMH³⁴ to cover the nursing staff deficiencies at the hospital. This prioritisation of CMH need over that of the prisons, further depleted the availability of psychiatric nurse input into some of the prisons visited.

³³ Estimated to be approximately 8% of the population.

³⁴ For example, an average of one day per month.

Other Therapy & Support Staff

- 3.21** The absence of any occupational and creative therapists (or associated dedicated therapy unit) in any of the prisons visited results in a lacuna in the therapy programme that should be available to mentally disordered persons. As one clinician stated regarding the deficit, “getting such therapy is a priority”, another said “we need to reduce these prisoners’ sensory deprivation and to be able to do individual work with the very poorly motivated”. It is noted that in some prisons (e.g., Cloverhill Prison and the HSU in Mountjoy Prison) funding had been identified for an Occupational Therapy Manager to oversee the development of an occupational therapy service however, recruitment had not so far been successful.
- 3.22** Although some prisons had social worker input (albeit input such as a 0.2WTE social worker in the Dóchas Centre is clearly insufficient), Housing Support staff, as found in Mountjoy Men’s Prison/Dóchas Centre and in Cloverhill Prison, were also deemed to be a beneficial resource, especially in assisting homeless prisoners. Staff in some prisons bemoaned the absence of such staff from their teams.
- 3.23** It was notable that, almost without exception³⁵, unlike in most clinical environments, there was no meaningful administrative support for all clinical staff in the prisons visited. This resulted in clinical staff often being occupied with relatively minor administrative tasks (e.g., time consuming phone calls with outside hospitals and pharmacies, making appointments etc.). As this lack of support further reduced their often-scant time available for the care of prisoners, the lack of administrative support was widely highlighted by clinical staff as a particular deficit requiring rectification.

B. Environment

General Material Conditions

- 3.24** Although some of the prisons visited were built in the 19th century (e.g., Limerick Prison which opened in 1821 and Mountjoy Men’s Prison which opened in 1850), others have opened in the last 25 years and several prisons visited offered modern and generally decent accommodation for prisoners, especially Cork Prison (which opened in 2016).
- 3.25** Nearly all cells visited (including in the special units) were well lit and ventilated and had en-suite facilities and functioning TVs. The Dóchas Centre had made particular efforts to provide a more personalised environment for prisoners, offering shared kitchen and dining areas where prisoners could associate; as one prisoner said, “it’s like prison here, but more homely”.
- 3.26** However, some of the accommodation in which mentally disordered prisoners resided was scruffy and somewhat dilapidated and, in Limerick Prison cells were drafty with prisoners (sometimes “tripling” three to a cell (see section 3.31), covering windows and vents with cardboard and cloth to stop cold air from entering the cells.
- 3.27** Prisoners who had previously been treated in the CMH remarked how the conditions they had encountered there were better than the conditions in prison.
- 3.28** Regarding SOCs and CSCs, seen in all prisons, these were specially designed with plinth beds, protective mattresses, screened TVs, en-suite facilities and call bells.

³⁵ A part-time prison officer was assisting in Cloverhill Prison and there was 0.1 WTE admin support in Limerick Prison.

- 3.29** Of particular positive note is the newly constructed 50-place, two-storey, women’s wing (G Wing) at Limerick Prison, which is nearly fully refurbished and should be ready to take prisoners soon. The environment there is especially impressive and will offer excellent conditions with attractive décor (colours, artwork and murals), smart furnishing, larger suite cells for long-stay prisoners, activities areas, a well-designed boothed dining area and attractive gardens, all in stark contrast to the very poor conditions currently provided on E Wing to women prisoners, where cardboard was being used to block window drafts and paint was peeling from the walls in some of the dilapidated cells holding mentally disordered prisoners.
- 3.30** With regards to the environmental safety of clinical staff, whilst their work is often hazardous, systems were generally in place to minimise risk, including interviewing prisoners in closed visits areas³⁶ when indicated. However, it was concerning that such an option was not usually available to clinicians in Limerick Prison, where there were many prisoners with histories of violence and where the consultant psychiatrist had received death and other threats.

Overcrowding

- 3.31** Except for Cork and Portlaoise Prisons, the other five prisons visited were filled to overcapacity and blighted with significant overcrowding (with cells “doubling” or “tripling” up). Apart from having extra bed places installed (e.g., bunks), necessitating prisoners having to share cells in these prisons, four of the five prisons also had prisoners sleeping on mattresses on cell floors. Indeed, in total there were 100³⁷ prisoners (men and women) sleeping on cell floors at the time of the Inspection Team’s visits. Amongst the prisons visited, the most serious overcrowding was found at Limerick Prison, which was running at 127% bed capacity.³⁸
- 3.32** When cell sharing was required, some efforts were made to ensure compatibility between cell mates. Further, although efforts had been made to avoid prisoners with mental disorders sharing cells, this was not always possible. A number of the mentally disordered prisoners reported finding the overcrowding difficult; one woman in prison described the experience of tripling as “horrible”. Staff acknowledged that cell sharing sometimes had a negative impact on prisoner’s mental wellbeing.
- 3.33** By way of specific example, at Limerick Prison, one prisoner suffering from schizophrenia who was distressed, tearful and complaining of hearing voices, and who was on the waiting list for transfer to hospital, was held in a single cell, which had been “doubled” by having a twin bunk installed and then “tripled” by having a mattress placed on the floor. The conditions in the cell were far from hygienic, with three prisoners sharing a semi-screened toilet in the corner and, when the men were in their sleeping places, there was nearly no space to stand, with one stepping over another to reach the toilet. Such conditions could be considered as degrading.

The Medical / Special Units

- 3.34** Although a number of prisoners with serious mental illnesses (e.g., schizophrenia) were being held in the general population, it was clear during the visit that many of the most vulnerable and difficult to manage mentally disordered prisoner-patients, including many who require psychiatric hospital care but were still waiting for a bed (or had no chance of one), had been placed in the medical/special units within the prisons visited; if the prison in question had such a dedicated unit.

³⁶ Through a screen.

³⁷ 37 in Mountjoy Men’s Prison; 7 in the Dóchas Centre; 26 in Cloverhill Prison; and 30 in Limerick Prison.

³⁸ Accommodating 309 prisoners (271 males; 38 females), 65 above the official capacity of 244 (210 males; 34 females).

3.35 Despite some clinicians in Limerick Prison suggesting that a special unit would be useful, the prison's senior management believed it may stigmatise prisoners and reduce their chances of transfer to psychiatric hospitals for treatment. Further, it was correctly identified that there were totally insufficient numbers of HSE in-reach clinical staff in the prison (see section 3.18) to provide input to such a unit. Therefore, mentally disordered prisoners were distributed throughout the prison.

Although there is no special unit in Portlaoise Prison, there has been some recent discussion about possibly creating one there.

3.36 In the Dóchas Centre, there was a unit referred to as the Healthcare/Committal Unit, the specific purpose(s) of which was not clear. This unit was a "multi-purpose" landing³⁹ for prisoners recently committed to the prison, prisoners with special needs and/or those who had been removed from the general population due to healthcare and operational concerns. Prison officers working in this area were not trained to support the mental health needs of women in this unit.

That said, given the number and nature of prisoners with multiple psychiatric, psychological, substance use and social problems, prisoners with unmet mental health needs were to be found throughout the establishment.

*The High & Low Support Units (HSU & LSU) & Challenging Behaviour Unit (CBU),
Mountjoy Men's Prison*

3.37 The HSU at Mountjoy Men's Prison, although located in a relatively claustrophobic corridor, offered a calm and generally relaxed environment, with nine single cells (all occupied) and an adjacent small dayroom with TV for prisoners to associate. The HSU was accommodating six prisoners with a diagnosis of mental illness (schizophrenia x 5; bipolar affective disorder x 1), a man with Asperger's Syndrome, another with intellectual disability and one diagnosed with personality disorder (who had recently returned from the CMH). Four of the prisoners had committed homicide, most of the others had histories of violence and threatening behaviour. One of the prisoners with schizophrenia had slashed his throat the night before the visit, been sutured in hospital, returned to prison, and was accommodated in an SOC wearing protective clothing. He was due for release from prison in approximately six months and staff reported that, despite their efforts, he had not been accepted onto a waiting list for transfer to psychiatric hospital.

3.38 The associated LSU, with eight single cells (all occupied), was holding three prisoners with mental illness (schizophrenia x 2; paranoid psychosis x 1), two men with Asperger's Syndrome and one with personality disorder (and a history of serious self-harm) and two prisoner cleaners. A number of these men had histories of serious violence, and some were receiving psychotropic medication.

³⁹ OIP (2021) COVID Thematic Inspection Report on the Dóchas Centre, pages 36-38 and OIP (2013) Interim report on Dóchas Centre, Chapter 3.2.

3.39 The CBU, situated in C Base, had six single cells (four occupied), some of which were scruffy and somewhat dilapidated. All four men accommodated in the CBU were said to have been diagnosed as suffering from schizophrenia and all were awaiting transfer to the CMH (two on the general waiting list, two on the VDP waiting list). All these men were deemed to be more suitably placed in the HSU (as the CBU is a segregation unit for disturbed prisoners, rather than a unit to contain mentally disordered prisoners), but due to their high levels of disturbance (e.g., assaults on prison staff, cell destruction, disruptive behaviour) required placement on the CBU. Two of the men were described as having delusional beliefs (e.g., believing that electronic devices had been implanted in the bodies), one was described as suffering from “untreated psychosis” for over one year as he was non-compliant with regular psychotropic medication. All four men were interviewed by clinical members of the Inspection Team within their cells. One, who had made drawings on the walls of his cell, described himself as “half-mad” but said that he did not believe that he needed transfer to a psychiatric hospital. Another stated that he had no mental problems. All four were deemed by clinical staff to require hospital care without delay.

3.40 One of the men (Prisoner A), who had been on the VDP waiting list for the CMH for 18 months, was found residing in a single cell in extremely poor conditions. The prisoner, who had a ragged beard, lay in silence in a dimly lit, fetid and somewhat rancid cell, on his bed, with his head covered by scruffy bedding. He was surrounded by food and litter which was strewn across his cell floor. It was reported by staff that he was uncooperative, disinterested, refused outdoor exercise, rarely washed, sometimes shouted in his cell, banged on the door at night and frequently urinated on the floor, often under his door into the corridor. When the prisoner was approached by clinical members of the Inspection Team (on two occasions, on two consecutive days), he refused to converse with them, re-covering his head with his bedding after a just few terse words. Prison staff reported that the prisoner spoke “98% gibberish” and was “difficult to make contact with, he doesn’t want to talk to anyone, he’s locked in his own world”. He had no TV or radio in his cell, received no visitors and made no phone calls.

Due to his inconsistent compliance with medication, resulting from his poor insight into his mental illness, Prisoner A remained ineffectively treated with medication and other attempted therapeutic interventions for over a year, his poor cell environment seemingly directly relating to his mental disorder. Staff commented that when the prisoner was more compliant with medication, he became more sociable, less withdrawn and functioned better. Due to the difficulties in maintaining Prisoner A in an acceptable level of hygiene within his cell, he was being rotated between two adjacent cells every three to four days, the two cells being at the end of the corridor to reduce the impact of the smell from his cell adversely affecting other nearby prisoners.

The conditions under which Prisoner A was held could be considered inhuman and degrading.

3.41 The assessment of some clinical staff at Mountjoy Men’s Prison was that 16 of the 19 prisoners held within the three special units required the level of care normally provided in a secure psychiatric in-patient environment, a level which could not be satisfactorily provided to the men in their current custodial setting. As one of the senior IPS nursing staff said, “these special units do not offer proper therapeutic environments”, their main aim being to basically segregate and contain, with medication being administered to those prisoners who would accept it, and passing supportive counselling offered when possible. Although exercise was, of course, offered to the prisoners in the units and some association was at times possible, their engagement with any psychosocial rehabilitation was minimal, and although some could access school twice per week, no occupational therapy was available. One of the HSE in-reach mental health nurses described these special units as de facto hospitals but added “we don’t have the facilities to do the treatment required, it’s the wrong milieu, there’s not enough clinical staff, we cannot compel medication and there are no real therapies”.

- 3.42** Due to the potential risks to others that men in these special units presented, clinical interviews with them often needed to occur in a screened visit area.
- 3.43** As regards the need for placement in the HSU, one of the HSE in-reach mental health nurses said that there were other prisoners on in the general population who were waiting for a place to become available, adding “we could fill it twice over”.

D2 Wing, Cloverhill Prison

- 3.44** Although D2 wing at Cloverhill Prison only had eight ordinary single cells and two health isolation cells (which were being used), because of “doubling” and “tripling” within the cells (including utilising mattresses on cell floors) and, having a small number of outlying prisoners on nearby wings, the wing was managing 27 prisoners at the time of the inspection (and had managed 39 prisoners during the previous week). Therefore, although the unit was generally light and airy and decorated agreeably with pastel colours and murals, it was significantly overcrowded (and said never to have vacant beds), with many prisoner-patients milling around on the landing or in the attached exercise yard. One clinician said that the care on the unit was “very good” but described the environment, with so many chronically mentally ill prisoners wandering around less than fully treated, as often rather chaotic. In fact, the atmosphere on the unit felt like the hybrid that it was, some form of longer stay mental health unit with a few clinical staff but featuring crowded prison cells and an environment monitored by prison officers. The unit’s semi-therapeutic nature is seemingly an improvement on the general population location for those residing there but is still far from the therapeutic milieu of a psychiatric hospital unit.
- 3.45** Staff reported that 24 of the 27 prisoners on the unit were mentally disordered (the large majority suffering from schizophrenia, a few being diagnosed as affective psychosis or personality disorder). Of these 24, there were eight waiting for transfer to psychiatric hospital (four to CMH and four to civil hospitals), all of whom were diagnosed as suffering from schizophrenia. The other three prisoners on the unit consisted of two mentally vulnerable individuals who needed support (one with intellectual disability, and another who was there for his own protection). Staff reported considerable energies being spent on trying to persuade prisoners on the wing to take medication.
- 3.46** Two of the four men awaiting transfer to the CMH stated at interview that they had “heard voices”; one describing them as the TV and radio speaking to him, the other describing voices making nasty comments about him, which could make him angry.
- 3.47** Apart from presenting risks to others, some of the prisoner-patients also presented risks to themselves. Indeed, there had recently been an attempted hanging (by a prisoner diagnosed with schizophrenia, who also described “hearing voices”) and an attempted self-asphyxiation (by placing a bag over the head), the latter being another patient awaiting transfer to the CMH.
- 3.48** As one of the prison’s senior managers said, “we have to keep patients here, in prison, as we’re just left to our own devices; it’s only by begging and pleading that we get any help”.
- 3.49** The two healthcare assistants employed on the wing were described as “brilliant” and as “adored” by the prisoners, with staff stating their presence made “a massive difference, they make a big impact on prisoners’ self-care and cell hygiene, if only we had two more”.

Vulnerable Prisoner Unit (VPU), Cork Prison

- 3.50** The VPU was full, accommodating seven prisoners with no doubling or tripling of cells. When there were more prisoners who required the VPU than there were places available (a frequent occurrence), the additional prisoners were placed on the adjacent CBU or on the Committal Unit. At the time of the visit there were ten such men placed elsewhere (many of whom were psychotic and on psychotropic medication) due to the lack of capacity on the VPU. Prison staff reported that although the expected length of stay on the Committal Unit was usually 24-72 hours, some prisoners residing there may have to stay there for weeks or even months, adding “that’s not appropriate for people with mental illness; there’s no visual stimulation, proper space, recreational area or resources there”.
- 3.51** Staff reported that all seven prisoners on the VPU were mentally ill, of whom only some were compliant with psychotropic medication. The VPU was the only part of the prison where 15-minute checks could occur. When interviewed by the Inspection Team, one of the two prisoner-patients waiting for transfer to the CMH (for seven months), appeared distracted and his speech was difficult to follow, he said he was refusing psychotropic medication and did not leave his cell; the other (who had been waiting over two months) was more compliant with medication, but was pseudo-philosophical, had written numerous words across the walls of his cell and described being under the influence of “Amazons”, as well as a woman’s voice who made him do things. The latter man acknowledged that he needed transfer to the CMH but said that he didn’t understand why it was taking so long.

C1 Left Wing, Midlands Prison

- 3.52** C1 Left Wing was a corridor of cells where vulnerable prisoners were placed. One senior clinician in the prison described it as “a pretty bleak environment, it’s not really suitable for those with mental illness”, but explained that it was all that was available.
- 3.53** The wing had two vacancies on the day of the visit. Of the eight prisoners resident there, all but one of the prisoners were said to have mental health difficulties. One was said not to be engaging with others and needed instruction to eat and wash, another was said to talk to himself when alone in his cell and one demonstrated especially poor self-care, sitting scraggily-bearded in his scruffy, malodorous cell, with dirty bedding and scrawled writing on his cell walls.
- 3.54** At the time of the visit, although some could be labile in their mood, none of the prisoners on the wing were deemed to be especially behaviourally aggressive to others; one clinical member of staff said, “they just float along, deluded, often not taking their medication”. Although a prison officer on the unit observed “prison is not the right setting for some of these men to be held in”, just one of the prisoners on the unit was on the waiting list for transfer to the CMH.

National Violence Reduction Unit (NVRU), Midlands Prison

- 3.55** The NVRU was accommodating six prisoners (with four vacancies) at the time of the visit, three of whom were unwilling to engage with the therapy being offered and none of whom were deemed to be mentally ill.

C. Assessment & Treatments Within Prison

- 3.56** Providing treatment to prisoners with mental disorder, particularly those with mental illness, is highly challenging. As one senior clinician said, “with services cut to the bone, there can be conflicts within teams when we are under such stress; it can be very frustrating”.
- 3.57** It was noted that prisoners who presented special challenges to staff were discussed at weekly MAMs which facilitated interdisciplinary and interagency communication. However, clinical staff reported some frustration that mutual access to clinical notes between psychology and other clinical staff (i.e. nursing, GP and in-reach psychiatric staff) was not possible, as notes were held on different systems.
- 3.58** A detailed analysis of the treatment of the large numbers of prisoners in the general population with personality disorder, self-harm and/or addictive disorders and not requiring psychiatric treatment or transfer to hospital was not undertaken.

Mental Health Screening

- 3.59** The initial mental health screening of prisoners on arrival in prison (first by a nurse and then by a GP), was generally being performed within a reasonable timescale following their arrival in prison. However, in Cloverhill Prison, due to IPS nursing staff shortages, the initial assessment could be delayed (see section 3.9).
- 3.60** Following initial screening, if secondary level mental health care was required, access to a psychiatrist in prison was not usually delayed and was probably easier and quicker than for persons in the community.
- 3.61** Staff in some prisons highlighted a concerning lack of availability of services for prisoners with intellectual and other development disorders, including assessment to identify such persons.

Treatment with Psychotropic Medication

- 3.62** Regarding treatment with medication, many prisoners were receiving antipsychotic medication, often as a mainstay of efforts to treat their mental illnesses. However, some prisoners, because of lack of insight into their need for treatment, due to the symptoms of their mental illness, either refused such medication or were inconsistently compliant with it. As prison is not a designated place of treatment, it is not legally possible to involuntarily treat such prisoner-patients (e.g., with injectable medication) and such persons were therefore left partially or un-treated, their only prospect of receiving the medication they required being via transfer to hospital.
- 3.63** By way of example, in Portlaoise Prison, clinical members of the Inspection Team interviewed, in the closed visits area, an especially challenging, notably muscular, life-sentence prisoner (Prisoner B), who had a history of a very serious violent incident (with bizarre features) within prison and past psychiatric treatment in the CMH many years ago. Having made satisfactory progress, he was said to have stopped his oral psychotropic medication approximately two years ago and over the last six to eight months there had been a gradual deterioration in his mental state and behaviour, including becoming disinhibited, abusive to other prisoners and staff, making threats to others, being elated, expressing grandiose ideas regarding his birth, and becoming easily angered.

At interview, Prisoner B's speech was at times difficult to follow, he was very agitated, angry, had a pressure of speech, labile mood, described insomnia, and demonstrated other possible signs of mental disorder (and possible psychosis), although he totally denied any mental ill health. He said he had recently smashed up his cell, and smeared its walls, as he had not received his tea, and said, "if I hear the wrong song, I snap". He had more recently been subjected to barrier handling by prison staff (being brought to the interview from a SOC, in handcuffs⁴⁰, escorted by six prison officers dressed in full protective clothing and helmets). He wanted to know when that very restrictive regime would end.

Although Prisoner B's lack of insight and continuing non-compliance with psychotropic medication appeared to underlie his current disturbed behaviour, mental state, and associated restrictive regime, it was impossible to treat him involuntarily in prison. Indeed, it was not even possible to adequately reassess this needy prisoner psychiatrically under such conditions in the prison, especially with the limited clinical input available there. Prisoner B had been assessed as unsuitable for transfer to the NVRU at Midlands Prison, as he demonstrated signs of active psychosis, an exclusion criterion for that unit. His only chance for meaningful psychiatric treatment seemed to be reassessment and treatment in the CMH.⁴¹

- 3.64** Regarding specific medications available to prisoners, Clozapine, a psychotropic medication used for persons with treatment resistant psychosis, was only very occasionally being dispensed due to the various complexities and risks involved in using the medicine outside a clinical environment. Therefore, this important and useful psychotropic medication is not easily available in prison to persons who may require it.
- 3.65** In some prisons, there were tensions around injectable depot medications and physical investigations related to medication (e.g., blood tests, ECGs) which were ordered by in-reach mental healthcare clinicians for patients on their caseload but then had to be administered or performed by IPS nurses. In Portlaoise Prison, apparently due to the absence of any psychiatric in-reach nurses, annual blood monitoring of prisoners receiving psychotropic medication (which sometimes exceeded 40) was not being done by IPS nurses.

Psychological Provision

- 3.66** Many prisoners have experienced traumatic and abusive backgrounds and trauma-focussed therapy is often indicated, as well as other psychotherapies. However, due to the serious shortage of psychologists referred to in section 3.14, only a small proportion of those prisoners requiring such therapy were receiving it at any given time. It was also stated that many psychological interventions were reactive, due to a lack of capacity to provide proactive input; as one psychologist said "it feels like risks are increasing over time". The deficiencies were clearly impacting upon the treatment of prisoners with mental illness and those with personality disorders, and had been noticed by prisoners; as one prisoner, a serious offender on remand with mental health difficulties, said "I'd really like the chance to talk issues through", and another stated, "I could do with more psychology".
- 3.67** Some interventions on offer were as simple as enhancing coping skills and anxiety management, others were more sophisticated, using CBT, DBT, MBT and CFT techniques, as well as Schema Therapy and EMDR. At the Dóchas Centre, a rape crisis counsellor should be available to offer support to prisoners, but the post was vacant at the time of the inspection visit.

⁴⁰ Which were removed for the duration of the interview.

⁴¹ At the time of the inspection, Prisoner B had not been accepted onto the waiting list for the CMH, although his name was apparently subsequently added to the CMH waiting list.

- 3.68** Many prisoners have substance misuse disorders (e.g., 88 of the 171 prisoners in Dóchas Centre and over 120 prisoners in Cloverhill Prison were receiving methadone) which pre-dated their placement in prison and/or abuse of substances in prison (including new synthetic compounds). Apart from the GP-led methadone regimes (maintenance or tapering, in consultation with addictions specialists), such persons also require psychological interventions (for alcohol and drug misuse) and, despite some visiting addiction counsellors offering support, the provision of an acceptable level addictions service is challenged because of the low numbers of psychology staff (and lack of input from addictions specialists).
- 3.69** In some prisons, the shortfall in psychologists had resulted in the Chaplains being seen as key additional providers of psychological support to prisoners, as well as offering their usual spiritual guidance.

Occupational, Educational & Creative Activities

- 3.70** Few occupational and creative activities were available to prisoners with mental disorders, apart from occasional educational opportunities, the delivery of small packs of art materials to their cells, and local cleaning tasks⁴². One prisoner with a mental disorder remarked about his day “I just wake up, drink milk, count the hours and watch TV; I’d really like something to do”.
- 3.71** Further, when activity was available (e.g., school attendance), some prisoners said that, as their mental illnesses reduced their motivation, they struggled to attend and that, due to that failure, were then unable to obtain the necessary credit to be awarded Enhanced, rather than Basic, regime privileges.
- 3.72** Additionally, prison staff reported that possibilities for occupational activities were sometimes curtailed as prison staff were drawn away for other duties (e.g., escorting).

Recreational & Exercise Opportunities

- 3.73** Regarding recreation and exercise, all the mentally disordered prisoners interviewed by the Inspection Team had access to reading materials and, with very few exceptions, to a working TV. They were also all offered outdoor exercise daily for up to one hour. Most were allowed association, subject to individual risk assessments.

D. System Wide Clinical Care Pathways

- 3.74** There are several concerns regarding clinical care pathways for prisoners with mental disorder when they require treatment in an external psychiatric hospital.

Local Civil Psychiatric Hospitals

- 3.75** It was reported that when some prisoners with mental health problems who had committed minor offences were arrested, an immediate diversion was often not possible due to a reluctance on the part of civil psychiatric hospitals to admit such persons, and, as such, they were then admitted to prison. As one senior manager said, “sometimes they come to prison, even with their solicitor’s support, just to get psychiatric assessment and treatment; it’s shocking”. One psychiatrist described frustrations, stating “psychiatric hospitals can refuse to take people, we in prison cannot”, another said, “the courts just send mentally disordered offenders to prison, as they just don’t know what else to do”, and a senior prison manager said, “prison is the place of last resort, except for women, then it is the place of first resort”.

⁴² For example, printing, engraving, framing, fabric & maintenance workshops, plus IT, art, cooking etc.

It was estimated by staff in the Dóchas Centre that potentially up to half the arrivals there resulted from service failures in the community, with some staff outlining the prison as almost a place for asylum, a hybrid between a prison and a psychiatric hospital.

- 3.76** For some prisoners on remand, and others deemed to have a mental disorder of a level requiring hospitalisation, achieving acceptance for transfer by a local civil psychiatric hospital (with a view to the prisoner then being, for example, bailed to hospital with a condition that they reside/receive treatment there) was sometimes successful (e.g., ten prisoners from the Dóchas Centre had been transferred during the previous year). However, the process was consistently described by clinical staff as very challenging and often unsuccessful (sometimes due to a lack of appropriately secure facilities). As one psychiatrist put it, “low secure beds in civil psychiatric facilities are pretty much absent”, another said “getting agreement for transfer to hospital is like horse trading” and another said “it’s very parochial, a network is required”, suggesting that obtaining treatment in a civil psychiatric hospital depended upon contacts and favours.
- 3.77** Even when a bed in a civil psychiatric hospital was agreed, there were delays in transfer; for example, in Cloverhill Prison, at the time of the visit, four men had been waiting for transfer to civil psychiatric hospital for between two and four weeks. Further, some managerial and clinical staff raised legal concerns, suggesting that there were areas lacking clarity regarding the transfer of prisoners to hospital under bail conditions, including in relation to the IPS transport of such persons.
- 3.78** Staff in many of the prisons described a number of mentally ill, minor offenders who required transfer to hospital, but whom they had not referred as they believed there was no chance that they would be accepted. The need is therefore estimated to be significantly greater than the formal numbers on waiting lists or achieving transfer.
- 3.79** Further, it was reported by some clinicians that up to half of those on the caseload with mental illness would improve, were hospital treatment available (i.e., 10 - 20 prisoners in some prisons) but that, as it was not, staff were often just waiting for prisoners’ sentences to end so that they could then finally try and arrange in-patient treatment for them. Some staff gave past examples (and predictions regarding current cases) of such prisoners who were seriously mentally ill but could not be transferred to local hospitals during their sentence, as the hospitals were not designated, and were therefore left to suffer untreated in prison for many months. They gave accounts of how such prisoners then received treatment immediately upon the expiration of their sentence, with substantial mental improvement occurring within just weeks. Staff said that such circumstances were not only regrettable and tragic, causing unnecessary suffering and potentially negative effects on prisoners’ physical morbidity and life expectancy, associated with untreated mental illness, but also avoidable, were the system to be revised. One senior clinician described the current system as “broken and burnt out”.

Difficulties for Homeless Prisoners

- 3.80** Many prisoners are homeless, and staff reported that this problem appeared to be increasing. Prisoners with mental disorder are over-represented within this group (and often also have lower daily living skills). For example, 50% of the mental health caseload of the in-reach psychiatric team at Cloverhill Prison were homeless. For many such persons, they have a triple handicap in accessing in-patient psychiatric treatment, in that they are disadvantaged by being offenders and mentally disordered, and by being homeless. Staff reported that some civil psychiatric hospitals would not even consider offering a bed to a homeless mentally ill minor offender, as they had no formal catchment area responsibility for the individual (as the system apparently relies heavily on allocating service responsibility through place of residence and Eircodes).

One senior clinician stated, “if we try and force the admission, the receiving doctor threatens that they’ll just discharge the patient onto the streets within hours”, another said “hospitals shouldn’t be able to refuse admission to a patient just because he lives under a bush”, and another said, “they just won’t take them, so there’s nowhere for them to go”.

3.81 As a result of these difficulties, homeless, mentally ill (often with schizophrenia) prisoners on remand who had committed minor offences were frequently not accepted for psychiatric hospital admission at the time of arrest or during the trial process, thus remaining in prison without the benefit of in-patient psychiatric hospital treatment. Such persons were then being released directly into the community, often with no reliable psychiatric follow-up, into fragile settings, frequently exposed to substance misuse, only to find themselves again homeless and without treatment, before again offending (often minor offences; one such prisoner had committed over 100 offences) and then re-entering the criminal justice system. Such persons were referred to by staff as “revolving door” or “frequent flyer” prisoners, who were also said to be serving “life sentences in prison, by increments”. This oft repeating cycle was described as frequently not being broken, despite the opportunity that custody could provide to do so. Staff described the deficit of services for homeless persons as tragic.

3.82 By way of specific examples of the lack of services for the homeless, the Inspection Team was informed of:

- mentally ill women attempting to mitigate the likelihood of their impending homelessness upon release from prison by seeking out strong male figures who were then likely to abuse or exploit them;
- mentally ill men re-entering the community, such as via the courts, without any planned healthcare follow-up nor access to antipsychotic medication or accommodation;
- prison services resorting to using a prison emergency fund (donations from managerial and clinical leads to form an emergency fund) to support the homeless mentally ill when they left prison;
- prisoners being given donations of clothing from prison surplus to ensure they had clothing and a coat to keep warm; and
- a chaplain conveying a prisoner across county divides to try and safely ensure access to accommodation.

Transfer to the CMH

3.83 It was clear that some prisoners were sometimes successfully transferred to the CMH (and some were also returned from there to prison custody), with some staff reporting an improvement in the numbers of such transfers in recent months. However, at the time of inspection of the seven prisons visited there remained 14 prisoners formally on the waiting list for transfer to the CMH (Mountjoy Men’s Prison - 4; Dóchas Centre - 2; Cloverhill Prison - 4; Cork Prison - 2; Limerick Prison - 0; Portlaoise Prison - 0; Midlands Prison - 4), with staff reporting ongoing difficulties in achieving transfer. Some prisoners, including those with schizophrenia, had been on the waiting list⁴³ for a bed in the CMH for long periods. For example, some men in Mountjoy Men’s Prison had waited over one year (as described in section 3.40); two men in Cloverhill Prison had waited over two years, and a prisoner in the Dóchas Centre had been waiting seven months. This woman, who was also diagnosed as suffering from schizophrenia, described to members of the Inspection Team of hearing voices, experiencing paranoid beliefs, and bore the scars of recent self-inflicted burns on her legs.

⁴³ And some on the waiting list had been referred many months before being accepted onto the list.

3.84 All the prisoners awaiting transfer were seriously mentally ill (often with other concomitant mental disorders), frequently described paranoid delusional ideas and auditory hallucinations, and some demonstrated reduced self-care. By way of example, one such prisoner in Midlands Prison, who had a history of in-patient psychiatric treatment, was in his cell 23 hours/day, and was scruffy, malodorous, and barefoot. Although he was taking some oral psychotropic medication, which he said, despite giving him tardive dyskinesic side effects, resulting in involuntary muscle movements, helped him to relax, he nonetheless said that he had sold his soul, could communicate with the TV in his cell and described hearing women's voices. He also complained that his cell was cold at night and that he wanted to be transferred to the CMH. Another person awaiting transfer to the CMH, also in Midlands Prison, said he was homeless, and described paranoid beliefs that his toothpaste and milk were poisoned as well as a staff plot (which had led to him refusing outdoor exercise for three months) led by a woman from outside the prison. He was not keen to take psychotropic medication.

Further, some prisoners awaiting transfer to the CMH clearly presented a potentially high risk to themselves or to staff supervising them within a custodial or clinical environment.

3.85 Clinical staff in many of the prisons also described numerous other prisoners who were mentally ill and required transfer to hospital, but whom had not been referred to the CMH as they believed there was no chance they would be accepted. Some described their experience of patients not even being accepted for a pre-admission assessment by the NFMHS. One senior clinician said, "I don't even think about referring people to CMH, it's pointless", and a senior manager said, "if they had TB, they'd be transferred to hospital for treatment, but for mental disorder there seems little chance of transfer". Some such prisoners not on waiting lists for transfer to the CMH, informed the Inspection Team they thought they required such hospital transfer for treatment but would not receive it. Thus, the formal waiting lists appear to be a significant underestimate of need.

3.86 At least two waiting lists were described for prisoners awaiting transfer to the CMH, the General Waiting List and the VDP Waiting List. The Inspection Team was informed there was only one VDP bed available in the CMH, so the wait for that bed could be very long (over one year). The distinction between these two lists seemed opaque, as some prisoners appeared acutely psychotic and in urgent need of hospital transfer on that basis but, as they were placed on the VDP waiting list rather than the General List, they had waited even longer periods for a bed at CMH. Further, the lists were ever-changing, as one HSE in-reach psychiatrist said, "the lists are movable feasts; someone might be first today and fourth tomorrow".

3.87 Decisions regarding possible admission to the CMH were also said to have been based upon the DUNDRUM Toolkit, a structured tool which was used to assist in assessing referrals there, grading urgency, risk and clinical need. Some clinicians in prisons were not confident that the tool was used reliably, suggesting that the scoring could be adjusted lower "as an excuse not to take a prisoner". Others said, "you need to kill and get in the papers to be accepted", suggesting that just being a very psychotic prisoner, who was non-compliant with treatment and aggressive, was not sufficient to merit the offer of a bed or transfer within a reasonable timescale. Whether correct or not, these views demonstrated the exasperation and lack of support that some clinicians felt when attempting to obtain treatment for their prisoners in the CMH.

3.88 Due to the long waits for a bed at the CMH, it was reported that some prisoners may never actually be transferred to a psychiatric hospital prior to the expiration of their sentence, with some staff recounting stories of dangerous prisoners with mental disorder leaving custody with no follow up.

3.89 Further, sometimes prisoners transferred to the CMH for assessment and treatment only remained there for a matter of a few weeks and although when they returned to prison they were described as much improved, they continued to still require relatively intensive clinical supervision, including initial placement in one of the prison special units.

4 RECOMMENDATIONS

A. Staffing

IPS Nursing Staff

- 4.1 The very concerning shortage of IPS nurses in Cloverhill Prison is unsustainable. The work pressures on the remaining nursing staff there are unacceptable and the potential effect of the shortage on the health assessment and treatment of prisoners is detrimental, not least as the health, including mental health, screening of prisoners is sometimes currently unacceptably delayed there.

It is recommended that the vacancies for IPS nursing staff in Cloverhill Prison be urgently filled (by recruitment or initially, partially, by redeployment). Recruitment may be enhanced by targeted recruitment events.

- 4.2 It is noted that Healthcare Assistants in Cloverhill Prison (D2 Wing) offer important assistance to nurses there with the care of prisoners, but this grade of staff is absent elsewhere.

It is recommended that the benefits of employing Healthcare Assistants in prisons other than Cloverhill Prison is formally assessed, particularly in the special units, with a view to employing such staff in support of IPS nurses in relevant facilities.

IPS Psychology Staff

- 4.3 Despite notable efforts to recruit, the gross shortage of IPS psychologists throughout the Irish Prison Service is very concerning, with 38% of posts vacant across the system. With long waiting lists for prisoners to access psychological therapy (sometimes up to three years), the treatment and rehabilitation of mentally disordered and other prisoners, is being significantly hampered. Even if all posts were filled, it is unlikely that there would be enough psychologists to meet basic demands.

As many prisoners' emotional difficulties are not being addressed, despite there being treatments, their suffering is not being ameliorated, their mental health is deteriorating, and the risks they present to themselves and others, including in the community upon their release, are going unaddressed. The potentially grave health, safety, and even financial consequences to society, cannot be underestimated.

It is recommended that efforts to fill the vacancies for psychology staff across the prison service are redoubled as a high priority, including reconsidering the terms and conditions of such staffs' employment, including enhancing incentives, to try and stem the loss of such staff to the HSE and/or overseas, and enhance the recruitment and retention of psychologists from home and abroad.

- 4.4 As the rape crisis counsellor post at the Dóchas Centre was vacant at the time of inspection:

It is recommended that the vacant post of rape crisis counsellor at the Dóchas Centre be filled as soon as possible.

HSE In-Reach Clinical Staff

- 4.5 At Mountjoy Men's Prison, there is only 0.3 WTE HSE in-reach consultant psychiatrist input, for a prison with 780 inmates and a mental health care in-reach team caseload of 58 prisoners. Staff there estimated, not unreasonably, that 1.0 WTE consultant psychiatrist input was required. At the Dóchas Centre there is only 0.2 WTE HSE in-reach consultant psychiatrist input, for the main prison accommodating women nationally, with 170 prisoners and a high turnover. Staff there estimated, not unreasonably, that 0.4 WTE consultant psychiatrist input was required as a minimum. At Limerick Prison there is just 0.2 WTE consultant psychiatrist for 309 men and women, remand and sentenced prisoners. At Cloverhill Prison, which receives the highest number of committals in the Republic, there is currently only 1.0 WTE consultant psychiatrist. At Portlaoise Prison, the highest security prison in the Republic, there is only 0.2 WTE consultant psychiatrist.

It is recommended that the consultant psychiatrist input to Mountjoy Men's Prison, Limerick Prison, Portlaoise Prison and the Dóchas Centre is substantially increased and that the vacant 0.5 WTE consultant psychiatrist post at Cloverhill Prison is filled. Liaison with the HSE regarding this should occur without delay.

- 4.6 With input from an HSE in-reach forensic mental health nurse at Limerick Prison on only one half-day per week, and no such input at all in Portlaoise Prison, the shortage of specialist in-reach nurses is neglectful of the mental health needs of the prisoners there, especially when the only other member of the in-reach team at each prison is a 0.2 WTE visiting consultant psychiatrist. Further, the HSE in-reach forensic mental health nurse input to Mountjoy Men's Prison and the Dóchas Centre is insufficient to meet the needs of the large numbers of prisoners with serious mental disorders in the prisons.

It is recommended that the specialist forensic mental health nurse input to Limerick Prison is increased to at least one whole time equivalent post, preferably more, and the level of such input provided to Portlaoise Prison, Mountjoy Men's Prison and the Dóchas Centre is increased by at least 50%. Liaison with the HSE regarding this should occur without delay.

- 4.7 A 0.2 WTE social worker in the Dóchas Centre is clearly insufficient for such a needy population with many homeless and/or substance misusing women with multiple social problems. There is no social work input at Limerick and Midlands Prisons.

It is recommended that social worker input is provided at Limerick and Midlands Prisons and at the Dóchas Centre it is increased to at least one whole time equivalent.

Prison Officer Training & Support

- 4.8 Although many of the prison officers working with mentally disordered prisoners have wide experience and a range of skills to assist them in that work, the work is especially challenging and some expressed a desire for greater training in the area, as well as psychological support.

It is recommended that further formal training regarding the recognition, assessment, and treatment of prisoners with mental disorder, including regarding communication and risk issues, is offered to prison officers.

It is recommended that the provision of individual and/or group psychological support sessions (e.g., monthly) are offered to prison officers, with particular emphasis on those staff working in areas where the level of mental disorder is more acute, such as the special units where such prisoners are accommodated.

Other Staffing Issues

- 4.9 The almost complete absence of occupational therapy opportunities for prisoners with mental disorders is hampering their care.

It is recommended that occupational therapists be employed by the Irish Prison Service, tasked with offering occupational therapy to mentally disordered prisoners. This will, of course, require them to be appropriately trained and there to be areas where they can safely work (including with sufficient prison officer presence to address safety issues).

- 4.10 The almost total lack of administrative support for all clinical staff was widely highlighted, as it wastes valuable clinical time which could be used for the care of prisoners.

It is recommended that administrative support staff are employed alongside clinical staff to support them, improving resource efficiency by freeing up the clinical care time of more expensive and higher trained staff.

- 4.11 Housing Support staff were deemed to be a beneficial resource in assisting prisoners in some prisons, but this resource was absent elsewhere.

It is recommended that the benefits of employing housing support staff in all prisons is reassessed, and the resource made available (or increased) for their employment as required.

B. Environmental Issues

General Material Conditions

- 4.12 The modern and acceptable conditions in some prisons are noted, as is the impressive new accommodation for women prisoners, soon to open at Limerick Prison, which it appears will offer very good accommodation. However, the material conditions within which some prisoners reside are dilapidated, with paint peeling from walls and drafty windows, resulting in a cold environment.

It is recommended that the dilapidation noted in certain cells in the prisons visited be rectified.

Overcrowding

- 4.13 Overcrowding has become a serious problem across the prison estate, affecting many prisoners in some prisons, not just those with mental disorder. The need for “doubling” and “tripling” of cell occupancy, with numbers of prisoners sleeping on mattresses on the floor (100 such prisoners in the seven prisons visited), with its effect upon the privacy and dignity of prisoners, is unacceptable. The situation is placing additional, significant psychological pressures upon prisoners and staff, potentially worsening the mental state of those prisoners already suffering from mental disorders, and causing mental distress in others, increasing the overall mental pathology found in the prison population.

It is recommended that assertive action is taken to ensure that every prisoner has their own bed and that prison occupancies do not exceed official capacities. As this requires a system-wide approach, potentially including a greater use of community sentences, diversion from custody, accelerated release and greater transfer to psychiatric hospitals, as well as provision of more prison places, there will need to be liaison between the Department of Justice, the Probation Service, the courts and the Department of Health and the HSE.

Safety

- 4.14 Maintaining the safety of all prisoners and staff is of paramount importance and systems were generally in place to minimise risk to clinical staff, including interviewing prisoners in closed visits areas when indicated. However, such an option was not usually available to clinicians in Limerick Prison (the consultant psychiatrist there also having received death and other threats).

It is recommended that a safety review of HSE in-reach clinical staff occurs in Limerick Prison to ensure that risks to them there are minimised. It is suggested that this would need to include involvement from the HSE, as well as the IPS.

C. Treatment Within Prison

Individual Prisoner Issues

4.15 *Prisoner A*

Due to his inconsistent compliance with medication, resulting from his poor insight into his mental illness, Prisoner A (CBU, Mountjoy Men's Prison) has remained ineffectively treated, residing in degrading conditions, which relate directly to his mental disorder. Having been accepted for transfer to the CMH, he has now waited for a bed, whilst in a disturbed mental state and in such conditions, for over 18 months. This cannot be justified and requires immediate action. Therefore:

It is recommended that Prisoner A, who has been accepted for treatment at the CMH, be transferred there without any further delay. Liaison with the HSE regarding this should occur as a matter of urgency.

4.16 *Prisoner B*

Prisoner B (Portlaoise Prison) demonstrates evidence of mental disorder and is non-compliant with medication. His behaviour has significantly deteriorated in prison where he cannot be effectively treated, resulting in the use of barrier handling and constraints upon his personal freedom. It appears that an urgent reassessment of his treatment needs is required, including how these can be safely and effectively met, including via in-patient reassessment and treatment. Having recently been accepted for transfer to the CMH, in light of his seriously disturbed mental state and behaviour, which poses substantial risks to himself and others, such a move cannot be delayed and requires immediate action.

It is recommended that Prisoner B, who has been accepted for treatment at the CMH, be transferred there without delay. Liaison with the HSE regarding this should occur as a matter of urgency.

Special Medical & Other Units for Mentally Disordered Challenging Prisoners

- 4.17 Special unit accommodation for prisoners with mental disorders allows for those prisoners to be in an environment more customised to their needs, surrounded by dedicated staff with an awareness of their specific needs and, away from areas where their vulnerabilities could be more easily exploited by other prisoners.

Clearly the current special units, where they exist, are above capacity and there are not enough places within them to meet demand, with numbers of prisoners deemed to require such placement remaining in the general population. Further, despite their benefits, the units do not offer sufficient therapy, nor an ideal milieu, for treating such prisoners. Although there is no enthusiasm for creating a designated treatment facility within prison (where prisoners could be involuntarily medicated), due to professional and ethical concerns and an understandable belief that prison can never replicate a hospital environment, proposals that have been made to create a new larger, dedicated and therapeutically enhanced unit for prisoners with mental disorder were broadly supported by many staff.

It is recommended that the proposals for expanding the number of places in special medical and other units for mentally disordered challenging prisoners' places be progressed. This could include the creation of a larger-capacity, dedicated, drug-free unit for prisoners with mental disorder, especially those awaiting transfer to psychiatric hospital, and for those who have returned to custody from psychiatric hospital and require reintegration into more mainstream prison accommodation. Apart from agreement on its location, number of places (ensuring its clinical manageability) and the construction/refurbishment of such a facility, its staffing complement would need to be sufficient, including enough staff of all relevant clinical disciplines, as well as of appropriately trained prison officers. Further, its safe and therapeutic regime and milieu would need to be planned, with senior clinical involvement in its development and in the associated clinical protocols.

Occupational & Creative Therapies

- 4.18** With the exception of Cork Prison, the lack of occupational and creative therapy available to mentally disordered prisoners is a concern; such activity should be part of an overall therapeutic approach for such individuals. Many such prisoners are spending weeks, even months, on end, idle, with no meaningful or creative activities, nor diversion from their preoccupation with their mental difficulties and incarceration.

It is recommended that greater efforts be made to offer prisoners with mental health difficulties meaningful and creative activities, so as to offer diversion and a sense of achievement, and to assist them in their psychosocial rehabilitation. This will require the appointment of appropriate occupational therapists and technical instructors, as well as sufficient prison staff across the prison service.

Other Assessment & Treatment Issues

- 4.19** The lack of medical and nursing expertise in the field of intellectual disability was highlighted in some prisons, including assessment and targeted remedial interventions.

It is recommended that greater expertise in the field of intellectual disability is made available to prisoners via the increased presence of staff with relevant training and skills, the development of relevant assessment protocols and the provision of targeted remedial interventions that are more sophisticated than just routine education.

- 4.20** The disharmony between IPS and in-reach nursing staff in some prisons regarding who holds the responsibility for administering depot psychotropic medications and the physical investigations related to the use of psychotropic medication (e.g., blood tests, ECGs) ordered by the latter for in-reach mental health team caseload patients, is an unnecessary tension. Further, in Portlaoise Prison, apparently due to the absence of any psychiatric in-reach nurses, annual blood monitoring of prisoners receiving psychotropic medication was not getting done.

It is recommended that the responsibility for administering depot psychotropic medications and physical investigations related to medication (e.g., blood tests, ECGs) for in-reach mental health team caseload patients is formally agreed and communicated to all relevant parties by the clinical management structures. Further, annual blood monitoring of all prisoners receiving psychotropic medication should be ensured.

- 4.21** The lack of mutual access to clinical records and documentation between psychology and other clinical staff, which is held on different systems, was a cause of some frustration to all clinical staff. Whilst recognising some information may be highly personal and confidential (e.g., that shared during individual therapy sessions), if key information that may impact upon the risks that a prisoner-patient presents to themselves or others is known but not shared, serious incidents can occur. Indeed, unshared knowledge is not infrequently found as a major compounder in inquiries into violent incidents in institutional settings.

It is recommended that the lack of mutual access to clinical records and documentation between psychology and other clinical disciplines is overcome. Even if certain information is deemed highly confidential and remains restricted, broader mutual access to certain core information should be facilitated, particularly when it relates to key risks to self and others.

D. System Wide Clinical Care Pathways

Transfer to Local Civil Psychiatric Hospital

- 4.22** It is unacceptable that prisoners convicted of minor offences who have mental disorders cannot easily access in-patient psychiatric hospital treatment, with some such individuals remaining in prison, untreated, for months.

It is recommended that urgent consideration be given to the systemic changes that are required to facilitate the swift transfer of minor offenders who have mental disorders to local psychiatric hospitals. As this is likely to require the development and opening of long-discussed, appropriately secure, intensive care facilities/designated beds in civil psychiatric hospitals, this calls for a multi-agency approach.

- 4.23** Homeless prisoners with mental disorder have particular difficulty in accessing civil psychiatric hospital in-patient treatment.

It is recommended that action be taken to remove the current impediments to homeless prisoners with mental disorders obtaining psychiatric treatment in civil psychiatric hospitals. Liaison with the HSE regarding this should occur as a matter of urgency.

Transfer to the CMH

- 4.24** There are many prisoners (often held within the special units) who require and/or would benefit from transfer to the CMH. Some require transfer as a matter of urgency.

Mentally disordered prisoners accepted for transfer for in-patient psychiatric treatment at the CMH can wait long periods for a bed there, and numerous prisoners who are deemed to require in-patient psychiatric treatment are not even referred there (and therefore not on a waiting list for transfer to psychiatric hospital) as there is zero expectation that they will be accepted for admission. It is clear that there is a significant shortfall in the number of required designated psychiatric beds available for mentally disordered prisoners. The current waiting lists are an under-representation of the true need. The significant number of unopened beds at the CMH, due to staffing insufficiency, and a reported lack of intensive care/seclusion rooms, is a profound concern. There needs to be far easier access to in-patient psychiatric beds for mentally disordered prisoners requiring them.

Urgent action is required to create a rapid pathway to allow mentally disordered prisoners requiring a designated psychiatric hospital bed to be swiftly transferred to the CMH.

This is likely to require additional staffing (of nurses and other disciplines) and opening of the currently unused beds at the CMH, greater freeing of CMH beds via opportunities for those patients in CMH to be rehabilitated along pathways where treatment can be provided in other hospitals or the community (and, possibly, the use of the independent sector provision) and wider designation. High-level interagency liaison, including with the HSE will be required. Specific protocols which define expected periods of assessment and treatment (including sometimes shorter admissions for compulsory treatment with medication) should be considered, as should waiting list criteria and targets.

Waiting Lists for Transfer of Prisoners to Psychiatric Hospital

- 4.25** The length of wait for transfer to hospital that some mentally disordered prisoners experience is concerning and potentially harmful to their health. It should be transparently monitored by the IPS and the HSE to build a shared understanding of where and why delays occur and to assist in their future resolution.

It is recommended that the size of waiting lists for admission to civil psychiatric hospitals and the CMH and the time taken for referral, assessment and admission be transparently monitored in a format jointly agreed by the IPS and HSE.

5 CONCLUSIONS

Although the Inspection Team found areas of good practice, and the staff met seemed to be trying their best, the quality of treatment for prisoners with serious mental illness varies considerably, with their mental health care needs not being fully or satisfactorily met in any of the prisons visited. With low mental health staff numbers (including of psychiatrists, psychiatric nurses and psychologists), inevitable delays occur for prisoners in receiving clinical care which, combined with the often-sub-optimal and isolating environments in which they live, is detrimental to their safety, mental health and wellbeing. As the necessary option of transferring such prisoner-patients to a psychiatric hospital is often difficult, delayed, or impossible, many are consigned to unnecessary suffering and unsustainable pressures remain on the prison system. **There is currently no equivalence of mental health care for prisoners in Ireland.**

Despite the multiple problems facing the IPS, and the wider based system, in managing persons with mental disorder, there is at least some cause for optimism. The staff involved are skilful and motivated, some investment has already been made in improving material conditions and facilities, and much good care is being provided despite the difficulties. There are multiple possibilities for substantial positive development and improvement across the whole system.

However, **the legitimate treatment needs of mentally ill prisoners are not currently being met, and their safety and dignity are not being respected.**

Far closer cooperation between the Department of Justice and the Department of Health will be critical if the fundamental problems identified in this report are to be tackled effectively.

This report presents pragmatic recommendations designed to directly address the factors that are undermining the quality of treatment, safety and dignity of prisoner-patients, including: the low – sometimes critically low – **staffing numbers** of specialist mental healthcare staff; inadequate **environmental conditions** in some prisons, including overcrowding and dilapidation; deficiencies in **mental health treatment** in prison, as well as a gross lack of **system-wide clinical care pathways** to access necessary treatment outside prison, including in the Central Mental Hospital.

The Inspectorate of Prisons stands ready to work closely with all relevant stakeholders to advise on the implementation of these recommendations.

6 ACKNOWLEDGMENTS

The Inspection Team would like to thank all the staff they met, in all the establishments visited, for so generously assisting us with their time, excellent cooperation, candour and openness in sharing key information, and in their efficiency in arranging access to all parts of the prisons we wished to visit. Our thanks are therefore conveyed to all the Governors, senior managers, and IPS nursing, psychology, and chaplaincy staff, as well as to the HSE in-reach clinical staff which we met within the prisons visited (psychiatrists, forensic mental health nurses and social workers). All staffs' forbearance with our multiple requests to facilitate our work was much appreciated and their dedication to their work was notable.

The Team would also like to thank all the prisoners they met, for their trust and willingness in sharing their stories and important experiences regarding their incarceration, as well as their hopes and fears regarding their mental health needs. Their contribution was invaluable to our work.

In the report, we have intentionally not named members of staff or prisoners with whom we met.

APPENDIX - CLINICAL EXPERT BIOGRAPHIES

Clive Meux has worked as a Consultant Forensic Psychiatrist for over 30 years in high and medium secure hospitals and in the community, as well as in a maximum security prison (the Close Supervision Centre at HMP Woodhill); he was the Clinical Director of a large forensic mental health service with in-reach teams working in various prisons and then the Medical Director of a large NHS Trust; he has worked as an expert for the European Committee for the Prevention of Torture (CPT) on 35 missions in 15 states, including inspection visits in over 60 prison establishments and as an expert for the Council of Europe on numerous projects (including on mental healthcare in prisons). He has also assisted HM Prisons Inspectorate as an expert assessing the UK CSC system.

Andy Flynn qualified as a Mental Health Nurse in 1989 and has maintained his registration with the UK's Nursing & Midwifery Council. He has a Diploma in forensic mental healthcare, a Degree in Psychosocial Interventions with Severe and Enduring Mental Health Needs and a Certificate in Using a Cognitive Analytic Therapy Approach to Patients with Complex Needs in Forensic Settings. He retired from the NHS in 2018 where he had worked as a Mental Health Nurse gaining significant experience as both a clinician and senior manager within the spectrum of forensic mental health services, including in-patient medium and high security mental health units and prison mental health services. He has significant experience in working with high harm risk prisoners with psychotic and personality disordered presentations.