The Politics of Prison Medicine

A policy paper to follow Out of mind, out of sight: the solitary confinement of mentally ill prisoners.

By Dr Valerie Bresnihan, 2002
IPRT Summary Findings:

♦ 'Treating' the mentally ill with solitary confinement is in breach of human rights standards.

♦ The Minister of Justice has publicly stated that more mentally ill people are likely to enter prison.

♦ The Minister has made no objections to this situation. Is this the new symptom of Zero Tolerance?

♦ Currently, the on-going academic debate concerning definitions, boundaries, and consequently, who gets treated by forensic psychiatrists, is acting as an impediment to the treatment of the mentally ill in prisons, in particular those with personality disorders.

♦ The Irish prison system seems to be sadly imitating international patterns of neglect.

♦ Officials of the prison service have refused to give a commitment to phase out strip cells and introduce observation rooms.

♦ The prison service do not wish to take responsibility for the mentally ill within the prison system; they believe that the Central Mental Hospital, Dundrum [CMH] should be responsible - and house - the mentally ill.

♦ The prison service fears medical services might become 'too good'; they are likely to become overused.

♦ The CMH management have stated they wish to cater for the mentally ill with psychosis only; this means no institution feels they should take responsibility for the other group of mentally ill prisoners: those with what is called personality disorders.

♦ The new and highly innovative CMH development plan appears to cater for the mentally ill with psychosis only.

♦ There appears to be little or no structured dialogue between the prison service and the CMH.

♦ We note the Inspector of Mental Health's concerns regarding the overuse of 'seclusion' (strip cells) in CMH and we welcome the new plans for observation rooms designed on the lines previously recommended by IPRT in "Out of mind, out of sight".

♦ During our conversations with both health and justice officials no clear policy on institutional responsibilities was evident.
In sum, in the words of Senator Dr Mary Henry 'a turf war' exists between the Department of Justice, Law and Equality and the Department of Health as to who will do least for mentally ill prisoners, in particular those with personality disorders.

The following questions arise from the above findings:

**Question for the Minister of Justice, Equality and Law Reform:**

- Minister John O'Donoghue has publicly stated that more and more mentally ill people will be imprisoned in the future
- **QUESTION:** Why is imprisonment the preferred style of administration for storing mentally ill people at this present time?

**Question for the prison service:**

- The prison service has refused our request to phase out strip cells
- **QUESTION:** on what grounds can a prison service justify the continuation of solitary confinement for the mentally ill?

**Question for the profession of psychiatry:**

- The profession of forensic Psychiatry, CMH in particular, have stated their unwillingness to take care for the mentally ill with personality disorders
- **QUESTION:** who is to treat, or at least take responsibility for the mentally ill with personality disorders if psychiatrists refuse to do so?
IPRT Summary Recommendations:

IPRT strongly recommends:

Community:
◆ That as with many European countries, community services should make every attempt to cater for mentally ill prisoners in community secure/semi-secure units as appropriate.

◆ The Health Boards should ensure that all service agreements include appropriate mental health services for their local prison population.

Political agreement:
◆ That all demarcation lines between institutional responsibilities, medical definitions and subsequent management be made explicit.

◆ That therefore all structures, quality and means of delivery of all aspects of the prison health service must be made clear.

◆ That health care in prisons is delivered through a formal partnership between the health service and the prison service.

More specifically, we recommend that:

◆ The prison service should remain financially and managerially responsible for the primary care (general practitioners) delivered in prisons.

◆ The health service should be responsible for secondary and tertiary care (consultancy and multidisciplinary teams), even within prisons.

◆ That the newly legislated mental health commission is established immediately.

◆ That an inter-ministerial agreement between the departments of health & justice be established.

Medical politics:
◆ The health service must care for the mentally ill with personality disorders and the situationally ill in prison.

◆ Forensic psychiatric services should be planned on a national basis with regional consultant appointees.

Management:
There is a need for 2 distinct layers of management:
◆ A policy unit needs to be established.

◆ An independent task force is needed to establish, support and monitor change.
• the task force and policy unit must address the related issues of suicide and self injury, women's issues, young people under 18 years of age and those intellectually impaired (not addressed in this paper).

• That health care building in prisons be structurally separate from the rest of the prison in order to emphasise the therapeutic needs of the mentally ill.
Background:

“No one truly knows a nation until one has been inside its jails. A nation should be judged not by how it treats its highest citizens, but its lowest ones”.

Nelson Mandela.

On April 19th 2001 IPRT released their report *Out of Mind, Out of Sight, The Solitary Confinement of Mentally Ill Prisoners*. This report revealed that mentally ill prisoners were put into solitary confinement (strip cells) for an unacceptable amount of time and frequently as a substitute for appropriate treatment. Solitary confinement as ‘treatment’ for mentally unwell prisoners is unacceptable, degrading and inhumane. Under the Irish Constitution, prisoners are constitutionally entitled to receive the same level of medical care as they would receive in the community.

In our view, this situation also breaches both the European Prison Rules (no R [87] 3) of the Committee of Ministers, Council of Europe, 1987 and the United Nations Standard Minimum Rules for the Treatment of Offenders, 1955. It also breaches the European Convention of Human Rights (ECHR) and the United Nations Conventions against Cruel and Degrading treatment (CAT). Inexplicably, the Irish government has refused to ratify CAT.

Since the release of *Out of Mind, Out of Sight* the New Mental Health Act has been passed by the Oireachtas. IPRT is concerned about the omission of some aspects of Chapter 7, originally an important chapter in the *White Paper, a New Mental Health Act 1995* from this new legislation. The contents of Chapter 7 gave the first indications of diversion schemes, with the judiciary having powers to call for psychiatric assessments of offenders before passing sentence. Furthermore the definition of mental illness has been narrowed considerably. Section 8 of the New Mental Health Bill gives appropriate consideration to the mentally ill with psychosis but is exclusive of the mentally ill with personality disorders. Therefore a disproportionate number of mentally ill people with personality disorders are likely to end up in prison. The new Bill appears to give inordinate powers of discretion to the Gardai as to who is judged to be mentally ill.

The solitary confinement ‘treatment’ as well as the omission of specific legislation for all mentally ill offenders must be seen to breach both the International Prison rules (above) and definite United Nations Standards.

Aim:

Since the release of the report *Out of Mind, Out of Sight*, IPRT have done further lobbying work on what has turned out to be a politics of prison medicine. We would like to acknowledge the openness and speedy accessibility of all those departmental personnel, health board officials and relevant experts with whom we met. The aim of this report is to record current policies and official attitudes concerning the establishment of basic human rights standards of medical care for mentally ill prisoners. In order to achieve balance these policies and attitudes were contextualised from an international perspective.
Method:
Meetings and interviews were conducted with a wide range of relevant interested parties. With one exception - a meeting with the Prison Health Care Review Group - at least three representatives from IPRT met with officials from either the Department of Health or the Prison Service. Literature on the subject of mental illness in prisons in USA, UK and Ireland was reviewed.

Introduction:
It ought never to be forgotten that most offenders eventually return to the community. The safety of the community must be paramount. Although not intended perhaps, the mentally ill in Irish prisons are subjected to degrading treatment that inevitably has severe punitive and damaging consequences. It is equally unacceptable that prison staff are asked to work under such inevitably stressful conditions. Civilised behaviour does not emerge from punitiveness. No illness can improve by punishment; no illness can improve with solitary confinement. Such a form of 'treatment' must be the ultimate stigma for the mentally ill. The annual report from Combat Poverty Agency has recently shown that despite - or perhaps because of - our Celtic tiger, the gap has widened between the rich and poor. The mentally ill poor are put into solitary confinement. Is it possible therefore that both our Celtic Tiger and the politics of Zero Tolerance may have taught us all to care much less and condemn much more?

Our political leaders accept that Irish mentally ill people are too easily being put into prison for the most trivial of offences that could be said to be related to their level of mental illness. The Minister for Justice, John O'Donoghue, has publicly stated: 'I accept that an increasing number of mentally disordered people are being committed to prison (May 23rd '01). Minister Cullen, speaking on behalf of the Minister also stated: 'prison may be used as a refuge ... by the courts [for] offences of a public order nature that are by-products of their illness (April 24th '01). Dr Dooley, Medical Director of the prison service has also written: 'there is no dispute that ... due to lack of suitable alternatives seclusion (strip cells) has been overused (both in frequency and duration within the prison system) (April 24th '01).'

Nowhere does the Minister for Justice object in any way to this situation. Will the Minister agree that offenders need to receive the same level of care within prisons as they would receive in the wider community.

Question for Minister O'Donoghue:

QUESTION: Why is imprisonment the preferred officially accepted style of administration for storing mentally ill people at this present time?
The Politics of Prison Medicine:
At the outset, one must acknowledge that within the prison world, there are two schools of thought regarding who ought to have responsibility for the care of the mentally ill in prison. One way of thinking proposes that all funding, provision and management of medical/para-medical services ought to be the responsibility of a Department of Health. In other words, independent medical and para-medical staff would work in prisons and hospitals like the Central Mental Hospital, Dundrum (CMH), for instance, under the auspices of a Health department and independent of prison management and staff. An alternative school of thought argues that the responsibility for funding, provision and management of services for the mentally ill should be the responsibility of the prison services alone. Each model obviously has policy and management implications. In reality, however, these models may be regarded somewhat as an oversimplification. IPRT believes that a highly structured and well-organised yet compatible mixture of responsibilities is preferable as outlined in IPRT Summary Recommendations.

Current international and national Intellectual debate
For the purposes of this report: 'Forensic mental health ... is an area of specialisation that, in the criminal sphere, involves the assessment and treatment of those who are both mentally disordered and whose behaviour has led or could lead, to offending'. ii The word treatment has been highlighted here because the politics of prison medicine in this country (not unlike other countries) is centred on the question of who is to be actually treated. Briefly, one definition of mental illness adheres to the notion that mental illness is to do with psychiatric illness only, e.g. schizophrenia, bi-polar disorders etc. In our view, the more progressive concept or definition also embraces the notion of mental illness associated with personality disorders in particular but also those who become situationally mentally ill while in prison. The point being made here is that practically speaking the narrow conservative definition has the potential to exclude the management of the mentally ill prisoners with personality disorders and perhaps also those who become situationally ill while in prison. 'Psychiatry is confused and illogical in its approach to the concepts under the broad umbrella of personality disorder' iii. In short, the ongoing academic debate concerning definitions, boundaries and consequently, who gets treated and who does not, by forensic psychiatrists has obvious powerful management repercussions.

IPRT Conclusions: The current debate on who is and who is not to be considered mentally ill inevitably gives 'permission' to those psychiatrists who are reluctant to treat patients with personality disorders (further evidence below).
International Studies:
In order to obtain balance we have introduced an international dimension to this report. The following studies have incorporated the more progressive notion of mental illness that includes personality disorders.

Studies suggest that:
- Prisons are replacing mental hospitals\textsuperscript{iv}.
- One study suggests that about 75\% of inpatients in UK prison healthcare centres have mental health problems\textsuperscript{v}.
- Another study: 50\% of female prisoners and 71.1\% of males had personality disorders.
- 17\% of male prisoners were diagnosed with psychiatric illness (e.g. schizophrenia or manic depression).
- This compares to 0.4\% of the general population who have a psychiatric illness.
- Rates of neurosis (anxiety, depression or phobias) in prison can be up to 4 times higher than in the community\textsuperscript{vi}.
- 80\% of the females were judged to be mentally ill in one USA study \textsuperscript{vii}.
- There is a strong correlation between mental illness, substance abuse and offending: 70\% of mentally ill offenders were also affected by substance abuse or dependency\textsuperscript{viii}.
- Comparatively, mental health rates could be said to be considerably higher that that reported by prison services\textsuperscript{x}.
- Examination of figures for England and Wales shows that the numbers of mental hospital beds and the numbers of prisoners have been inversely related in recent years\textsuperscript{x}.
- Equally, American studies indicate that their jails are taking over from mental hospitals: 'quietly but steadily, jails and prisons are replacing public mental hospitals as the primary purveyors of public psychiatric services for individuals with serious mental illness' \textsuperscript{xi}.
- USA studies have also shown that the majority of seriously mentally ill individuals who end up in prison have been charged with relatively minor offences \textsuperscript{xii}.
- Studies confirm that prisoners suffering from serious mental disorders are at significant risk in prison, the prison environment per se being detrimental to their health\textsuperscript{xiii}.

Irish Studies:
Unfortunately full comparative figures for Ireland are not available but the following figures, although limited, may well confirm a pattern of sad imitation.

- One in two women offenders in Mountjoy had psychiatric treatment before entry into prison with one in those four requiring psychiatric hospital admission\textsuperscript{xiv}.
- 30\% of males and 49\% of female prisoners stated that they had spoken to a health professional about mental health problems within 12 months\textsuperscript{xv}.
IPRT Conclusion:
- Prisons seem to be the preferred place of disposal for large numbers of mentally disordered people.
- Prison populations have a higher rate of mental illness - therefore all therapeutic service should be better not worse.
- The Irish prison system seems to be sadly imitating international patterns.

Psychiatric Confusion in Practice:
It has been noted that rarely does one model of medical responsibility actually exist. It has also been suggested that the current academic debate or 'philosophical muddle'\textsuperscript{xvi} has practical implications for management - or non-management - of mentally ill prisoners, particularly those with personality disorders. The following section provides an account of expressed institutional attitudes that, in our view, have serious policy implications.

Problems perceived by the prison service:
During our conversations, the prison service repeatedly emphasised the difficulty in getting commitments from the health services to provide services inside the prison and blamed them for many of the shortfalls. Societal attitudes were also said to be at the source of the problem of under-resourcing of prisoner health services. The prison service also expressed frustration in its inability to raise problems in any visible and constructive manner. IPRT promised wholehearted support in this matter. The prison service were of the view that all seriously mentally ill people - be they psychiatrically ill, suffering from severe personality/behavioural disorders or situationally ill should go to CMH. The view was also expressed that if health services in prison were good, they would attract inappropriate use! By which was meant that it was expected that the judiciary would put more mentally ill people in prisons as the services were so poor on the outside. This may indeed be true. IPRT believe that this institutional attitude may be one of the fundamental reasons why the prison service has refused to countenance the main recommendations cited in Out of Mind, Out of Sight: These were a) the phasing out of strip cells in Irish prisons, b) the introduction of observation rooms/wards as a substitute for strip cells, c) the establishment of 3 in-service clinics in Cork, Castlerea and Mountjoy.

IPRT Conclusions:
- Officials of the prison service have refused to give a commitment to phase out strip cells and introduce observation rooms.
- The prison service does not wish to take responsibility for the serious mentally ill within the prison system.
- The prison service believes that the CMH should be responsible - and house - the mentally ill.
- The prison service fears 'good' medical services: they may be overused by the judiciary.
Questions for the prison service:

- on what grounds can a prison service justify solitary confinement for the mentally ill?
- on what grounds can a prison service deny responsibility for at least managing the mentally ill?

Problems perceived by personnel in CMH:
CMH is the hospital where the seriously mentally ill are admitted. 98% of referrals to CMH come from the prisons. Under Section 208 the CMH is obliged to take mentally ill prisoners from other Health Boards. The management of CMH believe that many of these patients should not be in prison in the first place. Both the CMH and the Inspector of Mental Hospitals feel that Section 208 is overused. The Inspector notes that: 'many of the section 208 patients had been in hospital for several years and there had been no contact by their Health Boards with staff in the CMH. It should be a matter of principle for Section 208 patients to be joint care responsibility'\textsuperscript{vii}. These patients' crimes are mostly associated with trivial public order offences. CMH, for its part, blamed the courts for 'dumping' problems on them that they, in turn, feel ill-equipped to handle. IPRT were told that there was a 'black economy' of ill-adjusted prisoners being sent from the prisons to CMH and back. Despite the addition of new psychiatrists into the system, this trade-off still continues. For instance, June 2001 - many weeks after the Out of Mind, Out of Sight report - one prison was declared insane when in a strip cell on day 2. Although this prisoner was so ill he insisted on going naked, defecating into and then eating his food, he was not removed to CMH until 12 days later - until someone more 'suitable' was put back into the prison?

CMH wishes to maintain the current 89-bed level and reduce pressure through the creation of court diversion and community schemes, the building of a hostel within the grounds of CMH for those current residents who are not psychiatrically ill but are institutionalised. Most importantly, management in CMH was very clear that they did not wish to take prisoners suffering from personality disorders. Only those who were deemed to be psychotically mentally ill were considered to be acceptable. It was even more disturbing to learn from personnel in CMH that they do not feel in any way responsible for the management of patients who are mentally ill with personality disorders or situationally ill in prisons. They appear to be willing to diagnose these patients but not to care for them medically. The new development plans for CMH appear to confirm this situation. On the whole, it appears that the profession of psychiatry in CMH, in particular, adheres to the conservative model of mental health care. This is indeed regrettable and is a genuinely difficult issue to resolve.

The CMH has irregular but frequent discussions with the prison authorities. There is no permanent forum for discussions.
Seclusion (padded cells) in CMH
We note with considerable concern the high rate of solitary confinement or 'seclusion' in the CMH. The Inspector of Mental Health reports in 1999: 'the level of seclusion in the hospital was very high with more than 300 episodes recorded in 1998. Virtually all seclusion was prescribed by junior doctors and seclusion was provided in acceptable and unsatisfactory conditions'\textsuperscript{xviii}. The CMH has drawn up plans to update the buildings that had previously been condemned by the CPT. We are glad to see from the plans that observation rooms rather than padded cells (seclusion) are to be installed. We welcome this approach and would also hope that the Inspector's recommendations that 'a thorough revision of seclusion practices, both in relation to the frequency with which it occurs and the premises\textsuperscript{xix} for it, be undertaken'\textsuperscript{xx}.

IPRT conclusions:
- The CMH management appear to want to cater for the psychiatrically/psychotically ill only.
- Their new CMH plan for development appears cater for this traditional category if illness only.
- There is little or no structured dialogue between the prison service and the CMH.
- We note the Inspector of Mental health concerns regarding the overuse of 'seclusion' (padded cells) but welcome the new plans for observation rooms on the lines as recommended by IPRT.

Question for the profession of psychiatry:-
- Who is to treat or at least be in charge of the mentally ill with personality disorders if they do not?

Problems as perceived by various Health Officials:

This report contains many of the recommendations already called for by IPRT such as diversionary schemes for the mentally ill as well as a call for highly structured and well co-ordinated services for severely mentally ill prisoners. Further this document clearly states the problems of communications and responsibilities already outlined in this paper. Having said that, the Department of Health itself is clear that their financial and management responsibilities for mentally ill prisoners do not lie beyond the remit of CMH. It is hoped that these considerable problems of responsibilities and communications will not delay the recommendations outlined in the report.

In all our discussions with members of the medical profession associated with prisons and health, -including the Department of Health - it appears that the overall concern regarding medical care of prisoners operates from the conservative definition - and thus management - of psychiatric illness. In other words, no
institution seems to want to take responsibility for the mentally ill with personality disorders or the situationally ill. Having said that, however, we are aware that the Department of Health is willing to fund those Health Boards that operate from the more progressive model of health care. From the perspectives of human rights and good prison management we have serious concerns as to the fruitfulness of using such a narrow means of defining medical care. IPRT thus rejects this distinction on the grounds that this distinction is more to do with an institutional denial of responsibility than with humanitarian purposes. Having said that, however, IPRT acknowledges the good intentions of all concerned and the genuine difficulties that inevitably exist.

IPRT Conclusion:

- During our conversations with both health and justice officials no clear policy on institutional responsibilities was evident.
- It would appear that no institution wishes to cater for the mentally ill with severe personality disorders.

IPRT Overall Conclusion: a Politics of Social Control:

In this country, although no figures are available, the Minister for Justice has admitted that more mentally ill people are likely to be 'treated' in prison. He does not seem perturbed as outlined above. Is this aimless aping of punitive politics really necessary? In the view of IPRT, this is simply a disgrace.

The political agenda for the treatment of mentally ill offenders is partly driven by the medical profession, as was easily acknowledged by those to whom we spoke. Academically, the 'philosophical muddle' about terminology is 'confused and illogical' xxii. Practically, this is demonstrated by CMH, in particular, who have no desire to cater for the mentally ill with personality disorders and whose development plans actually reflect this.xxii The reality is also that the New Mental Health Act appears to have now given the forensic medical profession a convenient device for rejecting difficult, unpopular and antisocial patients.

Practically speaking also, this forensic 'confusion' - and the management implications behind it - may well have handed our politicians new devices for social control: the refusal by forensic psychiatry to define the mentally ill with personality disorders as 'mentally disordered' and thus treatable, inevitably reinforces the idea that some seriously unwell people can be better described in purely criminal terms only. The easy stereotype-facilitating ability embedded in zero tolerance provides an easy passage for such people to be quickly labelled, frequently by the media in particular, as 'monsters', 'devils' etc. The consequence of all this is that some types of serious - and destructive - mental illness will be treated with punishment. This is evident from Out of Mind, Out of Sight report. As a result, people will leave prison in a far worse 'criminal' state than they went in, if the present system of solitary confinement is anything to go by. In this sense IPRT believes that the politics of zero tolerance is greatly contributing to the criminalisation of the mentally ill. Thus the actual consequence is that right now the mentally ill -
particularly those with personality disorders - are being diverted to prison rather than from it. IPRT believes that the Minster's statement quoted at the beginning of this report and the prison services refusal to phase out solitary confinement for mentally ill prisoners offers indisputable proof of this criminalisation factor.

The problem for society is that when such patients are rejected, they do not disappear, they have to be looked after by other agencies that at the very least, and despite their genuine concern, are no better equipped than health care agencies to manage patients. This places an unhealthy burden on community agencies.

In short: there is a grave danger that the criminal system is now going to have to pick up the psychiatric rejects, as has been publicly stated by Minister O'Donoghue. If this situation is not addressed the inevitable consequence will be further community disturbance in our streets. The protection of the public cannot be assured by the current situation.

The treatment of all mentally ill patients, be they psychiatric or suffering from personality disorders must be seen as exclusively a health service task. Depending entirely on the severity of their crime, the seriousness of their mental illness and their social circumstances, IPRT's preference is that they be treated first in secure/semi-secure community units, and only in prison where absolutely necessary. No citizen of this country should ever be written off as untreatable. As in accordance with the literature, IPRT have been assured that 'difficult, aggressive and socially disruptive behaviour that leads to distress for patients, their carers and the wider community can be identified in advance and, with proper management, prevented' xxiii. What will never be possible is for mental health services to prevent all acts of violence in their patients, any more than such a perfection of prevention can be obtained in the wider community. One must be realistic always. What will be problematic is identifying in advance that tiny minority of people with mental disorders who may go on to inflict serious or fatal injury to others.

It is therefore obvious that a more progressive model of health care is badly needed. The traditional model of care, long ago decoded by Goffman in Asylum, as a model of control and patient objectiveness is to be seriously questioned. The health care pyramid needs to be inverted from the hierarchical order of the old traditional order to a more 'bottom up' empowerment approach reflecting the humanitarian requirements of the modern information age. In this alternative and complementary role, professional practitioners in mental health care will need to restate the values and beliefs that underpin their decisions and actions. The principle of respect for the person, even an offender, must become the central and guiding principle determining all other principles in health care including those of justice and autonomy, equity, quality and accountabilityxxiv. The model of care being advanced by IPRT is based on community safety and patient centredness as a priority. These two concepts are entirely compatible. The traditional model of care, useful no doubt, in its time, now needs to move on if it is to respond to the crisis of humanity first outlined in Out of Mind, Out of Sight.
The challenge therefore is threefold. The first step is facing the challenge for forensic mental health to include the personality disordered and situationally ill prisoners as human beings capable of improving their lives under medical guidance. Secondly, a challenge to the professional power base may be needed if the individual - particularly those with personality disorders - is to stop living in a criminal mindset or world and by implication the community is to become a safer place in which to live. Having said that, it must be acknowledged that the power of the medical profession is not normally the dominant factor in determining such desired outcomes. Both Prior and later, McCann James have concluded that the 'arbitrary nature of the legal system defines some people as mentally ill and others not'. We have seen this demonstrated through the omission of personality disorders as a form of mental illness in the recent Mental Health Bill. Finally, the challenge for the prison service to take responsibility for all those that pass through their system, including the mentally ill; to insist on humane treatment, to end solitary confinement as a 'treatment' for the mentally ill. The challenge for the Minister for Justice is to depart from a politics of punitiveness; to be aware of his responsibility for the potential increase in crime: for degrading treatment in prisons inevitably breed further illness and further discontent. The present situation should be seen as an opportunity to choose modern forms of management, to forget the past. In sum, the political process, forensic mental health and prisons services need to deliver adequate care for their patients for that is the only way an increased sense of safety in the wider community can be expected.

**IPRT believes that the only certainty that exists at present is that mentally ill prisoners - some of whom should not be in prison in the first place - will pay the price for the inability of the prisons, the health service and the more traditional members of the profession of Psychiatry to solve their problems over territory, roles and funding.**

Accordingly, IPRT sets out the following recommendations:

**IPRT Summary Recommendations:**

**Community:**
- That as with many European countries, community services should make every attempt to cater for mentally ill prisoners in community secure/semi-secure units as appropriate.
- The Health Boards should ensure that all service agreements include appropriate mental health services for their local prison population.

**Political agreement:**
- That all demarcation lines between institutional responsibilities, medical definitions and subsequent management be made explicit.
- That therefore all structure quality and means of delivery of all aspects of the prison health service must be made clear.
- That health care in prisons is delivered through a formal partnership between the health service and the prison service:
a) The prison service should remain financially and managerially responsible for the primary care delivered in prisons.
b) The health service should be responsible for secondary and tertiary care, even within prisons.
- That an inter-ministerial agreement is needed.
- That the promised mental health commission is established immediately.

Medical politics:
- The health service must care for the mentally ill with personality disorders and the situationally ill.
- As a result of the present system of solitary confinement for the mentally ill, forensic psychiatric services should be planned on a national basis with regional consultant appointees.

Management:
There is a need for 2 distinct layers of management:
- A policy unit needs to be established.
- An independent task force is needed to establish, support and monitor change.
- The task force and policy unit must address the issues of suicide and self injury, women's issues, and young people under 18 years of age.
- That health care in prisons be structurally separate from the rest of the prison in order to emphasise the therapeutic need of the mentally ill, e.g. the Medical Health Unit in Mountjoy prison.

Recommendations from Out of Mind, Out of Sight
Once again we reiterate our principle recommendations from the Out of Mind, Out of Sight report:

- **Mental Health Courts**: Although no figures are available in Ireland one UK study found that there is a substantial rate of psychiatric disorder in the court population. Further, this disorder was not satisfactorily detected with the current system\textsuperscript{xvii}. Hence the immediate need for Mental Health court systems and well planned co-ordinated diversionary schemes that would provide medical service to the courts.
- **3 (3-6 beds) in service clinics in Cork, Castlerea and Mountjoy**: Even with the most perfect of diversionary schemes there will always be those that will become situationally mentally ill in prisons; there are many in prison life that will become ill but not serious enough to merit admission to CMH or secure community hospitals.
- **Strip cells need to be abolished**: observation rooms/wards should be introduced.
- **A full time Inspectorate of Prisons** needs to be established.
- **A full time Ombudsman** needs to be established\textsuperscript{xviii}.

END
The above quotations are taken from Dail and Seanad debates respectively, and a document written by Dr Dooley obtained by IPRT under the Freedom of Information Act.


The above 4 findings are summarised from Fact Sheet 10, Mental Health and Prisons, The Howard League, 2001.


Report of the Inspector of Mental Hospitals, for year ending 1999, 22.

We are aware of excellent new policy documents e.g. CMH 'Seclusion Policy' and CMH 'Policy of Patient Observation'. At time of writing, however, we are not convinced that all old padded cells will be phased out.

Report of the Inspector of Mental Hospitals, for the year ending 1998, 22.


One study found that psychiatric patients are regarded by students 7 doctors as 'not easy to like and unsatisfying to treat'. Buchanan & Bhugra 1992 in Journal of Psychiatry, 2000, 176, 335.


See Mental Health Strategy, Mid-western Health Board, February, 1998 for further elaboration of these ideas.


Some of these recommendations have been already by IPRT before – see Out of Mind, Out of Sight, and else where, e.g. Response to the Prison Health Care Review Group by the Royal College of Psychiatrists (Irish Division). April, 2000.


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Irish Penal Reform Trust
Iantaobhas Eireannach Teo Um Leasu Pianuil

Mission: To campaign for the creation of a more rational and humane penal system, to promote constructive approaches to offenders and in every way to increase the respect for human rights.

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