

FOURTEENTH ANNUAL CONFERENCE



Mental Health in the Criminal Justice System

*- The deliverables of the Governments
'Vision for Change'*



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*ACJRD would like to thank the staff and offenders of Arbour Hill Prison
for their assistance in printing this report*



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Welcome Address

Maura Butler, Chairperson ACJRD Ltd

You are all very welcome to our 14th Annual Conference!

Traditionally our conferences facilitate cross-disciplinary discussion, reflecting the cross-disciplinary nature of the membership of ACJRD.

As many delegates present are ordinarily in a role that restricts open subjective discussion of their views in a public forum, ACJRD also has a tradition of invoking the Chatham House Rules to give the broadest possible space to air all and any views.

As you most probably know, The Chatham House Rules state:

"When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed".

The application of these rules today will maximise openness and facilitate the sharing of information between speakers and delegates.

Today's conference entitled - *Mental Health and the Criminal Justice System (CJS)* - falls during World Mental Health Week 2011. This topic was firstly explored in the forum that is our Association's Mental Health Working Group, under the stewardship of our Vice-Chairperson, Finbarr O'Leary. The subsequent decision of the ACJRD Council to facilitate interdisciplinary discourse on Mental Health in the CJS in an annual conference setting, whilst referencing current Government policy, is a welcome one.

In line with previous ACJRD conferences we will today hear from policy makers, agencies and professional & voluntary practitioners from many disciplines in our own and neighbouring jurisdictions, as they outline during plenary and workshop sessions, how they interact with those who come in contact with law enforcement agencies, in circumstances where mental health issues arise.

We will also hear from those individuals who have *been* that person who experienced those health difficulties within a law enforcement context.

The experience of Juvenile Offenders, who as children invariably warrant a particular focus, will be explored.

Therapies that assist recovery from mental illness, early interventions and survival and growth will be presented from a practitioner and recipient perspective.

It is the wish of our Council Members, our Manager, Danelle Hannan, our volunteer interns and assistants and I, that the expertise and experiences placed before you today will serve to create new insights that will enhance the very valuable work done in this area.

We sincerely thank all of our speakers today, who have travelled from far and near, in circumstances where they have left busy lives to freely give of their time, so that we can all learn and bring that knowledge back to our work, with a more informed perspective.

We also look forward to hearing about the deliverables of current Government policy on that aspect of the *Vision for Change*, which focuses of the theme of today's conference.

Mental Health and the Criminal Justice System – Working Together

Jimmy Martin, Assistant Secretary, Department of Justice & Equality; & Bairbre Nic Aongusa, Director, Office for Disability & Mental Health

JIMMY MARTIN

Ladies and Gentleman, the focus of our address today is on cooperation between the Justice and Health sectors in the area of mental health and the criminal justice system. This presentation is a joint venture between the two Departments, a concrete manifestation of the cooperation that now exists. The second half of the presentation will be done by my colleague from the Department of Health, Bairbre Nic Aongusa.

I will introduce the topic and outline the areas where mental health issues arise for the criminal justice system. *[Bairbre will give you some background on her office and explain the structures that have been introduced to ensure better cooperation between the Mental Health and Criminal Justice Services.]*

Cooperation between our Departments is of course not new. For example the Department of Health was part of an Inter-Departmental Committee established back in 1962 by the then Minister for Justice Charles Haughey to review our penal system which looked at mental health issues for prisoners.

What is new is the acknowledgement that cooperation has to be sustained and that structures have been put in place to identify problems and allow them be addressed at the appropriate level. The overall effect has been a significant improvement in the services provided.

While I am going to focus on the positive, I am not suggesting that the situation is now perfect and that there is not significant room for improvement. Difficulties in this area are not unique to this Jurisdiction. In this regard I would point you to a report from the Criminal Justice Inspectorate in Northern Ireland, March 2010, on Mental Health and the Criminal Justice in Northern Ireland. It states that "*The amount the justice systems spend on mentally disordered persons who are repeat offenders is substantial; to the detriment of the rest of the criminal justice system.*" It also points out that although responsibility for prison healthcare

was transferred from the Northern Ireland Prison Service to the Health Service in 2008, there was little sign of change as yet.

The first question to ask is why is there an overlap between the criminal justice system and mental health? After all the Department of Justice does not really get involved in other health issues such as cancer or measles.

The most obvious example is situations where an individual has been killed by a person suffering from a mental disorder.

Because there has been a homicide, it is in the interest of society to determine whether an unlawful act has been committed and if so was the perpetrator criminally responsible for that act. If the perpetrator is guilty, he or she is liable to criminal sanctions. If not criminally responsible, it has to be decided whether it is in the interest of society or the perpetrator that he or she be detained. A formal determination of these matters by a court with all the safeguards associated with a criminal trial is in the interest of the accused as well as society in general. People should not be locked up in a mental hospital on the mere assumption that they committed the act.

We have people with relatively severe mental health issues whose behaviour may stray into the criminal area. Decisions have to be made on a case by case basis as to whether the case should be treated under civil mental health legislation or go down the criminal justice route.

THE INTERFACE

There are 3 key areas where mental health issues arise for the criminal justice system and its agencies.

Courts and legislation

1. The courts are at the centre of the criminal justice system. When a person is charged with a criminal offence and a mental health issue arises, the courts are critical in determining how the matter is addressed. They do this within the

framework established by law and subject to the resources available.

If the charges are clearly serious, the court may have to satisfy itself whether or not that the accused has the ability to participate in a criminal trial - is the accused fit to plead? If the trial proceeds it is then for the jury to decide did the accused commit the act and if so was their mental state at the time of the crime such that they were not responsible for their actions?

Role of the Gardaí

2. The Garda Síochána has to deal with a variety of situations where mental health issues can form a critical element. They are in the front line of emergency services and one of the few State services that are on the street 24 hours a day. They can encounter situations where an individual has been killed by a person suffering from a mental disorder or there may be a hostage or barricade incident. They may come across circumstances where there is an individual who is clearly mentally ill and in need of care but where there is no criminal offence at issue.

Role of Prisons

3. The major complaints about the mentally ill in the criminal justice system tend to focus on their treatment in prison. We have a significant number of prisoners who have quite rightly been convicted and sentenced to terms of imprisonment but who develop mental health problems. As with any prisoner who is ill, they need to be treated but in a way consistent with their sentence. We also have remand prisoners, some of whom should not be in the criminal justice system at all.

Legislation

Now turning back to the question of legislation and courts. I want to give you a quick outline of the legislative framework. Until 2006, the key Acts dealing with mental illness and people charged with or convicted of criminal offences were the Criminal Lunatics (Ireland) Act 1838, the Central Criminal Lunatic Asylum (Ireland) Act, 1845, the Lunatics Asylums (Ireland) Act, 1875 and the Trial of Lunatics Act, 1883. I still have them in my legislation folder on my desk as I used to have to refer to them on a regular basis. They provided the legal basis for the special verdict of "guilty of the act but insane" and for the indefinite detention of a person so found *"during the pleasure, in such place and in such manner as the Minister for*

Justice may seem fit." They also provided the legal basis for transferring remand and convicted prisoners from prison to the Central Mental Hospital and back again.

Historically the prospect of indefinite detention seemed to have deterred the use of the plea of insanity except in murder cases where the alternative was in any event a mandatory life sentence. The issue did not get much attention in Ireland for most of the 20th century until in November 1978, the Interdepartmental Committee on Mentally Ill and Maladjusted Persons produced a report on the "Treatment and Care of Persons Suffering from Mental Disorder who appear before the Courts on Criminal Charges". This Interdepartmental Committee involved close work between the Department of Justice and the Department of Health among others and was chaired by Judge Henchy. It looked at the legal and practical aspects of dealing with mentally ill people in the criminal justice system and proposed new legislation.

However there was not much progress in addressing new legislation until the mid 1990's when the plea of insanity suddenly became topical.

At a particular trial, evidence was given on behalf of the State by a forensic psychiatrist that the accused was not insane. However counsel for the defence was able to convince the jury that the actions of the accused were not the actions of a sane man and the special verdict of guilty but insane was returned. As soon as the perpetrator was committed to the Central Mental Hospital the accused effectively reversed his position arguing that he was now perfectly sane and should be released.

A vista was beginning to open up that clever defence lawyers would be able to convince juries that the act of murder is not the act of a sane person, obtain a guilty but insane verdict and then get their client out because the person was not suffering from any mental illness.

At that stage, work on preparing legislation was given priority within the Department of Justice. The situation in other countries was examined as was the work of the Henchy committee. It was also recognised at that time that the role of the Minister in determining the period of detention of such persons was not consistent with the

jurisprudence of the European Court of Human Rights.

As it turned out the immediate problem resolved itself and did not arise again. Work on the legislation dropped down the priority list and finally saw the light of day when the Criminal Law (Insanity) Bill was published in 2002. As with all legislation, the relevant Departments, in this case Health, were consulted on its contents so that there was an agreed policy. This Bill was finally enacted in 2006.

While the 2006 Act is quite comprehensive, it did not significantly alter the principles of the criminal law as regards fitness to plead or the test of criminal responsibility. The only innovation was to introduce the option of a verdict of diminished responsibility in murder cases. This was intended to deal with borderline cases where the accused was suffering from a mental disorder but it was not such to absolve the accused of criminal responsibility. It is restricted to murder because this is the only offence where a sentencing judge has no discretion and must impose a mandatory life sentence. In all other cases, it is assumed that the sentencing judge will take into account the mental health of the accused as a mitigating factor. While the verdict clearly recognises the existence of a mental disorder, the 2006 Act makes no special arrangement for treatment.

The real change in the 2006 Act was how persons were to be dealt with on a finding of insanity. Such persons are no longer subject to automatic detention. Furthermore, if detained at all, responsibility for the determining of their release now falls to an independent tribunal. The Central Mental Hospital is the designated centre for treatment. There is an option to designate other psychiatric centres but that option has not been exercised.

This emphasis on release where appropriate was continued in the Criminal Law (Insanity) Act 2010. The primary purpose of the 2010 Act was to facilitate the conditional release by the Tribunal of patients back into the community. There have now been a number of releases of patients back into the community.

While the Minister no longer has any role in deciding on the ultimate release of patients, he still has a role in consenting to the temporary release of

patients. This has maintained an operational link between the CMH and the Department.

The 2006 Act also provides for the transfer of prisoners, both remand and convicted, to the Central Mental Hospital and their return to prison.

In summary, the 2006 Act sets out the formal framework within which the criminal courts may operate. By and large it is adequate for the traditional type case where a person is clearly suffering from a mental illness.

However a variety of individuals come before the criminal courts where the offence is relatively minor or where a question of mental health arises which is not necessarily relevant to fitness to plead or criminal responsibility. The criminal courts do not have powers to order the health services to provide mental health treatment. Traditionally when faced with this problem the courts remanded the individual in custody on the basis that the person was better off in prison and that there was some hope that some form of treatment might be provided.

Role of Gardaí

The Gardaí play a key role in dealing with people with mental illness. Their responsibilities cover both the civil and criminal side. Their response can determine whether a mentally ill person is diverted away from the criminal justice system to be treated under the civil law.

Section 13 of the Mental Act 2001 provides a statutory basis for their role in assisting the removal of a person to an approved centre. More importantly section 12 gives the Gardaí the power to take a person suffering from a mental disorder into custody and to initiate the process whereby that person can be admitted as an involuntary patient to an approved centre. The importance of the role of the Gardaí in this area can be gauged by the fact that in 2010 nearly a quarter of all applications for a person to be involuntarily admitted were made by members of the Garda Síochána.

When faced with persons suffering from a mental disorder who may cause harm to themselves or others, the Garda concerned has to take a decision whether to pursue the route provided by the Mental Health Act 2001 or the criminal law. If the route provided by the Mental Health Act 2001 proves

difficult, people will naturally turn to the criminal justice route under which the mentally ill person will end up in prison.

Good cooperation between the local Gardaí and the local health services is critical therefore to making sure that mentally ill people do not end up in the criminal justice system by default. To this end arrangements were put in place in 2010 whereby a Garda Inspector has been nominated in each Division to act as a liaison person to the Approved Centre for their catchment area.

The nightmare scenario for the Gardaí is a barricade incident involving a mentally ill person. Abbeylara immediately springs to mind. While relatively rare, it has been a source of great concern that the Gardaí should have access to suitable psychiatric advice on a 24 hour 365 days a year basis. This was one of the issues that were addressed under the structured cooperation arrangements between the two sectors.

Role of Prisons

Finally I want to turn to the role of prisons. I am not going into any operational detail as there are others speakers here that are more expert than I. However I do wish to give you an overview.

In 1956 there were 373 people in prison. In the same year there were nearly 20,000 involuntary patients in mental hospitals. (table 2.3 of *Crime, Punishment and the Search for Order in Ireland - Kilcommins S., O'Donnell I., O'Sullivan E., and Vaughan B.*) You can imagine the chance of any mentally ill person ending up in prison was extremely limited during this period.

The situation facing the Irish Prison Service has now changed dramatically. In November 2010 there were 4,440 people in custody in prison. Over 17,000 people were committed to prison that year. (IPS annual report 2010) In contrast there were less than 2,000 involuntary admissions to approved centres under the civil procedures in the Mental Health Act (Mental Health Commission annual report 2010).

The Department of Justice and Equality is a strong supporter of the *Vision for Change* and the allocation of greater resources to mental health services. Unless you have well resourced mental health services, an increasing number of persons

with mental health issues will end up in the criminal justice system and prison.

Closed prisons are not conducive to the mental health of anyone. The normal community and family supports are removed, you are forced into a very structured and controlled regime and your fellow prisoners may not be the most tolerant or supportive. Prison may provide a secure holding area for those whose illness may pose a perceived threat to themselves or to the good order of the community outside. However, it certainly is not an ideal therapeutic environment for the treatment of the mentally ill.

Even in the best of circumstances, prison will always have a higher percentage of those with mental disorders than that found in the community.

A significant number of criminals are dysfunctional and many have personality disorders. Furthermore a high percentage of prisoners engage in, or have engaged in, substance abuse and these are more prone to mental illness because of that substance abuse.

Until relatively recently, the only option in dealing with a prisoner with a severe mental illness was to transfer him or her to the Central Mental Hospital. However the CMH has very limited capacity and as a result we had situations where we had severely distressed mentally ill prisoners stuck in a padded cell for months on end while on a waiting list for the CMH. This was upsetting and led to very bad relations between those responsible for running the prison system and the CMH.

There is now a much more positive relationship, waiting lists have been reduced significantly and the Forensic Mental Health Services based in the Central Mental Hospital now provides an in-reach to a number of prisons. A special support unit for prisoners with mental health issues has been introduced in Mountjoy. This has won an award from the World Health Organisation. The Forensic Mental Health Services has also played a lead role in introducing a scheme for diverting remand persons away from the criminal justice system and into the non forensic mental health services.

Other speakers will expand on the progress made in the prisons area.

Having highlighted the key areas where the Mental

Health and Justice services interact, I will now hand you over to Bairbre.

BAIRBRE NIC AONGUSA

I'd like to thank Maura Butler and the ACJRD for the invitation to speak here today, together with Jimmy Martin. The very fact that Jimmy and I are doing a joint presentation to this Conference is a demonstration, in real terms, of the close cooperation and collaboration that is happening between our two sectors at the moment. I'm conscious that most people in this room are probably working within the criminal justice system looking out at the health system. So, I want to give you the perspective from the health system, looking in at the criminal justice system.

I'm going to tell you a story about what has happened over the last ten years, which is my story really. I came across the interface between health and criminal justice for the first time when I was assigned to the Mental Health Unit in the Department of Health in 1999. At that time, we had two Consultant Psychiatrists in the Central Mental Hospital who never set foot in a prison - they stayed in the Central Mental Hospital. The hospital itself was run in line with a custodial tradition - I think it had changed very little in the previous thirty years. There were many care staff who were functioning like prison officers or warders. There were no beds available, there was very little movement in or out of the hospital and as a result there was a mental health crisis in the prisons, with an increasing number of prison suicides. This was ringing alarm bells all over the place that something had to be done.

We had antiquated legislation in this area in both the civil and the criminal law in 1999. In health, we operated under the Mental Treatment Act of 1945 and on the criminal side it was 19th century legislation. Also, in the wider mental health service there was a very strong tradition of the Gardaí bringing people to mental hospitals for admission, particularly in rural areas and in the West. Many of you will be aware of the tradition of people being brought to 'The Mental' if they had problems with alcoholism or domestic issues and so on.

So that was then. We had a job of work to do and we made quite a lot of progress in the early 2000s. We enacted the new Mental Health Act in 2001. A

new Clinical Director came into the Central Mental Hospital – Dr. Harry Kennedy. Harry tells me he was formally appointed in 2003 but he was there before then as Acting Director and I know his influence was being felt from very early on. We were fortunate that there was some additional funding available in the early 2000s and we made investments which led ultimately to five consultant-led multi-disciplinary teams in the Central Mental Hospital and the beginnings of the National Forensic Service.

There were two crucial aspects about this change in the Central Mental Hospital. Firstly, the Consultant Psychiatrists started going into the prisons and running clinics there. Secondly, there was the introduction of multidisciplinary teams – psychologists, social workers, occupational therapists as well as additional nursing staff. This signalled a very significant change, a cultural change, within the Central Mental Hospital itself, away from the custodial approach to a therapeutic healthcare approach. The addition of the teams and more qualified nurses enabled that change to commence. The Central Mental Hospital has a long tradition of very active industrial relations activity and it's always a challenge to get cultural change and organisational change in such an environment. But there has been an awful lot of work done, and it is still ongoing, in changing the regime and the approach in the Central Mental Hospital.

In relation to the Gardaí, there was recognition on the part of Garda management of the need for training in mental health issues. In 2002 the Inspector of Mental Hospitals was invited to the Garda Training College in Templemore for the very first time to speak to Garda trainees. That was the beginning of what is now an extensive programme of training and education of Gardaí in relation to mental health issues, which is very welcome and necessary.

In 2006, *A Vision for Change- the Report of the Expert Group on Mental Health Policy* was published and I was a member of the expert group which produced it. What was welcome about *Vision for Change* was that it set out very clearly the policy parameters for where we wanted to go. In relation to forensic mental health services, it sent out a number of key messages to local mental health services and also to the prison service and the justice system. Primarily, it clarified that the

forensic route - that is the criminal justice route - is only appropriate for people with mental illness where there are cogent, legal reasons for the person not being treated elsewhere. We need to be very clear that depriving somebody of their liberty is a very serious matter and should only happen when there are cogent, legal reasons for so doing.

A Vision for Change also set out the need to develop services within the prisons for people with mental illness. It specified that they should be person-centred and recovery orientated. It recommended four more regional teams, which have not yet happened, but at least we know where we want to get to. There were also recommendations about court diversion, Garda training, liaison and the new Central Mental Hospital.

So, in *Vision for Change* we had officially mapped out where we wanted to get to and there was clarity now about what was required. But despite all of that progress, we still had problems in relation to the interface between the health and the justice systems. It was what I call “the blame game”. Everybody I spoke to about the problems to do with mental health in the criminal justice system told me it was somebody else’s fault!

The prisons were talking about how the Central Mental Hospital wouldn’t accept acutely ill prisoners who needed admission. The Central Mental Hospital were saying the prisons were sending inappropriate people and the prisons were asking them to deal with issues of discipline and order, as opposed to dealing with those who were mentally ill. The Gardaí were saying the local mental health services were not accepting people who needed admission. The mental health services locally were saying that the Gardaí were sending inappropriate people and asking them to deal with issues of public order instead of treating people who were mentally ill. The Central Mental Hospital then also complained that the local mental health services wouldn’t take people back and that’s why they couldn’t take people in from the prisons, because all their beds were blocked by the local services not taking people back. The local services on the other hand said they couldn’t take people back from the Central Mental Hospital because they didn’t have the skills to deal with the issues.

How do you deal with something like this - when everybody is saying that it’s somebody else’s problem? Well, my view is that you need to get everybody around the one table, taking joint ownership of the problems and working out the solutions instead of having people standing in their respective boxes and pointing the finger at the other.

The opportunity to do that presented itself when I was appointed in 2008 as the first Director of the new Office for Disability and Mental Health. The Office was given a very specific remit by Government to work on a cross-departmental basis in progressing *A Vision for Change*. Our remit – which was obviously broader than just the mental health and criminal justice interface - was to get departments and agencies working together across sectoral boundaries, to get joint ownership of the issues needed to implement *Vision*. Our approach was to put the person, the service-user at the centre of everything we did. The mechanism we developed for this work was the Cross-Sectoral Team.

What is a Cross-Sectoral Team? It is a group of people gathered around a particular issue which crosses the boundaries of organisations. You put the person you’re concerned about at the centre – in this case, the person with mental illness in the prison system or in the justice system - and all the people in the various state agencies who need to work together to make the service better for that person are on the team. So, our Cross-Sectoral Team is jointly chaired by myself on the part of the Department of Health and Jimmy Martin from the Department of Justice. The Irish Prison Service is represented and the Garda Síochána is also there. The HSE’s Assistant National Director responsible for Mental Health, Martin Rogan is a member, as is the local manager responsible for the Central Mental Hospital Jim Ryan, and its Clinical Director Professor Harry Kennedy. And we have the Court Service in attendance, as required.

So everybody who has a piece of the jigsaw is around the same table. And that is what makes the difference. We were very clear, Jimmy and I, when we set up this team that the objective was to bring about improvements in services for the people who are our end-users - the people with mental illness within the Criminal Justice System. Everything we do has to be centred around the needs of those people. Exploring mechanisms for

a more efficient service provision is obviously a really important part of our work at a time of contracting budgets, as the demands on the service are increasing with the increasing prison population.

What has been the progress so far? Both Jimmy and the Secretary General have referred to the progress made in relation to working with the Gardaí and the local mental health services. I cannot stress enough the importance of a good working relationship between the Gardaí and the mental health services at local level. This importance may not be apparent to those who are working in the Courts or working with the prisons, but people with mental illnesses can be sent before the Courts inappropriately and then on into prison and that needs to be prevented. First and foremost, it needs to be tackled because it shouldn't happen for human rights reasons, but secondly because it does cause huge strains on an already constrained resource.

The Memorandum of Understanding which was signed recently by the Garda Commissioner and the CEO of the HSE puts the working relationships between both organisations on a formal basis and enhances the important liaison arrangements. What we have in place now is a senior Garda in each division who has the responsibility to liaise with the local mental health services and the Clinical Director of each mental health service knows who that Garda is. So they're really starting to work well together and that fulfils one of the recommendations of the *Vision for Change*.

We have also been working very closely, between the two Departments, on amendments to the Criminal Law Insanity Act. It's an ongoing issue that we need to ensure the two pieces of legislation, the civil law - the Mental Health Act - and the criminal law, are working well together. We've also been working on operational arrangements with the Central Mental Hospital to ensure that we can actually comply with the law once it's enacted so that nobody stays in the Central Mental Hospital longer than they need to. We need to ensure that we have the facilities to ensure people are discharged – either back to the prison or to step-down accommodation in the community - when their clinical condition allows.

Reflecting on the work of the Cross-Sectoral Team, what strikes me is that, over time, we have

moved from having quite a lot of venting and complaining at the beginning to a very collaborative, cooperative spirit among all the people around the table right now. I think this is a vindication of our approach of developing relationships and an understanding of where the other person is coming from, rather than the "blame game" I described earlier.

For me, the real measure of progress in this area has been the absence of any high profile crisis in the last couple of years. My perception is that within the civil service and the public service in general, we don't get any attention or rewards for the absence of crises. If there's a crisis and we all roll in and solve it, we might get a gold star but the fact that there have been no crises is actually a measure of the progress we have made in the joint working together in the last couple of years.

However, there is absolutely no doubt that problems still exist and we have huge challenges ahead with contracting budgets, as I mentioned, and reduced staffing, particularly in the health services. But we talk about these kind of issues in the Cross-Sectoral Team before they get too big and we each try to understand where others are coming from and work out a joint solution.

In this context, I would emphasise the difference between coordination, cooperation and collaboration because I think this is a journey that we have travelled. Coordination means each of you is doing your own thing and you just check with each other that you are not stepping on each other's toes. Cooperation is when each of you wants to do something, you check with each other, and maybe work out a plan. But each of you has your own approach and you just make sure you're working together. Collaboration is when you come across a problem and take joint ownership of it and talk together about how to solve it together. It's really about working very closely together. In our work on the Cross-Sectoral Team, we go up and down this spectrum because we are all coming from different places, but I would say, personally, that we are well on the way. We're certainly beyond coordination, well into cooperation and certainly, very often, collaborating. And effective collaboration and good communication is what it is all about and that is what makes the difference.

Where we are going now? To use an old cliché – there's a lot done, and a lot more to do. Both

Departments are currently reviewing their legislation, despite the fact that in the last ten years we've had two new pieces of legislation after a gap of over 50 years. The good news is that the new Central Mental Hospital is still on the cards. I am not going to go into any great detail to the saga of the last ten years with the development of the new Hospital. There were shades of the Grand Old Duke of York – we were marched up the hill and we were marched back down again! It took up a lot of time, but the new Hospital is still there in the capital programme for the HSE, it is going to go ahead and we're going to be working away on that.

A real challenge is the growing prison population and the impact that is having on the demand for services. The prison population is expanding and health budgets are not. We will not be able to cope for the next ten years if we don't work to develop the regional services as well as the new Central Mental Hospital. Also, the question of prisoners

with an intellectual disability is a huge one, as is the issue of young people. We do have linkages with the Irish Youth Justice Service and the new Department of Children and we'll be building on them.

So, those are the issues that are on the "to-do" list, but having worked so well, and so fruitfully, with all our colleagues in the Department of Justice and the Criminal Justice System over the past few years, I am confident that we will be able to deal with them. In fact, I would go so far as to say that the interdepartmental group the Secretary General referred to, and wishes to set up, is actually already in place and working very well! No doubt we will be able to carry the good working relationships we've developed so far into any new mechanism that may be put in place in the future.

Thank you very much for your attention.

Severe Mental Illness - *Vision for Change* in the Criminal Justice System

Professor Harry Kennedy, BSc MD FRCPI FRCPsych. Executive Clinical Director, Consultant Forensic Psychiatrist, National Forensic Mental Health Service, Central Mental Hospital. Clinical Professor of Forensic Psychiatry, University of Dublin, Trinity College. Medical Council No: 05923.

There have been enormous changes in the way that mental health services have been delivered over the last century in Ireland and prison services have also developed rapidly in recent years. I hope to describe briefly how we have surveyed psychiatric morbidity in the Irish Prison Service and what might follow from what we found. My colleague Dr. Conor O'Neill who is speaking later this afternoon will describe how we have built on that research to develop court diversion in Ireland. I also want to describe briefly the earlier results of some research on psychiatric morbidity in young offenders in St. Patrick's Institution. If there is time I also want to mention the development of a High Support Unit in Mountjoy Prison.

Vision for Change relies heavily on the language of mental health and mental health services. But as a doctor my task is to advocate for better services on behalf of the severely mentally ill. Language can sometimes confuse or hide the real issues. Politically correct language is a means of ensuring that discriminatory or insulting language and usage is eliminated, but it can sometimes hide the real problem. It can be better to ignore stigma and say what we mean in plain terms - like 'Mad Pride'. My concern is with diseases of the mind such as schizophrenia, bipolar affective disorder, severe intellectual disability and other severely disabling mental disorders.

Penrose's Law used to be thought of as a sort of statistical fallacy. Penrose's Law shows that there is an inverse relationship between the number of psychiatric beds and the number of prison places. As the number of psychiatric beds goes down, the number of prison places goes up. Everyone knows that statistical associations are not signs of a causal link. There is no link between the number of storks nesting in Sweden and the number of live births there even though they may be statistically associated. In recent years however, in various countries around Europe and North America, people are revisiting Penrose's Law because the

effect is so strong and so striking that we now think there must be something in it.

A colleague Dr. Brendan Kelly examined the statistics for Penrose's Law in Ireland and found the inverse correlation between prison numbers and hospital numbers in Ireland is stronger than in any other countryⁱ. The numbers in psychiatric hospitals have fallen like a stone all throughout the second half of the 20th century up until the date of *Vision for Change* in 2006. The numbers in prison were pretty steady at about 300 in the 1960's but recently these have increased dramatically so that there are now consistently more than 4000 people in prison.

*Vision for Change*ⁱⁱ is a national policy setting out plans for all the mental health services for the country. The forensic mental health services account for only 3% of the mental health budget and the mental health budget is only about 6% of the HSE's total budget. *Vision for Change* could be seen as a way of limiting the spill over from the closure of the asylums to the expansion of the prisons in the hope of limiting or preventing an expansion of the forensic hospital population. The plan is that by improving community services, fewer people with severe mental illness will get arrested, go to prison and end up in forensic hospitals.

What has happened in other countries? In London the homicide rate is strongly correlated with the rate of recorded crimes of violence overall and homicide and violence are strongly correlated with suicide rates across different London boroughs. The strong correlation between the suicide rate and the rates of violence and homicide is because, to some extent, there is a common underlying factor relating to mental disorder. It is not surprising therefore that the use of forensic mental health service secure beds, is strongly correlated with the homicide rate. This is because violence, suicide, mental illness and the services needed to cope with them are all indirect effects of underlying causes in

communities. These underlying causes can be measured from census variables concerning deprivation, social cohesion and population density. The more deprived, the more disorganised an area is and the more densely populated it is the higher will be the homicide rate, the suicide rate and the rate of use of forensic bedsⁱⁱⁱ.

We looked at the same sort of effects in Ireland. The rate of admission to the Central Mental Hospital from different parts of the country depends very strongly both on deprivation and population density. What is interesting in Ireland is that deprivation has no effect in rural areas with low population densities because social cohesion remains strong there. In densely populated urban areas however deprivation has the same toxic effect as in London leading to high rates of admission to the Central Mental Hospital^{iv}. This is important because London is all urban and most modern European countries are 90% urban and 10% rural. Ireland is different, 2/3 rural and 1/3 urban.

In a rational system you would allocate all your mental health resources to where the population has the greatest need. In Ireland this should mean focussing most resources in the cities, particularly Dublin where population density and deprivation is greatest. In practice however surveys published by the government almost every year, if analysed, show that most psychiatric resources, most beds, most money spent per population, most manpower is allocated to rural areas where the psychiatric morbidity is actually low^v.

It is no surprise therefore that seriously mentally ill people fall through the net of service provision because the net is stretched most thinly where demand is highest. These are the people who end up in Garda stations, district courts and prisons because of their mental illnesses. They accumulate particularly in remand prisons^{vi, vii}.

One of the ways we have responded to this and tried to meet the policy objectives of *Vision for Change* is by establishing court liaison and diversion systems through the main remand prison, Cloverhill Prison, while avoiding special legislation - the existing civil mental health legislation works best^{viii}. We are able to operate a national service centrally, covering 70% of the country. People committed to the remand prison are screened for mental illness on arrival and if

found to have a severe mental illness we liaise with the courts and arrange for them to be admitted to their local services if they are charged with minor matters. If they are charged with something more serious or need higher levels of therapeutic security they are admitted to the Central Mental Hospital^{ix}.

Young Offenders

We have recently begun to survey the needs of young offenders in St. Patrick's Institution where people are aged sixteen to twenty. We have been very influenced by the work of Professor Pat McGorry. Pat McGorry is a Dubliner who grew up in Melbourne. Last year he was made Australian of the year. He is an adult psychiatrist who looks after adolescents, he is not a child psychiatrist. What he does is to apply an adult perspective on people in late adolescence looking for the early signs of severe mental illness, a topic that up until now has not be of interest to child psychiatrists.

What Pat McGorry has done is to stage severe mental illness the way oncologists stage cancer. If you think about how we all try to cope with cancer, treating stage 4 advanced cancer is often about hospice care, sadly. Treating stages 1, 2 and 3 is where we hope to achieve a cure. The odds are often against you and what we increasingly try to do is to treat stage 0, pre-cancer. There are now national vaccination programmes and screening programmes where the aim is to identify pre-cancer and find other ways of preventing the causes of cancer.

McGorry's brilliant insight is to apply this approach to schizophrenia. He has successfully found a way of identifying stage 0 pre-schizophrenia which he calls the ultra high risk state. Using a carefully structured interview he is able to find out about family history, genetic risk and sub-threshold symptoms. It has now been shown in a number of countries that a very high proportion of those identified as ultra high risk will progress to frank psychosis or bipolar affective disorder in the following year^x.

We have used McGorry's interview diagnostic instrument in St. Patrick's Institution and to the best of my knowledge this is the first time this has been done for young offenders.

In 2010 St. Patrick's Institution admitted 1248 prisoners, about 24 people a week with a daily average in custody of 214. 18% of them were aged

under eighteen. In 2011 we started screening. We are able to screen only one in three new committals. Of the first 121 young male offenders interviewed the mean age was eighteen.

We identified psychosis in one. This is what we expected. The psychosis rate is 3% or 4% of adult committals to prison but because the age of onset is in the late teens we would expect it to be lower in young offenders. However we found that 26% were at ultra high risk of psychosis using Pat McGorry's special interview and criteria. We also found that 88% had a significant drug or alcohol problem.

We found that alcohol did not increase the risk of being in the ultra high risk group. Cannabis increased the risk to an extent but ecstasy, amphetamine and cocaine greatly increased the risk of being in the ultra high risk group. Mephedrone which was sold in head shops until recently also greatly increased the risk of being in the ultra high risk group. We were surprised to find that benzodiazepines bought on the street also increased the risk of being in the ultra high risk group. This is probably because people are trying to self medicate with them when coming down from the use of other drugs such as cocaine. Overall we found that the more types of drug a young person takes the more likely they are to be in the ultra high risk group.

Other researchers have shown that cannabis, which in our study was the weakest association with ultra high risk of psychosis, is associated with the risk of developing schizophrenia when young people are followed up over prolonged periods of time^{xi}. The real difficulty we have in prisons is that people simply continue their substance misuse in prison as easily as they do in the community because drugs circulate so freely within the prisons.

High Support Units in Prison

Special observation cells have been built in a number of the prisons. Although they are cleaner and better lit than old style isolation cells they should not be mistaken for the therapeutic use of seclusion in a psychiatric hospital, where there are constant nursing observations and alternatives to seclusion which enable seclusion to be minimised. Special observation cells are in effect high technology toilets, isolation cells by another name.

In order to minimise the use of special observation cells in prisons the psychiatric in-reach team at Mountjoy, in partnership with the prison healthcare and discipline staff there, has established a high support unit (HSU). This is fundamentally an alternative to the use of special observation cells. In December 2010 a ten bed high support unit commenced in Mountjoy Prison. Those prisoners who were either mentally ill and awaiting transfer to the Central Mental Hospital or at increased risk of harm to themselves or others can be managed without the use of the special observation cell. They are separated from the general prisoner population where they are often bullied and their medication is stolen from them and they are closely monitored in a safe environment. We found that about a third of the people benefiting from this unit actually had a severe mental illness while the others had a diverse range of problems including personal crises and being picked on in the general population of prisoners. They moved back into ordinary prison locations pretty successfully, some transferring to the Central Mental Hospital, some transferring to other prisons when they were ready to go. Most actually had no mental health issues at all and simply sorted out their issues in the prison. The use of special observation cells across all of Mountjoy Prison fell by 59% so the goal was achieved by a very simple innovation. There was no decrease in the rate of transfer to the Central Mental hospital so the HSU is not being used as a substitute for imprisonment^{xii}. The WHO award for Health Innovation in Prison Health Services (2011) recognised this project and it is an outstanding achievement for the combined forensic mental health and prison team who accomplished this.

Law Reform

The Unites Nations covenant on the rights of people with disability (UNCRPD)^{xiii} will have far reaching beneficial effects on how mental health services and the criminal justice system respond to people with disabilities including mental disabilities. The UNCRPD places a special emphasis on dignity and assisted decision making. The emphasis on dignity is one of the most important advances in this area in many years. It should end the clash of cultures between legal and medical definitions of best interests where the medical definition has always emphasised the need to restore health and dignity while the legal definition has focused narrowly on liberty - "dying

with your rights on” leading to the accumulation of the mentally ill in prisons^{xiv}.

In the light of the UNCRPD, now would be a good time when revising the Mental Health Act 2001 to merge the Mental Health Act 2001 and the Criminal Law (Insanity) Act 2006. This would help to eliminate double standards. A greater emphasis on assisting the mentally incapacitated would be a much preferable way of ensuring care and dignity than the current approach which only allows intervention based on risk of harm and criminalisation.

My colleague Dr. Conor O’Neill will be speaking later this afternoon about prison in-reach and court diversion. We have established a very successful prison in-reach and court liaison/diversion service in Cloverhill Prison without the use of the Criminal Law (Insanity) Act 2006, using the Mental Health Act 2001 where necessary, with the goal of reconnecting people with their community mental health teams, mostly voluntarily. The specialist mental health courts in Florida and Toronto are much less successful. They process very small numbers because they do not use systematic screening as employed in Cloverhill Prison. Therefore they miss a great many of the most serious cases of mental illness.

Introducing hospital orders as an alternative to insanity and unfitness to plead would be a useful reform of the Criminal Law (Insanity) Act 2006. Courts should not have to find somebody legally insane in order to send them to hospital. The legal definition of insanity rests largely on moral theology rather than ethics or rights to health and treatment. Hospital orders would be a pragmatic and successful solution, connecting people with severe mental illness to mental health services. Of course judges should only be empowered to send someone to hospital if the person has first been certified by two doctors, one of whom is the admitting consultant psychiatrist. Again this ensures that there is no double standard when compared with the Mental Health Act 2001.

Another essential overdue reform is the introduction of assisted community treatment orders based on a right to dignity and assisted decision making. We have seen the way forward here with the introduction of conditional discharges under the Criminal Law (Insanity) Act 2010. The UNCRPD should facilitate the

introduction of a more generalised form of community treatment order for those with a mental disorder leading to impaired capacity for decision making.

Drug Free Prisons

There is clear evidence that cannabis and stimulant street drugs are related to the onset of lifelong psychosis. Drugs are as readily available in prisons as they are on the streets, sometimes more so. There are arguments that it is inhuman to prevent open visits. However difficult choices must be made and I believe this is a very clear choice. Prisons should be drug free. This could be introduced by designating some wings drug free, asking prisoners to volunteer for those wings and rewarding those who demonstrate that they remain drug free with substantial remissions of sentence. Because of the voluntary element this would not offend anyone’s human rights. Prisoners often tell me that their rights are impaired by being surrounded by drug users who force drugs on them. Not enough is heard about the right to be imprisoned in a drug free environment.

In prison, we should be addressing literacy and numeracy deficits, health, education, drug and alcohol awareness, work retraining and community alternatives to custody.

We should be maximising pre-release planning for all prisoners. One of my daily problems is finding every kind of service, housing, mental health, welfare benefits for people leaving prison particularly the mentally ill. The mentally ill leaving prison are the minority that my colleagues and I happen to know about. Yet every year thousands of people leave prison who are homeless, who do not have a G.P, who do not have their benefits sorted out and who are going to reoffend because of this. We need pre-release planning and the sort of specialist social intervention agency that you would find for instance in Seattle. Seattle has a particularly good example of such a service which we should all be learning from.

The HSE has a responsibility to do much more about early intervention in psychosis. This is not about counselling for the worried well. We should spend money only where it counts. There is little or no evidence that counselling for the worried well reduces suicide rates. There is a great deal of evidence that early intervention for those at ultra

high risk of psychosis would reduce the burden of severe mental illness in the population.

Effective Mental Health Services

The HSE should be prioritising services for those with severe and enduring mental illness, acquired brain injury and intellectual disability. When choices must be made we should prioritise the few severely disabled over counselling services for the many worried well. Unfortunately voters prefer to vote for the soft end of services.

There is an urgent need to have forensic mental health services for children and adolescents. Such a service would be very different to the traditional child and adolescent mental health service because it would be “hybridised” with adult mental health services, placing a special emphasis on the ultra high risk states which begin earlier than we had thought. We also need forensic mental health services for the intellectually disabled and those with acquired brain injury.

Conclusion

I am going to conclude by looking at *Vision for Change* goals as they might apply both for the HSE and the Irish Prison Service. Recovery and rehabilitation summarise the aims in *Vision for Change*. Getting there requires reform and integration. There are a number of ways the IPS could reform and integrate to work in a more human way. These include stratifying prisoners in terms of the level of risk they present, putting those prisoners who bully other prisoners and steal their medication in one place and taking those who are vulnerable and putting them in another place. This happens in most jurisdictions and is very successful when it is implemented.

The HSE also needs to reform its structures and processes. Resources for mental health services in Ireland are allocated according to custom, tradition and local politics, rather than population based need.

All prison health care should be transferred to the HSE. Prison culture is not compatible with health care culture. We can however work together and we have shown this. We can work as an island within the prison with permeable perimeters. The HSE has a responsibility to prevent the imprisonment of the mentally ill and much of the reform process in recent years has failed to take note of this.

In prisons high support units for the vulnerable and the recovering mentally ill have already shown the way to minimise the use of isolation cells. Psychiatric in-reach and court liaison services have shown the most efficient, fair and affordable way of diverting newly remanded prisoners with severe mental illness to the appropriate mental health service. Both of these now need to generalise from Dublin prisons to the rest of the country.

In the HSE we need to push programmes that succeed and pull back from ineffective customs and practices. Only programmes that are supported both by evidence and by results should be continued. These are hard times, there are budgetary constraints which should be forcing us to concentrate on what works and in particular we should be obliged to stop doing what does not work.

What does work is having crisis teams, home treatment teams, assertive community treatment teams and for those too unwell for home treatment, psychiatric intensive care units. What does not work is having large numbers of admission and rehab beds where different types of patients are generically mixed in much the same way as prisoners are generically mixed. This does not work in psychiatric hospitals and it does not work in prisons.

Ireland will continue to cut the number of psychiatric beds. When you do that the only beds you cannot cut are the intensive care beds. Currently Ireland needs 13 psychiatric intensive care units in 13 super catchment areas, possibly a few more. Currently we have about 6 psychiatric intensive care units. This is the main reason why the Gardaí despair of taking people who are mentally ill to their local mental health services. This is the main reason why people with long histories of severe mental illness, well known to their mental health services still end up in front of a district judge for minor public order offences. If the 13 psychiatric intensive care units were provided, the amount of mentally ill people in prisons would fall sharply.

Finally the new Central Mental Hospital is urgently needed. There are plans underway now to build a new Central Mental Hospital and 4 intensive care rehabilitation units (ICRUs) around the country. The ICRUs will I hope be a stepping

stone towards the 13 psychiatric intensive care units. There is an idea that Ireland has four regions. This dates back to the annals of the four masters. But in epidemiological terms, when planning rationally for services for a population of 4.6 million Ireland is not big enough to have four regions.

Post Script

Since this talk, a process of reform that was already underway in Mountjoy has seen the opening of the renovated B wing where slopping out will be ended. The wing will operate as an incentivised drug free unit and will form part of a modern system of stratification. It is impressive to see such rapid reform.

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Bringing recovery principles to the secure environment: Changes, challenges and emerging concepts

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Introduction

Thank you for inviting me to be here today. When I asked Maura what she wanted me to speak about she replied ‘talk about whatever is exciting you at the moment’. I’m assuming she meant what’s exciting me work wise so thank you Maura, I have taken you at your word and grasped the opportunity with both hands! The discussions and concepts that I am going to share with you today are not mine alone but are part of the work I share with the lead psychologist within our service Dr Gerard Drennan. I hope you will find them an interesting contribution to your day.

For the last four years Gerard Drennan and I have been working together to develop recovery based practice within the secure and forensic services in Sussex Partnership NHS Foundation Trust. I will begin by setting the context and discussing some of the history, research and concepts of recovery in mainstream services before moving on to explore the challenges and solutions that arise when incorporating and interpreting the principles of recovery into a forensic and secure setting. Finally, I will describe some of the concepts about offender recovery which are arising from our work.

Firstly I would like to introduce our service. The Secure and Forensic Services in Sussex comprise of medium and low secure in-patient services based on two sites fifty miles apart. We currently have 40 male medium secure places, 43 low secure and 4 ward in the community places for men and 6 medium secure, 6 ward in the community and 6 supported accommodation places for women. In addition the service has specialist community forensic teams in East and West Sussex and Court Diversion Teams. In January the service will be expanding with the opening of a new 45-bedded medium secure centre.

Four years ago the services in East and West Sussex joined as Sussex Partnership NHS Foundation Trust was formed. The bringing together of both sides of the county gave us the opportunity to develop a service philosophy that would underpin and bring together the work of the

units and community services across the county. Recovery principles were the obvious choice to provide the foundation of our model. Partly because they were the principles that informed a number of department of Health documents, (DoH, 2000, 2001, 2007) and partly because the Trust had recently adopted recovery principles (Badu, 2007). So that is the context of where we work. Now I would like to go on to share some of the research that has led to our current understandings.

A Little bit of History

Recovery is not a new concept; in fact it can be traced back 200 years. I think it is interesting to know where it came from and so here is the brief sound bite version. In the 1700’s mental illness and physical illness was conceptualised as a punishment from God. People with mental illness were locked away and chained until it was deemed that they had repented from their sins and could be released. Philippe Pinel, a French psychiatrist, described by some as the father of modern psychiatry, took the radical step of releasing them and instead of being attacked, as was predicted, the patients were grateful and began to work in cooperation with Pinel to assist with their recovery. Pinel was the first person to suggest that people who have experienced mental illness should be employed in the treatment of others with mental illness (Foucault, 2006).

In Britain a similar approach was being developed with the establishment of the Quaker Retreat in York, as described by Samuel Tuke’s grandson (Tuke, 1813), it came to be known as ‘moral treatment’. Roberts & Wolfson (2006) describe moral treatment as based on kindness, compassion, respect and hope of recovery. There were many elements at the Retreat that would be recognisable to today’s practitioners, notably the therapeutic use of occupation, resulting in a varied programme of outdoor activities, gardening, farming, exercise and indoor activities such as dressmaking, reading writing and maths (Wilcock, 2001).

Tuke distinguished between “cure” and “recovery”. He preferred the word “recovered” because of the emphasis on recovery of social

function, and humility in recognising that their approach supported a natural healing process rather than providing a direct cure. The Retreat became a model for asylums around the world. However, in the rush to develop large institutions founded on the Retreat principles this distinction between recovery and cure was lost. Even back then the expense of these institutions had to be justified and the most convincing argument was to claim that people were being cured. The institutions became increasingly overpopulated which led to recovery rates declining. Then in the 1800s Emil Kraepelin described a new diagnostic category of dementia praecox or schizophrenia. Following this recovery or cure was no longer expected and institutions took on the role of custodial caretakers (Starnino, 2009).

In the mid 20th century new medical advances and treatment were increasingly effective in managing psychiatric symptoms. In addition studies found that people did recover from schizophrenia and other mental illness (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987; Harrison et al., 2001; Jobe & Harrow, 2005). The 1970s saw the emergence of the women's movement, gay rights movement, and disability rights movements. The empowerment agenda was taken up by people with mental illness and by the 1980s, individuals who considered themselves "consumers" of mental health services rather than passive "patients" had begun to organize self-help/advocacy groups and peer-run services.

Recovery as a concept, as we know now, is a recent term. It is so widely used now that it is hard to believe that as recently as the year 2000 recovery was not being used as a technical term. In their report 'Recent advances in understanding mental illness and psychotic experiences' (BPS, 2000), the British Psychological Society uses the word "recovery" 33 times but none of these relate specifically to the concept of recovery as it has developed in the service user movement. In this report the recovery concepts and philosophy were emerging, the report talked about a developing understanding of the impact of the social environment as well as biological factors influencing psychosis and also incorporated individual narratives, but the term recovery was not being used. In recent years there has been an explosion of writing and exploration of recovery. In fact 60% of literature, both peer reviewed and grey literature, focusing on recovery in mental

health has been published in the last 4 years (Strickley & Wright, 2011).

Recovery research

There is no universally recognised definition of recovery. Although the following two definitions are some of the earliest cited in the literature and are the most commonly referred to. Patricia Deegan is a clinical psychologist diagnosed with schizophrenia; she described her experience as a journey of personal recovery and made comparisons with recovery from physical disability. She describes recovery as 'a process whereby people accept the challenge of being socially disabled by their mental ill health and recover a new sense of self' (Deegan, 1998)

William Anthony is one of the earliest and most prolific academic writers on the subject. He states recovery 'involves the development of new meaning and purpose in ones life as one grows beyond the catastrophic effects of mental illness' (Anthony, 1993). He goes on to say 'recovery-orientated system planners see the mental health system as greater than the sum of its parts. There is the possibility that efforts to affect the impact of severe mental illness positively can do more than leave the person less impaired, less disabled, and less disadvantaged.' (Anthony, 1993)

When holding discussions with our service users, one of them defined recovery in a more succinct and pragmatic way: Recovery is 'Getting better and getting out' (Forensic Service User 2010).

Recovery concepts have seen a great deal of interest internationally and a number of research projects have taken place with the intention of exploring and defining what recovery is and what it means. *The Mental Health Recovery: What Helps and What Hinders* was a large multisite project carried out in the United States (Onken, Dumont, Ridgeway, Dornan, & Ralph, 2002). A number of focus groups were carried out to interview 115 people over 9 states. It revealed detailed information about what supports recovery, characterising it as an interplay of internal and external resources that incorporated:

Characteristics of the individual:

A sense of self and self efficacy, a sense of hope, meaning and purpose, making own decisions.

Characteristics of the environment:

Basic material resources such as home, income, social relationships, meaningful activities, peer support, formal services, formal staff.

Characteristics of the interchange:

Whether it is supportive and consistent. Whether it supports hope, options of choice and flexibility. The important balance between dependence and independence.

This study and others have identified different aspects of recovery.

- Clinical recovery, the recovery from mental illness indicated by the absence of the signs and symptoms of disease (Bellack, 2006; Davidson, O'Connell, Tondora, Styron, & Kangas, 2006).
- Functional recovery, when the individual develops or regains coping strategies for carrying out life's functional tasks: daily living skills, working, maintaining the home and relationships without necessarily being symptom free (Lloyd, Waghorn, & Lee Williams, 2008).
- Social recovery, being able to reintegrate into the social environment including participating in work, education and living in a desirable place (Repper & Perkins, 2008).
- Personal recovery (Anthony, 1993; Deegan, 1996), the personal experiential journey of moving beyond mental illness.

Earlier this year Strickley and Wright published a comprehensive literature search of the British research evidence, both peer reviewed and grey literature (Strickley & Wright, 2011b; Strickley & Wright, 2011). They analysed the literature and suggested the implications for practice that arose from them. They identified four themes that echo these four elements of recovery. The themes are: There is a need for professionals and services to have a therapeutically optimistic approach. Recovery is strengthened by approaches from services that are respectful, hopeful and informed by a humanistic philosophy. Recovery is also dependant on social factors such as racism and poverty indicating that the responsibilities for promoting it lie wider than healthcare providers alone. Meaningful occupation is central to individual recovery.

So to date the literature has defined recovery and has begun to make suggestions for how service providers can create environments where recovery can be encouraged. Most of the studies have been carried out with mainstream populations. The challenge for us is to consider how we can take these principles and adapt them to a forensic setting.

Challenges to Recovery in the Forensic Setting

There are challenges to incorporating recovery in forensic settings, both in relation to the environment and the characteristics and needs of the forensic population. Forensic patients carry a double stigma of being both mentally ill and dangerous which means that management decisions are likely to be dictated more by the need to manage risk to the public, than by the stated choices and wishes of the service user.

The specific challenges have been written about in a number of studies and include the following: Service users are legally detained which limits the opportunities for service users to exert control and choice over their environment. Service users spend prolonged periods of time within a secure environment, which can make it difficult to foster hope and optimism. Finally there are questions about the therapeutic approach with forensic patients which often requires challenging and confronting, rather than affirming or accepting, maladaptive patterns of behaviour or identity (G Mezey & Eastman, 2009; GC Mezey, MKavuma, Turton, Demetriou, & Wright, 2010).

However despite these obstacles, secure services have agreed with the assertion that there should be 'no recovery free zones' (Roberts & Wolfson, 2004). Secure services have begun to use practices that are reflective of the core recovery values of person orientation, service user involvement, self determination/choice and growth potential (Farkas, 2007; Shepherd, Boardman, & Slade, 2008). Recovery based practise has also been incorporated into the Medium Secure Standards published by the Royal College of Psychiatrists Quality Network (RCP & CCQI, 2007). Although it was only recently that the term recovery as a principle has begun to be explored in more depth by the Quality Network who will hold their first study day on it in January 2012.

There is a parallel process that is occurring with people who commit crimes. Criminologists and clinicians have described the rise of "desistance from offending" as an approach to working with

men and women who commit crime (Farrall & Calverley, 2006; Gadd & Jefferson, 2007; Maruna, 2001). Ward & Maruna describe the “what helps” model in the desistance paradigm where the issue of personal agency is given a central position, mirroring a recovery orientation (Ward & Maruna, 2007).

Offenders described the importance of work, and relationships as motivators for desisting from further offences. If the provider could support the offender to achieve and work towards the issues they regarded as priorities: housing, work and relationships rather than providing ‘expert’ offender management systems then they would focus their efforts differently. Similarly, the Desistance approach seeks to promote strengths (i.e. strong social bonds, pro-social involvements, and social capital) linked with desistance through research and reformed-offender narratives. The parallels with a recovery orientation are striking.

Translating the principles of recovery into a forensic setting.

In 2007, when my colleague and I began to develop our service model we recognised that any incorporation of recovery into forensic settings would have to consider the specialist needs of the residents, the impact

of the secure environment, including all the security procedures and curtailment of opportunities, and finally the needs of the staff teams in supporting the recovery of the residents. We acknowledged that the concepts championed by recovery were universal and applied to the staff experience as well as the patient experience and were aware of the need attend to this.

We also recognised that the nature of recovery principles meant that they could not be imposed from above but needed to evolve from the needs, interests, concerns and skills of the current service users and staff teams. We therefore began by carrying out a series of workshops for service users and staff from all areas of the service. In these sessions six of the key tenants of recovery: hope, partnership working, responsibility, strengths, education supportive environment and an ongoing journey, were considered under the following headings (see Figure 1).

This provided a platform to recognise the good practice already happening and to identify limitations and priorities for our developing model. The service users and staff threw themselves into the task in what was a series of lively discussions. These resulted in the following themes that have underpinned the development of the recovery practice within our service over the last four years and still hold true.

Firstly, there was a recognition of the staff need to be empowered in order to support service user recovery. Regular opportunities for reflective practice and education needed to be developed to provide the bedrock of any recovery programme. There was an acceptance that without this, staff anxiety may lead to a control culture, which could impede hope. Reflective practice and supervision was a vehicle by which staff could learn, and receive support. Secondly, any recovery based programme needed to recognise the central value of the provision of opportunities to succeed. These would increase service user’s confidence and have an important social function. Thirdly, while it was important to value strengths, it was also vital to not

Figure 1:

Recovery principle: hope, education etc	What are we doing to promote this	How do we promote this in the inpatient settings	What are the barriers to promoting this
The client group			
The nature of the setting			
The staff group			

lose sight of weaknesses. The service users in the workshops emphasised the importance of receiving clear guidance about what they needed to achieve in order to move on. Maintaining communication about the progress and sharing practice around recovery was regarded as a way of maintaining momentum and a sense of a service working together despite the geographical challenge. People wanted to develop a newsletter as a way of tracking and sharing the development of the model. There was also acknowledgement of the importance of a continuing forum to steer the project.

We distinguished the recovery orientation in forensic services from general services by renaming it Secure Recovery. This title held the balance of security and recovery, which was central to the responsible adaptation of recovery to a secure environment. We defined it as follows:

Secure Recovery acknowledges the challenges of recovery from mental illness and emotional difficulties that can lead to offending behaviour. It recognises that the careful management of risk is a necessary part of recovery in our service but this can happen alongside working towards the restoration of a safe, meaningful and satisfying life.

In the last four years, we have gradually developed a programme with events throughout the year. Individual and group work designed to support the development of a recovery and hope-inspiring environment.

Emerging Offender Recovery

We began with the assumption that the recovery tasks facing our service users were the same as those in other mental health settings and that the main adaptations we needed to make were those linked to the setting where recovery was being carried out. Over the last four years of supporting recovery, writing about it and sharing experiences with others working in forensic settings, we are beginning to see a different picture. Gerard Drennan and I are currently editing a book titled "Secure Recovery – Approaches to Recovery in Forensic Settings". It is due to be published by Routledge in Spring 2012. As chapters came in from contributors we recognised the same issues arising in their work. The concept of 'offender recovery' began to emerge more clearly.

Offender recovery is not a distinct recovery task. Instead there appears to be offender recovery tasks related to the previously defined recovery tasks of functional, social and personal recovery.

Offender aspects of *personal* recovery includes the subjective experience of coming to terms with the experience of having offended, including accepting the social and personal consequences of having offended. Recovery from the fact of the offence and its impact on the individual's sense of self is important and in many ways more difficult than recovery from mental health problems. Individuals are tasked with reconciling their sense of self with a person who committed a violent act. In order to move, on individuals need to come to terms with the offence and forgive themselves or at least accommodate the act of the offence in their sense of identity. To engage in their recovery they need to view themselves as worthy and deserving of recovery following the act of the offence. This can be one of the most challenging tasks for individuals to achieve.

There are a number of *social* recovery tasks linked to the offence. The individual will need to come to terms with the responses of others to the offence. This will include their family and social network as well as the views of the victims and the victim's family. If the crime is a violent one the response of the community at large may also be a consideration. The individual may live in ongoing fear of community or family retribution. With the advent of the internet where news of the offence will be available to anyone who can Google, the individual may find that they will be constantly managing this. For example one individual who joined a college course had to leave it when another student Googled all the class members. The report of his crime, committed years previously, was still available online. The impact of this is to increase the not inconsiderable barriers to social inclusion that are already encountered from experiencing mental illness.

The *functional* recovery tasks around the offence include managing the legal process, including court appearances. This may be an additional stressful and unfamiliar task to manage at a time when they are at their most vulnerable. Depending on the offence, individuals may be required to move to a new community on discharge. This will mean beginning again in developing social and work contacts and relationships, a not inconsiderable additional challenge.

Finally, the individual needs to come to terms with the necessity of having these extra dimensions to their recovery pathway.

I can see some nods as people recognise some of the offender recovery tasks. You may well have examples of recovery tasks and challenges that your clients are experiencing. I have briefly described emerging offender recovery tasks, which we have just begun to name and identify. They constitute a significant additional burden for our service users, not only while in hospital but also on into the community. It is possible to have a full clinical recovery and yet if these additional offender recovery tasks are not addressed it can disrupt the outcomes for the individual. We recognise that the term 'offender recovery' is not a very person centred term but have struggled to identify a term that adequately encompasses the range of additional recovery tasks. It seems that the connecting factor is the offence and the impact of the offence so the term offender recovery is the best fit to date.

The book "Secure Recovery – Approaches to Recovery in Forensic Settings" will be published in the Spring of 2012. It has contributions from a range of professionals supporting recovery in Forensic settings through out the country in a variety of levels of security and settings.

Finally I would like to leave you with this quote by Julie Leibrich (Leibrich, 1999) which I think best describes the work we are doing as we continue to work with service users and staff to learn about and support the ongoing recovery of our service users:

'A Progressive Discovery of Solutions'

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Address of His Hon. Justice Michael Moriarty, Patron of ACJRD

Ladies and gentlemen, I have been a very indolent patron of this association in recent years, partly due to being incarcerated in a not very secure unit in Dublin Castle!

It is a particular pleasure to come back to see a number of old friends and founder members and a vast number of new ones to show that the association is thriving under the immensely dynamic and committed leadership of our Chairperson, Maura Butler.

In addressing this morning's immensely important and fascinating topic it does remind me somewhat of the circumstances in which this association came into being a little over 15 years ago, partly under the inspiration of our Scottish colleagues in the Scottish Association for the Study of Offending (SASO).

In the vastly important fields of criminal justice, in what, even then, was a much beleaguered industry, so many of us in the different constituencies in the public service at large, in the guards, the prison service, the medical related agencies, the judiciary and all practicing lawyers, instead of trying to pull together, displayed a general disposition to look balefully at the other guys and gals from our individual bunkers.

In a small way, this association, giving rise to this morning's enormously encouraging attendance, shows that by trying to pull together, with all the beleaguered aspects of resources, a great amount is to be gained.

Now, the topics we have heard on this morning are something which are fantastically important and in my part-time job sitting for a couple of days a week in the Court for Criminal Appeal over recent months, I have seen every week, very aged offenders due to the considerably high incidence of very stale sex offences. Perhaps in the majority of cases very properly prosecuted you would have befuddled 80-year-olds coming before you in the courts and you have people who are plainly dysfunctional in many other ways; in the ways Paul O'Mahony commented on very trenchantly several years ago.

To have heard this morning's four contributions from Deborah Alred, from Bairbre Nic Aongusa, from Professor Harry Kennedy and from Jimmy Martin, I have to say that I found it nothing less than inspiring as regards the integration and the potential developments that are being made despite diminished resources. Certainly, as regards my going back to my day job, I will do so with a bit more of a spring in my step on foot of what I have heard this morning! I hope as the day wears on and we exchange ideas even more that it will have the task of reenergizing all of us.

So, may I now please ask if Maura might please be kind enough to give each of our distinguished, and vitally informative, speakers little tokens of our appreciation. Thank you very much ladies and gentlemen.

Mental Health Issues in Criminal Trials

Dara Robinson, Partner, Sheehan & Partners

Good afternoon everybody. I'd like to welcome you to the afternoon shift. Can I make an immediate disclaimer: the introduction that Maura has given me is a year or two out date: I'm no longer a member of the Law Society's Council, I'm no longer the Chairman of the Criminal Law Committee... it's all lies! And I'm sure most of you aren't interested in the remotest about the work I do with the Criminal Assets Bureau because that's not what we are here about. But I do have a continuing engagement in, and interest in, mental health law, as much of civil as criminal these days, arising from my membership of the Mental Health Tribunal Panels.

We're here to talk about mental illness and criminal trials and I want to touch on four aspects of the legislation. I'll acknowledge there are a lot of non-lawyers here and so those of you who are lawyers will excuse the fact that I'm basically teaching my grandmother how to suck eggs, but some of it is fairly technical stuff.

The issues I want to look at are, in a broad view the issue of being not guilty by reason of insanity, the issue of diminished responsibility, disposals – that is what a court does with a person who has been convicted or acquitted, depending how you look at it following on from the raising of one of those two defences – and finally a very brief look at designated centres, which is a very vexed question indeed.

Looking firstly at the question of pleading not guilty by reason of insanity, there's a number of things I want to talk about here and the first of them is obviously the language that is used in the definition. Prior to 2006, we operated a Statutory Framework, The Trial of Lunatics Ireland Act 1883, which we had 123 years to get right and the result was the Criminal Law Insanity Act 2006 and it is my view that we did not get it right at all.

The pleading of not guilty by reason of insanity – and at least we call it that instead of guilty but insane now – is where someone is tried for an offence and the court decides that the accused at the time was suffering from a mental disorder. And get this: The mental disorder was such that the

accused person ought not to be held responsible by virtue of the fact that a) they did not know the nature or the quality of the act or b) they did not know what they were doing was wrong or c) were unable to refrain from committing the act. Then the accused is entitled to an acquittal.

Obviously we have to look at the meaning of mental disorder, which is defined in Section 1 of the act to include mental illness, mental disability, dementia or any disease of the mind, but does not include intoxication.

There are a number of points I'd like to make and I'll make them quite briefly. Firstly, I do not believe that doctors in practice anymore use the word insanity. Secondly, using the term disease of the mind – which derives from a case in the mid 1800's in England, the McNaghten Rules, which has raised as many issues as it has competently dealt with, most of them complete red herrings – is a seriously bad idea. I'm gobsmacked, and I've said this many times, absolutely gobsmacked that after 123 years to revise the statute they continue to use Victorian language. This is very important because the relevance of language has both symbolic and stigmatic implications and it is a matter of great concern to me that we still use that sort of labelling.

The exclusion of intoxication specifically has left some interesting issues which arise possibly in the idea of diminished responsibility and possibly in the context of intoxication and I'll talk about them in a while.

I want to have a look now at possible alternatives that might have been explored in terms of the language. For example, if you look at the derivation of the McNaghten Rules – which themselves came into being in the mid 1800s – there was a serious resistance in the criminal judicial fraternity throughout the Middle Ages to excusing a mentally disordered offender. The earliest adverse language I can trace is a definition in a trial of a man called Arnold in the early 1700s where the jury were told that a person must be totally deprived of understanding and no more

aware of what he is doing than an infant, a brute or a wild beast to avail of an insanity defence.

There was a bit of an upgrade in 1800 where the jury were told – and this is kind of where we should be going at this stage – if a man was in a deranged state of mind at the time, he is not criminally answerable for his acts. The McNaghten Rules were actually developed, in a minor way, in Ireland in a case called *Doyle vs. Wicklow County Council*, which was not a criminal case at all, ironically, where an enlightened judge – Mr. Justice Griffin – said that the McNaghten rules do not take into account the capacity of the man on the basis of his mental state to act or to refrain from acting. I believe it is correct psychiatric science to say that certain serious mental diseases – such as paranoia or schizophrenia – in certain cases enable the man, in certain cases, to understand the morality or immorality, the legality or illegality, or the nature or quality of the act, but nevertheless not have a free volition whether to do or not do that act. So, we are talking about issues of volition and so forth.

There was a model penal code in the United States which set out a note where the accused may not be found criminally responsible if his act was the result of a mental disease or defect. And then the French penal code proposes excuses for individuals where – Article 2.2 of the new criminal code – a person will be free from criminal responsibility if he is affected at the time by a psychiatric or neuropsychiatric disorder which removed his judgement or his control over the act.

Now, the reason I mention all that is because the French penal code is a contemporary language – it is a language that is understood by lawyers and understood by psychiatrists. There's a very interesting study that you might want to look at, those of you interested in this sort of thing, in Oregon where it was discovered that there was never a meeting of minds between lawyers and psychiatrists – they simply spoke different languages. This is important when you are trying to create what is a very important defence in law. It needs to be clearly set out and clearly understood by all the participants in it, and the participants, in the most, will be medical witnesses.

Intoxication is an interesting exclusion from the law and I will refer to that in a case in a moment. I happen to have a watching brief of the very first

case in which the insanity defence was run, which took a day. It was a person who was an extremely long term psychiatric patient who probably should not have been at large from civil committal at the time of the commission of the homicide. Evidence was given in the Central Criminal Court which was absolutely unequivocal. The facts of the case were absolutely horrendous and there wasn't a dry eye in the house when the husband of the deceased gave his evidence about his wife's killing. The jury hated the accused and had to be bullied into bringing in an insanity verdict. Perhaps I am overstating it slightly but they had to be pressured severely by the trial judge into bringing in an insanity verdict.

One of my pet bugbears about the insanity and diminished responsibility verdict is that it has to be returned by a jury and I'll return to that in just a minute. Another case where it has been run and successfully won was the case of a very unwell middle class woman who suffered from quite a severe depressive disorder. She killed her daughter believing that she was so unwell, too unwell to raise a daughter, that killing her was an altruistic act.

The point about these cases is that it is very, very difficult to bring home an insanity verdict, I'll say this for the benefit of the non-lawyers which is most of the audience - unless prosecution and defence are in agreement that an insanity finding is the correct finding. As a consequence, insanity trials tend to be very short trials where most of the facts are not in dispute and the only issue is what psychiatric specialist evidence is to be put in front of the jury.

Intoxication is an interesting issue and I'll take a look at an intoxication case in just a moment in the context of diminished responsibility. The whole point and purpose of insanity and diminished responsibility arising as defences at all is – the real issue is – that we as lawyers believe, and presumably as citizens believe, that guilty people should in some way be held responsible for their actions and punished for their actions. The issue of diminished responsibility directly addressed the question of responsibility. That is to say, whether the responsibility of the accused person for the act he or she performed on the occasion is diminished or lessened.

And then the law having met morality at that point – enter the doctors. It is, almost invariably, a matter of medical evidence. I want to read out some very brief extracts from the Redmond judgment, a very low key judgement of Mrs. Justice Denham in the Supreme Court, where she says: *“As I understand the law, a person who is found not guilty by reason of insanity is deserving of treatment, not punishment, where a person who pleads guilty or is found guilty is deserving of punishment”*. She goes on to say: *“The question of whether it is appropriate for a criminal to be categorised as a criminal and sentenced as a criminal, as opposed to a person who believes that they have substantial grounds for the trial judge to believe he is not a criminal. The dignity of the person is also relevant”*.

All of that comes out of a very interesting case and the facts of it are of no great importance to us here. But I may as well look at it now since I'm on the subject. Mr. Redmond was accused of a serious assault and there was absolutely no doubt that he had a full insanity defence. He was quite clearly extremely unwell, sufficient to be committed to a psychiatric hospital at the time. And that was more than enough to avail of an insanity defence.

However, the downside of an insanity defence is what happens to you if you succeed in it. If you succeed in an insanity defence – this relates only to insanity and not to diminished responsibility – there is a very good chance that you will be committed, strictly without a limit of time set, to a designated centre, there being only one in Ireland, the Central Mental Hospital.

If, on the other hand, you plead guilty to the offence and raise insanity in what is known by lawyers as mitigation, then you get a penalty that is limited by time, so you might get four, five, six years. But at least you know that by the end of the four, five, six years – you're out, you've done your time, you've paid your penalty and there's no comeback.

A committal to the Central Mental Hospital can result in an almost indefinite detention. In fact, I have a number of clients in the Central Mental Hospital who have been there for a very long time and had they pleaded guilty, they would have been out of prison long ago. So there is a fairly substantial downside of using insanity as a

defence, notwithstanding that in law it is probably the correct thing to do.

That brings me onto the question of who can raise the defence. Now in the ordinary way it is the defence that raise the defence, not the prosecution. That is to say, it is the accused's legal team who will raise it; it can also be raised by the prosecution. But in the Redmond case it was actually the judge who raised it and the judge was not prepared to sanction the rubberstamping of a guilty plea in circumstances where it was abundantly clear to the judge that the accused should be found not guilty by reason of insanity, or guilty but insane, as it was in the old days.

The judge then, by way of a procedure, asked the Supreme Court whether he was correct in being the one who raised the insanity defence. The Supreme Court ruled, not only was he correct, but he actually had a duty to do it. It was building on old case law, but it was quite important because the judge didn't want to see somebody using the system to try and get a verdict that was, by the end of the day, demeaning to them.

Now, if it's more demeaning to be a criminal who has committed a very serious assault or a psychiatric patient who has been acquitted of that same serious assault by reason of insanity is, for most people, a very open question. Some people would wonder which carries the more sanction, the more stigma and the stigma is very important obviously. However, within our constitutional framework it was held by the Supreme Court that Justice Haugh did the right thing.

Insanity, for the lay people that are here, relates to the state of mind of an accused person at the time of the alleged offence. This morning, I think Niall Nolan dealt with the question of fitness to plead which is the state of mind of the accused person at the time of his or her trial.

Diminished responsibility – now this is a queer old harp and I have a few things to say about diminished responsibility. The first thing to do is look very closely at the definition of it. In Section 6 of the Criminal Justice (Insanity) Act, it says: Where a person is tried for murder – so note it applies to murder only – and the jury, or as the case may be, the Special Criminal Court finds that the person—(a) did the act alleged, (b) was at the time suffering from a mental disorder – so we are

back to possible disease of the mind scenarios – and (c) the mental disorder was not such as to justify finding him or her not guilty by reason of insanity, but was such as to diminish substantially his or her responsibility for the act.

So, this is what I call the defence of insanity ‘light’. I think this is very difficult and dangerous concept. There is also a well known senior counsel who describes it as ‘half mad’. Let’s look at the definition – the mental disorder was not such as to justify finding him or her not guilty by reason of insanity, but was such as to diminish substantially his or her responsibility for the act. This is a judgment that can, strictly speaking, only be brought in by a jury unless the accused is being tried in front of the Special Criminal Court which, as you all know, is a non-jury court. It applies only to murder cases so it’s triable only in the Central Criminal Court. Now, I think this is a tall order for a jury, a very tall order indeed.

Diminished responsibility cases can be in effect not contentious, which is to say both prosecution and defence psychiatrists can agree that the accused is suffering from a mental disorder, not quite enough for an insanity defence, but enough for diminished responsibility. I’ll tell you the peculiar facts of a case I was involved in quite recently which brought about that end result.

But in contentious cases, that is to say the prosecution are contending for a murder verdict, the defence are contending for a manslaughter verdict or even an insanity acquittal – this is a very tough test for a jury. For them to have to say: “Well, mental disorder goes out that far, but where do we draw the line?” It’s really not satisfactory in my view.

There is a solution in England where the definition is vastly different to our definition, and frankly I think we should have adopted it – our definition talks in such inappropriate language as ‘abnormality of the mind’. The solution they reached in England is to say, by virtue of the statute which is the Homicide Act 1957 and subsequent case law, diminished responsibility is what is called ‘an acceptable plea’. When the accused is asked on the morning of the trial “How do you plead, guilty or not guilty?” they can say “Not guilty of murder, but guilty of manslaughter by reason of diminished responsibility”. The prosecution can accept that as a plea and say to the

trial judge that the plea is acceptable to the Crown, so there’s no trial.

Interestingly enough, it doesn’t always work out quite to plan such as in the case of the Yorkshire Ripper. There are some of you in the room who will remember the Yorkshire Ripper; he was one Peter Sutcliffe who was responsible for possibly as many as 20 murders in a relatively small area in Yorkshire in the mid-to-late 1970s. He was actually prosecuted by the Attorney General of England who, at the time, was Sir Michael Havers and his legal team and the retained psychiatrists were all agreed that he was entitled to diminished responsibility. So when Sutcliffe was arraigned on the morning of his trial he was asked how he was going to plead to the, I think, eight murders and 11 attempted murders and in relation to every one of them he said: “Not guilty to murder but guilty of manslaughter by reason of diminished responsibility”. The Attorney General stood up for the prosecution and said those pleas were acceptable to the Crown and the judge said “not to me, they’re not”.

So, the upshot of it was, by the direction of the judge, a full trial went ahead and he was convicted of murder on every count. He has spent a lot of his time since then in specialist hospitals. Most doctors would probably not have differed from the view that he was a very seriously ill person throughout the period of the killings. There is quite an entertaining description of that trial on Wikipedia, if you find that sort of thing entertaining.

The Homicide Act 1957 states that when a person is suffering from such abnormality of mind – and get this – whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury. The whole point of this disease of the mind phenomenon is that it doesn’t have to be a disease of the mind at all and, in fact, diseases that have been found by courts to be diseases of the mind over the last 50 years have included; epilepsy, arteriosclerosis and things like sleep walking. So, these are not what would normally be considered diseases of the mind at all which is why I consider the language used to be wholly inappropriate. We really need to get into the 21st century and I must say the 2006 Act is a massively lost opportunity.

I want to talk to you very briefly about a case called the DPP v Collins. Alcohol Dependency

Syndrome is regarded by one of the international classifications of diseases as a mental illness or mental disorder. In Collins, which was a murder trial, the defence and prosecution psychiatrists differed as to whether Alcohol Dependency Disorder constituted a mental disorder or not. In the heel of the hunt Mr. Collins was convicted of murder and I'm trying to track down that case in the appeals system some place. But there was a lot of confusion in the case between intoxication and Alcohol Dependency Disorder. Alcohol Dependency Disorder is a whole different ballgame to intoxication which is expressly excluded in the 2006 Act definition of a disorder.

We've already talked about how difficult it is for a jury to understand diminished responsibility. The last time I talked about diminished responsibility, the meeting was chaired by Mr. Justice McCarthy and I was giving my usual spiel about juries and how I don't trust them in insanity cases. He rallied to the cause and gave out stink to me in a quiet, polite way, as he does publicly, at the meeting, and then he said we should place our faith in juries. Believe it or not, six months later I was running a diminished responsibility case in front of him and in front of a jury.

Now, I don't know if he remembered what I said at the meeting but I sure remembered it. It was a very sad case, a case that would conventionally be called – not, mind, by Harry Kennedy if he was around – battered woman's syndrome or battered wives syndrome. A combination of long-term alcoholism, long-term depressive illness, domestic violence, the whole nine yards: a woman who finally lost the plot and killed her husband. So it was a case that was essentially agreed by the prosecution and the defence, and she was acquitted on grounds of diminished responsibility by the jury, so maybe I do trust juries after all. So, that's the sort of circumstance where the defence arises.

One thing that did occur to me was that, given we only had a diminished responsibility in our law as a defence from 2006 onwards, and given that there were a) a number of failed insanity trials in the period before 2006 and b) cases where the accused had pleaded guilty to murder because their lawyer had told their clients they had no insanity defence at all. I wonder if there should be a review of old cases to have them brought before the Court of Criminal Appeal but who listens to me?

Disposals of these types of cases – disposals means what the judge can do with you if you are either acquitted of murder by way of diminished responsibility or acquitted by NGRI which is not guilty by reason of insanity. The disposals of diminished responsibility are really very simple: a judge can do whatever he wants. In the aforementioned case of the battered wife, he ended up imposing a suspended sentence of imprisonment; there was absolutely no public interest in sending her to prison. It was an extraordinarily sad case and he finished up handing out a suspended sentence, but he could have handed out anything between a life sentence and a €10 fine. The disposal is entirely at large.

Disposal after an acquittal by reason of insanity is a whole different ballgame. There are certain easy cases where the judge has no options, no decision to make. Firstly an acquittal by reason of insanity. Secondly, the patient is suffering from a mental disorder. Thirdly, there is evidence that the patient is in need of inpatient care or treatment. And fourthly, the option kicks in – Section 5(2) of the Criminal Law Insanity Act 2006 – the person is committed strictly without limit of time to a “designated centre”, which I'll come back to in just a moment.

The not so easy cases arise when the judge has options because then the judge has to make up his mind what to do in the case. Having been acquitted on grounds of insanity – remember insanity dates back to the date of the alleged offence – at the trial, if, maybe two years later, there is insufficient evidence that the person is suffering from a mental disorder and/or they are in need for in-patient treatment, in that case, the judge has no options set out for him in the statutes, which is quite an extraordinary thing so the judge has to make it up as he's going along, or she's going along.

Designated centres – these are a very big problem. It has always been posited in the context of the Insanity Act that there would be more than one designated centre. Those of you who do a bit of civil mental health law will know that approved centres, as they're called, are in every county in the state. In every large town in the state there is an approved centre – usually in the local psychiatric hospital. A number of private psychiatric hospitals are also approved centres. There is only one designated centre and that's the Central Mental Hospital in Dundrum.

I am not going to go into any detail into what was said in the case 'B' but the Central Mental Hospital as the designated centre for Ireland has been the subject of a great deal of critical observation over the years. This has nothing to do with the therapeutic regime that is operated there and everything to do with the resources available to the hospital and the physical surroundings of the hospital.

It was to be hoped that Dundrum would be sold off for a huge fortune for the Government and we'd have apartment blocks and everyone would relocate to Thornton Hall. That's just not going to happen. The existence of only one designated centre means that every prisoner in Ireland who is heading towards an insanity and mental health issue has to go to the Central Mental Hospital.

I want a very quick word on hospital orders in the United Kingdom. The 1983 Mental Health Act

provides for remands to hospitals for pre-conviction treatments and sentences both with and without the limit of time in hospitals for people who are appropriately unwell. I think it is an absolute disgrace that we don't have a like regime here. Remember our Act came into being 23 years after the 1983 Act in the UK.

A Vision for Change? Well, well, well, well, well... say no more. Anyone who wants to see what the foreigners are saying about us: have a look at either the periodic review of the United Nations or the Review of the Committee for the Prevention of Torture. This is the last good joke that my assistant found out on the internet, which I think is a cracker, and the caption is "Paying my fee will also help as evidence for our insanity defence".

Thank you.

Mental Health in the Criminal Justice System - The Perspective from the IPS

Fergal Black, Director of Healthcare, Irish Prison Service

I might just start by seeking a little bit of indulgence in terms of giving a perspective of where we are in the Irish Prison Service in general. The core business of the IPS is to provide safe, secure and humane custody of prisoners. We operate within the Prisons Acts. We seek to address the reports of the European Committee for the Prevention of Torture (CPT), the Inspector of Prisons etc.

At the moment – this is kind of important and I'll get back to it later on – there has been a considerable modernisation of the prisons. What that has manifested itself into in the last ten years is considerable additional accommodation. I was struck by the inverse relationship Dr. Kennedy spoke of this morning, between the reduction in accommodation in acute mental health facilities and the increase in capacity in the number of people with a mental health illness in the prison service.

Just a couple of other things to mention – recently our Minister spoke about front door and back door strategies. The front door strategies refers to giving the courts the power to impose wider non-custodial sanctions, I understand it is due to come into effect at the end of this month. Judges will have to consider non-custodial sanctions where a sentence of less than 12 months is being considered.

The back door strategies concern the recently launched initiative giving people temporary release (TR) on community service, where it is considered they should pay back their debt to society on TR in relation to community service. We're still involved in Integrated Sentence Management, my colleague Kieran O'Dwyer is here, and what that's really about is reinforcing incentives for good behaviour and incentivised regimes which are part of the process we're involved with at the moment.

The Irish Prison Service, similar to every other public service or organization, is looking at where we are in relation to doing more for less and that's what the transformation process is all about. We're looking at how we can make the prison better, both for the prisoner and the effective deployment of

staff and we've set the target of saving €21 million annually between now and 2014.

As most people know, there has been a considerable increase in prisoner numbers over the last few years. At the end of 2009, the prisoner population went through the 4,000 threshold. This continued quite significantly throughout the course of 2010. In 2011, we reached our highest numbers in custody in February of this year when we reached 4,621. But there has been a noticeable reduction in the number of prisoners in custody, particularly since the middle of the year. That's interesting – we don't yet know whether that can be sustained, there has been a slight lift and obviously with the return of the courts sessions, we'll know more in the future. It's interesting, the reduction started around the same time of this year in May when we had a couple of international visitors to our shores!

So, where are we at? Healthcare in prisons is delivered by the IPS currently. The three main 'care domains' we deal with are: primary care, including chronic disease management, addiction and mental health. They are the three areas where we have the greatest challenges. Within mental health, as Martin Rogan said earlier, there is an expectation in the community that up to 90% of people with mental illness can be treated at a primary care level. Primary care is the linchpin of our prison healthcare system. We have healthcare standards that act as a kind of benchmark in terms of delivering healthcare within prisons which are a lift from our Scottish colleagues some years ago.

We are involved in various care prevention schemes but I'll come to that later. We have a prisoner health management system and the importance of that is we have a complete, electronic patient record. This means as prisoners transfer between prisons, their record goes immediately with them. We are becoming less and less reliant on paper files. We are currently introducing scanning which will mean that externally generated documents can be incorporated into our system. So, for the first time ever, we can argue we have the complete

electronic patient record which is an important instrument, or tool, in safe-guarding prisoner healthcare, particularly as prisoners move between various institutions.

Professor Kennedy referred to the elephant in the room this morning - the risks associated for people who are addicted to illicit drugs and the impact that can have on mental health. I think what he said was that it was heavily related to the onset of psychosis. From our perspective, we believe there is lack of recognition of the role the IPS performs in addressing addiction in Irish society. We have invested quite significantly over the last number of years in relation to drug treatment in prisons. It is, however, the most resource intensive challenge in relation to healthcare in prisons.

The IPS has put counselling services in place; we are heavily involved in drug treatment. For instance, 20% of persons involved in methadone substitution therapy nationally were treated in Irish prisons over the course of the year. In 2009 we accounted for 31% of all new entrants onto the Central Treatment List. So, we are a very active player in drug treatment and addiction. The number of prisoners receiving methadone treatment has continued to rise over the last number of years. Since 2005 we've had a 78% increase in the number of prisoners on methadone substitution therapy. Interestingly again, between 2009 and 2010, we had the exact same number of prisoners, 2,424, who received treatment. It was just unique over the two years.

There are significant health deficits amongst prisoners. The fact is that any research that has been done has evidenced that prisoners have a poorer level of health than people in the general community. Going back to the National Health Strategy – prisoners were defined as a special needs group. The prevalence, as people said earlier, of mental illness amongst prisoners is significantly worse compared to the general population.

Professor Kennedy referred to the study himself and colleagues conducted in relation to psychosis in the prison population – 7.5% of men on remand suffer from psychosis, twice the national average. So, the evidence clearly illustrates a high level of need among this population for mental health services.

In terms of the services we have in place at the moment, my view, as Director of Healthcare with the Irish Prison Service, is that we receive an excellent service from the National Forensic Mental Health Service – Professor Kennedy and his team. They operate within the prisons in Dublin and the two prisons in Portlaoise. Other prisons, such as Limerick Cork, Castlerea etc, are serviced by a mix of HSE and privately contracted psychiatrists.

I just wanted to mention, and Professor Kennedy mentioned this, there has been significant improvement and development in relation to services in St. Patrick's Institution. I was struck by the evidence from the audit to date, that Professor Kennedy had, and that shows that young people who are currently in St. Patrick's Institution can have an 'ultra-high' risk of developing psychosis. So, the development of the service by the Central Mental Hospital in St. Patrick's Institution is a particularly welcome development. Especially in the current environment where any service where you have a development is very significant and is to be welcomed.

In relation to how we operate – we have our own healthcare staff, our own nurses directly employed by the IPS; we employ doctors directly and by contract. All prisoners on committal are assessed by our staff. As part of the initial screening conducted by our own nurses and subsequently by our own doctors, where there is a view that a person warrants a more detailed assessment by the psychiatric in-reach then they are referred onwards. So there's a fairly integrated service there. The difficulties can arise in relation to the number of prisoners who are awaiting transfer to the CMH.

For us, as I've previously stated, we have a significant amount of people in the prisoner population who suffer from a mental illness. Within that, there is a sub-group of people who the consultants from the CMH believe warrant admission to the CMH. Now, that's a fairly high threshold because they are people who, in the view of the treating consultants, require a transfer to the CMH and treatment in an appropriate, therapeutic environment.

People need to bear in mind that prisons do their best to manage people who are acutely unwell within our institutions. However, there is a limit to

what we can do. The infrastructure of some of our older prisons do not lend to it, they are not therapeutic environments. Notwithstanding the best efforts of our own staff, both discipline staff and healthcare staff, there are limitations to what we can do.

The real difficulty is that, in any given week, we could have 6 or 8 people who are currently in prison, waiting for their admission to the CMH. I would have to say that the situation has actually improved over the last year. We were fortunate that our colleagues in the HSE opened up an additional ten beds in early 2009. Prior to that, there were somewhere in the region of 15 or 20 prisoners, who had been clinically assessed, who were waiting admission every week. Currently, it is in the lower to early teen figures but it is still a significant issue for us on a weekly basis.

I know people referred to diversion earlier but just to say the project that is currently being run since 2006 by the National Forensic Mental Health Service is something that we in the IPS need to acknowledge how well it has operated and the benefit it has brought to us.

Dr. Conor O'Neill is the person who has driven this in Cloverhill Prison. When an individual prisoner on remand has gone through the filtering process of our own healthcare staff, and referred onto the in-reach team, then Conor's team will make a submission, where they deem it warranted, to the courts for a noncustodial disposal. Conor's team identifies someone whose infraction is more of a reflection of their mental health than any real criminal intent. The criteria generally, are a person suffering from a severe mental illness who has committed a minor offence. Anyone who attended Dr. O'Neill's presentation this morning would be clearly aware of this.

In terms of the IPS and the day-to-day operation of the prison system – the opportunity of transferring people with significant mental illness to a hospital or an appropriate community treatment centre is something we endorse and something we want to see expanded. Last year, 114 prisoners were transferred from prison settings to appropriate community settings.

Specifically in relation to our more outlying prisons, such as Limerick, Cork or Castlerea, where we also have a population of prisoners on

remand – we would like to see, in conjunction with the HSE, the development of a more robust arrangement in potentially diverting more people to appropriate community services. As it stands, when someone is identified in Cork or Castlerea – they can be transferred up to Dr. O'Neill's service, they can be assessed but it then falls back to the local service to make the case to the District Court. It's not as successful as it is in Dublin because Dr. O'Neill's team actually attends the court sitting and makes the case to the judge. We would like to see this operation developed further. Diversions have grown steadily over the last number of years. In 2006 I think there were 41 diversions and that's up to 114 last year.

Professor Kennedy mentioned high support units. We've traditionally had a high support team in Cloverhill Prison where Dr. O'Neill's team are based, and there is a more recent one in the medical unit in Mountjoy. It provides an increased level of observation for vulnerable prisoners but I need to emphasize that while the majority of the individuals that are placed there suffer from a mental illness, it is also used for people who are vulnerable from a physical health perspective as well. So, it is not only for prisoners who are suffering from a mental illness.

It does, from our perspective, facilitate the stratification of prisoners and improved intensity, in terms of delivery of healthcare, for prisoners who are, in many cases, going through a disturbed phase of mental illness. There is a requirement, Professor Kennedy alluded to it this morning, for the IPS to develop additional high support units, particularly, we feel, in the Midlands Prison. With the high number of people within the prison population who are suffering from a mental illness or have physical ailments that require a higher level of intensity of observation – there is a requirement on us to facilitate that.

The Criminal Law Insanity Act Amendment – an Act that became operational on the 8th of February this year – facilitates the conditional discharge of patients from the Central Mental Hospital. Where it's interesting for us is there is a mechanism now for an effective discharge of prisoners through the CMH that will free up space for prisoners who are currently awaiting admission to the CMH. So we would see that as a potentially very effective tool in ensuring a greater throughput through the CMH.

As I understand it, the intention is, in some situations, for people to be discharged to community settings. I know from discussion with the HSE that they are looking at the development of community settings which will offer a safe transition for patients from the CMH, which is a very structured facility, to the community, to provide follow up and access the risks subsequent to discharge, providing an intensive social care model to ameliorate the possibilities of relapse.

Within the IPS, we are looking at a number of amendments to the prison rules. For instance, there are amendments coming through, and our Minister is very anxious to get these amendments finalised, in relation to prisoner complaints, deaths of persons in custody and the use of special cells. The IPS has been criticised for their use of special cells both for discipline and operational services and the placing of people who are in a disturbed phase of mental illness in special cells.

The Inspector and the CPT have clearly stated that they believe that there needs to be a clear distinction between what they would consider close supervision cells for operational control purposes and safety observation cells. What is intended with the amendment is that the placement of a patient in a safety observation cell will solely be under the remit of medical personnel. The Governor will have no role. The discipline staff will have no role. It will only be used when all other avenues have been exhausted and would be subject to ongoing review and scrutiny.

Essentially what we are trying to do is to improve the conditions and management of prisoners who are experiencing a disturbed mental health issue while in prison. It's to address the concerns that have been made by the various bodies. There wouldn't be a complete measure of agreement between ourselves and the HSE on this matter but we're clear we are not a hospital setting and we have to take cognizance of that and the limitations that custody imposes.

What we are trying to do is lessen the use of safety observation cells but where they are used that there is very clear guidance in place and it's solely under the remit of medical personnel. We are trying to effectively, as much as we can, mirror the rules of the Mental Health Commission in relation to the use of isolation. We are in the process of

designating observation cells across the prisons system in Ireland.

As most people know, the CPT came to this jurisdiction in January/February 2010. In relation to the IPS, and specifically in relation to mental health, these were some of the comments that the CPT made – “the CMH in-reach program had a noticeably positive impact,” I think that's a fair comment. In terms of more general comments – “there is a limit to the care that can be provided in prison to persons with severe mental disorders and the Irish authorities need to develop urgently the capacity of *hospitals* to receive and treat prisoners with such mental problems”.

The difficulty for us is we don't provide a therapeutic environment. We accept that we can't manage people who are in the disturbed state of mental illness within prisons. Another comment was “the transfer to regular psychiatric hospitals is rare” and that's something I'll touch on in a moment because, while we have really good, effective collaboration with our colleagues in the National Forensic Mental Health Service, our relationship with community based teams is more fragmented.

What are the barriers? As I said, there are effective collaboration arrangements – the National Forensic Mental Health Service and the Assistant National Director Martin Rogan – we continue to engage with them. But difficulties can arise when effecting transition to community health services. As was mentioned this morning, particular issues arise with homeless prisoners and I've described it as a Turf War between Executive Clinical Directors within the HSE. We've had a number of instances where people have been treated within the prison setting and the clinical judgment was that the individual required ongoing treatment in the community and we were unable to secure that.

We were unable to secure that, in my view because I know some of these cases, where the clinical judgment of the clinician operating in the prison clearly stated there was a requirement for in-patient treatment post-release. And, in my view, the decision not to provide a mental health service on release was based on nonclinical grounds. Mainly this concerned homeless prisoners, but, in my view, it was a form of discrimination against prisoners.

I personally have a very strong view that community health teams need to see prisons as part of their catchment areas. Prisons are part of the community. They are not a distinctive, separate entity. Unfortunately, the view of some clinicians is that prisons are something separate. Prison mental health care services will operate best where there is good integration, cooperation and support between prison and community mental health services.

Recently, in trying to address this issue, I got a communication and what the Executive Clinical Director group stated was they recognised the particular vulnerability of individuals in prison but they are not in a position to provide an in-reach service from the local community mental health teams. So, if you take a prison like Castlereagh, which would have a population of just under 400 prisoners and a portion of those would suffer from low level mental illness – many of them would have been diagnosed in the community, many of those would have links in the community and all of them will be released back into the community yet we cannot get the services of the community to assist us ensuring that safe transition between prison and community.

Having said that, there are good models of integrated policy, particularly in Cork where we provide a privately contracted psychiatrist and the local service provide a community psychiatric nurse to shadow our psychiatrist in the prison. What that does is effectively assists in the transition of prisoners between community and prison and visa versa.

That moves me on to one of my own pet projects – the stewardship of prison healthcare. Both myself and the next speaker, Dr. Andrew Fraser, were at a conference of prison healthcare recently and the key issue for discussion in Europe, and internationally, was around stewardship of prison healthcare – which effectively means who should operate prison healthcare within the prisons and what is the best system to deliver the best healthcare in an Irish context – is it the HSE or is the IPS?

All prison healthcare entities work towards an objective of what we call equivalence of care. It is a real challenge for all prison services – I've already outlined some of the difficulties of where it is difficult to provide the same level of care for

prisoners in prisons compared with treating them in the community. The objective of equivalence of care in this jurisdiction is very simply: we seek to provide prisoners with the same level of care they would expect to get if they were a medical card holder in the community.

Because we employ doctors and other health professionals directly, there can be an element of professional isolation where they are not properly linked in with the wider health service and that's something we have to deal with. In addition to that, there can be an issue of what is referred to internationally as dual loyalty – that you have healthcare staff that are working to their ethical framework but they are always part of the prison staff and that dual loyalty can present difficulties.

There is an opportunity where we have better integration with national healthcare provision. For instance, there is an opportunity in prisons, to tackle significant societal health challenges – TB & Hepatitis, if we had more effective cooperation with our HSE partners. We have excellent cooperation, in some instances. In other instances, it isn't there.

The other question that has to be asked is 'What is the best mechanism to ensure we deliver the optimum level of healthcare?' Where some of our healthcare personnel are isolated, and are not part of the bigger structure, there is an issue of clinical governance. There is also an issue about continuing professional development (CPD). There have been some discussions with the Department of Health of what the future should hold in terms of the delivery of healthcare and I was interested to hear Professor Kennedy say this morning that we should transfer all healthcare in the prisons to the HSE. I suppose I'm being somewhat provocative in saying that there is an issue there to be considered.

In the Irish context, in my view, there is an opportunity with the development of primary care teams, with the reorientation of addiction services and mental health services – which are the three primary domains I mentioned at the beginning – we need to ask how we can better integrate with the HSE services. There is an international trend of transferring healthcare provision for prisoners to the jurisdiction of the Department of Health. Will that happen here? I don't know.

A case study in England. After a highly critical review of prison healthcare, by the Chief Inspector of Prisons in 1996, a political decision was taken to transfer prison health responsibility from Her Majesty's Prison Service to the Department of Health. After the reorganisation, the Department of Health instructed the NHS to recognise prisoners as part of the local community. This goes back to what I said earlier – my concern is that the needs of prisoner are not appropriately considered by the HSE, particularly at a local level. Now, in England, all health services are available to prisoners in the same way as they are provided for other citizens by the NHS. They have developed partnerships between the governor and the primary care trust.

Here, the HSE are in the process of creating primary care teams. If we have an effective primary care team in Roscommon, why could the doctors not link into that team and provide services on an in-reach basis which would address the issues of professional isolation, which would address the issues of CPD, which would, in my view, provide an enhanced service for prisoners. Prison has become just another part of the NHS provision within the community. That's what our colleagues in England are saying.

Now I know the next speaker who is just about to transfer his prison healthcare service in Scotland to the NHS, I think from the 1st of November, will have some issues because it isn't all perfect.

Unfortunately, with the current downturn, if we transferred services now, my concern would be that prisoner healthcare would be so far down the pecking order of the HSE that the service we provide at the moment may actually be better than what might be available through the HSE.

Just to finish up, I was struck by a couple of comments this morning. From my perspective, as prison numbers rise, there are more people entering prisons with complex health and social needs. Martin Rogan, the Assistant National Director of Mental Health Services, spoke about the dramatic reduction in acute beds available in psychiatric hospitals which is down to 1,200 from wherever it was. But the target is to reduce it to 650 acute beds by 2015. My concern is, given the relationship that seems to exist between the reduction in mental health acute hospital services and the increase in prisoner population; we will end up with an even more disproportionate number of prisoners with mental health problems in the prison. And I think that's something we all want to avoid and we need to plan.

I am part of the Cross-Sector group between the Department of Health and the Department of Justice and it does work quite effectively. The difficulty I have is translating that locally at prison level to ensure we improve services for prisoners.

Thank you.

Mental Health in Prisons – Because you're worth it

Dr Andrew Fraser, Director of Health and Care, Scottish Prison Service

In this talk I will focus on; the whole prison approach as regards mental health, about our work and experience in Scotland and a small amount about the international situation.

I will start by highlighting the need to put the patient or offender at the centre. It is one matter to create structures, policies and capacity which both our countries have, in many respects, to treat people with severe and enduring mental disorder. It is quite another matter to move to the next level – to do all the things you would want for people with mental health problems, but in prison.

The title of my presentation includes the phrase, 'because you're worth it,' as a fundamental element of mental wellbeing in prison is about self-worth. Mental health and addiction are the two things that prison health does to enable prisoners to get to the starting gate for rehabilitation. If you are a prison governor, you cannot rehabilitate these people unless you have their head sorted out, clear from or reasonably stable with mental health and addiction problems. Self-worth is a foundation for wellbeing, recovery and reducing the risk of re-offending.

Referring to the scale and burden of mental health problems in prisons, I quote here from a chapter in the 2007 WHO Guide written by two Dutch psychiatrists, Blaauw and Von Marle. They say that the prevalence of psychosis is around 4%, very much like in Ireland. They also state that, 6-12% of prisoners require mental hospital care. You have got a very limited capacity, so where are all these people coming from? If 4% of people have psychosis, and some of them are unwell, the 6-12% figure worries us. The figure is an international average and what it does not do is reflect our national systems. It does not reflect the adequacy of prisons, the adequacy of the alternative in the health system and also the rate of incarceration, which is higher in Scotland than it is in Ireland. But the burden of mental health problems in prison is substantial and we have to cope outside of hospital, as well as refer when appropriate.

Mental Health in Prisons: 'A WHO Guide' (Blaauw and von Marle)

- **Psychosis** - ~4%
- **Major Depression** - 10% male; 12% female
- **Personality Disorder** - >50%
- **Depressive Symptoms** - 89%
- **Stress-Related Symptoms** - 74%

Prisoners' Health v Community

- **Alcohol Problems** - 41% male / 36% female v 13% male / 7% female
- **Illegal Drug Use** - 67% v 8%
- **Smoking Rates** - 78% v 23% male
- **Hepatitis C** - 20% v 1%
- **Asthma** - 12% v 5.4%
- **Epilepsy** - 2.1% v 0.7%
- **Chlamydia** - 12% v 0.8%
- **Severe Dental Decay** - 29% male / 42% female v 10% male / 3% female
- **Psychosis** - 9% male / 36% female v 0.5%
- **Depression** - 25% v 5% approx
- **Personality Disorders** - 66% approx v 5% approx

In Scotland we compared the prevalence of various problems in prison and the community. There is Scottish data that looks at alcohol problems, drug use, psychosis, depression and personality disorders. It is clear that, if you add together the prevalence of the five mental health characteristics, then that amounts to 206%. But we are describing, instead, one person who is actually capable of having all these conditions. We deal with a person with a range of problems, of which mental health is one.

Statistics also show a concentration of problems in prison. In fact, there is a concentration of almost every health problem in prison apart, perhaps, in the young offender community.

Multiple Health Risks

- **Mental Health – Depression** - 5 times
- **Dental Health in Men** - 3-4 times
- **Alcohol Problems** - 3-5 times

- **Smoking** - 3 times
- **Illegal Drug Use** - 8 times

In Scotland, we have compared what we are prescribing in the prisons to communities around Scotland. We have shown a multiple of 2.3 times for the prescription rate for anti-depressant and anti-anxiety medication in prison compared to the community, and a rate over 10 times greater for some anti-psychotic drugs. The top six drugs in the psychiatry and psychosis field are being prescribed many times more in prisons than in community provision. That may be appropriate because of the high level of psychosis in prisons but you may also argue that we could be medicating our mental health problems. This picture suggests a bit of both. Scotland's prisons have a large burden of people with mental health problems but we do have a problem with the capacity to deploy psychological treatments – i.e. alternatives to medication. We are medicating a lot of prisoners.

Prison Health in Scotland: A Health Care Needs Assessment

Defined Daily Dose, Mental Health Treatments - SPS/Scotland

		<u>DDD/1,000</u>
Citalopram	1.6	
Escitalopram	3.5	
Fluoxetine	2.3	[12,664/5,525]
Mirtazipine	8.5	
Paroxetine	1.1	
Trazodone	9.7	
Quetiapine	11.2	[2,098/187]
Olanzapine	8.2	[5,533/678]

In Scottish and Irish prisons, we have people with common characteristics who have a very high health burden. We have a very sick population and not just with mental health problems. The challenge is to address the needs of prisoners so that they can reach the starting grid for rehabilitation in a broader sense. We've got to employ mental health resources to deal with mental health, also addiction, and I would add literacy. Literacy is vital.

So what do we do about that? In Scotland we have 15 prisons and no inpatient accommodation. This is because prison healthcare should do what it is good at. Offenders commonly come in with a mental health problem or an addiction problem – lots of people have them and prisons are quite

good at dealing with them – but we can't open hospitals for unusual or very severe problems. We want to sustain expertise in common and important problems at the right levels. When someone requires hospital care, they should go to hospital.

In the days of modern governance, it is not right for people expecting competent care to get poor care for uncommon conditions in prison. For severe and enduring mental illness, our relationship with the hospital and the forensic mental health service is similar to Ireland. Scotland has one high secure prison in Scotland which has been completely rebuilt. We also have two, becoming three, medium secure units being built and a series of low secure units with IPC units supporting. What is really important is community based forensic mental health care. That's vital because it is the valve that releases the pressure on mental healthcare and forensic mental healthcare in hospitals. That is probably the most important development for the future. So, services should build hospitals to replace but don't build up capacity. Every person who is an expert on prison reform says the same and it's possibly true also for mental health care.

We have talked about mental illness as a disease and the need for certain treatments but we should also address the context in which we support people in prisons. We are supporting whole people in prison, it's about a person with a mental health problem and all sorts of other problems, the need to cope and connect in with self, with others and the community. The connection is not medical or medication.

Self-worth and meaning matters to mental well-being – and Chaplains have a role. A lot of prisoners think fundamentally about how they got there and they have a lot of time to think about it. Self-worth and meaning is the undercurrent to addressing other problems that we call mental health issues and other problems. Mental health does not stop at the mental health service.

For people with a severe and enduring mental disorder our arrangements in Scotland are reasonable and we have good liaison and capacity to cope. It is the burden of less severe conditions that overwhelm. Mental health services in prisons are focused for much of the time on depression, anxiety and stress and their consequences – and personality disorder. Over 50% of prisoners have

a personality disorder and we need to devise the right approach.

In order to move people on and make sure they won't re-offend, this is an area for renewed attention. We can address some types of personality disorders – borderline or psychopathy for instance. Perhaps we can't do so much about the others. But we've got to get to grips with the people and disorders where there is the potential for benefit. This challenges current services, particularly forensic mental health services.

We now address the structure of mental health services in prisons - Tiers One to Four. Tier One – involve general practitioners or general nurses. Tier Two is specialist care staff. Tier Three – is team care by psychologists and mental health nurses. Tier Four – is hospital specialists. But there is also a Tier Zero. The last ten years in the Scottish Prison Service has seen more done on Tier Zero than on any other kind.

Tier Zero is an ethos, organisation of services, an orientation of the prison, encouraging and being encouraged by interested prison officers. These measures have wider beneficial effects on the system.

In Scotland, we are doing more on leadership and involvement, culture, and mental health first aid. Prison officers are very interested in mental health, they want to be skilled up and confident to deal with people, whatever problems or behaviour, they have.

We have further to go – to an extent, dependent on the resources, especially non-drug treatments. Constructive daytime activity is very important. Prison life can be very boring. Efficiencies tend to cut the opportunity for the prisoners to get out of their cells and do something useful, which is very important for mental health. That is important to highlight because, unless you have a stimulating environment and hope, problems can't get better – it's absolutely fundamental. Prison misuse and

overcrowding is going to squeeze out any goodness about the environment of prison if there are too many people to cope with and there are lots of reasons for saying that.

The picture of mental health in prisons is therefore more than about medical services. It's more than meeting our obligations. It's more than treatment, although treatment is absolutely vital. It's about the detail – and specifically, a feeling of being safe in prison.

What are the challenges? The first is the overwhelming burden of care that we face. Mental health problems are becoming more prevalent in prison, we are more aware of them and, more aware of the possibilities of intervention.

Where prisons have to strike a balance, though, is the extent to which they style themselves as rehabilitation institutions. We're quite proud of that fact. Prisoners come to us and there are no waiting lists. There's a chance that we may turn them into a willing player in the inflation of sentences primarily to treat mental health and addiction problems – I worry about that. I think community alternatives are better, more effective, and I would rather offenders stayed away from prison.

In conclusion

Mental health in prisons is a system issue. The prominence of the issue is rising; the burden, too, is rising. Prison healthcare responses are improving in partnership with community based health systems. There are many challenges ahead but the best successes will come when alternatives to prison, in the community, have the capability and appetite to integrate mental health care and support justice programmes.

Self-worth underpins the capability of individuals to cope and take opportunities to recover. Mental health is a component of that state, just as mental health services are a component of our approach to improvements in mental wellbeing.

Workshop Discussions

Workshop One: Child and Adolescent Psychiatry – Interface with the Criminal Justice System

Co-ordinator: Dr Keith Holmes, Consultant Psychiatrist, Lucena Clinic, Rathgar
Chair: Finbarr O’Leary
Rapporteur: Emer Ní Chuagain

Historically, Child & Adolescent Psychiatry Services catered for those under the age of 16. With the implementation of The Mental Health Act 2001, which defined a child as being a person under the age of 18, the remit, in most parts of the country, for Child & Adolescent Mental Health Services (CAMHS) has now been extended to the 18th birthday. Unfortunately, because the promised resources to deal with this added caseload have not been put in place, it is extremely difficult to meet the level of need which exists. It has certainly brought about a higher level of collaboration between different agencies, and this is certainly a beneficial step. With respect to the treatment of these children, the vast majority are treated on an outpatient basis, with a limited number of inpatient beds. While this number is increasing, it remains difficult to obtain an emergency bed if necessary, but nonetheless it is one area where there has been significant investment.

Consent is a very important issue for Child & Adolescent Mental Health Services. The Non-Fatal Offences against the Person Act (1968) allows those 16 years old and over to consent to medical, surgical and dental treatment, but is silent on the matter of psychiatric treatment. While many 16 year olds have the maturity to consent to such treatment, the law, as it is applied, does not take this into account, although The Law Reform Commission has made recommendations which would, if enacted, change the situation. Therefore, it is up to the guardians to consent on behalf of a young person, and if it is the case that a legal guardian dissents, then a legal remedy is sought before they can be seen by our teams, except in the case of emergencies.

In dealing specifically with the interface with the Courts, there is a lack of child forensic psychiatry consultants in the country. Therefore, the level of involvement of the local CAMHS team is very

much a function of the awareness of the local District Justice as to the benefit of such involvement, where appropriate, and the willingness of the team in question to respond at what can often be extremely short notice. In the Dublin area, because of the mobility of Courts and Judges, it is perhaps a little more difficult to generate that level of familiarity between Courts and services that would be to the benefit and smoother functioning of the wheels of justice.

Dr. Holmes spoke a little on the common features relating to children who form the bulk of the interface between Child and Adolescent Psychiatry. First among these is Attention Deficit Hyperactivity Disorder, which is a heritable condition, usually through males, which predisposes children to be more likely to become embroiled in forensic difficulties. A combination of hyperactivity, impulsivity and inattentiveness creates a high level of risk seeking, and unfortunately a limited ability to manage themselves with authorities.

Autistic Spectrum Disorders are less frequent, but nonetheless can be problematic because, given that a lack of empathy is a core feature of such disorders, these children can treat people as though they had no feelings, and even as objects, and therefore the propensity to recidivism is significant because of the relative lack of remorse. It is also quite commonly the case that children with Autistic Spectrum Disorders, because of their limited social understanding, can misinterpret what is said to them and react in a somewhat belligerent way, without the obsequiousness which might be of use in such situations.

Dr. Holmes then spoke a little about the rationale behind subdividing Child & Adolescent Mental Health Services into services for younger children and youth mental health services. This is very much based on the model of Prof. Patrick McGorry (from Melbourne in Australia) who has made the very convincing case that significant psychiatric morbidity increases exponentially from the age of 15 on, and indeed he would argue that it makes little sense to limit the service to 18 year olds, but rather should progress to young adulthood, through to the mid-twenties. This, from an epidemiological point of view, makes very good sense, but of course it does cross over the child-adult legal boundary which, for administrative reasons, seems to have become sacrosanct.

Dr. Holmes also spoke a little about the concept of “ultra high risk for psychosis” teenagers. These are a group who can be identified and the question arises as to how they can be protected from developing a full blown psychotic illness. Some early work which has been done on this has identified that significant stressors for such youngsters include family discord and also the return to school following a holiday period. These teenagers find the structure of school, and the stresses which come with it, quite testing, and Dr. Holmes pointed out that if such situations are so difficult for them, then the prospect of incarceration for such youngsters is almost guaranteed to trigger psychotic illness. This does call into question the facilities where such young people are incarcerated, and the need for mental health input is significant. It goes without saying that all of these risk factors are exacerbated and accentuated by drug misuse, and this is a very prominent area which was not discussed to any great extent during this workshop, but would very much reward further consideration.

Group Discussion

Discussion ensued regarding various issues, including a child’s refusal to cooperate, ADHD, prison facilities, detention schools and the differing psychiatric needs of the 0 to 14 age group when compared to the 15 and older age group.

Workshop Two: ‘Girls Behind Bars: Female Experiences of Criminal Justice’ exhibition

Co-ordinator: Eve McDougall, Artist & Curator, Together Our Space Gallery

Chair: Jane Farrell

Rapporteur: Adele Smith

Eve McDougall is an artist & Curator for *Together Our Space* art gallery, a national charity working alongside people with health problems across 70 projects in England, which has been running for 5 years. *Together* provides opportunities for emerging artists from a range of backgrounds, including those with health problems, to show their work and share their experiences. The gallery has also sold pieces of work on behalf of the artists at their exhibitions, where they say the artists are thrilled to have their work on display. Eve tells us that creating and finishing a piece of art can be fulfilling and therapeutic to ex-offenders and persons with health problems who often have come

from chaotic lives and often have never completed a project to the end.

Eve spoke of her first hand experience of health problems associated with prisoners and explained how at the age of 15 (in 1972) she was arrested for a petty crime (breaking a window in a bakery in order to steal the bread) and was subsequently held in an adult prison for 2 years due to legal technicalities of being unable to hold her elsewhere. It was thought that the other prisoners would be a bad influence on her mind (Eve admits she was taught a lot about crime, especially fraud) therefore she was kept in isolation for 23 hours a day; and often missed her one hour of exercise time due to the bad Scottish weather. Eve explained how she managed to keep sane by day dreaming of being somewhere else, and keeping her mind active by following a spider across the wall and back for hours at a time. Eve also relied on other prisoners sneaking items from the shop to her. Eve also mentioned that although there were prison staff who took advantage of the balance of power and used their position to intimidate prisoners, there were some friendly staff who maintained a sense of humour and made a difference in bringing down anger and giving her morale boosts.

Eve placed a large emphasis on the impact of staff relations and insisted that if prison staff were educated in counselling techniques, it would have a positive impact on prisoner health as the majority of prisoners either come to prison with, or develop during their stay, some form of health problem. Eve suggested that the issue was so bad that if all prisoners with health problems were to be moved to the special hospital, then there would be no prisoners left, therefore it is vital for the prison staff to have some basic training on how to deal with mental health. Less prisons and more educational facilities on the outside would also reduce the cost of each prisoner.

After witnessing the horror of inmates self-harming, and dealing with the isolation, as well as being imprisoned as a child for a petty crime, Eve was released and left to deal with the psychological impact on her own. Many of her fellow inmates went on to commit suicide and Eve felt that she would never live past the age of 20. This led her to an abusive relationship, self harming, a dependency on alcohol and eventually to a special hospital where she stated that the conditions and

experiences were very similar to her time in prison, although her experiences here were less horrific due to the staff being more compassionate.

After moving to London and away from her lifestyle, Eve has made an example from her life experiences; writing a book and a play about her life, publishing magazine articles, becoming a self taught artist and running art workshops and exhibitions, and completing college counselling courses in order to help others who have suffered health problems as well as working with other charities helping vulnerable people.

Group Discussion

The session concluded with a question and answer session where members of the seminar were able to ask Eve specific questions about her experience. Members were also able to examine some of Eve's own work and read about the programmes she is involved in.

Workshop Three: Prison In-reach and Court Liaison Services in Ireland

Co-ordinator: Dr Conor O'Neill, Consultant Forensic Psychiatrist, Central Mental Hospital

Chair: Kieran O'Dwyer

Rapporteur: Séamus Ó Coighligh

This workshop was designed to inform attendees of the work undertaken by the Central Mental Hospital to identify remand prisoners with mental health problems with a view to referring them to the most appropriate services for treatment. The work is carried out in Cloverhill Prison by the Hospital's Court Liaison Service (PICLS).

Context

A disproportionate number of people with mental health issues end up in the criminal justice system. A study in 2004 found that 7.6% of male remand prisoners demonstrated indicia of psychotic illness, a rate ten times higher than the community average. Between 3% and 4% of new remands demonstrate active psychotic symptoms on committal.

It is widely accepted that prisons are inappropriate places for prisoners with mental health problems. At the same time, capacity for secure hospital beds is limited. There are currently 93 secure forensic beds in the Central Mental Hospital (CMH) in Dundrum but these are generally occupied by

patients who need long term treatment and as a result there is a small turnover of beds. Transfer of prisoners to the CMH is appropriate for those suffering from more severe conditions and charged with serious offences or posing significant risk to others. Appropriate use of resources, combined with the negative effect of detention on mental health, clearly make it preferable that people be treated as far as possible within the community rather than in the criminal justice system.

The UN Declaration on the Rights of the Mentally Ill states that the mentally ill should have an equal right to bail and liberty as others, but in practice they face a number of significant obstacles. Typical bail requirements include presenting a sum of money, being able to give an address and having a person to vouch for the individual. Many persons suffering from mental illness are unable to fulfil these requirements and are therefore more likely to be remanded into custody for minor offences.

A Vision for Change recommended the provision of diversion services. In the absence of specific legislation, the PICLS diversion system relies on existing provisions, notably powers of the Courts regarding bail and probation and s.12 of the Mental Health Act 2001.

Designing a Service

It was recognised early that a diversionary service in this area requires the co-operation of a number of agencies and services. A consultation process was carried which enabled various stakeholders to identify their concerns. Judges requested assistance in identifying defendants with mental illness; they also requested rapid access to psychiatric reports giving clear information regarding healthcare solutions, and for those solutions to be put in place. Psychiatric Services were frustrated by what they felt to be inappropriate referrals from courts and lack of communication. Patient groups felt that the time at which a person is most in need may also be when it is most difficult for them to access services, e.g. homelessness puts you outside a service catchment area. It was clear that the new service needed to act as a conduit between these various bodies.

Various service models were considered. It was not possible within available resources to provide a daily service to all Garda Stations and Courts nationally. A prison based model was agreed as the most effective and equitable delivery point given

that it would be possible in Cloverhill Prison to screen the vast majority of remanded male prisoners.

Assessment process

The team at Cloverhill consists of one consultant forensic psychiatrist, three psychiatric nurses and two trainee psychiatrists. The process of assessment involves a number of stages:

1. Initial screening of all remands, complemented by referrals from sources including courts, prison staff, other prisons, and others.
2. Detailed assessment and liaison with patients' families, GPs, Gardaí, local psychiatric services, homelessness and addiction services, family members and others.
3. Triage according to service need, broadly as follows:

Less Serious Illness +Low Risk Offence:
Treatment in Prison

Major Illness + Low Risk Offence:
Community Treatment

Major Illness + High Risk Offence:
Referral to CMH

4. Arrangement of treatment options in the event of custodial and non-custodial disposal through liaison with local psychiatric services and others.
5. Preparation of a Court Report and arrangement of transport to hospital if required. The Court Report is designed to give the judge guidance as to treatment options which have been arranged in the event of custodial and non-custodial disposal.

Results

The PICLS have seen a steady increase in the amount of successful diversions. In 2005, before the PICLS was established, there were a total of 19 diversions, all to the CMH for an average of 2 months. In 2010 there were 114 diversions, most of whom were given treatment in community setting. In 2009, the PICLS were awarded the Irish Healthcare Award for Best Healthcare Project.

Group Discussion

The response from the floor to the PICLS was very positive. It was accepted that prisons are not a suitable place for the treatment of psychiatric patients. The lack of universal availability of the

service was regretted - the Dóchas Centre provides a similar service for female prisoners and a programme of psychiatric assessment has begun in St Patrick's Institution, but other prisons could potentially benefit. In response to a query about client fitness to stand trial, it was pointed out that consideration of this issue can be deferred to enable individuals to access treatment. Diversion should not be regarded as a "get out of jail free card", since in general individuals are released on bail which may be subject to conditions, thus providing a balance between rights and responsibilities.

Workshop Four: Making the Vision Visible

Co-ordinator: Martin Rogan, Assistant National Director for Mental Health, Health Service Executive

Chair: Brendan Callaghan

Rapporteur: Jane McGowan

Introduction

In January 2006, the HSE published its national policy detailing the provision and development of mental health services in Ireland. An expert group was formed, comprising of diverse professionals e.g. health services managers, service users and researchers. Following the fifth year implementation of *A Vision for Change*, Martin Rogan discussed the original goals and reported on the progress made thus far.

Pre-2006, Mr. Rogan noted that Ireland hospitalised those suffering from mental health illnesses, all too readily. Discharged patients often found difficulty reconnecting with their lives. Notably, *A Vision for Change* has successfully adopted the 'service-user' perspective. Furthermore, an academic post for these 'experts by experience' was founded in DCU. Trained and accredited peer advocates are working in every HSE acute unit, nationwide. The Health Service Executive has affirmed a collaborative leadership training programme which provides for active service-user engagement with caretakers and professionals.

Two nationwide campaigns for adults and youths alike, have been created – www.yourmentalhealth.ie and www.letsomeoneknow.ie. These campaigns were designed by, with and for the peer groups.

Martin Rogan submitted that “mental health is about being in the right place at the right time”. 5% of mental health sufferers are in ‘continuing care’. However, prison is becoming another place on this spectrum.

In 2011, the “WHO Health in Prison – Best Practice Award” was bestowed upon a team of health professionals and prison staff at Dublin’s Mountjoy Prison. The team opened a high-support unit for prisoners with mental health problems so that they could be monitored in a safe environment.

Issues arising from statistics

Mr. Rogan presented stark statistics regarding the general population’s mental health. 16% are deemed mentally healthy, 54% are deemed moderately mentally healthy and 20% have been diagnosed with a mental illness. 10% are languishing in their lives.

In 1970, Ireland had 749 prison places with 15,000 psychiatric inpatient beds. By 2011, the prison population has risen to over, 4,000 while the acute bed capacity for mental health has dropped to 1,227.

Currently, there are 124 community mental health teams (CMHTs). However, many of these teams are missing key professional workers. Currently only 48% of teams have clinical psychologists, 55% have social workers and 41% have the occupational therapists recommended in the *Vision for Change*.

Mr. Rogan noted that

- With every 1% increase in unemployment, there has been a corollary 0.79% increase in suicide and self-harm. (Lancet July 2009)
- In 2010, the cost of imprisonment per prisoner was €70,513 (per annum)
- In 2011, the cost of an acute psychiatric bed in an acute hospital was €303,000 (per annum)

Conclusion

Mr. Rogan held that the purpose of a *Vision for Change* was to rework and adapt an archaic system into modernity and relevance. The project had a realistic timeline of 7-10 years. However, it was noted that given the economic climate, all of the goals may not be achieved as all of the expected funding had not materialised.

	Expenditure (P.A)	Original objectives
Capital	€50million	€796million
Staffing WTEs	8,959	10,657
Revenue	€708million	€950million
Health Spending	5.2%	8.4%

A Vision for Change Independent Monitoring Group reviews the annual activities and expenditure of the expert group each year.

Group Discussion

Although the mental health services available to offenders within the criminal justice system were recognised, the availability of similar services for victims of crime was questioned. It was stated that a Rape Crisis Network study (2009) claimed that the most likely reason for a rape case not proceeding to trial was because a victim who suffered with a mental illness in the past or present, was often perceived as being unreliable. It was noted that there is a pressing need for a lot more work and interface between services available to both rape victims and offenders.

It was opined that the ‘prisoner’s voice’ i.e. the voice of the service user, should be listened to and utilised. A huge cultural change was called for amongst the expert group, the government and mental health service providers. This was in a bid to make the aforementioned parties adhere to their original goals and policies which were expressed in a *Vision for Change*; namely utilising the ‘experts by experience’ more.

The merits of ‘Proposition 63’ (also known as the Mental Health Services Act 2004, California, USA) were discussed. This Act imposes a 1% income tax on personal income in excess of \$1 million. Throughout California, Proposition 63 was projected to generate approximately \$254 million in the fiscal year 2004-05, \$683 million in 2005-06 and increasing amounts thereafter. Much of the funding has been provided to county mental health programs to fund programs consistent with their local plans.

The practical tension that arises when one attempts to satisfy an offender’s right to bodily integrity per Article 6 of the European Convention of Human Rights and uphold their custodial sentence upon conviction, was noted. It was opined that as detention is a crucial element of their punishment, the quality of mental health treatment that a public

patient receives is often substantially higher than the limited treatment received by a mentally ill offender in prison.

Workshop Five: Recovery & Growth within the Criminal Justice System

Co-ordinators: Michele Kerrigan, Ellen Ryle, Leo Pattison, Ruairi Powell, Patricia Kenny, Area coordinators for GROW; and Paddy

Chair: Gerry McNally

Rapporteur: Adele Smith

GROW's mission is to nurture mental health, personal growth, prevention and full recovery from all kinds of mental illness.

GROW is a mental health organisation which helps people who have suffered, or are suffering, from mental health problems. GROW was founded in Australia in 1957 by former mental sufferers. GROW was established in Ireland in 1969 and now has 130 community groups.

Following the introduction of a GROW group at the Central Mental Hospital a GROW group was established in recent years at Arbour Hill Prison, with financial support provided by the Department of Justice through the Probation Service. GROW has since established another group at the Training Unit at Mountjoy Prison.

GROW is a voluntary organisation with a small number of paid employees. It is not a counselling group but rather an approach to mental health that emphasizes and supports each individual's potential for recovery by restoring hope and self belief, developing supportive relationships, empowerment, social inclusion, coping skills, strengthening an individual's emotional resilience, promoting self-esteem and imparting life and coping skills.

Grow groups meet weekly and discuss issues affecting the individual and work out a goal or task to complete for the week ahead. The group is organised and run by participants. They choose their own speed and progress to work through a structured programme using a manual which they can refer to for added guidance throughout the week.

In prison each participant volunteers for the programme and needs to have a desire to change,

as participating in GROW is not seen as 'the norm' within the prison life and the participants may face ridicule from other prisoners. To participate in the programme requires enormous strength and desire to change.

GROW helps inmates to cope with the effects of long term imprisonment, with many facing a struggle with depression, isolation and hopelessness. The group structure brings people together to help them develop their social interaction skills and combats isolation. GROW also helps those coming to the end of their sentence to prepare for the challenges they will face when they return to the community.

A GROW participant, Paddy, from Arbour Hill Prison shared his life story and experiences with the Grow programme in prison. Paddy pinpointed childhood abuse and expulsion from school as trigger points in his life contributing to his running away from home, engaging in a life of petty crime as a means for survival and to drug abuse as means of escapism. Serving time in prison Paddy felt a form of belonging and made this his new family, leading to a lifetime of crime and heroin addiction.

During the 6 year sentence which he is now serving, 17 people Paddy has known have died from heroin abuse; a road Paddy believes he was heading down. Paddy engaged in self detoxification in prison and participated in counselling and education programmes which have helped build his confidence and self-esteem. Paddy also credits GROW as a turning point in his life where he was able to share his life story and listen to other experiences. The GROW group became a source of support and positive reinforcement for the participants attending. Paddy can also see positive changes in other group members.

Paddy has completed a course on facilitation to help run and organise Grow meetings for other prisoners, a strong indication of the level of faith and belief that Paddy has in the Grow programme and how it has helped and sustained him in changing his self management and coping skills. After his release he hopes to continue with GROW in the community, to support his resettlement and maintaining his positive change.

Since its introduction in Ireland GROW has expanded in communities through the

determination and commitment of GROW members. The work of GROW, in the prisons where it is established, has provided a valued and important resource for prisoners living with mental health difficulties, coping with the stress of imprisonment and working towards making real and sustainable changes in their lifestyle and self management.

GROW has been supported by the Probation Service, medical and mental health services and prison management in its work in Arbour Hill and Mountjoy prisons. It is recognised and valued by participants and professionals for the positive contribution it has made.

GROW hopes, over the coming years, to introduce GROW groups in more prisons. Working in prisons is different from the experience in community based groups. It is a challenging environment with particular needs and stresses.

GROW can make a difference but needs to staff and manage the introduction sensitively in partnership with prison management, mental health and related services. The immediate priority for GROW is to ensure that each group is well managed and supported, meets the needs of participants and makes a positive difference.

Further information on the work of GROW can be accessed at www.grow.ie or by calling their info line 1890 474 474.

Workshop Six: Mental Health Law & The Criminal Justice System – When Two Worlds Collide

Co-ordinator: Niall Nolan, Barrister at Law

Chair: Eugene Corcoran

Rapporteur: Jane McGowan

Introduction

Niall Nolan presented his paper “Mental Health and the Criminal Justice System - When two worlds collide” to the Conference and discussed the interface between mental health and criminal laws. He noted that conflicts have arisen in terms of rights and responsibilities and he identified areas of mutual misunderstanding.

The book entitled “Going Sane” by Adam Philips, details the case of Charles Lavergne Singleton, who was convicted of stabbing Mary Lou York to

death (1979). While incarcerated, he was diagnosed with schizophrenia. In *Ford v. Wainwright* 477 U.S. 399 (1986), the Supreme Court prohibited the execution of the mentally insane i.e. offenders who could neither understand nor appreciate their crime and/or punishment. Thus, in October 2001, Charles Singleton was afforded a permanent stay of execution and was sentenced to life in prison without the possibility of parole. In February 2003, the State successfully appealed and overturned this sentence, in the 8th U.S. Circuit Court of Appeals. In Arkansas, on January 6, 2004 at 8.06pm, the State forcibly administered anti-psychotic medication to control Singleton’s behaviour. He was executed by lethal injection.

Legislation and case law

Although the Mental Health Acts 2001 – 2008 are primarily concerned with civil detention, there are many repercussions for the criminal justice system flowing from said legislation. It is notable that 25% of all applications for civil detentions are done by the Garda Síochána. However, one ought to consider whether Garda doctors are adequately equipped to apply the Mental Health Acts.

Section 12 of the Mental Health Act, 2001 expressly provides for the powers of the Garda Síochána to take a person believed to be suffering from mental disorder into custody. Section 12(1) states that a member of the Garda Síochána must have “reasonable grounds for believing that a person is suffering from a mental disorder and that because of the mental disorder there is a serious likelihood of the person causing immediate and serious harm to himself or herself or to other persons.”

Pear J expressed a “certain disquiet” about the manner in which the Garda doctor conducted his examination, which led to the making of a recommendation for an involuntary admission. However, he stated that “*as the doctor was a registered medical practitioner, and thus a qualified person to have examined the applicant for the purpose of the s.10 recommendation...[it] could not be gainsaid that the examination carried out for the purpose of an application under s.9 or indeed under s. 10 is not to be equated with the later examination to be carried out by a consultant psychiatrist under s. 14 of the Act within 24 hours of any admission of the patient, even though the definition of ‘examination’ covers an examination*”

in relation to a recommendation.” Thus, even though the Court pronounced its’ reservations about the appropriateness of such an examination taking place in an informal way, the examination was upheld.

Mr. Nolan stated that informal or improper examinations of persons suffering from mental health difficulties while detained in Garda stations can lead to further problems with the admissibility of evidence for the prosecutor at trial, if a criminal prosecution in fact ensues.

Group Discussion

Mr Nolan noted that there was an issue in relation to the fitness to be tried provisions of the Criminal Law (Insanity) Act 2006, where a person in respect of whom there may be a psychiatric report suggesting unfitness to be tried, may nevertheless have to be sent forward to the Circuit Court to have the fitness issue determined in respect of certain offences, notwithstanding that the DPP directs summary disposal before the District Court, thus considering such cases minor and a District Judge accepts jurisdiction. Mr. Nolan noted that the Criminal Law Insanity Act, 2006 was in gestation for a number of years. However, many issues regarding the implementation of the Act have been identified since its enactment. In *O’Callaghan v DPP*, Hardiman J held that “[l]ike many modern statutes the Act is not very clearly or logically drafted...”

A question on whether it is worthwhile to have a full hearing to determine the accused’s ‘fitness to plead’ for minor offences, was posed. It was noted that in fact determination of this issue can sometimes be held without employing psychiatrists. It was also indicated that these hearings generally work well and swiftly in the District Court.

The possibility for a judge to adjourn a case until an accused enters a hospital and receives treatment was noted.

The importance of having an ‘on-call, 24hour’ psychiatric liaison to assist police officers was stressed. It was opined that if the preliminary medical examination and subsequent interview(s) are not conducted properly, very serious prosecutions could be derailed. Thus, it was suggested that examinations by a Garda doctor are probably insufficient.

Workshop Seven: A Northern Perspective on Mental Health Care & Legislation

Co-ordinator: Dr Ian Bownes, Consultant Forensic Psychiatrist, Tyrone and Fermanagh Hospital

Chair: Geraldine Hurley

Rapporteur: Séamus Ó Coigligh

Mental Health legislation in Northern Ireland is currently undergoing major reform. The purpose of this workshop was to gain an overview of the treatment of the mentally disordered within the Northern Ireland Criminal Justice System (NICJS) and to consider the effects which the reform process is likely to have. The workshop consisted of a talk given by Dr Bownes, followed by a group discussion.

Introduction

The workshop began with a brief overview of the intersection of the Forensic Services with other bodies within the NICJS. Forensic services deal directly with those bodies involved directly in the criminal process including the Police, Prisons, the Courts and the Probation Services. They also deal with community services, the independent and voluntary sectors and with the healthcare system. The forensic service deals with ordinary hospitals, medium and high security hospitals, all of which have a psychiatric intensive care unit (PICU).

An outline was then given of patients who are likely to be encountered in the course of providing psychiatric care in the NICJS. A number of characteristics are particularly prevalent in practice:

- A mixture of treatable and untreatable conditions will present in a single patient making a clear diagnosis difficult
- Neuropsychological difficulties which compound psychiatric conditions
- There is often a background of childhood deprivation or abuse
- Substance abuse is common
- ‘Troubles trauma’ is frequently a factor. This can range from Post Traumatic Stress to aggravating factors such as having violent role-models and anti-authoritarian leanings
- Patients tend to be interpersonally alienated
- Hostile attribution of blame to external sources

- Tendency to see the statutory services as oppressive agents of social control
- There is often non-compliance with therapeutic interventions

As a result there is an attempt to move away from 'state repressive' forms of therapy towards 'talking therapies' in order to encourage engagement on the behalf of the mentally disordered within the NICJS.

Prevalence of Mental Disorder in NICJS

It is apparent from various studies that there is a very high rate of mental disorder in persons who come into contact with the NICJS. A report presented by the Secretary of State for Northern Ireland to the Houses of Parliament declared that the overall rates of incidents of mental disorders within the NICJS indicate that it is certainly not a marginal problem. 16% of individuals arrested into custody met one or more of the criteria for mental disorder. 78% of male and 64% of female prisoners met the criteria for a personal disorder. Over 44% of probation officers surveyed reported having at least one client with a significant mental health issue, while 52% reported having between 1-4 clients with a less serious mental illness.

Research based on 200 non-psychotic referrals in Maghaberry Prison demonstrates that inmates suffer from a very high instance of post-traumatic stress disorder. Other prominent conditions include Anxiety(48%), Dysthemia(65%) and low self-esteem(52%). Often problems will be trans-generational and will relate to family killings and ongoing feuds between rival families. In this context it is certainly very difficult for the prison system to cope.

Legislative Framework

The management of mentally disordered offenders in Northern Ireland depends on the application of a number of pieces of legislation.

Mental Health (N. Ireland) Order, 1986

The operation of the 1986 Order makes it immaterial whether or not a person has the capacity to make decisions. If you are considered to pose a risk to yourself or to others then decisions regarding treatment would be made for you. (This section does not extend to cover instances of freestanding personality disorders, sexual deviancy or alcohol dependency.) This approach is currently

under revision. One important procedure under this Order is the *interim hospital order*. This allows for a person to be removed from a police station and transferred to a safe location, and then to be transferred to a psychiatric hospital following a court appearance.

Criminal Justice (N. Ireland) Order, 1986

This Order supplements the Mental Health Order and contains a number of provisions which can be used to manage the treatment of a mentally disordered offender. These include probation orders, community service orders, combination orders, custody probation orders, and supervision and treatment orders. This Order was updated by the Criminal Justice (N. Ireland) Order, 2008 which brought about a conceptual change by making public protection the primary consideration in the management of an offender. The 2008 Order introduced electronic monitoring (tagging) which can be used in conjunction with treatment and also, significantly, placed the Probation Board at the heart of the CJS.

Work of the Probation Board N. Ireland

The role of the Probation Board involves making an assessment of the convicted offender to facilitate decision makers. The Probation Board will then oversee any prescribed Court Orders including a sex offender or life sentence licence and will provide treatment to address criminal behaviour in offenders. The Probation Board produces over 9,000 reports per annum. It supervises 4,000 Court Orders at any given time. Thus the work of the Probation Board allows for the implementation of the 2008 public protection criteria so that offenders not judged to be dangerous may be diverted to community programmes or given determinate sentences. Where this alone is deemed not to be sufficient the Probation Board can supervise an extended custodial sentence.

The 2008 Order sets out definitions for what constitutes dangerousness. This test considers whether there is a risk of the offender causing serious physical or psychological injury to members of the public. This test can be applied to both mentally ill and mentally sound offenders. There are a number of stages in deciding the level of an offenders' dangerousness with reference to significant considerations. This process culminates in a co-ordinated system of risk management, Public Protection Arrangements for Northern

Ireland (PPANI) which then determine how an offender is best managed.

Change

There have been a number of drivers for change in the treatment of mentally disordered offenders. A report by the Northern Ireland Criminal Justice Inspectorate highlighted the need for early intervention. The European Court of Human Rights decision in *HL v The United Kingdom* found that a detention made under the Common Law doctrine of 'necessity' was unlawful. Furthermore, a recent judicial review case found that detention of a female prisoner with a borderline personality disorder was in breach of Articles 2 (right to life) and 3 (torture/cruel and unusual punishment) of the European Convention on Human Rights.

The Bamford Review made a number of recommendations including the need for timely interventions, the adoption of capacity based legislation and the transfer of healthcare responsibility to the Department of Health, Social Services and Public Safety. The last recommendation has been operating as a shadow arrangement for roughly 12 months prior to being formally adopted in 2012 and has been very successful. However, the question of capacity based legislation is more contentious. The Chiswick Report stated that capacity is a poorly defined idea and that a system based on capacity gives health services the opportunity to pass on patients. In English law there is a legal presumption in favour of capacity which is not necessarily vitiated by a lack of wisdom or having only a short term ability to retain information. It was suggested that the MacArthur Competence Assessment Tool for Treatment might be a potential alternative method of measuring legal capacity.

As capacity will be central to any new mental health legislation it will be of paramount importance in practice. It is, therefore, essential that it is clearly defined. Capacity based legislation needs to have clarity on whether all parts of a test must be satisfied for committal to be ordered, whether public protection will remain the overarching criteria and it is also important to ensure that psychiatrists do not become agents of social control.

Problems

A number of problems are envisaged with the new system:

- The proposed system does not seem to cater for emotional storm patients
- Difficulties will arise when there are disagreements between psychiatrists
- Patients with fluctuating capacity may not be catered for
- Those suffering from Personality Disorders often have 'capacity' but may still be poor decision makers or have the potential to cause harm
- The introduction of the capacity element will result in medical diagnoses being questioned under judicial review. This has the potential to be procedurally unattractive if technical questions end up overbearing the patient
- There is a risk that doctors will have to spend a disproportionate amount of time in court
- Mentally disordered persons may have the capacity to refuse treatment

A number of issues have been raised in the context of Advance Directives regarding the issue of hunger strikers and capacity and what the position will be with regard to prison liability for corporate murder. An important question is what response will be possible in the case of social self-harm occurring despite capacity being present?

There are three practicable options:

- 1) Don't apply the civil capacity test to the Criminal Justice System
- 2) Apply the test fully
- 3) Apply the test but with exceptions

The outcome remains to be seen.

Group Discussion

The group discussion centred on a number of topics including new initiatives for the treatment of personality disorders and the consequences capacity would have in everyday life, particularly financial dealings. The role of the European Court of Human Rights in the development of a new emphasis on an individual's right to be involved in their treatment was discussed. As was the question of force feeding, particularly with regard to juveniles who may fall outside a statutory limit. The shadow period of Department of Health local

trust management akin to stewardship over the provision of services was also discussed. It was opined that presently there is a continuum which proves effective in practice. There is concern that a legislative focus on capacity could interrupt this continuum if it resulted in the ability to make choices regarding the management of treatment being removed. As a capacity test has not yet been nailed down there is a fear that a relatively seamless process will be interrupted.

Workshop Eight: Youth Mental Health: Prevention and Early Intervention

Co-ordinator: Dr Joseph Duffy, Director of Clinical Support, Headstrong

Chair: Gerry Hickey

Rapporteur: Emer Ni Chuagain

This workshop focused on youth mental health and the criminal justice system. Dr Duffy asked what happens to some young people that they end up in prison, what do we know about their mental health? The number one issue for young people is mental health. 76% of adults diagnosed with a mental illness have experienced mental health difficulties by the age of 25. 20% of adolescents and young adults experience serious emotional distress. The vast majority are not in contact with any helping agency.

In 2007 Headstrong looked at research data in the Irish context from the Clonmel project and the pilot phase of *My World*, (the first national study of youth mental health). The data showed:

- Over 1 in 4 (27%) reported serious personal, emotional, behavioural or mental health problems
- Over 33% reported feeling generally not happy
- 1 in 5 (20%) reported having no one to talk to about their problems
- 10% of those who reported serious problems did not seek professional help.

We know that suicide is now the leading cause of death among young people in Ireland (aged 15 – 25). Ireland currently has the fourth highest rate of suicide (amongst 15 -25 year olds) in the European Union. In terms of total population Ireland ranks 20th. Adolescence, or emerging adulthood, is identified as a peak period for suicide. This is when young people may feel particularly vulnerable. It would appear that adolescence is

starting earlier, but equally that adulthood is not reached until later.

“The transition to adulthood is poorly understood in spite of the fact that it is probably the age period when most adult disorders have their peak rates of incidence”. Mrazek & Heggerty (1984)

Vulnerable groups were identified by Dr. Duffy who noted that a person who ends up in prison is likely to be an early school leaver and male. Belonging to one of the following groups increases the risk of developing mental health difficulties:

- Economically disadvantaged
- Males
- Travellers
- People with learning difficulties
- Asylum seekers and recent immigrants
- Early school leavers
- Young people in transition
- People who are or have experienced child abuse
- Offenders

Shufelt & Coccozza (2006) found that 65 – 70% of youth involved in the criminal justice system in the USA have at least one diagnosable mental health disorder. They concluded in their 2006 report that the “prevalence of mental disorders is higher in juvenile justice population than in the general population”.

A recent report from the Office of the Ombudsman for Children looked at the needs of young people in the prison system. The Ombudsman recommended that “particular attention should be given to young people’s mental health and to the delivery of programmes that bolster young people’s willingness and capacity to speak about and become active participants in safeguarding their mental health”.

Dr. Duffy asked “How do we change the focus from reducing psychopathy to improving resilience?” A needs and resource analysis conducted by Headstrong found that “the existing systems of services and supports for young people are insufficient, inaccessible, inefficient and in need of significant re-engineering”.

Dr. Duffy suggested that in Ireland the focus is on mental *illness* and not on mental *health*. By

focusing on resilience and developing the young person's ability to cope in general terms, and by encouraging people to access the Headstrong services, this focus may shift to promoting positive mental health.

Dr. Duffy presented information on Jigsaw. Jigsaw is an initiative aimed at creating a network of support for young people within their communities to promote their mental health and well-being. There are three levels of intervention within the Jigsaw framework. The 'universal' level is the level which is focused on enhancing the well-being of all young people by promoting their resilience and enhancing their environments. The second or 'indicated' level is focused on providing support to young people who are vulnerable or at risk for developing mental health difficulties. The final group is categorised as 'at risk' or 'selected' and the service looks at ways of supporting the young person. This level is focused on interventions for young people in actual distress or crises.

In addition to the Jigsaw hubs, Headstrong provides training to members of the community whom young people trust. This person could be a football coach or a person involved in the community. Headstrong is helping to provide training to these community members, which is aimed at enabling them to flag situations where young people are in distress and sign post them to services.

The Probation Service is among the top ten referrers to Jigsaw at present. Since Jigsaw Galway commenced, services have opened in Ballymun, Meath, Roscommon and Kerry. In addition to Jigsaw demonstration sites, Headstrong operates a Learning Network that is aimed at developing a community's readiness to meet the mental health needs of young people. These projects are funded by through the Health Service Executive (HSE) and philanthropy. Six more Jigsaw sites were announced in 2011. Dr. Duffy stated that the ultimate idea is that young people will have some where to turn to and someone to talk to. If all counties are to be covered, more funding is needed and it will also require a significant change in how we think about mental illness.

Concluding his presentation, Dr. Duffy discussed the importance of involving young people in all aspects of the service. He demonstrated Headstrong's commitment to this principle by

describing his appointment to Headstrong. A panel, including a young person, selected him for the appointment to his position. Dr. Duffy cited the O2 *Think Big* campaign as a good example of involving young people with mental health topics. Here, funding is provided to groups of young people to promote small projects that promote positive mental health.

Group Discussion

Questions and Answers, all answers are provided by Dr. Duffy.

Q1. The approach in Ballymun may be more challenging. You said there is a difference in how you run Jigsaw there?

A1. There were a lot of individual organisations already working in Ballymun when Jigsaw was established and a dispersal model was developed rather than operations from a hub. This involved training workers to support young people in the community through our Youth Centred Practice training.

Q2. Working with young people until they are 25 must be challenging when some services are not available after the age of 18?

A2. The challenge here is about engaging young people, maybe they won't go (to seek help) from 15 or 16 years of age. Sometimes groups come in and access one of the Jigsaw sites; particularly where there has been a suicide and it helps them to help the community. Data from Jigsaw Galway show that young men do access the service.

Q3. It is admirable that youth advisors are on the selection panel but they are most likely middle class young people. What socio-economic background are the people who attend the Jigsaw sites from?

A3. Young people from all backgrounds attend Jigsaw and work with Headstrong. Some people have used the mental health services and others have not and are interested in learning about and promoting positive mental health.

Q4. Do you operate to particular protocol in relation to reporting abuse?

A4. We operate under the Children First child protection policy.

Closing Address

Maura Butler, Chairperson ACJRD Ltd¹

I want to thank the following for ensuring that we had such a successful conference today. Our

- Plenary speakers
- Workshop presenters
- Council members who chaired workshops and
- Rapportuers: Jane McGowan, Emer Ní Chúagáin, Seamus O Coighligh and Adele Smith
- Interns
- The Camden Court personnel. We had our Annual Conference here last year and were looked after so well that we decided to come back!
- Danny Conneely who has been the temporary administrator at ACJRD in the lead up to this conference.

Most especially I want to thank our Manager Danelle Hannan for her well executed skills in ensuring that we had a wonderful list of contributors for this conference, and for the delivery of today's conference which matched her usual meticulous standard.

Now for those of you who are here in the room that are not ACJRD members, I want to say – get with the programme! Please *do* join us! We don't charge a fortune in membership fees and we do allow for organisational memberships

I want to remind you that we have collaborated with Barnardos and due to their generosity, and in particular their Director of Advocacy (and ACJRD Treasurer) Norah Gibbons, there will be a session here in The Camden Court on Tuesday the 8th of November from 9.30 – 12.45 entitled ***Juvenile Justice 2001 – 2011***. That conference will review Juvenile Justice legislation on the 10 year anniversary of the 2001 Children's Act. The speakers will include: Minister Frances Fitzgerald; Gerard Durkin, SC; Michelle Shannon of the IYJS (Irish Youth Justice Service); Supt. Collette Quinn and Geoffrey Shannon Solicitor. This planned event is financed by Barnardos.

So its just leaves me to say thanks again for the huge commitment of the members of the Council who have, in a very difficult year, as we'll hear at the AGM, managed, on a voluntary basis, together with the tenacity of our Manager ensured that ACJRD came back here for another year, for another conference. We are still here 15 years after our formation, recession or no recession! That would not have been possible without the support of the Department of Justice administrative grant. Finally it is you the members, working group members and conference attendees and our researchers that make this Association for Criminal Justice Research and Development such a vibrant one.

¹ Association for Criminal Justice Research & Development. CHY 15012

CONFERENCE ATTENDEES

Name:	Organisation:
Deborah Alred	Secure and Forensic Service, Sussex Partnership NHS Foundation Trust
Catherine Ashe	Candle Community Trust
Graham Betts-Symonds	Irish Prison Service
Shalom Binchy	Shalom Binchy & Co
Fergal Black	Irish Prison Service
Dr. Ian Bownes	Tyrone and Fermanagh Hospital
Orla Brady	Extern
Nadine Brennan	NUI Galway
Margaret Burnes	Jesuit Centre for Faith and Justice
Maura Butler	Law Society of Ireland
Eoin Carroll	Jesuit Centre for Faith and Justice
Joyce Clarke	Irish Prison Service
Aidan Collins	Scottish Association for Mental Health (SAMH)
Patrick Conboy	NUI Galway
Sean Conlon	Extern
Danny Conneely	ACJRD Ltd
Shane Conneely	
Paula Cooney	The Probation Service
Bairbre Corcoran	Depaul Ireland
Eugene Corcoran	An Garda Síochána
Rosemary Cronin	The Probation Service
Mary Crowley	Focus Ireland
Lisa Cuthbert	PACE
Frances Daly	Irish Prison Service
Lorraine Dooly	Irish Prison Service
Dr. Joseph Duffy	Headstrong
Valerie Fallon	Department of Justice & Equality
Jane Farrell	Office of the DPP
Aine Flynn	Terence Lyons & Co
Patricia Flynn	Oberstown Girls School
Nadette Foley	Facing Forward
Dr. Andrew Fraser	Scottish Prison Service

Name:

Brian French
Vivian Geiran
Norah Gibbons
Ailish Glennon
Michael Grange
Mark Hall
Diarmuid Hanifin
Danelle Hannan
Catherine Hayes
Sinead Henry
Liam Herrick
Greg Heylin
Gerry Hickey
Brian Hogan
Maeve Hogan
Dr. Keith Holmes
Paul Hughes
Geraldine Hurley
Grace Hutchinson
Brian Johnston
Mary Keevans
Enda Kelly
Prof. Harry Kennedy
Samantha Kennedy
Patricia Kenny
Michelle Kerrigan
Sharon Levins
Christine Littlefield
Hector MacLennan
Katie Mannion
Sandra Manthe
Jimmy Martin
John Martin
Vanessa McCarthy
Shari McDaid

Organisation:

Department of Justice (Northern Ireland)
The Probation Service
Barnardos
The Probation Service
The Parole Board
Scottish Association for Mental Health (SAMH)
Amnesty International (Ireland)
ACJRD Ltd
Mental Health (Criminal Law) Review Board
Depaul Ireland
Irish Penal Reform Trust
Mental Health (Criminal Law) Review Board
Garda Síochána Inspectorate
Oberstown Boys School
Garda Síochána Inspectorate
Lucena Clinic
PACE
The Courts Service
Waterford Institute of Technology
Candle Community Trust
Irish Prison Service
Irish Prison Service
Central Mental Hospital
PACE
GROW
GROW
Irish Prison Service
Depaul Ireland
Irish Prison Service
Amnesty International (Ireland)
Office of the DPP
Department of Justice & Equality
John F Martin & Company Solicitors
The Probation Service
Mental Health Reform

Name:	Organisation:
Eve McDougall	Together Gallery
Jane McGowan	Trinity College Dublin
Gerry McNally	The Probation Service
The Hon. Mr. Justice Michael Moriarty	The High Court
Dr. Michael Mulcahy	The Parole Board
Frank Mulhern	N.I. Housing Executive
Brian Murphy	Irish Prison Service
Emer Ni Chuagain	University of Aberdeen
Eithne Ní Mhurchadha	Trinity College Dublin
Bairbre Nic Aongusa	Office for Disability & Mental Health
Niall Nolan	Barrister
Séamus Ó Coigligh	University College Dublin
Tara O'Connor	Irish Prison Service
Liz O'Donoghue	The Probation Service
Kieran O'Dwyer	Irish Prison Service
Tracy O'Keefe	Department of Justice & Equality
Finbarr O'Leary	Revenue
Charles O'Mahony	NUI Galway
Conor O'Neill	Central Mental Hospital
Orla O'Neill	Mental Health Commission
Patricia O'Sullivan Lacy	Mental Health Commission
Leo Pattison	GROW
Yvonne Phillips	Garda Síochána Inspectorate
Ruairi Powell	GROW
Brian Purcell	Department of Justice & Equality
Mairead Quigley	Irish Mental Health Lawyers Association
John Redican	National Service User Executive
Dara Robinson	Sheehan & Partners Solicitors
Martin Rogan	Health Service Executive
Fergal Rooney	Lighthouse Programme
Frances Russell	Irish Prison Service
Ellen Ryle	GROW
Sarah Sheridan	Trinity College Dublin
Adele Smith	ACJRD Ltd

Name:

Katherine Wade
Aisling Wall
Kate Waterhouse
Sr. Imelda Wickham
Joanne Williams
David Williamson
Karen Wilson
Siobhan Young

Organisation:

University College Cork
Rape Crisis Network Ireland
Children's Research Centre
Irish Prison Service

Irish Prison Service
Office of the DPP
Irish Youth Justice Service