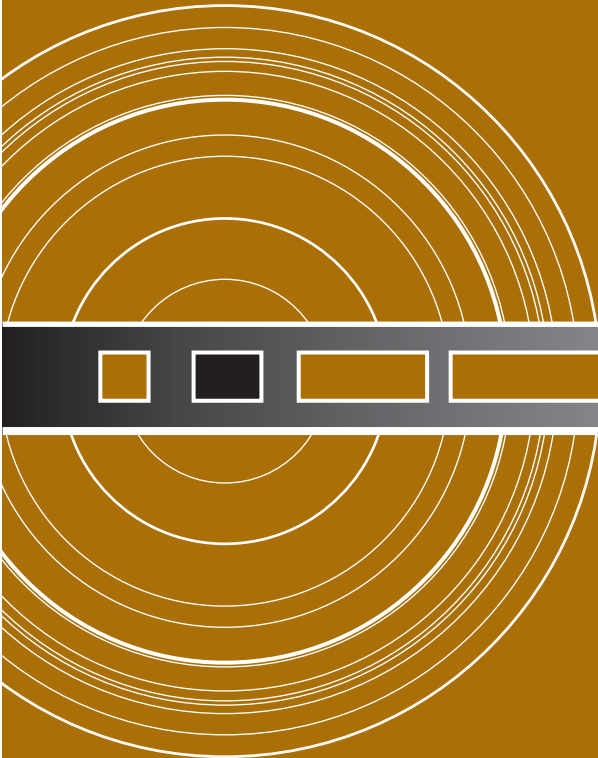


# Forensic Mental Health Services for Adults in Ireland



Discussion Paper

"...fostering and promoting high standards  
in the delivery of mental health services..."

# Forensic Mental Health Services for Adults in Ireland

## Discussion Paper

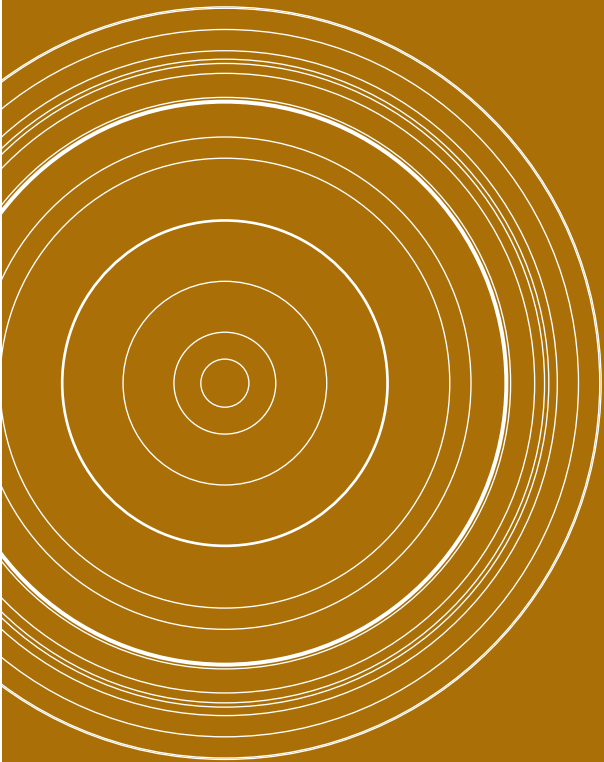
Mental Health Commission

February 2006

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# Introduction



## Introduction

The Forensic Mental Health Services committee was established in 2004 by the Mental Health Commission and held its first meeting in May 2004.

The committee adopted the following terms of reference:

- To review models of best practice in forensic mental health services
- To review and clarify definitions within the area of forensic mental health
- To review current provision of secure care and forensic mental health services in Ireland for adults and children/adolescents
- To review mental health services within prisons
- To prepare a discussion paper including recommendations on forensic mental health services for the Commission with a view to wider circulation as a discussion paper issued by the Commission.

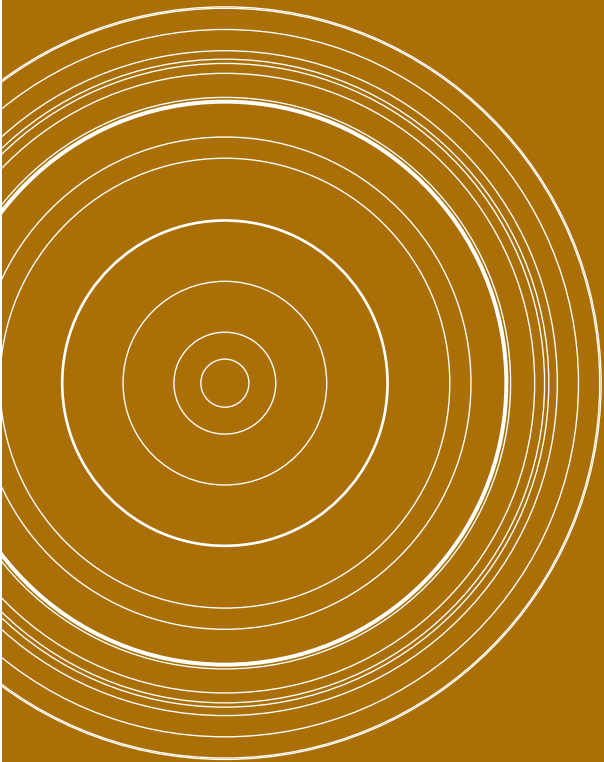
This area of enquiry is in line with a number of the Mental Health Commission's strategic priorities, in particular the following:

- to promote and implement best standards of care within the mental health services
- to promote and enhance knowledge and research on mental health services and interventions.

(Mental Health Commission, Strategic Plan 2004-2005)

The committee began its work by looking at services for adults with forensic mental health needs. Because of the scope of this piece of work the committee has continued to concentrate its discussions on adult services to date and this discussion paper deals solely with forensic mental health services for adults who meet the definition of mental disorder under the Mental Health Act 2001. However many of its recommendations will also apply to forensic services for children and adolescents and persons with intellectual disability. This paper explores the scope of forensic mental health services for adults and suggests a set of principles which should underpin their provision. The core elements of a comprehensive forensic mental health service are mapped out. The legislative framework within which our forensic mental health services are provided is also examined. Recommendations for the development of a modern comprehensive forensic mental health service capable of meeting the complex and diverse needs of its service users are put forward. It is hoped that this discussion paper will stimulate discussion and debate about the future development of our forensic mental health services.

# Executive Summary



## Executive Summary

### General Principles

1. Service developments in the area of Forensic Mental Health must be underpinned by the United Nations '*Principles Regarding the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*' 1991 (Office of the High Commissioner for Human Rights).
2. Principles 1.1, concerning the right to equivalence of care, 7.1 and 7.2, concerning the right to be treated and cared for in or near to one's own community as far as possible, and 9.1, concerning the right to be treated in the least restrictive environment appropriate to the individual's needs, are considered to be particularly important underpinning principles for forensic mental health services.
3. Residential forensic mental health services should be provided in centres which are registered as approved centres under the Mental Health Act 2001 and subject to inspection by the Inspector of Mental Health Services.
4. All residential services must also be capable of meeting legislative requirements for designated centres arising from the Criminal Law (Insanity) Bill 2002.
5. All patients in forensic mental health services should have access to a regular independent review mechanism such as the Mental Health (Criminal Law) Review Board proposed in the Criminal Law (Insanity) Bill 2002, as passed by Seanad Éireann.

### Framework for Services

1. Forensic Mental Health Services, including low and medium secure inpatient provision, should be provided on a regional basis for the most part, rather than centralized mainly in the capital as at present. The needs of service users are not well served by the provision of forensic mental health services from one large central complex and a more regionalized service is a very necessary development in moving towards a modern service.
2. The development of a regionalized service must take account of the higher concentration of demand for Forensic Mental Health Services in urban areas and the distribution of the prison population but should also be compatible with the current framework of the Health Service Executive which divides the country into four health regions.
3. Each regional service should form part of the spectrum of mental health services available in that region and serve the needs of a defined geographical area, working in close alliance with the other mental health services in the region. For example Cork and Limerick, both of which are urban centres and have a prison within their region, could each develop a regional forensic service for the Southern and Western Health regions respectively with a low secure unit, a medium secure unit and a related community forensic mental

health service. Medium secure provision for the remaining two health regions, both of which encompass parts of the Dublin region could be located within the Dublin area with low secure provision provided close to the general mental health services in those regions.

4. High secure care should be provided in one national centre. A national strategic management group with representation from each of the four health regions should be established to oversee the utilization of high secure inpatient beds. This group should also have a policy development role.
5. It may well be possible to develop some of the required regional low secure units through reorganization of existing provision. However medium secure units require to be purpose built if they are to provide a modern medium secure service.
6. A needs assessment to determine the inpatient provision required at each level of secure care should be completed as a priority to allow the development of new inpatient facilities to be aligned to need.
7. Regional Forensic Mental Health Services, in addition to providing secure inpatient care, should have a strong community focus and provide
  - care to persons with forensic mental health needs in the community
  - specialist assessments and consultation services to generic mental health teams
  - specialist assessments for court diversion schemes and
  - a service to prisons within the region.

### Treatment and Rehabilitation

1. Forensic mental health units need to be clearly identified as being treatment and rehabilitation facilities which operate in particular conditions of security rather than facilities offering mainly containment.
2. All aspects of the Forensic Mental Health Service should have a strong ethos of rehabilitation and recovery.
3. The full range of therapeutic interventions and programmes need to be made available to patients and care pathways identified for progression through the treatment and rehabilitation system.
4. The systematic assessment and management of risk is a key function of the forensic mental health services.
5. Close relationships and agreed protocols between forensic and general mental health services in each region are essential to allow services to provide treatment and rehabilitation for individuals in the most appropriate and least restrictive setting.



### Staffing of Services

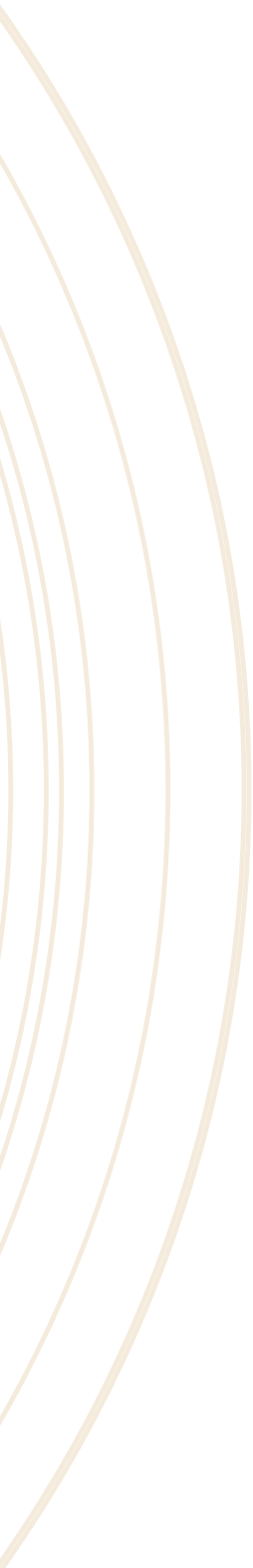
1. Forensic mental health services must be staffed by specialist multidisciplinary teams. Basic forensic mental health teams need to have psychiatrists, mental health nurses, clinical psychologists, social workers, occupational therapists and addiction counsellors.
2. Other specialist staff such as vocational trainers, teaching staff, forensic psychologists and staff with hostel management experience will need to be added to the core staff teams to develop the full range of therapeutic programmes.
3. It will be necessary to develop training initiatives to provide a sufficient pool of trained staff for the service.
4. Clinical staff on the multidisciplinary teams should work across both inpatient and community services. Nursing staff should rotate between inpatient services and regional community services to allow skills development and to prevent staff burn-out.

### Mental Health Services for the Prison Population

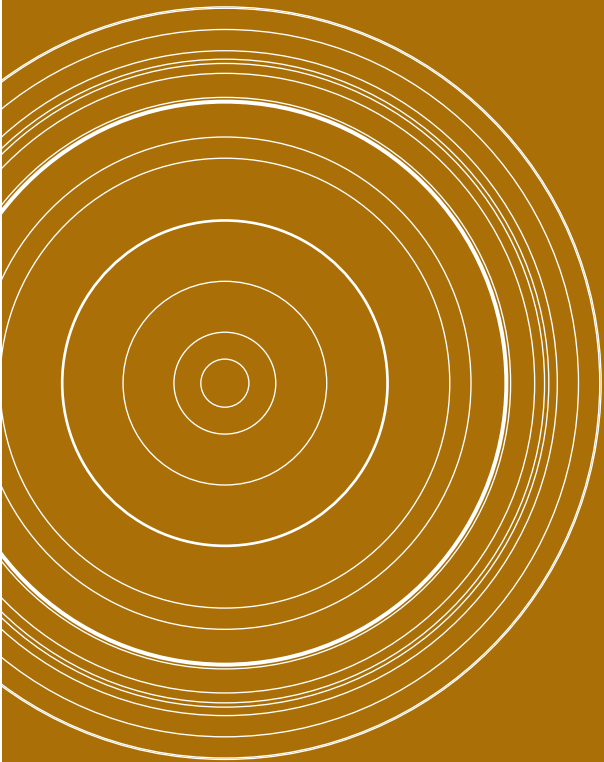
1. Mental health services to each prison population should be provided by the Forensic Mental Health Service for the region the prison is situated in as a secondary referral service accessed through the prison healthcare service.
2. Regional Forensic Mental Health Services providing services to the prison population should work very closely with prison medical, psychology, social work (probation and welfare), addiction counselling and vocational services to maximize the effectiveness of their input into the individual prisoner's care and formal liaison with each of these services is strongly recommended.
3. In addition, these prison services, which form the primary care level of service for the prison population, should be resourced appropriately to allow them to deal with issues within their remit thus reducing the potential for inappropriate referrals to the secondary mental health services.

## The Legislative Framework

1. Legislators should give greater priority to reform of the legal framework governing mental disorder as this provides the basis for many essential aspects of forensic service provision.
2. Mental health professionals, Gardai, lawyers and the courts in all regions should have a comprehensive range of legislative and service options available to them in relation to mentally disordered people involved in criminal proceedings. Services should be based on a nationally funded policy of diversion towards treatment and recovery options and away from punitive measures.
3. Legislation must provide other options, apart from certification, whereby mentally disordered persons who present before the courts can be detained for assessment or treatment. This must include mechanisms for facilitating treatment in the community. In addition, a clear mechanism is needed for a matter to be transferred back to court where this is the appropriate course of action.
4. A number of significant amendments to the Criminal Law (Insanity) Bill 2002 are required to ensure that any legislation arising from it is fully compliant with international principles on human rights and with the provisions of the Mental Health Act (2001). For example, the designation of a prison (or part thereof) as a designated centre for the care and treatment of persons with a mental illness is not, in the view of the Commission, appropriate and appears to be in contravention of the United Nations *'Principles Regarding the Protection of Persons with Mental Illness and the Improvement of Mental Health Care'* 1991. The Bill should also be amended to facilitate remand of the person on bail (thereby integrating it with the Bail Act 1997) with their informed consent to attend for assessment on an outpatient basis. The inclusion of this option is in line with best practice regarding diversion schemes in mental health care and treatment.
5. Court diversion arrangements must always rely on consent and cannot override the right to due process, that is, the right to have one's case heard before the courts under the criminal law, if that is the person's informed preference.
6. Ireland's legislation in relation to mental disorder should seek to have reciprocal arrangements that allow for the transfer of detained mentally disordered patients from England, Wales, Scotland, Northern Ireland and within the wider European Community.



# Chapter 1



# 1

## Chapter 1

### Scope of Forensic Mental Health Services and Guiding Principles

#### 1.1 Scope of Forensic Mental Health Services

*'Forensic mental health services deal with those mentally ill people whose presentation has been assessed as requiring a more focused level of expertise and/or increased levels of physical security. Some of these people will have exhibited behaviours which present major challenges, with or without associated violent conduct, beyond the capabilities of general psychiatric services. Others will be mentally disordered offenders who have broken the law or who have the propensity to do so. Some patients will have been identified at the level of general psychiatry and some via the criminal justice system. Of the latter some will be on remand ... others however will be convicted prisoners who are subsequently transferred from prison during the course of their penal sentence.'*

(McFadyen 1999)

This definition raises a number of key issues:

- Forensic mental health services are extremely complex, with several routes in and a wide variety of service users.
- Forensic mental health services potentially involve a large number of agencies (such as social services, health care, probation and the prison service).
- Forensic mental health services work with people who may display extremely challenging behaviour including those whose care could not be managed in other settings prior to their referral to forensic mental health care.

The complexity and difficulty of the forensic environment is captured by McCann (1999), whose account of forensic mental health services attempts to summarise current developments in the organisation and delivery of care:

*'Mentally disordered offenders, the recipients of forensic care, are a diverse group. They span the range of mental health problems and diagnosis, and the spectrum of criminal offences. Often their needs are complex and involve a number of agencies, requiring a coordinated and collaborative approach across service and professional boundaries. Invariably there is also an element of political and media interest depending on the degree of dangerousness or notoriety of the offence, decisions about an individual's care will be made in a climate of intense scrutiny ... It is understandable therefore that professionals are cautious, treading carefully the narrow path between their roles as therapist and custodian. Generally however the needs of mentally disordered offenders are no different to any other individual with mental health problems, and they require access to a similar range of services.'*

(McCann 1999)

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The 2004 Comhairle na nOspidéal Report on Consultant Psychiatrist Staffing suggests that patients likely to come within the remit of forensic psychiatry fall into three categories:

- Individuals found 'not guilty by virtue of insanity' or found unfit to plead by the legal system
- Prisoners with mental illness
- Persons who have not offended or who have not been charged with an offence but who have a mental illness that results in their behaviour being characterised by violence. This violence is usually physical, is of a magnitude which puts others at risk, and renders them unmanageable in general psychiatric outpatient settings or inpatient units. Such patients often have a dual diagnosis of a major psychiatric illness (such as schizophrenia or an affective disorder) which is associated with a personality disorder, substance misuse or both.

(Comhairle na nOspidéal 2004)

## 1.2 Guiding Principles

Forensic mental health services provide assessment, treatment, rehabilitation and supervision services to persons with mental illness who are deemed, by virtue of an assessment of risk, to require treatment under particular conditions of security. This client population is recognized as having particular needs and particular vulnerabilities which necessitate that their care be provided by a specialist tertiary service. Mindful of the special vulnerabilities of this group of clients, not least because of the involuntary nature of most of the care provided to them, it is important to restate the internationally accepted principles which should guide service provision in this area.

In terms of general principles we take as our starting point the United Nations General Assembly's 1991 resolution '*Principles Regarding the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*'. In particular the following principles have, it is considered, special relevance to forensic mental health services.

- Principle 1.1** All persons have the right to the best available mental health care, which shall be part of the health and social care system.
- Principle 7.1** Every person shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives.
- Principle 7.2** Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible.

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- Principle 8.1** Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons.
- Principle 9.1** Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patients health needs and the need to protect the physical safety of others.
- Principle 9.2** The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by professionally qualified staff.
- Principle 11.11** Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose.
- Principle 13.2** The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age.
- Principle 14** A mental health facility shall have access to the same level of resources as any other health establishment and in particular (a) Qualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a programme of appropriate and active therapy (b) Diagnostic and therapeutic equipment for the patient (c) Appropriate professional care and (d) Adequate, regular and comprehensive treatment, including supplies of medication.
- Principle 20** This principle deals specifically with 'criminal offenders' and reiterates that all of the U.N. Principles apply to this group '*to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances*'.

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The Royal Australian and New Zealand College of Psychiatrists 2001 Position Statement on Forensic Mental Health Services similarly puts **equivalence of care** at the head of the list of principles underpinning the development of forensic services.

*'The mentally ill offender, whether on remand or convicted, has the same right to access mental health assessment and treatment as the non-offender'*

(Royal Australian and New Zealand College of Psychiatrists, Position Statement 49, (2001))

The Mental Health Act (England and Wales) 1983 also clearly espouses this principle in its insistence that mentally disordered people who are the subject of criminal proceedings have the same rights in regard to psychiatric assessment, treatment and care as all other persons. The 1983 Act further specifies that compulsory psychiatric treatment must be given in an appropriate psychiatric centre and cannot be given within the prison system. The Reed Report (1994) set out a number of principles to guide service development in England and Wales, stipulating that persons in the care of a forensic mental health service should be cared for:

- With regard to the quality of care and proper attention to their needs
- As far as possible in the community, rather than institutional settings
- Under conditions of no greater security than are justified by the degree of danger they present to themselves or others
- In such a way as to maximise rehabilitation and the chances of sustaining an independent life
- As near as possible to their own homes or families, if they have them
- With respect for their rights as citizens.

(Reed Report HMSO 1994)



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A similar viewpoint is well expressed by Kennedy (2002)

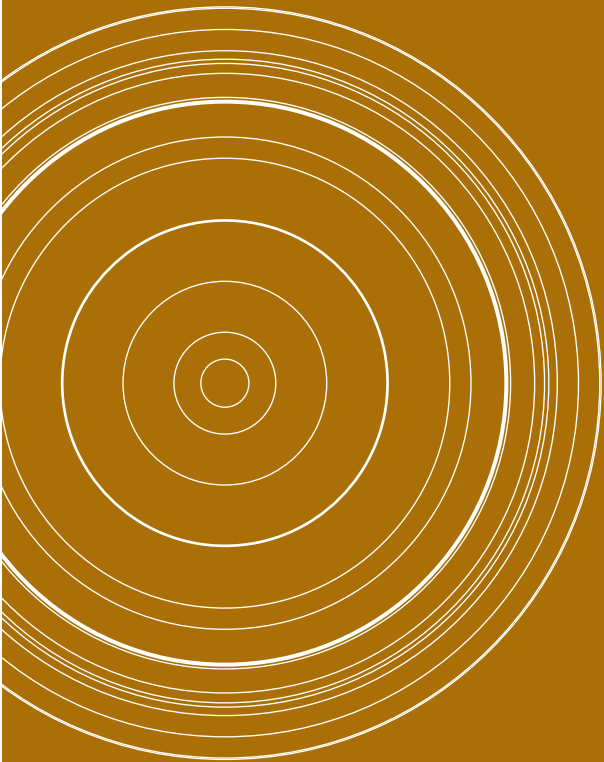
*'Facilities should provide individuals with an environment that is least restrictive, safest, homely and local. Decreasing reliance on distant providers should therefore be a priority for service development'*

Kennedy (2002)

We consider the principles of **equivalence of care, the right to treatment facilities as far as possible in, or near to, one's own home or community and the right to be treated in the least restrictive environment** *'commensurate with the degree of risk posed to themselves and others'* (Royal Australian and New Zealand College of Psychiatrists, 2001) in particular to be the basic principles informing all our deliberations.

In addition, as in other areas of mental health services, the Commission is committed to the development of services which are user focussed and where service users *'have legitimate input into care and treatment plans and their views on service provision are encouraged'* (Mental Health Commission, 2004-2005 Strategic Plan) and to services which make proper provision for the involvement of families and carers.

# Chapter 2



## Chapter 2

### Core Elements of a Comprehensive Forensic Mental Health Service

This chapter describes the elements of a modern forensic mental health service. It is based on an extensive literature review and contact with services in different jurisdictions. The chapter concludes with a brief overview of our current services in Ireland.

Effective forensic mental health services require a range of services at different levels of security. It should be possible to identify clear pathways for progression through the forensic mental health system from initial assessment, through treatment and rehabilitation, to discharge and follow-up.

It is widely accepted best practice that mental health services should be delivered by multidisciplinary teams and this is perhaps especially true in the area of forensic mental health. Treatment programmes will generally involve multiple components to address both the alleviation of psychiatric symptoms and psychological disturbance, the preservation or installation of personal, social and occupational skills required for successful community living and the reduction or elimination of inappropriate or destructive behaviours. Working with families and carers of persons within the forensic services is also an essential component of a treatment package. Comprehensive clinical care involves the integration of all of these different perspectives. Psychiatry, social work, clinical psychology, mental health nursing, occupational therapy and addiction counselling are core disciplines in multidisciplinary teams in forensic mental health. A recovery model of treatment is increasingly used in secure forensic services where it is recognized that promoting and preserving hope is vitally important to the development of a therapeutic environment.

Service user involvement in service development and advocacy services for service users are important aspects of modern mental health services which need to be developed in our forensic mental health services.

*'There are many barriers to effective systems advocacy, including stigma, the lack of meaningful participation by consumer/survivors in the development of services and policies, and the lack of education about how systems work. Many systems are very resistant to change and funding is rarely provided for education in systems advocacy.'*

Sangster (1999)

#### 2.1 The Assessment and Management of Risk

It is largely the occurrence of violence and the risk of further violence that determines the person's admission into forensic mental health facilities. The systematic assessment of risk, at the point of initial referral, on an ongoing basis and at the point of discharge or transfer is therefore a key function of the forensic mental health services. Accurate risk assessment is an important element in preserving the person's right to be treated in the least restrictive setting appropriate to his or her needs.

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The assessment of current and future risk has become increasingly sophisticated. Traditionally, experienced professionals made a clinical judgement about risk category based on careful clinical assessment and consideration of the index offence and the person's history of violence. A number of studies have shown that the assessment of risk based on clinical assessment by health professionals alone has poor predictive power and several studies have indicated that the overprediction of violence was a serious difficulty (Webster and Bailes (2004); Gray (2005)). At present clinical judgement by experienced forensic mental health professionals still forms the cornerstone of risk assessment but the basis of risk assessment has been expanded. Over the past two decades several well standardized risk assessment tools with good predictive value have been developed. In the 1990s the Violence Risk Appraisal Guide (VRAG) was developed. More recently a 20 item scale, the HCR-20 (Webster, Eaves, Douglas and Wintrup (1995)), has come into general use. This scale uses 10 'historical' items, 5 current clinical items and 5 future risk oriented items. For the assessment of psychopathy, the Psychopathy Checklist (PCL-R) (Hare 1991) has become standard. Monaghan (2005) one of the best known researchers in this area, through research supported by the MacArthur Foundation in the US, has recently developed a new measure for assessing the risk of violence, the 'Classification of Violence Risk' (COVR). This new instrument uses Dispositional Factors, Historical Factors, Contextual Factors and Clinical Factors to produce an assessment of future risk and has been available on software since late 2005. Risk assessment is a complex and skilful process and the increasing availability of psychometric instruments should not imply a short-cut to risk prediction. For example Hare (1998) has cautioned that the notion of psychopathy is complex, and notwithstanding the availability of the user friendly Psychopathy Checklist (PCL-R), its assessment requires a substantial degree of clinical sophistication and training. Clinicians undertaking risk assessments must be facilitated in acquiring training in the use of risk assessment tools and in keeping their knowledge updated in this area.

The management of all risk is an integral part of the patients ongoing care plan. All services must be involved in the systematic assessment, documentation and communication of risk. Risk assessments are individualized by their nature and as far as possible the person should be involved in his or her own risk management and risk reduction plans. Facilitating the individual, as much as possible, in identifying his or her own triggers and risks for incorporation in the risk management plan is in keeping with a collaborative approach to treatment. Services must have structures for communicating risk and sharing information with all staff on the unit and all disciplines should have an input into risk assessment and risk management plans.

# 2

## 2.2 Secure Inpatient Settings within Forensic Mental Health

### Introduction

*'Patients should be detained at no greater level of security than is necessary. This principle can be seen in the organization of secure psychiatric services according to stratified risk'*

Kennedy (2002)

Forensic mental healthcare is provided in a range of residential settings in particular conditions of security. Security refers to the security conferred by secure buildings and secure external spaces and facilities including monitoring systems but also to 'relational security' where it is the provision of high staff to patient ratios of well-trained staff, allowing not only appropriate supervision and monitoring but also the opportunity for building good therapeutic relationships with patients, which in large part confers security. The different levels of secure care provision are described below.

The philosophy of care for all secure units should incorporate the following:

- The unit should promote the dignity, privacy and safety of all patients, balanced with the safety and security of the wider community
- Each patient should have an individualized treatment plan addressing his/her psychiatric, psychological, psychosocial and spiritual needs
- Patients should be involved in the care planning process so that care plans take account of individual circumstances, choices and expectations
- A structured system of advocacy should be available to patients and service user involvement in service development should be encouraged
- It should be possible to map out care pathways for individuals allowing people to move through the rehabilitation process with an absence of artificial barriers
- The unit should provide a support system for the families and carers of patients and facilitate involvement with peer support networks.

In terms of the day to day service delivery each person in the care of the forensic mental health services should:

- Undergo a period of assessment, which will identify the individual's strengths and needs and facilitate a thorough risk assessment
- Be allocated a key worker who will co-ordinate the patient's care during their stay and ensure a co-ordinated approach to discharge/transfer back to his/her own area and other service where appropriate

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- Participate in regular multidisciplinary reviews of their care and be given every opportunity to contribute to their own care plan including their ongoing risk assessment.

Leeds Mental Health NHS Trust (2002)

## (a) Low Secure Forensic Units

Low secure units deliver intensive, comprehensive, multidisciplinary treatment, care and rehabilitation for patients who present with a level of behavioural disturbance in the context of a serious mental disorder. Treatment and rehabilitation is provided, usually over a lengthy period, with ongoing risk assessment and review. Patients in low secure units will be admitted under mental health legislation and will present a less serious physical danger to others than persons requiring a medium or high secure treatment setting. Security arrangements provided are designed to impede rather than completely prevent those who wish to escape or abscond. Low secure provision should have a greater reliance on staff observation and support rather than physical security arrangements. Low secure units have an ethos of active rehabilitation and therefore emphasise patient access to acute and community services and promote a philosophy of community integration. Low secure units should be distinguished from Psychiatric Intensive Care Units (PICU) described below which are designed for the short-term care of persons with disturbed behaviour in the context of acute illness.

### *Typical Service User Characteristics*

- Admitted under mental health legislation
- Risk assessment indicates that this level of security is required
- Mix of offending and non-offending behaviours such as challenging behaviour, self neglect and deliberate self harm
- Persons who offend but do not get charged
- Risk predominantly to others

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## *Typical Security Characteristics*

- Perimeter security that impedes rather than prevents a determined escape attempt
- Secure exercise area
- Locked entrance doors
- High dependency areas
- Seclusion facilities
- Good levels of observation and support
- Alarm systems
- Appropriate environmental design including use of space to provide a restful environment with low levels of stimulation.

Entry to low secure care will usually be from generic mental health services following a risk assessment, from court services where an inpatient assessment is required or from prison where a period of inpatient treatment is required and this level of security is indicated. Low secure care is therefore available as a resource to the generic mental health services for the management of persons requiring assessment and treatment in conditions of greater security than can be provided in the generic mental health services and teams working in low secure care services should have close working relationships with generic mental health teams so that there is ease of movement in both directions for persons requiring care and treatment.

Low secure units should provide a full range of treatment options i.e. pharmacotherapy, psychological therapies, psychosocial programmes and vocational training opportunities. Each low secure unit must have a clear link to community based residential facilities, whether these are dedicated facilities or shared with mental health rehabilitation services, in addition to having a pathway to transfer patients back to the generic mental health services in the person's local area.

Within our current service provision this level of secure care tends to be provided, in an unsatisfactory way in very many cases, by a number of 'locked units' throughout the services. The difficulties inherent in our current use of locked units are described in the later section on current service provision. To provide a modern low secure forensic service these units would require substantial re-organization in terms of physical layout, staffing levels and staff training, admission criteria and the provision of therapeutic facilities.

**Note:** Good environmental design in forensic mental healthcare, in addition to producing environment layouts which enhance security, tends to make use of natural light, high ceilings, good sound-proofing, neutral colours, soft furnishings and other design elements to promote a restful environment with low levels of stimulation and to maximize the feeling of space and freedom of movement within units.

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## (b) Medium Secure Forensic Units

Medium secure units provide a treatment environment for patients who present a serious but less immediate danger to others. Physical security protocols and procedures, supported by high levels of staff, should be sufficient to deter all but the most determined to escape or abscond. Patients accepted into medium secure services will present with a serious risk to others and the potential to escape or abscond.

Within the perimeter of the medium secure service a good range of therapeutic and recreational facilities and activities should be available. These facilities and activities should be comprehensive in order to meet the needs of patients who are not ready for leave into the community, but with an emphasis on graduated use of ordinary community facilities when possible.

### *Typical Service User Characteristics:*

- Formally detained
- Risk assessment indicates that level of security is required
- Offending behaviour
- Risk predominantly to others
- Significant capacity or risk to attempt to escape or abscond
- Serious but less immediate risk to the public if at large
- Non-Offenders with a history of violent behaviour whose needs cannot be appropriately met by local services.

### *Typical Security Characteristics:*

- Perimeter fencing to a height of 3-4 metres with close-welded steel mesh, with bars at 12 mm centres in one direction
- Controlled access lobby to secure area, with outer and inner doors controlled by reception staff to form an airlock arrangement
- Where the fabric of the building acts as part of the secure perimeter of the unit the specification should be commensurate with preventing external access to the unit and ensuring that contraband items cannot be passed to patients
- Provision of exercise space internal to the building stock and exercise space with access to fresh air within the secure perimeter
- Provision of alarm systems
- Procedural security checks



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- Locked doors to regulate access and movement of patients and visitors within the secure perimeter
- Appropriate environmental design including use of space to provide an environment with low levels of stimulation
- Visiting facilities, specifically separate areas for children.

The medium secure unit should be purpose built to provide up to date therapeutic facilities for service users. A modern medium secure unit will provide a high level of environmental security so as to allow maximum freedom of movement for individuals within the unit. Medium secure units must be staffed and managed by specialist forensic mental health staff and must have access to facilities at a lower level of security e.g. a staffed 24 hour hostel and/or easy transfer to a low secure unit in order to provide proper rehabilitation pathways for patients. Patients may also be transferred to high secure care if their risk status is changed. These units should be models of best practice providing a full range of treatment interventions i.e. pharmacotherapy, psychological therapies, psychosocial interventions and vocational training opportunities.

In England and Wales these units have often been sited on the campuses of generic mental health services rather than as stand alone units.

## (c) High Secure Forensic Units

High secure units provide a treatment and rehabilitation environment for those patients who would pose a grave and immediate danger to others if at large. Security arrangements should be capable of preventing even the most determined escape attempt or absconder.

Within the high secure perimeter a full range of therapeutic and recreational facilities and activities should be available. The comprehensive range of services, both recreational and clinical, acknowledge the severe limitations for patient access to community services and facilities.

### *Typical Service User Characteristics:*

- Formally detained
- Charged or convicted of a grave offence
- Assessed as being an immediate danger to others in the community
- Significant capacity for co-ordination of outside help to perpetrate an escape attempt or absconding
- Patients may have a high public profile

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- Risk predominantly to others
- Non-Offenders with a history of violent behaviour whose needs cannot be met in medium secure services.

### *Typical Security Characteristics:*

- Perimeter fencing or escape proof wall to a height of 6 metres
- Access and egress to the secure area via regulated airlock arrangements for staff, visitors, patients and vehicles
- Regular monitoring and inspection of perimeter
- Monitoring of potential risk items through the secure perimeter
- Security checks of staff
- Security checks of all visitors
- Provision of exercise space internal to the building and exercise space with access to fresh air within the secure perimeter
- Educational, rehabilitation, therapy and recreational facilities for patients sited within the secure perimeter
- Appropriate environmental design including use of space to provide an environment with low levels of stimulation
- Provision of alarm systems
- Procedural security checks
- Locked doors to regulate movement of patients and visitors
- Specific visiting arrangements especially for children
- Regulated access by patients to communication systems and communication equipment
- Monitoring of mail.

Entry to the high secure service will usually be from the prison service where this level of security is required, from the courts under particular circumstances and from medium secure units. Clear protocols for transfer of persons from medium secure services to high secure care are required and conversely back to medium secure care when treatment in a high secure service is no longer indicated. A national high secure service will inevitably be geographically distant from family for a high proportion of service users and special care needs to be taken to preserve contact with families.

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Currently the Central Mental Hospital at Dundrum with 89 beds is the only facility in Ireland providing care and treatment at medium and high secure levels. It is difficult to ascertain the precise requirement for high secure places for our population. A recent needs assessment conducted at the Central Mental Hospital suggested that, of the 88 patients in residence on the study date, 47% of the long-stay group and 24% of the shorter stay group were inappropriately placed i.e. did not require care in these conditions of security (O'Neill, Heffernan, Goggins, Corcoran, Linehan, Duffy, O'Neill, Smith and Kennedy (2003)).

## (d) Forensic Rehabilitation Facilities

Forensic rehabilitation focuses on preparing individuals for transfer to lower levels of security and gradual reintegration into community settings with appropriate support. The service works with the service user, their carers and their support networks to address both mental health issues and issues of risk management, allowing the person to move gradually towards living safely and independently in the wider community. In each area, forensic rehabilitation services need to have access to community based facilities, including residential facilities, whether these are dedicated facilities or shared with mental health rehabilitation services.

## Psychiatric Intensive Care Units (PICU)

There has been much debate about the need to develop Psychiatric Intensive Care Units (PICU) as part of our mental health services and confusion has arisen about how Psychiatric Intensive Care Units relate to forensic mental health care.

Psychiatric Intensive Care Units are designed for patients, usually detained, who are in an acutely disturbed phase of a serious mental disorder. There is an associated loss of capacity for self-control, with a corresponding increase in risk, which does not enable their safe therapeutic management and treatment in a general open acute ward. Care and treatment offered is patient-centred, multidisciplinary, collaborative and allows an immediacy of response to critical situations. Length of stay will be appropriate to clinical need and assessment of risk but would ordinarily not exceed eight weeks in duration - recommended maximum of 12 weeks (Department of Health UK, 2002). There are no dedicated psychiatric intensive care units within our current service provision and generally their functions are tending to be performed by secure observation areas within open acute admission wards or by locked units.

In the Northern Ireland Mental Health Services, Psychiatric Intensive Care Units - along with Challenging Behaviour Units - commonly function as the 'first rung' on the forensic mental health service 'ladder' and low secure units are less commonly available. There are, however, serious difficulties in requiring Psychiatric Intensive Care Units to act as treatment centres for patients who are not acutely disturbed but rather in need of low secure care on a medium or long term basis. Brown and Bass (2004) highlight the difficulties of allowing PICU beds to be utilized by longer term patients because of a lack of longer term low secure provision. They point out that

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the typical PICU unit is small and lacks longer term rehabilitation facilities.

**Psychiatric Intensive Care Units are a resource for the generic mental health services and are not suitable for forensic mental health treatment beyond the period of acute disturbance.**

## Regional Forensic Mental Health Teams working in the Community

Regional Forensic Mental Health Teams are specialist multidisciplinary teams with specialist forensic training offering services to all those with forensic mental healthcare needs within a specified geographical area. In addition to the provision of secure in-hospital care within the region these teams provide a community assessment and treatment service and a continuing care and monitoring service to several groups of service users within their catchment area. Their client group in the community are mainly comprised of:

- firstly those who have been discharged from secure care and who continue to require a specialist forensic service to manage their continuing care
- other clients whose forensic mental health history is such that they require specialist monitoring and continuing care services. Some clients with forensic mental health needs may be managed by the specialist forensic team for a period and will then be transferred back to their own catchment area community mental health services when their level of risk and need for specialist care has decreased
- some clients may be managed jointly with the catchment area mental health teams where the catchment area mental health team requests assistance and specialist advice regarding management.

In addition:

- the Regional Forensic Mental Health Teams provide an in-reach assessment and consultancy service to generic inpatient facilities
- regional forensic teams can also provide a service to prisons and places of detention
- regional forensic teams can provide back-up specialist assessments to court diversion schemes where a specialist assessment is required.

In their work in the community the ethos of the regional Forensic Mental Health Team is an assertive multidisciplinary approach towards the mental health and psychosocial needs of persons with forensic mental health needs in the community. The overall objectives of work in the community are:-

1. To complete an assessment of any individual referred in order to determine the mental health and risk issues.
2. To provide advice to other professionals and partners within the criminal justice system on mental health issues or on the management of individual patients.

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3. To provide liaison with other mental health services to ensure that patients are being linked into the most appropriate services for their care.
4. To provide treatment and monitoring to patients with long term forensic mental health needs.
5. To take a co-ordinated approach to care planning and delivery.
6. To provide a comprehensive risk assessment and risk management package.
7. To support patients, carers and their families to develop plans of care, support networks and ongoing case management.
8. To explore relapse prevention techniques and to promote mental health and non-offending behaviour.
9. To provide a range of treatment packages to promote insight into offending behaviours, significantly reducing risk and recidivism.
10. To promote insight into and maintain stability of mental, physical, social, intellectual and spiritual health.
11. To promote good working relationships with appropriate agencies in the criminal justice system, housing, social services, government agencies and the voluntary sector.

## 2.3 Court Diversion

Court diversion schemes are available in a number of jurisdictions. These schemes seek to promote diversion and discontinuance mechanisms as a means of ensuring that mentally ill offenders do not get involved needlessly in the criminal justice system. Where offending behaviour is clearly related to mental illness a diversion scheme can allow the offender to be diverted to the care of the mental health services rather than into the prison service where there may be a delay in identifying and responding to his or her mental health needs. Diversion schemes may vary in their structure, manpower requirements, level of staff training and number of weekly sessions which they are available to the courts. Most schemes in England and Wales include the availability of a psychiatrist and nurse who have experience of forensic psychiatry or knowledge of the court system and many are managed by community mental health nurses. Other schemes have approved social workers, probation officers, clinical psychologists and ward-based-nurses as part of the team. Burvill, Dismohamed, Hunter and McRostie (2003) describe a successful scheme in Southern Australia which is staffed by a clinical psychologist, a mental health nurse and a co-ordinator from a social work background. There is no single model on which court diversion services are based. Some schemes seek to screen all detainees, but most operate a filter system, accepting referrals from non-health care staff who raise suspicions of underlying mental disorder. In England and Wales the court diversion scheme operates through the Magistrates' Courts, equivalent to the Irish District Court level. James (1999) explains that the Magistrate's Court was chosen for

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diversion intervention because it is located near the beginning of the criminal justice process and therefore provides a cost-effective filter through which all cases must pass.

All of these schemes operate by performing or commissioning assessments, gathering information and presenting a comprehensive report to the court with recommendations. In each jurisdiction the range of options open to the courts in terms of diversion of the person to hospital treatment or to a suitable community setting where treatment can be given is dependent upon the legislation operating in that jurisdiction. The information gathered for the court report would generally include:

1. The defendant's account of the offence.
2. Previous involvement with mental health services and forensic history.
3. Mental state examinations specifically addressing whether the mental state warrants detention in hospital, and the relationship between the offence, mental state findings at assessment and mental state findings at the time of the offence.
4. Presence of mental disorder as defined by the relevant Mental Health Act.
5. Defendant's degree of insight into their offending behaviour and illness.
6. Need for treatment or other intervention and the most appropriate setting.
7. Dangerousness of the offender and risk of absconding.

All defendants coming before the courts have the right to due process and court diversion schemes operate by informed consent. A person may judge it to be in his or her best interests in particular circumstances to refuse diversion and instead opt for his or her case to be heard in the normal way under the criminal justice system.

Ireland does not currently have a legislative basis to allow court diversion schemes to operate. This is further explored in chapter 6.

At an earlier stage in the criminal justice process Police Liaison Schemes in other jurisdictions employ mental health nurses based at police stations to provide on-the-spot mental health assessments of detainees, to liaise with police officers and other agencies, and to provide staff training for the police in mental health issues. Other liaison schemes involve co-operation between on-call crisis intervention teams and the police. These schemes recognize that some persons with mental illness may come in contact with the Gardaí because of domestic or public disturbance or other minor offences or indeed homelessness and their diversion to the local mental health services may allow the person to access appropriate help and therefore often represent a better option than processing these individuals through the criminal justice system. The Mental Health Commission has recently set up a joint working group with An Garda Síochána to examine the issues involved and this group will make recommendations for the improvement of services in this area of interface.

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## 2.4 A Brief Overview of Current Service Provision

The National Forensic Mental Health Service is currently centrally based at the Central Mental Hospital, situated in Dundrum, Dublin. The Central Mental Hospital was established in 1850 and is thought to be the oldest forensic psychiatric hospital in Europe. There is general agreement that the physical facilities at the Central Mental Hospital are very substandard and that the Forensic Mental Health Service requires new purpose built facilities in order to develop as a modern forensic mental health service. There are currently 89 beds, including seven beds for female patients, in the Central Mental Hospital, providing short, medium and long-term care in conditions of high, medium and low security.

At the time of the 2004 inspection by the Inspector of Mental Health Services there were 75 patients in the Central Mental Hospital. There is a hostel on site for male patients. The Central Mental Hospital is in the process of developing five multidisciplinary forensic mental health teams (Mental Health Commission, Annual Report 2004 including the Report of the Inspector of Mental Health Services). The service currently provides four consultant psychiatrist prison sessions and arranges 11 further prison clinics each week. There is, in addition, an outpatient facility at Ushers Island in central Dublin. Current referral pathways are shown below.

### *REFERRAL TO FORENSIC SERVICES*

*There are a number of pathways to referral, all of which are legally determined:*

- *A Ministerial Order requires the signatures of two independent medical practitioners. The patient is then transferred from the prison service to the Central Mental Hospital. All such patients are deemed to be involuntary and can be detained in the Central Mental Hospital against their will and treated against their will.*
- *A Hospital Order requires the signature of one medical practitioner. The prisoner is then transferred to the Central Mental Hospital. Such patients are considered voluntary patients.*
- *Patients may be transferred to the Central Mental Hospital from other mental hospitals or units under Section 208 of the Mental Treatment Act 1945. (Section 207 is no longer used).*
- *Patients can be admitted to the Central Mental Hospital following court verdicts of Guilty but Insane (GBI) or Unfit to Plead.*

Mental Health Commission, Annual Report 2004  
including the Report of the Inspector of Mental Health Services



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The National Forensic Service has endeavoured to adopt an integrated rather than a parallel service model in relation to generic mental health services in that it is the stated goal of the service that all patients treated in conditions of security will be rehabilitated so that they can be reintegrated into their catchment area services. However the absence of suitable regional facilities at lower levels of security has made this model of service very difficult to operate. An aggregated needs assessment of all patients resident in the Central Mental Hospital on a particular date in 2000 showed that, of the 88 patients in residence, 49 had lengths of stay over two years. Of this group, 25 (58%) had been in the hospital over ten years and 17 (40%) had been in the hospital more than 20 years (O'Neill et al, 2003). The majority of this long stay group, 33 (77%) were receiving regular parole outside hospital grounds with 15 (35%) enjoying regular unaccompanied parole. 20 (47%) of this long-stay group and a further 11 (24%) of the shorter stay group were rated to be inappropriately placed in the Central Mental Hospital i.e. their care and treatment could be managed outside a secure setting if a suitable alternative setting was available. The authors of the report express frustration at the 'deficiencies' in the forensic mental health service and the larger mental health service which allows a situation to arise where a large number of people remain in secure care despite being assessed as no longer requiring special security arrangements, and point out that *'the consequences of these deficiencies have considerable human rights implications for those affected'* (O'Neill et al, 2003).

The needs assessment further showed that of the approximately 150 admissions to the Central Mental Hospital per year, 98% come from the Irish Prison Service and two thirds of those admitted come from the Dublin Inner City catchment area (O'Neill et al, 2003). Many admissions are brief crisis admissions or short admissions of people with established psychiatric histories who have been remanded on minor charges. A substantial number of those admitted, however, have severe mental illnesses and are serving long prison sentences for violent offences. The needs assessment surveyed the population admitted to the forensic service at the Central Mental Hospital and therefore did not include those referred for forensic care from different areas of the country but not accepted because of lack of available beds. Similarly it did not include information on those mentally disordered offenders in other settings who have not been charged and yet continue to have need for secure care and specialized forensic input. Hence it is not possible to make an estimate of the true level of requirement for secure forensic inpatient care from this data.

A number of local services have also developed throughout the country to accommodate those with violent histories who are considered to be an ongoing risk. Many of these services appear to have evolved by the grouping of challenging patients in long-stay units together in a locked unit and providing them with seclusion facilities and possibly higher staffing ratios than are usual on general units. However some of these units also admit acutely disturbed patients requiring a secure environment during a short period of acute disturbance (the group best served by psychiatric intensive care provision) and in addition patients with organic impairment or intellectual disability with security needs may also be admitted. This mixture of needs militates against the development of a coherent therapeutic programme for longer-term patients in these settings. It is difficult to ascertain the number of units of this kind in the country but information regarding the location of 'locked units'

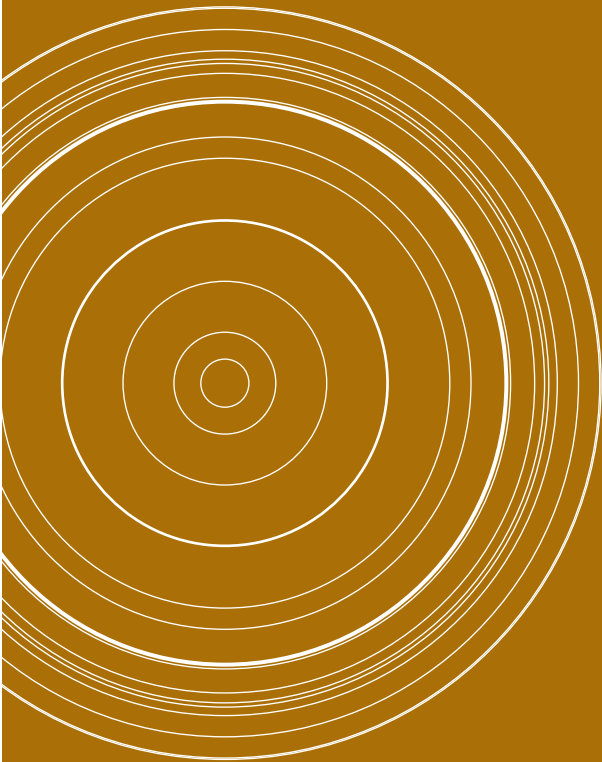


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some which care for this population is contained in the Mental Health Commission, Annual Report 2004 including the Report of the Inspector of Mental Health Services. In the Dublin area the Special Care Unit in St Brendan's Hospital is comprised of four wards and provides care for 22 women and 26 men. These wards accept patients referred from other units and hospitals in the Dublin area and from the Central Mental Hospital. In the Southern area the Carraig Mór Unit is a 40 bedded Unit which accepts referrals from acute units in the Cork area. However the upstairs portion of this unit was used as long stay accommodation at the time of the 2004 inspection (Mental Health Commission, Annual Report 2004 including the Report of the Inspector of Mental Health Services) so that only 20 beds were available for secure care. The HSE Southern Area has recently appointed a consultant forensic psychiatrist. In the HSE Western Area, a site on the campus of St Joseph's Hospital Limerick has been identified as suitable for a secure unit and a post for a consultant forensic psychiatrist has been approved. Other locked units throughout the country also provide care for persons who cannot be managed in an open treatment setting including Teach Aisling in Castlebar, a locked unit in St Brigid's Hospital, Ballinasloe and the Special Care Unit in Sligo (10 beds).

There is an urgent need to develop dedicated secure units which can concentrate on the task of rehabilitation for those with forensic mental health needs and be relieved of the task of caring for other groups of patients with very different needs. The development of high observation units in admission facilities (and possibly the development of PICU provision in some areas) should end the practice of transfer of patients who are acutely disturbed in the context of acute illness. In addition there is an acknowledged need for dedicated units for people with disturbed behaviour in association with dementia and for dedicated units for people with disturbed behaviour in association with intellectual disability (Mental Health Commission, Annual Report 2004 including the Report of the Inspector of Mental Health Services).

# Chapter 3



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## Chapter 3

### Mental Health Services for the Prison Population

*'Persons detained in secure psychiatric hospitals and prison inmates have much in common. Both are particularly vulnerable to developing mental health problems. Histories of abuse, deprivation, homelessness, unemployment, substance abuse and previous contact with mental health services are commonly encountered. Many prisoners have numeracy and literacy problems and most prisoners have a below average IQ'*

(Birmingham 2004)

The Prison population is recognised to be a particularly vulnerable population with a high rate of psychiatric illness and of psychological difficulties. There are 3,200 prison places in 14 centres in Ireland. A 1996 study of prisoners in Mountjoy Prison, surveying a sample of 235 prisoners (109 remand prisoners and 126 sentenced prisoners) found that ten of the sample had current major mental illness and a further 17 had less serious psychiatric disorder suggesting an overall prevalence rate of 9% for psychiatric disorder, (Smith, O'Neill, Tobin, Walshe and Dooley (1996)). In addition, 46 of the sample were dependent on psychoactive substances (mainly heroin) and 63 were dependent on alcohol exclusively. The 2000 '*General Healthcare Study of the Irish Prisoner Population*', looking at the wider question of psychiatric and psychological health, suggested that 48% of male prisoners and 74% of female prisoners were in need of some level of psychological or psychiatric help. A 2005, as yet unpublished, study of the Irish prison population '*Mental Illness in Irish Prisoners, the psychiatric morbidity in sentenced remanded and newly committed prisoners*' (Kennedy, Monks, Curtin, Wright, Linehan, Duffy, Teljeur and Kelly, Central Mental Hospital, 2005 unpublished) has found similar levels of serious mental illness in the sentenced population with significantly higher levels among remand prisoners. In addition the study found very high levels of drug and alcohol abuse (between 61% and 79%) and high levels of other psychological and psychiatric disorders. Those from poor urban areas were significantly over-represented in the prison population.

These Irish figures are broadly in line with international figures for prevalence of psychiatric morbidity in the prison population. A point prevalence study of the prison population in England and Wales in 1997, which involved interviewing over 3,000 prisoners, found rates of functional psychotic illness much higher than in those reported in general population studies with an overall prevalence of psychotic disorders for males on remand of 10%. Co-morbidity was a very significant problem with between two thirds and three quarters of prisoners who showed evidence of functional psychosis also found to have three or four other disorders (Singleton, Meltzer and Gatward, 1998). A more recent systematic review of serious mental disorder among prisoners in the UK (Fazel and Danesh, 2002) suggested that typically about one in seven prisoners have psychotic illnesses or major depression.

It is important to note the findings of Smith et al (1996), referred to above, that 45% of prisoners surveyed had a significant substance abuse problem. The 2005 study confirms that drug and alcohol abuse are central issues. In common with other jurisdictions the Irish prison population shows high levels of drug and alcohol abuse and higher levels of social disadvantage than those which pertain in the general

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population and the travelling community are over represented, (Linehan, et al (2002). A recent report on homelessness and persons before the courts and in custody (Seymour and Costello, 2005) suggested that 25% of those sent to prison were homeless on committal and of those 25% one in three had been previously diagnosed with a mental illness and two in three had previously spent time in a psychiatric hospital. In addition 90% of those homeless on committal were drug users, the majority with serious drug problems.

This complex picture of psychiatric and psychological morbidity, substance abuse and social disadvantage suggests that mental health services to the prisons cannot function in isolation from other aspects of the prison health and social services. The input of a mental health service which links only to the prison health services is likely to be limited in its effectiveness in addressing the complexities of treatment, rehabilitation and reintegration within the prison service. Mental health services need to be interwoven with the other services addressing the psychological, social, educational and addiction counselling needs of the prison population. In the UK, O'Grady (2001) makes a similar argument for an integrated approach.

*'Medical, drug dependence and psychological services have all developed separately with different goals and different administrative and philosophical foundations. There is a real risk that this separation of services will result in poorly co-ordinated and patchy care for prisoners with complex needs'*

O'Grady, J. (2001)

The Irish Prison Service is organized into a number of directorates. The Medical Services Directorate includes mental health services. The Regimes Directorate provides psychological and social work (probation and welfare) services, addiction services and educational input including programmes of personal development and programmes targeting offending behaviour (Irish Prison Service, Strategy Statement 2001-2003). Addiction services are particularly key in terms of rehabilitation and initiatives are being developed in this area. A blueprint for the development of comprehensive prison based drug treatment services developed by the HSE Eastern Area was published in 2000. The Prison Psychology Service in Ireland is somewhat unique in that it is staffed mainly by clinical psychologists (rather than forensic psychologists as in many other jurisdictions) and therefore provides some individual clinical services in addition to group programmes (Report of the Group established to review the Psychology Service of the Department of Justice, Equality and Law Reform, August, 1999). The Probation and Welfare Service has become increasingly involved in working within the prison on structured group programmes in conjunction with other disciplines (Department of Justice, Equality and Law Reform 2004).

The Regimes Directorate is also responsible for the Positive Sentence Management Programme which is a multidisciplinary team programme providing a planned approach to the management of the individual prisoner's time in custody, incorporating individual assessment and goal setting with periodic review to maximise the productive use of time in custody (Irish Prison Service, Strategy Statement 2001-2003).

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Mental health services addressing psychiatric morbidity and co-morbidity in prisoners need to work closely with all of these services in the prisons including the Positive Sentence Management Programme which is guiding the overall programme for each particular prisoner. In addition mental health teams providing services to the prisons need to participate in prison wide initiatives such as multidisciplinary suicide prevention groups in the prisons (Irish Prison Service, Strategy Statement 2001-2003).

## 3.1 Effective Provision of Mental Health Services in the Prison Service

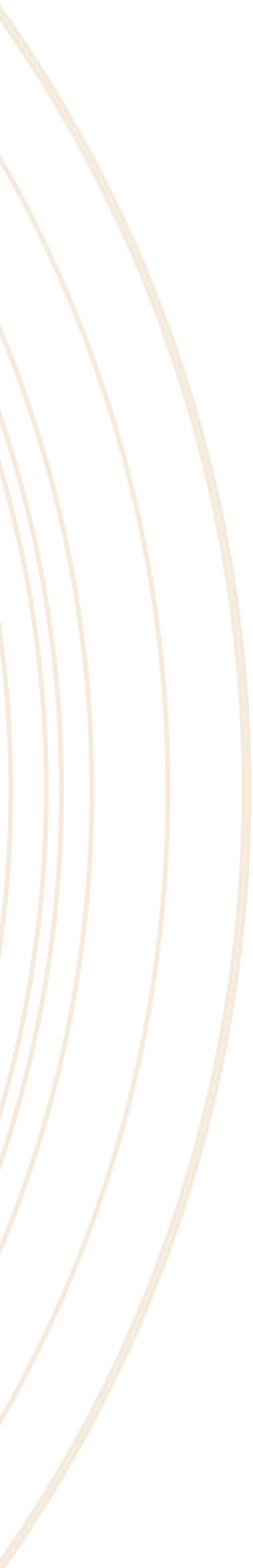
- Mental health services to prisons should be provided by the Regional Forensic Mental Health Service as a secondary referral service accessed through the prison health care services
- Each prisoner on admission should have a thorough mental health assessment as part of the initial healthcare screening
- Mental illness, significant psychological or psychosocial difficulties or substance abuse identified by the Primary Care physician (or Primary Care Team where this is in place) at the initial assessment or during the period of custody may be managed by the Primary Care physician (or Team) or dealt with by referral of the person to the service most appropriate to his/her needs
- The referral might be to a service within the prison system i.e. the Probation and Welfare Service, the Prison Psychology Service or the Addiction Counselling Service or to the Regional Forensic Mental Health Service where a specialist mental health service is required
- Prison Psychology Services, Addiction Services and Probation and Welfare services should be resourced appropriately to deal with issues within their remit thus reducing inappropriate referral to the secondary mental health services. All of these services should have formal liaison with the mental health services and engage in joint work to meet the needs of particular individuals.

Mental health services to the prison population will best be provided by the Forensic Mental Health Service which covers the locality within which the prison is located. The provision of mental health services to the prisons by the Forensic Mental Health Services has a number of important advantages over the provision of services by local Community Mental Health Teams.

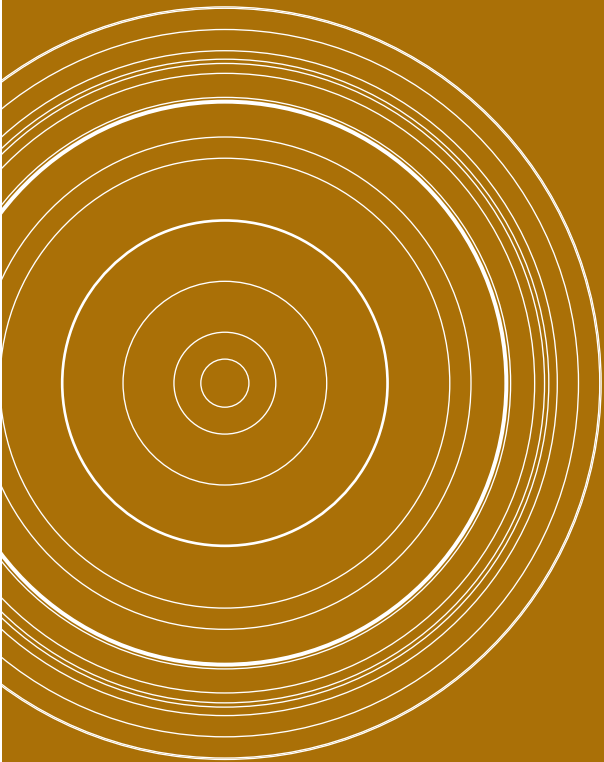
- Forensic Mental Health Services are specialist multidisciplinary services with particular expertise in the assessment, treatment and monitoring of mental health difficulties in people with a forensic history and persons in custody. They have particular expertise in the assessment of risk

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- Inpatient treatment of prisoners always involves the added consideration of security requirements and hence local acute psychiatric units are often unsuitable because of their open nature. Forensic Mental Health Services will have access to low and medium secure inpatient beds within their catchment area where a period of inpatient treatment is required
- The current situation where prisoners are transferred to the Central Mental Hospital for inpatient treatment often results in the person being treated in a facility with a higher level of security than he/she requires and does not preserve the person's right to be treated in his/her local area as far as possible. A regionalized forensic mental health service could provide inpatient treatment within the region at an appropriate level of security for the majority of prisoners requiring a period of inpatient care
- Forensic Mental Health Services will also however be in a position to request transfer for inpatient treatment in a high secure setting where this is required
- Forensic Mental Health Services will have close links with the generic mental health services in the region so the individuals can be gradually transferred to the care of their local mental health service and their local Community Mental Health Team if this is the more appropriate service after their release and re-integration into the community
- Prison populations are often not from the immediate local area and hence provision of mental health services by the local sector Community Mental Health Team throughout the period in custody would not necessarily ensure continuity of care after release
- Some prisoners because of their risk category will continue to need specialist follow up from the Forensic Mental Health Services after release.



# Chapter 4





## Chapter 4 Legislation

It is important when discussing forensic mental health services to consider the legislative framework governing mental disorder as this provides the basis for many aspects of forensic service provision. This is particularly pertinent at the present time when reform of Ireland's mental health legislation is about to be implemented and a new bill, The Criminal Law (Insanity) Bill 2002, provides proposals for a legal framework for detention and treatment of mentally disordered people involved in criminal proceedings. There have been significant changes in the way mental health services are provided in the past two decades but reform of related legislation in Ireland has lagged behind. A summary of relevant features from legislative frameworks used in other countries is provided in Appendix 1.

### 4.1 Legislative Framework for Mental Disorder in Ireland

The central piece of mental health legislation in force in Ireland at time of writing, the Mental Treatment Act 1945, is soon to be replaced by the Mental Health Act 2001. Both these Acts deal only with civil confinements. Mental disorder is defined in the Mental Health Act 2001. A diagnosis of personality disorder on its own is not sufficient grounds for involuntary admission under the 2001 Mental Health Act. There are similar restrictions in relation to social deviancy and addiction to drugs or intoxicants. Mental health legislation in England and Wales has taken a different position in relation to personality disorders but this has drawn criticism for being overly restrictive, particularly from a human rights perspective. Personality disorder is one of the most common co-morbid forensic mental health disorders and there is ongoing debate in Ireland on the provision of appropriate treatment facilities for persons with significant personality disorders who are drawn into criminal activities. The committee recognises that specific therapeutic interventions for people with co-morbid personality disorder must be part of comprehensive therapeutic programmes at all levels of mental health care including forensic mental health care.

The Minister for Justice, Equality and Law Reform has introduced the Criminal Law (Insanity) Bill 2002 to address the fact that Irish legislation concerning mentally disordered people who become involved in criminal proceeding is in need of reform. Some aspects of current Irish legislation concerning mentally disordered people involved in criminal proceedings are based on legislation introduced in the 19th century. There is a view that the current Irish law is unsatisfactory as there is not a partial defence of diminished responsibility, fitness to plead is not adequately addressed and the dispositional arrangements available to the courts are restrictive.

The Criminal Law (Insanity) Bill 2002 sets out arrangements for an Act to:

- amend the law relating to the trial and detention of persons suffering from mental disorders who are charged with offences or found not guilty by reason of insanity
- amend the law relating to unfitness to plead and the special verdict

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- provide for the committal of such persons to designated centres and for the independent review of the detention of such persons and, for those purposes, to provide for the establishment of a Mental Health Review Board and
- repeal the Trial of Lunatics Act (1883).

The Bill contains provisions dealing with:-

- fitness to be tried (Section 3),
- a new verdict of 'not guilty by reason of insanity' (Section 4) to replace the present 'guilty but insane' verdict, and
- a new plea of 'guilty but with diminished responsibility' (Section 5) in cases of murder where the mental disorder is not such as to justify an insanity verdict.

The Bill has wider provisions for appeals. Under the present law, a finding by a court of 'unfitness to plead' or an insanity verdict are not convictions and consequently there is no provision for appeal against them. The Bill will also establish a new statutory review body, a Mental Health (Criminal Law) Review Board, whose function it will be to review cases of persons who are detained following verdicts of 'not guilty by reason of insanity' and also 'fitness to be tried' cases. This provision is designed to comply with obligations under the European Convention on Human Rights.

Section 2 of the Bill passed by Seanad Éireann states that the Minister for Health and Children may, after consultation with the Mental Health Commission, by order, designate a psychiatric centre or, with the consent of the Minister for Justice, Equality and Law Reform, a prison or any part thereof as a centre for the reception, detention and, where appropriate, care or treatment of persons or classes of persons committed thereto under the provisions of the proposed legislation. Any psychiatric centre, prison or any part thereof so designated is in the proposed legislation referred to as 'a designated centre'.

The Commission has provided a comprehensive response to the Bill in the consultation phase (Mental Health Commission, 2003, 2004 and 2006). The alignment of the civil and criminal law provisions in regard to mental disorder, implicit in the Bill, is in general welcomed by the Commission. However, it is the view of the Commission that a number of significant amendments are required to the Bill to ensure that it is fully compliant with international principles on human rights and with the provisions of the Mental Health Act 2001.

The Mental Health Act 2001 (Sections 62-64) defines an approved centre as a hospital or other inpatient facility for the care and treatment of persons suffering from mental illness or mental disorder. The Commission has the statutory responsibility for the establishment and maintenance of a list of approved centres that must meet the criteria for registration as specified by the Commission. The amendment to the Criminal Law (Insanity) Bill 2002 which provides for consultation by the Minister with the Mental Health Commission in relation to the designation of psychiatric centres (other than the Central Mental Hospital) as designated centres has

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been welcomed by the Commission. A designated centre, under the Criminal Law (Insanity) Bill 2002, should, in the Commission's view, be registered as an approved centre and therefore come within the remit of the Inspectorate for Mental Health Services. Further the Commission is conscious that the majority of approved centres at present are acute units within general acute hospitals and would be unsuitable for designation under the Criminal Law (Insanity) Bill 2002. These acute units tend to be relatively small, open units and the staffing would not generally include personnel with expertise in forensic mental health services. They are not designed to provide the conditions of security which would be required in a designated centre.

The designation of a prison (or part thereof) as a designated centre for the care and treatment of people with a mental illness is not, in the view of the Commission, appropriate. It appears to be in contravention of the United Nations *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (1991), in particular, Principle 1.1 as referred to earlier '*All persons have the right to the best available mental health care, which shall be part of the health and social care system.*' The use of compulsory powers under mental health legislation in a prison setting is not considered good practice and in some countries is prohibited. This applies equally to patients in prison awaiting transfer to a psychiatric hospital for assessment. Treatment without consent for a mental disorder should only be provided in a prison in emergency circumstances, and compulsory treatment for a mentally disordered person if permitted to be used in a prison must be strictly monitored and controlled to provide protection for the rights of this vulnerable client group.

At the present time the absence of suitable secure regional facilities would prevent the detention of patients committed under legislation arising from the Criminal Law (Insanity) Bill 2002 or those presenting with severe and persistent aggressive and disturbed behaviors in any centre other than in the Central Mental Hospital.

There is also a need to provide separate facilities for those aged under 18 who could be committed under the provisions of the Criminal Law (Insanity) Bill 2002. The placement of those under 18 in centres for adults is at variance with best practice. This issue has been highlighted in reports by the Inspector for Mental Hospitals and the Inspector of Mental Health Services (Department of Health and Children, 2004 and Mental Health Commission, 2005 respectively).

## 4.2 A Modern Legislative Framework

Most comparable jurisdictions have mental health policies and legislation which provide a modern integrated framework for civil confinements and/or the detention of mentally disordered people who become involved in criminal proceedings, (see Appendix 1). Such frameworks place the responsibility for providing care and treatment to patients involved in criminal proceedings and suffering from mental disorder with a forensic mental health service. In general mental health services have moved from institutionally based services to community based services and forensic mental health services in other jurisdictions have moved in this direction. The separation in Ireland of legal powers for civil and criminal confinements in relation to

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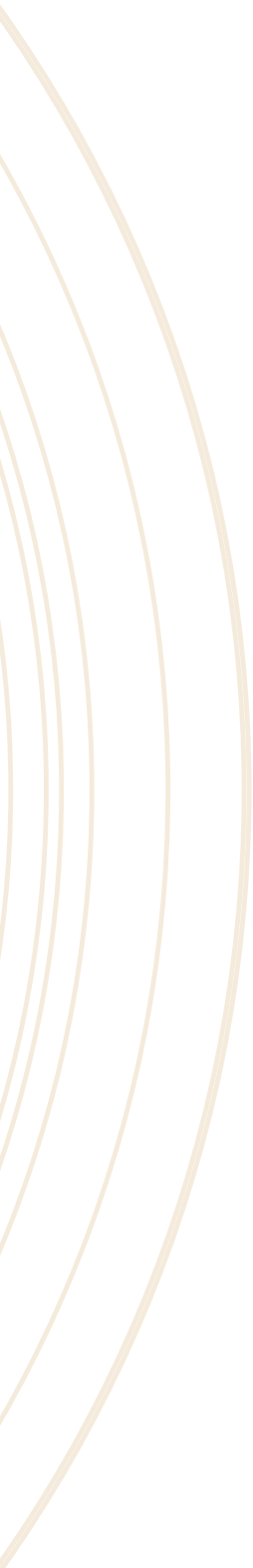
mental disorder may cause confusion as to the responsibilities of the relevant state agencies. The danger is that this results in ambiguities concerning strategic service development and the implementation of modern methods of effective patient care.

The Commission's proposed amendments to Section 3 of the Criminal Law (Insanity) Bill 2002 are also of note in relation to diversion schemes. As currently worded the Bill allows only one option to the judiciary, i.e. committal to a designated centre, if a question arises about the charged person's fitness to be tried. The Commission proposes that this section be amended to allow the judiciary a wider range of options and to ensure that the most appropriate intervention is offered to the person, as does the legislation for example in Scotland and State of Victoria, Australia. A mechanism is needed for community treatment of mentally disordered patients.

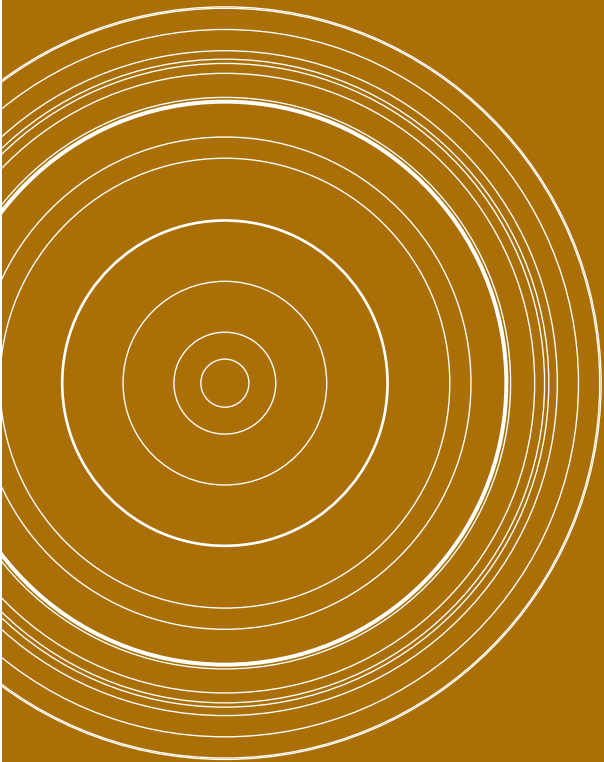
The Commission's proposal is that the Criminal Law (Insanity) Bill 2002 should be amended to facilitate remand of the person on bail (thereby integrating this Bill with the Bail Act 1997) with their informed consent to attend for assessment on an outpatient basis. The inclusion of this option is in line with best practice regarding diversion schemes in mental health care and treatment. It would also ensure compliance with United Nations Principle 7.1 and the *Third Report of the Interdepartmental Committee on Mentally Ill and Maladjusted Persons* (Henchy Report 1978).

In many jurisdictions a limiting factor in diversion schemes for persons with mental disorder has not been the legislation but a lack of resources leading to a general shortage of initiatives at the local level. In England the flexibility of a patient advocate to suggest remand to hospital rather than prison was often constrained by the difficulty in finding an appropriate hospital place (Greenhalgh, Wylie, Rix and Tamlyn, 1996). Mental health professionals, Gardaí, lawyers and courts need to have legislation that allows a comprehensive range of options to be available to them. We need to be very clear as to the appropriate scope and target population for a national policy on diversion. Mentally disordered people who are subject to criminal proceedings have the same right to psychiatric assessment, treatment and care as any other person.

It is also important that in any new legislation Ireland should seek to have reciprocal arrangements that allow for the transfer of detained mentally disordered patients from England, Wales, Scotland, Northern Ireland and the wider European Community. This will reduce the current level of frustration and confusion for practitioners and families who become involved in inter-country transfers and make best use of referral to specialist services.



# Chapter 5



# 5

## Chapter 5

### Moving Towards A Modern Forensic Mental Health Service

Our forensic mental health services require investment and re-organization. Service development must be firmly underpinned by principles which emphasise the right of service users to appropriate care and treatment and rehabilitation opportunities in environments which respect their dignity and citizenship rights. The 1991 United Nations '*Principles Regarding the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*' provide a set of principles by which services can be measured. Principles 1.1, 7.1, 7.2 and 9.1 which deal with the right to equivalence of care, the right to be treated and cared for in or near to one's own community as far as possible and the right to be treated in the least restrictive environment appropriate to the individual's needs are particularly important underpinning principles for forensic mental health services.

#### 5.1 Organization of Forensic Mental Health Services

Forensic mental health services form part of the spectrum of mental health services and should fit within the overall framework of mental health services governed by the Mental Health Act 2001. All residential units providing forensic mental health services should be approved centres under the Mental Health Act 2001 and subject to inspection by the Inspectorate for Mental Health Services. In addition these services must also be capable of meeting the proposed requirements for designated centres under the Criminal Law (Insanity) Bill 2002. All patients in forensic mental health services should have access to a regular independent review mechanism such as the Mental Health (Criminal Law) Review Board proposed in the Criminal Law (Insanity) Bill 2002.

Forensic mental health services, including low and medium secure inpatient provision, should be provided mainly on a regionalized basis throughout the country rather than centralized in the capital as at present. The needs of service users are not well served by the provision of forensic mental health services from one large central complex and a more regionalized service is a very necessary development in moving towards a modern service. Each regional service should serve the needs of a defined geographical area and should be closely allied to the generic mental health services in that region. The development of a regionalized service must take account of the higher concentration of demand for forensic mental health services in urban areas but should also be compatible with the current framework of the Health Service Executive which divides the country into four health regions. Based on our current population distributions and the distribution of prison services it is suggested that Cork and Limerick, both urban centres with a prison within the region, could each develop a regional forensic mental health service for the Southern and Western Health Regions respectively with a low secure unit, a medium secure unit and a related community forensic mental health service for their regions. Medium secure provision for the two remaining health regions, both of which encompass part of the Dublin region, could be located in the Dublin area. However it is very strongly recommended that low secure units for these health regions, if they are to fulfil their function of active rehabilitation and gradual reintegration in the community, should be situated alongside generic mental health facilities in the region, rather than within a forensic mental health service complex.

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Reorganization of the forensic mental health services on a regional basis will require additional resources. It may well be possible to develop some of the required regional low secure units through reorganization of some existing provision. However medium secure units require to be purpose built if they are to provide a modern medium secure service. High secure care, which is required by a smaller percentage of those availing of forensic mental health services (O'Neill et al, 2003), should be provided in one national purpose built facility as in a relocated Central Mental Hospital complex. A national strategic management group with representation from each of the four health regions should be responsible for overseeing the utilization of high secure places and should also have a policy development role within the high secure service. A needs assessment to determine the inpatient provision at each level of secure care should be completed as a priority so that the reorganization of services and development of new services is closely aligned to need.

A regionalized model of service has very significant advantages over a centralized model of service for service users and similar regionalized models of service are in place in England and Wales and in Northern Ireland.

## 5.2 Community Focus of Forensic Mental Health Services

Forensic mental health services should, in addition to providing inpatient care, have a strong community focus and provide:

- care to persons with forensic mental health needs in the community
- specialist assessments and consultation services to generic mental health teams
- specialist assessments for court diversion schemes and
- a service to prisons within the region.

Regional Forensic Mental Health Teams should cultivate close links with Community Mental Health Teams in their region through joint work and consultation and through joint training opportunities for staff, including encouraging staff from generic mental health teams to gain forensic mental health experience. This will help to create a regional forensic mental health service which is an integral part of the mental health services in each region.

Close relationships and agreed protocols between forensic and generic mental health services are essential to allow services to provide treatment and rehabilitation for individuals in the most appropriate and least restrictive setting. Good working relationships will be facilitated not only by the regular contact between personnel and services which a regionalized service will foster but also by clear protocols for transfer of clients between services. Clear protocols for obtaining specialist forensic assessments and for transfers between generic and forensic mental health services and between prison services and forensic mental health services should be developed. The development of clear pathways of referral and transfer between



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services and the fostering of partnerships in the care of particular individuals and the development of joint initiatives between services will help to overcome tendencies towards rigid boundaries. Managing the interface between generic mental health services and specialist forensic mental health services is key to developing a service which can respond flexibly to the varying needs of people who may need forensic care.

### 5.3 Active Treatment and Rehabilitation

Forensic mental health facilities need to be clearly identified as being treatment and rehabilitation facilities which operate in particular conditions of security rather than facilities offering mainly containment. All units should have a strong ethos of rehabilitation and recovery. The full range of therapeutic interventions and programmes need to be made available to patients and clear care pathways identified for progression through the care system. Average length of stay is very lengthy by comparison with acute mental health facilities but this creates an even stronger imperative for care planning with regular review to avoid stagnation both at an individual and system level. Each person within the service should have a comprehensive care plan with regular review.

Forensic mental health services must be staffed by specialist multidisciplinary teams. Basic forensic mental health teams need to have psychiatrists, mental health nurses with forensic training, clinical psychologists, social workers, occupational therapists and addiction counsellors. Other specialist staff such as vocational trainers, teaching staff, forensic psychologists and staff with hostel management experience will need to be added to the core staff teams to develop the full range of therapeutic programmes. The size of the teams required will vary according to particular regional needs. Clinical staff on the multidisciplinary staff should work across both community and inpatient settings. Nursing staff should rotate between inpatient services and community services to allow skills development and prevent staff burn-out. We do not currently have a large pool of staff with specialist training and experience in the forensic mental health area and it will be necessary to develop training initiatives to provide a sufficient pool of trained staff for the service. Inpatient units require adequate support staff to maintain the environment to a high standard.

The systematic assessment of risk both at the point of initial entry to the forensic mental health service and on an ongoing basis during the person's involvement with the service is key to providing services which are appropriate to the person's needs. Accurate risk assessment is an important element in preserving the person's right to be treated in the least restrictive setting appropriate to his or her needs at any particular point in his/her progress through treatment. Training in risk assessment and risk management needs to be available to all clinical staff.

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## 5.4 Mental Health Services to the Prison Population

Mental health services to the prison population should be provided from the Forensic Mental Health Service. A comprehensive mental health service should be made available to the prison population through the Regional Forensic Mental Health services. Where there is a large prison population in a particular region additional team members should be added to teams to allow them to fulfil this commitment. Regional Forensic Mental Health services providing services to the prison population must work very closely with prison medical, psychology, social work (probation and welfare), addiction counselling and vocational services to maximize the effectiveness of their input into the individual prisoner's care and we recommend formal liaison with each of these services. These in-house services, which form the primary care level of service for the prison population, should be resourced appropriately to allow them to deal with issues within their remit thus reducing the potential for inappropriate referrals to the secondary mental health services. The addition of mental health nursing to the primary healthcare services in the prisons could be piloted.

## 5.5 Legislative Reform

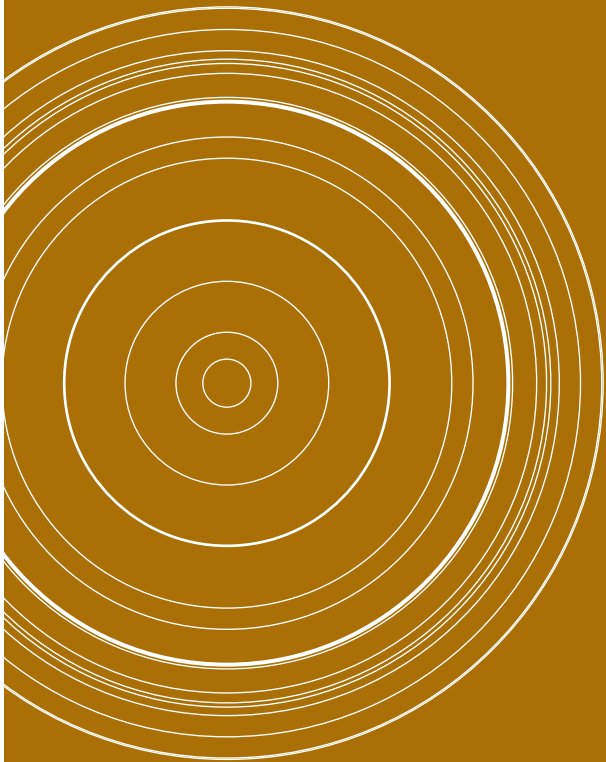
It is recommended that priority be given to reform of the legislative framework governing mental disorder as this provides the basis for many aspects of forensic service provision. Further alignment of civil and criminal law provision in regard to mental disorder is required. The Criminal Law (Insanity) Bill 2002 represents a significant move in this respect. However, a number of significant amendments are required to the Criminal Law (Insanity) Bill 2002 to ensure that it is fully compliant with international principles on human rights and with the provisions of the Mental Health Act 2001. The Commission's response to the consultation process for the Criminal Law (Insanity) Bill 2002 recommends a number of important modifications to the Bill. For example, the designation of a prison (or part thereof) as a designated centre for the care and treatment of persons with a mental illness is not, in the view of the Commission, appropriate and appears to be in contravention of the United Nations '*Principles Regarding the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*' 1991. The Bill should also be amended to facilitate remand of the person on bail (thereby integrating it with the Bail Act 1997) with their informed consent to attend for assessment on an outpatient basis. The inclusion of this option is in line with best practice regarding diversion schemes in mental health care and treatment.

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Legislation must provide for options, other than certification, whereby mentally disordered persons who present before the courts can be detained for assessment or treatment. This must include mechanisms for facilitating treatment in the community. In addition a clear mechanism is needed for a matter to be transferred back to court where this is the appropriate course of action. Mental health professionals, Gardaí, lawyers and the courts should have a comprehensive range of legislative and service options available to them in relation to mentally disordered people involved in criminal proceedings. Services should be based on a nationally funded policy of diversion towards treatment and recovery options and away from punitive measures. The development of court diversion schemes will require further legislative change. These schemes necessarily operate on the basis of consent and cannot override the person's right to due process i.e. the right to have his or her case tried under the criminal justice system if that is the person's informed preference.

Ireland's legislation in relation to mental disorder should seek to have reciprocal arrangements that allow for the transfer of detained mentally disordered patients from England, Wales, Scotland, Northern Ireland and the wider European Community.

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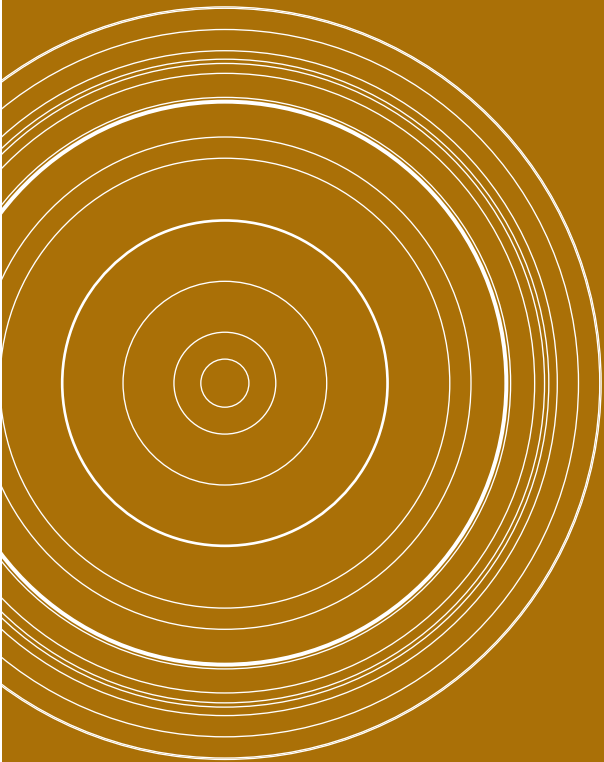
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# Appendix 1





## APPENDIX 1

### Summary of relevant features from legislative frameworks used in other countries

Perspectives from Scotland, England and Wales, Northern Ireland and the State of Victoria Australia are provided for comparison.

#### SCOTLAND

The Mental Health (Care and Treatment) (Scotland) Act 2003 was passed by the Scottish Parliament on 20 March 2003. The Act provides a legislative basis for civil confinements and the care of mentally disordered people who become involved in criminal proceedings. The Act, which is in the process of implementation, substantially reforms the law relating to people with mental disorder who enter the criminal justice system.

The Scottish Ministers authorize transfers between hospitals, and temporary suspensions of detentions for mentally disordered people involved in criminal proceedings. The Ministers can also transfer a prisoner to hospital for treatment of a mental disorder. Courts have new options under the 2003 Act in how they deal with people with mental disorder, and the Act provides a number of orders which a court may make. These include:

- Assessment orders of a person at any stage of the process prior to sentencing, pre-trial and post sentencing. This order is made on the evidence of one medical practitioner and detains the person for up to 28 days in hospital. Treatment can be given without consent if required
- Treatment orders made by the court at any stage prior to sentencing. Two medical practitioners, one must be a consultant psychiatrist, are required
- Interim compulsion orders for use in cases where a person has been convicted of a serious offence punishable by imprisonment, (apart from murder). The continuous period of assessment can be up to one year, thereby allowing the court to gather further evidence prior to sentencing to assess whether forensic criteria may apply. Requires two medical practitioners (one Approved Medical Practitioner).

Compulsion orders allow a court to order the detention and/or treatment of a convicted person for a period of six months, with regular reviews. These are intended for use in cases where the person's mental disorder would benefit from treatment and there would be significant risk to themselves or others if the order were not made. It requires two medical practitioners (one an Approved Medical Practitioner). The order can vary from detention in hospital for up to six months to requiring the person to reside at a certain address and keep specified appointments for treatment of their mental disorder. This is a major change as hospital orders under the current Act always require detention. Once appointed the Responsible Medical Officer has a duty to prepare a care plan and a Mental Health Officer has to complete a social circumstance report as with other orders.

The Mental Health (Care and Treatment) (Scotland) Act (2003) is in the process of implementation. It is viewed as a progressive piece of mental health legislation which takes account of the movement by services from institutional to community care and provides patients with significant protection of their rights.

## ENGLAND & WALES

The Mental Health Act (England and Wales) (1983) provides the legal framework for compulsory admission and treatment of patients suffering from mental disorder. The Act provides the legislative basis for civil confinements and for the care of mentally disordered people who become involved in criminal proceedings.

Principles of treatment under the Act are set out in the Mental Health Act (1983) Code of Practice (1999) which stresses the following:

- Mentally disordered people who are subject to criminal proceedings have the same right to psychiatric assessment, treatment and care as anyone else
- Anyone in prison who needs medical treatment that can only satisfactorily be given in a hospital should be admitted to an NHS hospital or appropriate registered mental nursing home. Prison hospitals/healthcare centres do not qualify as hospitals under the Act, so compulsory treatment under it may not be given in them
- If it is essential to give medication without the patient's consent to anyone in prison that needs medical treatment, this can only be administered under common law and where the patient lacks 'capacity'.

Use of compulsory powers under the Mental Health Act (1983) is not allowed in prison. This applies equally to patients in prison awaiting transfer to a psychiatric hospital for assessment or treatment under the compulsory powers of the Act. Treatment without consent for mental illness may be provided in prison under common law under certain circumstances. Decisions about whether to seek to transfer a prisoner under the Act require that the statutory criteria are met. Sections 47 and 48 are used to transfer to hospital from prison a patient in need of hospital treatment without the involvement of a court. The Home Secretary's consent is rarely refused if it can be demonstrated that the level of security at the receiving hospital is adequate. If a defendant on remand is mentally disordered but does not require urgent transfer to hospital under Section 48, practitioners are advised to refer the defendant for psychiatric assessment and, with patient consent, notify his/her solicitor that this has been done. This may prompt the court to consider a hospital order.

There is a proposal within the Mental Health Bill (2002) that prison establishments be considered as being 'in the community' and that this should allow treatment to be given under compulsion in prison under civil law powers. There are some who view this proposal as an extension of a current British government policy of diminishing the need for diversion at the custodial end of the system by improving the quality of healthcare in prisons, (Bartlett and Sandland 2003). In theory a variety of diversion options should be available at different stages of the system to provide a range of flexibility in disposals. These options should include:

- diversion from prosecution via police liaison schemes
- diversion within the criminal process pre-sentencing

- sentencing as diversion by way of hospital or treatment orders.

In practice the available options may vary at the local level, (Greenhalgh et al 1996).

The 1983 Act has provisions for mentally disordered people who become involved in criminal proceeding to be:

- transferred as an un-sentenced prisoner from prison to hospital
- transferred as a sentenced prisoner who has become mentally disordered after entering prison or whose mental disorder was not identified before sentence to an NHS hospital
- held on a hospital order (a sentence of the court) imposed as an alternative to sentencing that individual to prison.

The power of the courts to order admission to a named psychiatric unit was introduced by the Crime (Sentences) Act 1997 to enable the court or the Home Secretary to specify the level of security under which the patient needs to be detained. A named hospital unit can be any part of a hospital which is treated as a separate unit. It will be for the court to define what is meant in each case where it makes use of the power. Admission to a named unit will mean the Home Secretary's consent will be required for any leave or transfer from the named unit, whether the transfer is to another part of the same hospital or to another hospital.

The need to consider the longer term implications of a recommended disposal is particularly important following the introduction of powers under section 45A of the Act (introduced under the Crime (Sentences) Act 1997). This provides a new option, if the offender is diagnosed as suffering from psychopathic disorder within the meaning of Section 1 of the Act (with or without an additional category of mental disorder), for the court to attach a hospital direction and limitation direction to a prison sentence. Where either a hospital order under section 37 or a prison sentence with a hospital direction under section 45A is available to the court the choice rests with the court. The making of a hospital direction and a limitation direction will mean that from the start of his or her sentence the offender will be managed in hospital as if he or she was a transferred prisoner (under section 47 and 49). Thereafter the Responsible Medical Officer (RMO) will have the option of seeking the patient's transfer to prison at any time before his or her release date if no further treatment is likely to be beneficial. It is a matter for the discretion of the court whether to make a hospital order subject to restrictions. A hospital direction must always be accompanied by a limitation direction which applies restrictions.

It remains to be seen how the proposals in the Mental Health Bill (2002) will influence the legislation. The Bill has generated a degree of controversy over what is seen by some as its over emphasis on public safety as opposed to treatment and human rights.

## NORTHERN IRELAND

Mental health legislation in Northern Ireland is provided under the Mental Health (Northern Ireland) Order 1986 (the Order). The Order has been closely modelled on the Mental Health Act (1983) of England and Wales and the Mental Health (Scotland) Act 1984. The Act provides a legislative basis for civil confinements and the care of mentally disordered people who become involved in criminal proceedings. The Order is substantially different from the Republic of Ireland's Mental Treatment Act 1945 and from the Mental Health Act 2001. At the present time reform of mental health legislation is being considered in Northern Ireland and a comprehensive consultation process is in place which includes forensic services and associated legislation.

Part 3 of the Order provides for the admission to hospital or placement under guardianship of persons concerned in criminal proceedings or under sentence. Courts may remand to hospital a person who has been accused of an offence for a report on his/her mental condition. The remanded person must be admitted to hospital within 7 days of the date of the remand and can be kept in hospital for up to 28 days. Thereafter there may be further remand by the Court for similar periods up to a maximum of 12 weeks. Anyone so remanded has the status of a patient compulsorily detained in hospital, except that the right to give treatment without consent does not apply. Article 43 provides for remand for treatment. The Crown Court may remand an accused person to hospital for treatment. Anyone so remanded has the status of a detained patient.

The Crown Court or a Magistrate's Court can order the hospital admission of a person convicted of an imprisonable offence. A Magistrate's Court may also make a hospital order in respect of an accused person without conviction if it is satisfied that he/she committed the act of which he/she is accused. Either court may in addition make an order restricting discharge from hospital either for a specified period or without time limit. The Order requires that the court must receive evidence from two medical practitioners, one of whom must be a consultant psychiatrist. The subject of a hospital order must be admitted to hospital within 28 days of the date of the order, and has the status of a detained patient. If there is a restriction order the Secretary of State exercises authority, through the Northern Ireland Office, over the patient's discharge or leave of absence from hospital. The Crown Court or a Magistrate's Court may (by an interim hospital order) order the hospital admission of a person convicted of an imprisonable offence, if it has reason to suppose but is not certain at the time that this is justified. The effect of an interim hospital order is similar to that of a hospital order, except that the Court specifies its duration, which must not exceed 12 weeks. It may be superseded by a hospital order made under Article 44. The maximum period for an interim hospital order is six months.

Article 49 of the order deals with unfitness to plead. Where the Crown Court decides that an accused person is unfit to be tried it will order that the person be admitted to hospital. The effect of such an order is similar to that of a hospital order together with a restriction order made without limitation of time.

Article 50 of the Order deals with not guilty on the ground of insanity. Where the Crown Court finds that a person committed the offence with which he/she was charged but was an insane person at the time, the Court will order his/her admission to hospital. The effect of such an order is similar to that of a hospital order together with a restriction order made without limitation of time.

The Secretary of State may direct the hospital admission of a person serving a sentence of imprisonment or of certain other persons who are in custody, most commonly those on remand. Person removed to hospital in this way may be subject to restrictions regarding leave or discharge.

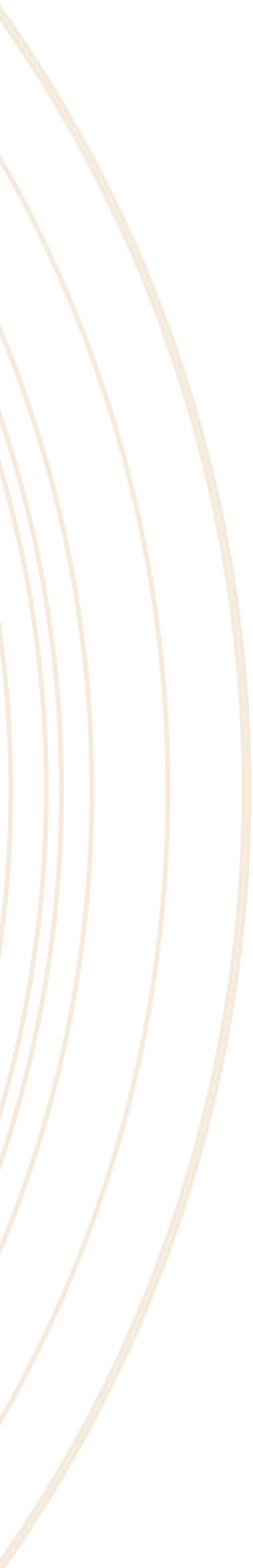
It is a matter for the relevant Health & Social Services Board to designate the hospital to which the patient is to be admitted, Department of Health and Social Services (1992). A Designated Officer in each Board has responsibility for ensuring the admission arrangements. The legislation makes no provision for Health Board representation where the Secretary of State is considering hospital admission. In practice the Northern Ireland Office will ensure that the appropriate Health Board is adequately consulted and that Board staff are given the opportunity to assess the patient. The majority of psychiatric centres in Northern Ireland are generic units with a policy of open access and a staffing mix which does not include personnel with high levels of expertise in forensic psychiatry. A 34 bed medium secure unit has recently opened in Belfast as a regional service and community forensic mental health services are to be developed in each of the four Health Board areas with links to the Belfast unit. It is anticipated that this will reduce current levels of transfers to Scotland's medium and high secure units. Northern Ireland has provisions for the transfer of detained patients between England, Scotland and Wales. There is no reciprocal legislation that allows for transfer of detained patients between Northern Ireland and the Republic of Ireland.

#### **STATE OF VICTORIA, AUSTRALIA**

In the State of Victoria the Mental Health Act (1986), the Crimes (Mental Impairment and Unfitness to be Tried) Act (1997) and the Mental Health (Amendment) Act (2003) provide the basis for the legal framework for compulsory admission and treatment ('orders') of patients suffering from mental disorder who become involved in criminal proceedings.

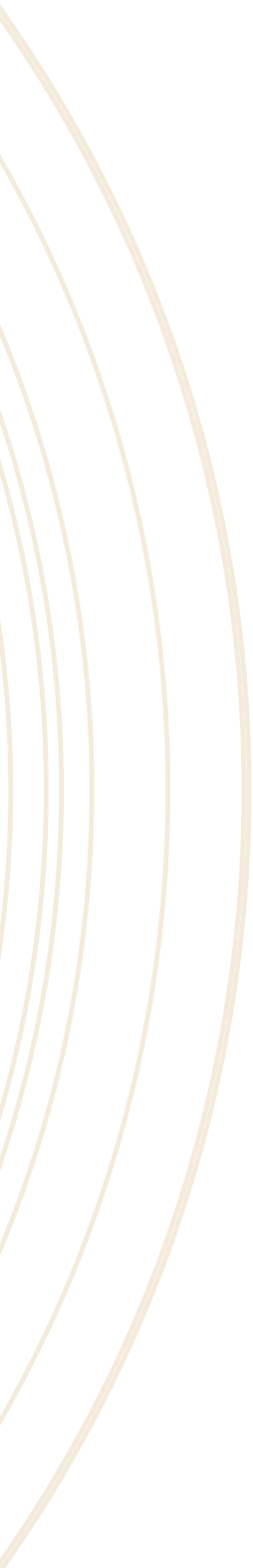
The Mental Health Act (1986) provides a mechanism for community treatment of hospital order patients and provides for their discharge in certain circumstances. The Secretary to the Department of Justice can also make a hospital order to transfer a person (to an approved mental health service) who is lawfully imprisoned or detained in a prison or other place of confinement and appears to be mentally ill. The Crimes (Mental Impairment and Unfitness to be Tried) Act (1997) radically reformed the law relating to persons found unfit to plead or not guilty by reason of mental impairment. It enables the Supreme and County Courts to make custodial and non-custodial dispositions for the treatment and care of persons with a mental impairment, and provides for a scheme for gradual rehabilitation and reintegration into the community.

Policy papers from Victoria indicate recognition among the legislators that mental health services have changed radically in recent decades, with associated need for significant legislative reform concerning mentally disordered people who become involved in criminal proceedings, (Mental Health Branch, Department of Human Resources 2003). Recent amendments to the legislation (Mental Health (Amendment) Act 2003) allow a court to make an order for involuntary community treatment on the advice of the responsible authorized psychiatrist, without requiring the person to be admitted to an inpatient service.









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