

PRISON PSYCHIATRIC INREACH AND COURT LIAISON SERVICES IN IRELAND

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INTRODUCTION

The overrepresentation of mental illness in prison populations compared to community samples has long been recognised internationally,¹ and is particularly true for pre-trial settings.² Many reasons have been proposed for this. The majority of crimes committed by the mentally ill are minor and non-violent. Only a very small number of individuals with major mental illness carry out serious offences. When an individual with mental illness comes before the court, however, he may be less likely to be successful in seeking bail (and therefore more likely to enter custody) than a non-mentally-ill defendant, for a number of reasons: he may be homeless and unable to provide an address, or he may not have access to the requisite bail bond or a family member to vouch for him. Due to active symptoms of mental illness, he may present as disruptive during court proceedings, and create doubt as to the likelihood of attending his next court appearance.

Recent Irish studies demonstrate rates of psychosis (the most severe and disabling form of mental illness) in the sentenced prison population comparable to other jurisdictions,³ but a much

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¹ Torrey, "Jails and prisons – America's new mental hospitals", (1995) 85 (12) *American Journal of Public Health* 1611. See also Brugha *et al*, "Psychosis in the community and in prisons: a report from the British National Survey of Psychiatric Morbidity", (2005) 162 (4) *American Journal of Psychiatry* 774.

² Fazel and Danesh, "Serious mental disorder in 23,000 prisoners: a systematic review of 62 surveys", (2002) 359 *Lancet* 545.

³ Duffy *et al*, "Psychiatric morbidity in the male sentenced Irish prisons population", (2006) 23 (2) *Irish Journal of Psychological Medicine* 54.

higher prevalence than in other countries in remand settings, and almost 10 times the level in the community.⁴ Possible reasons for the disproportionately high rate of major mental illness in Irish remand settings include: the lack of a formal legal mechanism for court diversion in this jurisdiction, the absence of mental health courts, and inadequate investment in community psychiatric services. There are particular shortfalls in services for two groups over-represented in the prison population: those who are homeless and those whose illness co-exists with substance misuse.

Such individuals are vulnerable in the prison setting, and are typically too disturbed to learn from the punitive aspect of incarceration or to be deterred by it. Moreover mentally disordered offenders cannot be said to receive equivalent psychiatric care to their community counterparts in the toxic environment of prison. Diversion schemes have therefore developed internationally to meet the needs of this group of people.⁵ The purpose of such schemes is simply to identify those with mental health needs, and facilitate treatment in healthcare settings in the least restrictive environment appropriate (notwithstanding legal constraints). Ireland has recognised the need for such a service for some time, an aspiration expressed in the 2006 blueprint for mental health service provision in Ireland, *A Vision for Change*,⁶ which stated that “every person with serious mental health problems coming into contact with the forensic system should be afforded the right to mental healthcare in the non-forensic mental health services unless there are cogent and legal reasons why this should not be done”.⁷

There are several points on the pathway through the criminal justice system where an individual with severe mental illness can be identified and diverted to appropriate treatment.

⁴ Linehan *et al*, “Psychiatric morbidity in a cross-sectional sample of male remanded prisoners”, (2005) 22 (4) *Irish Journal of Psychological Medicine* 128; Curtin *et al*, “Psychiatric Morbidity in 615 male committals to Irish Prison”, (submitted), *personal communication*.

⁵ O’Neill, “Liaison between criminal justice and psychiatric systems: Diversion services”, (2006) 23 (3) *Irish Journal of Psychological Medicine* 87.

⁶ Department of Health and Children, *A Vision for Change – Report of the Expert Group on Mental Health Policy* (Dublin: Stationery Office, 2006).

⁷ *A Vision for Change* (previous note), p. 136.

These include the point of arrest, the holding Garda station, the first or subsequent court appearance, and the prison to which he is committed. Resources do not at this time permit a psychiatric presence distributed through all of Ireland's widely-spread courts and Garda stations, so the most equitable base for such a service in Ireland was assessed as being Cloverhill Prison, in which the majority of Ireland's remand prisoners are placed. On this basis the Cloverhill Prison Inreach and Court Liaison Service has been developed, by the National Forensic Mental Health Service based at the Central Mental Hospital.

Prison psychiatric inreach and court liaison work has been carried out for many years, but the service has been formalised and intensified over the past two years. Cloverhill Prison was hitherto served by regular psychiatric clinics carried out by various members of the national forensic mental health service staff. The success of this service was hampered by the rapid throughput in remand prisons, limited continuity of care, failure to maximise detection of severe mental illness and, when identified, challenges in ensuring that prisoners received timely treatment in an appropriate setting. Particular difficulties were experienced in linking patients with their local psychiatric service, and recommendations regarding psychiatric treatment often failed to materialise into a practical outcome for the individual. Concerns were raised by the courts regarding delays in providing reports and particularly in terms of accessing practical assistance in implementing psychiatric recommendations such as transfer to hospital. The Prison Inreach and Court Liaison Service aimed to specifically address these shortcomings.

While the Criminal Law (Insanity) Act, 2006, allows immediate mental health diversion in the event of a defendant being deemed unfit to stand trial,⁸ the law in its present form only allows for admission to the Central Mental Hospital, an inappropriately restrictive option for those charged with minor crimes and posing a minimal risk to others, representing the majority of mentally ill persons before the court. Helpfully, the Act does not appear to oblige transfer to a forensic mental health

⁸ Criminal Law (Insanity) Act, 2006, s. 4(6). See also Whelan, "Fitness for trial in the district court: the legal perspective", [2007] 2 J.S.I.J. 124.

setting, however, and appears to anticipate such issues by providing for deferral of the question of fitness to be tried “where the court deems it expedient and in the interests of the accused” to do so.⁹ One might anticipate this scenario to arise when a severely mentally ill defendant is in need of urgent psychiatric treatment in his local hospital.

The Court Liaison Service aims to provide timely reports where the court directs examination by an approved medical officer (a consultant psychiatrist) at a designated centre for the purposes of determining whether or not to exercise a power under the Criminal Law (Insanity) Act, 2006, s. 4(3) or (5). While the court may commit the person to the Central Mental Hospital for a period of not more than 14 days, the Court Liaison Service at Cloverhill Prison aims to provide such reports more rapidly than this. The service is intended to advise as to whether the accused person is suffering from a mental disorder within the meanings of the Criminal Law (Insanity) Act, 2006, and the Mental Health Act, 2001, whether the person is in need of in – or out – patient care or treatment in a designated centre or whether, from a psychiatric perspective, such treatment could be delivered through general psychiatric services. In particular, the service also provides practical assistance in this regard, by liaising with local service providers to ensure that arrangements for such treatment are put in place, increasing the range of options available to the court should a non-custodial disposal be considered.

Since its inception in 2006 the Cloverhill Prison Inreach and Court Liaison Service (PICLS) has grown in size and experience. At the time of writing, it consisted of an eight-person team, comprising one consultant psychiatrist, three trainee psychiatrists, three psychiatric nurses and a team administrator. This team is based on-site at the prison (rather than being provided by visiting individual clinicians), allowing provision of a full-time Monday to Friday service.

⁹ Criminal Law (Insanity) Act 2006, s. 4(7).

I. THE PSYCHIATRIC COURT LIAISON MODEL

The aim of the Prison Inreach and Court Liaison Service is to assist the courts by identifying mentally ill remands as rapidly as possible, providing timely reports voluntarily and on request (regarding fitness and the presence or otherwise of mental illness) and to put in place practical solutions to accessing appropriate mental healthcare. In practice this involves a number of steps:

A. Identification of Prisoners with Severe Mental Illness

To this end, daily screening by mental health staff was introduced, in addition to the standard committal interview carried out by Irish Prison Service nursing staff. Screening consists (based on a modification of an international instrument¹⁰) of selecting for interview all committals with a history of previous psychiatric contact or prescription of psychiatric medication, a history of deliberate self-harm, specific charges such as homicide or arson, a history of homelessness or observed unusual behaviour. In addition to this screening process, referrals are accepted from a wide range of sources including the judiciary, legal representatives, Irish Prison Service nursing and correctional staff, members of An Garda Síochána and probation staff.

B. Identification of Appropriate Treatment Options

When a person detained by the Criminal Justice System requires psychiatric treatment, the following options exist:

1. Transfer to the Central Mental Hospital (Designated Centre)

This is Ireland's only forensic inpatient hospital, serving the entire country and providing treatment in conditions of high, medium and low security. This option is ideally reserved for persons with severe illness who are thought to pose a high risk to others.

¹⁰ Gavin *et al*, "Reception screening and mental health needs assessment in a male remand prison", (2003) 27 *Psychiatric Bulletin* 251.

2. Treatment in a Local Psychiatric Hospital (Approved Centre)

This may represent the best option for many individuals with severe mental illness charged with a minor offence (and deemed to pose a low or negligible risk to others). In this instance, bail or a suspended sentence may represent more attractive options than discontinuation of legal proceedings, as they allow for conditions to be put in place to promote adherence to psychiatric treatment (therapeutic jurisprudence), and may provide reassurance that psychiatric diversion does not equate to a “get out of jail free card”. Treatment may take place in inpatient or outpatient settings. Local psychiatric hospitals also have the capacity to provide treatment to mentally disordered individuals admitted involuntarily.

3. In-reach Treatment in the Prison Setting

This is generally suitable for persons with less severe mental illness who are facing serious charges.

C. Collateral History and Liaison

Liaison with all relevant stakeholders is important to ensure the most appropriate care is provided for the individual; this includes communication with the individual’s relatives, the arresting member of An Garda Síochána, and the person’s community psychiatric service. Information-gathering at this stage will pay particular attention to the individual’s previous history of violence in order to assess the potential level of risk posed. If it is anticipated that the individual may receive bail at the next court appearance, provisional arrangements are made in advance with the community psychiatrist to take over care, so that any recommendation put before the court has the agreement of all parties.

D. Provision of Advice to the Court

Where a mentally ill offender may be entitled to bail, and a suitable treatment option is available to that person, it is usual practice to provide a psychiatric report (either on request or voluntarily) to the court. This report details both the custodial and non-custodial treatment options available. Where admission to a local hospital is recommended, defendants will typically be accompanied to court by a member of the Prison Inreach and

Court Liaison nursing staff. This is to facilitate communication regarding the mental health needs of the individual and to assist in transfer to hospital from court, where necessary.

Many of these individuals lack insight into their illness, and have a history of poor compliance with treatment. Non-adherence to treatment is considered a significant factor in the recidivism risk for those with psychotic disorders, and it is increasingly recognised that legal leverage may be helpful in addressing this issue.¹¹ Bail conditions are therefore usually sought in order to facilitate the person receiving the treatment they require. Conditions typically include accepting psychiatric treatment as well as abstinence from drugs and alcohol, where that is a contributing factor.

In the case of a seriously ill person requiring involuntary psychiatric treatment, the relevant civil legislation paperwork¹² will be prepared in advance of the court appearance; the assistance of An Garda Síochána in transfer to hospital is sometimes requested in this instance.

II. PROGRESS OF THE SERVICE TO DATE

In order to assess the performance of the service, information was gathered on psychiatric activity at Cloverhill Prison from 2005, 2006 and 2007, representing the year before the introduction of the service, the period of transition while the service was set up, and the period of full functioning of the service respectively.

A. Psychiatric Assessments

Introduction of the new service in January 2007 led to an overall increase in the number of prisoners assessed (from 326 in 2006 to 388 in 2007).¹³ The total numbers of patient contacts carried out reduced, however, in the same period (from 1115 in 2006 to 868 in 2007), possibly reflecting increased efficiency in the service.

¹¹ Lamberti, "Understanding and preventing criminal recidivism among adults with psychotic disorders", (2007) 58 (6) *Psychiatric Services* 773.

¹² Mental Health Act, 2001.

¹³ Data on overall prisoners assessed not available for 2005.

B. Individuals Identified with Psychosis

Considerable improvements were seen in the rate of identification of psychosis when the service was introduced. While in 2006 74 people were identified with active psychotic symptoms (and 115 with a lifetime history of psychosis) this increased to 95 in 2007 (with 126 having a history of psychosis in their lifetime). These figures approach the expected rate in Cloverhill Prison.

C. Diversions to Non-Forensic Mental Health Settings

The area of greatest growth was seen in the numbers of individuals afforded treatment in non-forensic mental health settings. 19 individuals were diverted to local mental health services in 2005, increasing to 44 in 2006 and 72 in 2007. At the time of writing it was anticipated that this figure would exceed 100 in 2008. Equally encouraging was the time spent in custody for those individuals deemed suitable for treatment in local psychiatric services, reducing from an average of 57 days in 2005, to 19 (2006), and 21 (2007). The health gain can be quantified in numbers treated and time at risk of deterioration in prison reduced. While it is not possible to calculate exact monetary savings made in this reduction of prison occupancy, it is thought to be substantial.

2007 saw five individuals with complex needs (typically combining major mental illness and a learning disability or brain injury) transferred from the Criminal Justice System to high-support community placements. All five had spent repeated, lengthy periods in custody in recent years, thus the sourcing of long-term solutions led to substantial health gains for those diverted from the criminal justice system and reduced burden on the criminal justice system. The slight increase in time spent in custody in 2007 may reflect these persons for whom an individualised placement was required; as these placements were costly, and provided in the independent healthcare sector, greater time was required to negotiate funding agreements from relevant Health Service Executive bodies.

Some diversions of persons with major mental illnesses and minor offending occur via admission to the Central Mental

Hospital. This is undesirable for several reasons: these individuals may not require conditions of special security, transfer to the Central Mental Hospital will increase time spent in custody, and the individual may face even greater difficulties accessing care in the community because of the stigma following an admission to a high secure forensic unit. While in 2005 the majority (74%) of individuals were admitted to the Central Mental Hospital before diversion to local psychiatric services, this had reduced to only 10% in 2007, the remainder proceeding directly from court to their local hospital.

D. Transfers to Forensic Mental Health Settings

The main impact that the Prison Inreach and Court Liaison service has had on admissions to the Central Mental Hospital has been to liberate beds for those individuals who do require psychiatric treatment in conditions of special security, typically those defendants with active symptoms of major mental illness charged with serious offences or assessed as posing serious risk to others. While in 2005, the majority (77%) of all patients transferred from Cloverhill Prison to the Central Mental Hospital were not actually deemed to need high secure or medium secure psychiatric treatment, this has reduced to 28% by 2007.

CONCLUSION

Pathways to care for the mentally ill have been distorted through under-resourcing of community mental health services, such that major mental illness increasingly presents to the courts in the form of minor offending behaviour rather than to psychiatric services. Legal, mental health and human rights policies advocate the provision of equivalent access to psychiatric treatment for mentally disordered offenders as for those with mental illness in the community. Standards of care should also be equivalent. To achieve this, persons in the criminal justice system with severe mental illness should be identified as early as possible, in order to facilitate treatment. Treatment should then be provided in the least restrictive setting, with transfer to the secure unit at the Central Mental Hospital reserved as far as possible for those who pose a high risk to the public. Inappropriate transfer to

conditions of excessive security may be counterproductive for the patient, and may paradoxically increase risk elsewhere in the system by limiting admission capacity for higher risk individuals.

Many minor offenders can be appropriately and safely managed in general psychiatric healthcare settings. Those who may be entitled to bail should have appropriate community treatment options made available. Treatment should be provided as soon as possible after identification of the need. Irish courts should not be expected to act as a proxy for local mental health services in identifying mental illness and deciding on the most appropriate treatment.

In Ireland, as in other jurisdictions, courts have responded to this “criminalisation” of major mental illness by applying existing law in a manner that incorporates the intention that the individual will receive appropriate treatment in an appropriate facility. This approach has been termed “therapeutic jurisprudence”.¹⁴ The Court Liaison Service can assist this process by identifying defendants with major mental illness, and making arrangements for the provision of such treatment in the community through liaison with local psychiatric services in the event of non custodial disposal. This increases the range of options available to the courts.

The introduction of the Prison Inreach and Court Liaison Service has led to increased detection of serious mental illness in Cloverhill Prison, the prison with the highest prevalence of mental illness nationally. The catchment areas of the courts served by Cloverhill Prison have a “footprint” of over 2.4 million people. The service also increasingly receives referrals from other remand centres also. The detection of major mental illness in 2007 approached the expected annual rate based on the findings of previous research carried out at this prison. The number of diversions to non-forensic mental health settings has increased fourfold between 2005 and 2007. Persons with severe mental illness deemed suitable for treatment in a non-custodial setting spent considerably less time in custody in 2006 and 2007 than in

¹⁴ Wexler and Winick, “Therapeutic Jurisprudence as a New Approach to Mental Health Law Policy Analysis and Research” (1991) 45 (5) *University of Miami Law Review* 979.

2005. Those admitted to the Central Mental Hospital were more likely to be deemed a significant risk to others. Equally, those posing a low risk of violence, who in former times were treated in conditions of security that exceeded their need, have been considerably more likely to receive their treatment in a non-custodial setting.

Future research will focus on measuring the effects of diversion to non-forensic mental health settings in terms of subsequent offending behaviour and measurable mental health outcomes. Formal feedback from the judiciary, An Garda Síochána, correctional staff, patients and their families, and the receiving psychiatric services, will all assist in improving the quality of service provided.

The necessity to locate the court liaison service in Cloverhill Prison inevitably means that an opportunity is missed to divert to hospital before entering prison. Equally while individuals remanded to other prisons nationally are assessed on request, specialised screening is only carried out in Cloverhill Prison. Inappropriate custodial periods for persons with major mental illness and minor offending behaviour may be further reduced by extending the service in the future to intervene at the point of the Garda station or the Court. Specialised mental health courts have been introduced in other jurisdictions.¹⁵ Such courts accept referrals from other courts nationally, and provide on-site assessment of mental health needs of defendants with a view to arranging direct transfer from court to the appropriate mental health setting. Limitations of such an approach include that many of the individuals referred to such courts may still be remanded into custody while awaiting court appearance. “On the day” assessments in court settings would be less comprehensive than under the current model. Such courts are most effective when there is clear legislation providing for the diversion of minor offenders with mental illness to community inpatient or outpatient facilities.

¹⁵ Goldkamp and Irons-Guyn, *Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage: A Report on Community Justice Initiatives*, (Philadelphia: Crime and Justice Research Institute, 2000).

In the meantime however, the Prison Inreach and Court Liaison Service at Cloverhill Prison increases the range of options available to the courts through early detection of mental illness, and assisting access to prompt, appropriate treatment in both custodial and non-custodial settings within existing legislation.