Meeting of the High Level Task Force on mental health and addiction challenges of persons interacting with the criminal justice system

19 May, 2021 by videoconference

Minute

Attendance:

Kathleen Lynch: Chair - former Minister of State for Primary Care, Mental Health and Disability
Deborah White; Principal Officer, Dept. of Justice, Penal and Policing Policy
Colm Desmond; Assistant Secretary, Dept. of Health, Corporate Legislation, Mental Health, Drugs Policy and Food Safety Division
Seamus Hempenstall; Principal Officer, Dept. of Health, Mental Health Unit
Michael Murchan; Assistant Principal Officer, Dept. of Health, Mental Health Unit
Prof. Harry Kennedy; Executive Clinical Director, Central Mental Hospital
Dr Eamon Keenan; National Clinical Lead-Addiction Services, HSE
Jim Ryan; Head of Operations for Mental Health Services, HSE
Pat Bergin; Head of Service, Forensic Mental Health Service, HSE
Mark Wilson; Director, Probation Service
Paula Hilman; Assistant Commissioner, an Garda Síochána
John Devlin; Clinical Director, Irish Prison Service
Enda Kelly; Chief Nursing Officer, Irish Prison Service
Graham Hopkins; Dept. of Housing, Homelessness Policy, Funding and Delivery Section
Tony O'Donovan; Principal Officer, DCEDIY., Child Welfare Advisor, Children Detention Unit
Secretariat – John Dunphy & Yvonne Phillips, Dept. of Justice, Penal and Policing Policy

Apologies:
Ben Ryan; Assistant Secretary, Dept. of Justice, Head of Criminal Justice Policy

Minute:

1. Chair welcomed group, thanked for materials submitted.
2. Minutes:
    a. Detailed minutes and comprehensive. No comment received. Chair informed group that future minutes, will cut minutes. Matter arising meeting HNA work chair is complete to brief either group John Devlin.
3. Recommendations.
    a. Discussion was had on the recommendations update table with a view of using the results in establishing the subgroups. Diversion release housing and CMH capacity. Submission received from Mark on through care, and how.

b. MW considering how people are cared as they reenter community, and how supports tie together. How we can work with partners to address certain matters. How to identify and how to stream individuals. Community aspect is very complex.
    i. Chair that is one of the subgroups in the future and one of the groups that will be most active and hope MW will be part of it. MW, happy to be.

c. Chair mentioned paper from Prof Kennedy's draft submission, and that it will likely be a subgroup on this. PK, very much in draft form, focus on model of care, and suggests taking same approach on mental health broadly and defining goals.
    i. JD-IPS very interested in that role. Synergies will be needed

- CD subgroups way to go. Some dealt with STV and review of MHA. Model of care presupposes structure and resources that exist to serve that, defer to HSE, but make sure we don't commit ourselves to something we can't deal with, with our resources.
- Chair; vitally important that a model of care be developed notwithstanding that there may be roadblocks on the way.
- EK; agree with MW and PH, EK important to remember that a lot of people will come into prison but will not need to go to CMH forensic services, so diversion is absolutely important. Prevent people getting into system.
- DW; clarify we haven't shared
- Keenan HSE; echo Enda, diversion, learning to be had from the model for diversion being developed between HSE and AGS on drugs for personal use. Related person with addiction issues can get diverted and this group could learn from addiction.
- PH; a subgroup on diversion necessary adult cautions for certain things eg drugs, could look at other work on ASPFF also, AGS central on that subgroup yes.
- MW; probation supervision, a lot of them have, opportunity to prevent someone getting a prison sentence later.
- JR; diversion and MH, in services I'm involved in are secondary services, diverting people who have a mental illness that are associated with mental distress, need to make sure that we have the right door. Mental illness. Mental distress. Need to avoid duplication. Within STV there is a subgroup on capacity for acute mental health services. Might need to reflect on this avoid duplication. Or worse looking for the same information two or three times. Need to be cognizant of that. – Chair subgroups shouldn't be seen as in isolation will work with other groups information sharing connectivity in terms of services that someone in prison doesn't end up outside the door.
- MM; will need to discuss whole table, to absorb table due to technical difficulties, on roles etc.
- Pat; subgroups need to work together, should get us to a point. List of subgroups are core to the next step forward.
- Chair; hope for face to face meeting how we will put this plan together.
- KL; how many people in prison need treatment, what treatment is needed, mild severe.
    - Need on mental health observations
- JD; re need to avoid duplication, value of subgroups is opportunity to take brass tax, re Colm
- PK; can tell you exactly how many people are on waiting lists, in treatment but this is of course for people with severe mental health issues. But there is a wide meaning of mental health.

Model of care good for specifics on specific things, but if you broaden it out, then it becomes something else altogether.

- Chair: PHK; substance misuse. Less visitors in prisons during Covid meant less drugs in prison. Less morbidities in prisons. Will this come back after. MHA and other leg very focused on mental illness.
- JDIPS; any model of care is dependent on the system it operates at. All prisoners undergo examination mental health and addiction. Sometimes prisoners refuse treatment. Offer visit to subgroup/ or group to prison to see how it works.
- JR; wondering capacity, CMH issue of capacity of SMH is pretty well understood, issue is pathway in and pathway out. Not as much to be done with CMH capacity. Diversion may be of more value. JR issue that prisoners don't have to take medication is a problem. Need to look at. Big difference in terms of diversion. Very limited capacity in open units, this is exacerbated with – Chair assume leg will deal with that.
- Chair: when we talk about mental health capacity, it can't be only about that one building no? Through put seems an issue.
    - PHK; difficulty is, if we detain someone via Section 5 or section 22A. New Portrane hospital will take about 150, about half can receive some care in high support community service. Some will have legal requirements for longer term care. Some people need long term care for decades, you might have 150 a year, but if five stay every year it takes only about 5 years before you lose your capacity to admit. Know how to solve this, but there is element of denial/ Can we prevent it, lots of stuff in the community, can we resolve it through strong community service. Prevention does not work, planning for the need, before the whole service seizes up again.
- EndaK; about treatment, where it happens and how. In prison cannot enforce compulsory treatment in prison, questions about this. Part of work for subgroup. Preventing need to escalate further.
- CD; re PHK talking about individuals ICRU thinking on going on about regional basis, one up. There is a subgroup being set up under STV, on mental health services generally not specifically on CMH. Becoming more persuaded by CMH model of care, need to separate out the pathways from those trapped in a cycle and those with very acute mental health issues.
- Chair need to
- JR; diversion takes capacity, but it is not CMH capacity. Those in prison on remand, that could be diverted. Cloverhill small number high need, causes difficulty.

Clear subgroups way forward, discussion in meet in one room. Slight disagreements. All agreed subgroups are the way to go. Things will emerge as those subgroups meet. Secretariat will contact people in terms of how the subgroups will be set up.

- Deborah, conversation very illuminating. Mindful of issues of resources, model of care aspects allay concerns perhaps we could workshop three types of subgroups. Workshop Harry's idea. Diversion, conscious of the need to avoid duplication AGS, who ever. Agree in principle on

middle piece a model care/CMH capacity over arch theme model of care. Set up an terms of reference.

- PHK; original suggestion of subgroups was to the point. Model of care is at intersection of all. My suggestion model of care is way to bring it all together.
- CD; agree with PHK, model of care is ideal state. Focus on diversion and step down/after care. Workshops to do some thinking with different groups would be very helpful.
- Mark, see your group as being more for after care (albeit with elements of diversion.
- Agree with DW on subgroups steps forward.
- MM; flagging one issue HSE re-organised services including for MH. May have impact, need to consider. If necessary can bring experts from organisation with more relevant information.
- 1. Diversion, 2. Release/aftercare. 3. Model of care/service/
- CD; re legislation; love to have a subgroups that looks at the legislative piece.
- Chair; leg piece very important, need to have a very strong hard look at voluntary involuntary treatment, right to refuse medical care. Further discussion.
- JDIPS; see legislation following the recommendations that follow. Link with other countries. Worth considering. For secretariat to look up.
- AGS; leg, supportive of that, and the fourth working group. Identified some issues that a re challenge.
- JDIPS;
- support what John was saying there Dutch have in recent years have overhauled. One of large prisons, three times our population, equivalent to ours, proper hospitals within prison, and interact with. Experience with other. Mental Health Act is ineffective in B Ontario, and it has damaged care.

Communications:

-DW standing items on agenda. Highlight contact by Deputy JCMcN all party penal reform Oireachtas group working with HLRG. Secretariat will be joining meeting. Couple of PQs looking for update on .

- Date of next meeting. I think that we allow some time suggesting next meeting the week of 14 June. If that is not agreeable, you might come back. Interim report from subgroups might be a good venue.

- JR; concern about capacity to engage due to technical issues. Capacity, slight caveat.

- CD; that's four weeks no problem with meeting but the timelines is very demanding. Could be optimistic to have meet.

- MW; agree membership of the subgroups should be ready for agreement.

- Back

Actions:

Kick back from Health.

Kick off workshops.

Mark Wilson. Look at his availability who does he want to reach out to. Kathleen at it?

1. IDG and report