High Level Taskforce on Mental Health and Addiction challenges of Persons interacting with the Criminal Justice System

Subgroup 2: Irish Prison Service and CMH Capacity

Tuesday 22 June 2021

15:00 – 16:30 via Video Conference

Minute:

Agenda:

1. Welcome from Chair
2. Matters arising
3. Scope of NFMHS (capacity, activity trends)
4. Clinical care pathways
5. Consultation
6. AOB and Date of next meeting

Attendees:

- **Chair** - John Devlin, Clinical Director, Irish Prison Service
- Prof. Harry Kennedy; Executive Clinical Director, Central Mental Hospital
- Colm Desmond; Assistant Secretary, Dept. of Health, Corporate Legislation, Mental Health, Drugs Policy and Food Safety Division
- Michael Murchan; Assistant Principal Officer, Dept. of Health, Mental Health Unit
- Ben Ryan, Dept. of Justice, Assistant Secretary, Criminal Justice Policy
- Deborah White, Dept. of Justice, Principal Officer, Penal and Policing Policy
- Enda Kelly; National Nurse Manager, Irish Prison Service
- **Secretariat** – John Dunphy, Yvonne Phillips Dept. of Justice, Penal and Policing Policy

Apologies:

- Patrick Bergin, Head of Service, Forensic Mental Health Service, HSE

Minute:

1. **Welcome from Chair:**
   1.1. The minutes of the previous meeting were approved without change.
2. **Matters Arising:**
   2.1. The Chair informed the members that he had raised the issue of consultation with the HLTF Chair, further discussion will happen at plenary.
   2.2. It was said that international research would come towards the end of the work of the subgroup.
3. **Scope of NFMHS (capacity, activity trends)**
   3.1. A discussion was held on scope. It was said that the wording here should be broader, as it also includes prisoners' needs, beyond patients and those specifically in the NFMHS.

3.2. The Chair updated the group regarding the ongoing Health Needs Assessment within the IPS. This almost complete, the organisation completing the HNA have said they will be available to present this to the subgroup.

3.3. The Chair acknowledged the documents provided by the CMH which were said to provide a good idea of scope that there is, activity levels overtime, referrals from prison, trends, duration of stay.

3.4. A discussion was held on establishing 'as-is' situation. It was said that this is relevant to understanding the scope involved. It was agreed that information on the numbers involved and challenging areas was required, and would show in theory what prevents individuals from accessing the required care at CMH or elsewhere in the system.

3.5. It was agreed that there was a lot of data in the HSE reports shared by the CMH. It was said that there may be additional useful data held by the IPS, including on numbers involved in special observation. It was said that in-reach treatment and associated waiting lists are managed by the CMH.

3.6. It was agreed that there would be value in developing a document which illustrated the as is situation, highlighting numbers, any bottle necks. The Secretariat agreed to discuss this within the Department to see what assistance can be provided in this regard.

4. Clinical care pathways

4.1. It was said that the new CMH at Portrane would not be a panacea, there is a need to consider the requirement for slow stream beds, long term medium security beds. It was said that without adequate provision of this form of bed the additional capacity represented by Portrane would be exhausted over time.

4.2. A discussion was held about the in reach capacity and whether this support had been utilized to the maximum. It was a said that this capacity was fully and perhaps over utilized, with several thousand prisoners being dealt with by a small number of clinicians and support staff. It was said that the ratios (forensic specialist beds/population) in Ireland were significantly less than in other comparable jurisdictions.

4.3. It was said that service strain is the key to understanding whether capacity was sufficient. Internationally the most widely accepted and relevant metric of service strain is the number of individuals in prison on waiting lists for mental health care.

4.4. It was said that capacity of open stepdown in the community is also at capacity. It was said that long term dynamic care in medium security setting is required, and that the HSE documents relating to Portrane also acknowledge this requirement.

4.5. A discussion was held on the care pathways that are proposed and view on whether there are other areas that people can be discharged to.

4.6. It was said that care pathways stratification is in line with international standards however perceptions of differing levels of care/care requirements can be misleading as there is a requirement to recognise dynamic nature of care needs, and that even for lower care needs this can involve intensive pharmalogical and psychological care, as well as intensive nursing care.

4.7. It was said that working with small units can create difficulties, leaving vacancies in one unit while underserving other units. It was said that seamless movement between care is easier with an average 80% occupancy but that this is not a realistic level of occupancy in our system which is oversubscribed.

4.8. A discussion was held on the outflows from care with a question asked that if the expectation is that there would be 60 entrants to care annually is it the case that there would 60 leaving care during this period. It was explained that this would not be the case, that a certain portion of individuals will not be discharged in time to allow for an exact match between referrals and discharge. It was said that even if this number is very low, it will build up relatively quickly overtime creating backlog. It was also said that some individuals will require care for much longer than average and these individuals require proper supervision, to not do so will create serious capacity issues.

4.9. A question was asked about whether staff can follow the need and can be moved from underutilized units to areas of particular need. It was said that this is possible but it is important to recognise that each form of care has specific training needs and that a lack of training is dangerous.

4.10. A discussion was held on what the system looks like when well done. Positive examples were mentioned as being at Zeeland in the Netherlands. It was said that there were excellent examples in UK. The wardship model was said to be well done but that it was extremely expensive, this involves individuals residing alone in rural settings with extensive care provision. It was said that capacity for this may be maxed out and that similar results could be achieved more efficiently in more collectible settings.

4.11. It was said that the original plan for Portrane involved a second phase involving three ICRU units nationally. It was said that this plan was interrupted and the plan for the three national ICRUs was not confirmed. It was said that an alternative plan to establish an ICRU alongside Portrane was agreed and funded. It was said that to renew the second phase for the other ICRUs would depend on future funding for the HSE capital budget, and would take at least 4 to 5 years to implement if approval was given to go ahead with the ICRUs and the bed capacity review under *Sharing the Vision*.

4.12. It was said that ICRUs provide acute and sub-acute care in the short to medium term but do not provide longer term care. The Director CMH said that it is critical that there a recognition of the need for medium to longer term care for discharged prisoners in particular. It was said that failure to adequately provide this long to medium term care will cause problems and could lead to dangerous results. It was agreed that there was a degree of crossover with the work of HLTF Subgroup 3 which is focused on community issues including through care from detention. Dept Health noted the view of the Director CMH but pointed to the priority implementation of the ICRU model to support *Sharing the Vision* in the first instance.

5. Consultation

5.1. The Chair noted that there would be further discussion on consultation at plenary.

6. AOB and Date of next meeting

6.1. No date for the next meeting was specified, it was agreed to hold meetings every two to three weeks.

6.2. Discussions between the Chair and secretariat are required before the next meeting will be scheduled.

Actions:

1. Members to review material provided by CMH and model of care pathways.
2. Secretariat to discuss within Department of Justice capacity to develop an as is document.

3. Secretariat to arrange and issue invitations for the next meeting of the subgroup.