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

Thursday 15 July 2021

09:00-10:30 via Video Conference

Minute:

Agenda:

1. Minutes
2. Matters arising
3. Consultation
4. Process map – scope of current NFMHS/IPS service
5. Care pathway
6. HNA
7. AOB

Attendees:

- **Chair** - John Devlin, Clinical Director, Irish Prison Service
- Prof. Harry Kennedy; Executive Clinical Director, Central Mental Hospital
- 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
- Patrick Bergin, Head of Service, Forensic Mental Health Service, HSE
- Dr Narayanan Subramanian, Consultant General Adult Psychiatrist & HSE National Clinical Lead in Dual Diagnosis, HSE
- **Secretariat** – John Dunphy, Yvonne Phillips Dept. of Justice, Penal and Policing Policy

Apologies:

- Seamus Hempenstall; Principal Officer, Dept. of Health, Mental Health Unit

Minute:

1. Welcome from Chair:

1.1. The minutes of the previous meeting were approved without change.

1.2. The chair welcomed the new member Dr Narayanan there was a tour de table of introductions.

1.3. Introduced agenda, main task looking at process map, second main task plan appropriate models of care. Hoping to get a good understanding of the challenges being faced today with the process map good understanding of what those processes look like and quantify these.

APPROVED

1.4. Circulated basic process map yesterday, first attempt to describe how people move through the system. Need to be clear what the steps are.

2. Matters Arising:

2.1. Chairs of SG's met with the plenary chair and agreed to have a form of a process map to present at the next plenary meeting.
2.2. HNA to also be presented into the plenary group.

3. Consultation

3.1. Secretariat outlined a plan for consultation through plenary late September - seminar type event. Plenary Chair will consult with named stakeholders in advance i.e. IPRT invited to present at plenary, plan to invite IoP and MHC to meet (DoH to arrange MHC meeting).
3.2. Other suggestions: Mental Health Reform, College of Psychiatrists, IHREC, Courts Service, any of the ombudsman's offices, Irish Advocacy Network (lived experiences).
3.3. The CPT was discussed, as they take a more inspectorate role, and issue policy reports, it was suggested to collate these recommendations rather than consult.
3.4. It is envisaged the subgroup will consult on international experience.

4. Process map – scope of current NFMHS/IPS service

4.1. Basic outline of map circulated with need more details, figures etc.
4.2. The 3 key areas that need to be tackled are:
Flow of persons not guilty by reason of insanity (NGRI). There may be a need for law reform.
Long term capacity in the CMH.
Step down in prison.
4.3. IPS outlined the draft map - approx. 25 on waiting list for CMH, most won't get there, sentence expires before they are accepted into CMH causes serious problems with linking into services.
4.4. 250 requiring care but not admission to CMH, need things like PICU, community places. Huge number of people in prisons within prisons with mental health problems, rely on NFMHS but acceptance that these individuals may require additional treatment. Main problem that the system is always at capacity.
4.5. The 250 cases in prison are equivalent of the community caseload (they are not on a waiting list). This is a cohort that also needs to be addressed. They may require additional care.. Main capacity issue is that beds been filled with long term care people who can't leave the CMH. Step down care needed for those who can leave and/or return to the prison. Concern regarding the rise in NGRI need to look at how the law on NGRI is working at the moment.
4.6. What data is available on the level of mental health and addiction comorbidities, could these take a different care pathway.
4.7. This discussion was very helpful and are seeing there may be alternative pathways other than prison and CMH.
4.8. The IPS on dual diagnosis, do not want people with drug induced psychosis being directed into the CMH, it is not the aim, want them to get to them to the appropriate care possible in prison. Separate issue of how you maintain a drug free environment in prisons. Focus of this is people with major mental health problems who need access to CMH.

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4.9. Regarding the 250, are there other pathways? Depends on what is wanted. Problem with legal interpretation of NRGI. Only have diminished responsibility for murder but may not involve a mental care pathway.

4.10. DoH see two broad categories, medium and long term recommendations, changes to legislation any proposals to build new infrastructure over 3/5 years. And also need to focus on system we have and can we do things differently in the short term over 1/2 yrs.

5. Care pathway

5.1. CMH presented on the processing of patients through the system against the circulated flow chart displayed. 60 admissions a year. 45 people in three months ready to move on. 15 persons won't be ready. This causes the system to silt up over time. After 2010 CLIA we had increase in admissions to 10 new entrants each year. 10 per annum going into a pool of beds of 30 beds, the sustainable length of stay is that they must go somewhere after three years. This doesn't happen in reality so it is leading to silt. ICRU not a long term care facility. Will silt up the same.

5.2. It was agreed the need to allow admissions get people into care, get them treated and returned to prison. There is another piece for the map, those who don't need the high secure level of treatment.

5.3. Discussion will be had between CMH and IPS re employment of mathematical modellers. IPS will progress this.

5.4. Prioritisation of sustainable lengths of stay. Comparison Priority to ICU bed movements.

5.5. Are the patients coming from the judicial system the ones that need long term care? They are in the large part of civil patients.

6. HNA

6.1. Not finalised but identified: issues of CMH capacity, homeless prisoners, good process in CMH diversions from court into community settings, is there is a case for community CPNs to garda stations so that when they come to court could they use this up straight, need for formal risk assessment for all prisoners, services across the estate is not uniform, with different set ups in different prisons.

6.2. Asked if the HNA covered choice, or engagement with services? Not just about availability, but also uptake, choice decision of prisoner to take up care**.**

7. AOB and Date of next meeting

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

<u>Actions:</u>

1. CMH to provide Dr N.S with data available.
2. Discussion will be had between CMH and IPS re employment of mathematical modellers. IPS will progress this and report to next meeting of the Group.
3. Discussions between the Chair, CMH and secretariat will be had re narrative of process before the next meeting will be scheduled.
4. Secretariat to arrange and issue invitations for the next meeting of the subgroup.

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