IRISH PENAL REFORM TRUST LTD
Iontaobhas Éireannach Teo Um Leasú Pianúil

Out of Mind, Out of Sight

Solitary Confinement of Mentally Ill Prisoners

By Dr Valerie Bresnihan

A Report from the Irish Penal Reform Trust
April 2001

IPRT
Dominick Court
41 Lower Dominick St
Dublin 1
Ireland
Tel: 01 872 0344
Fax: 01 872 0399
e-mail: info@penal-reform.ie
www.penal-reform.ie

Table of Contents

OUT OF MIND, OUT OF SIGHT 1

Introduction 3
Solitary confinement: 3
The inhumanity of strip cells 4

IPRT Summary Findings 5

IPRT Summary Recommendations 6

IPRT Report: 7
What type of individual ends up in a padded cell? 7
The facts about solitary confinement and the mentally ill 8
Reasons for detention 8
IPRT comment 13
Anecdotal evidence 13
Are there consequences for the prison staff? 13
IPRT comment 14

IPRT Solutions To The Problem Of Medical Human Rights 15
Inside prisons 15
Observation wards 16
Basic code of practice 16
A radical overall of the prison health system 16
In-service Clinics 17
Pre-release Re-Integration Programme 18

Conclusions 19

COMMUNITY SOLUTIONS TO THE CRIMINALISATION OF THE MENTALLY ILL IN IRELAND 1

IPRT Summary Recommendations 2

Introduction 3

The Court Co-ordinated Resources Project 4

Jail Alternative Service (JAS) 5

Do mental health courts and the CCRP (JAS) programmes work? 5

Health Warning notice! 5

Endnotes 6

Introduction

This IPRT report reveals that mentally ill prisoners are put into solitary confinement (strip cells) as a substitute for appropriate treatment.
But first, a few words on solitary confinement and strip cells.

Solitary confinement:

During the early days of space travel, it was normal to put trainees into isolation chambers to see how long they would last. They were on their own in silence, without any means of knowing the time. Many men cracked. One cosmonaut, Andrian Nikolayev, lasted the longest. He spent 4 days in the isolation chamber and he was then called 'The iron man'. An important difference between the solitary confinement of prisoners and the isolation chamber is that the trainee in the isolation chamber could press the buzzer and come out at any time. Neither, obviously, was any trainee mentally ill.

IPRT is particularly concerned with mentally ill/disturbed prisoners who are put in solitary confinement for a lot longer than Andrian Nikolayev. Not only are mentally ill prisoners not receiving proper treatment but being locked up for 23-24 hours a day for any significant period can cause a very specific kind of psychiatric syndrome. Dr Stuart Grassian, psychiatrist, member of Harvard Medical School faculty and an expert in the area of solitary confinement says,[i]

> *the restriction[s] of environmental stimulation and [the] social isolation associated with confinement in solitary are strikingly toxic to mental functioning … the harm caused by such confinement may result in prolonged or permanent psychiatric disability, including impairments which may seriously reduce the inmates capacity to reintegrate into the broader community upon release from prisons*

In a separate interview Grassian pointed out,

> *The [US] courts have recognised that solitary confinement itself can cause a very specific kind of psychiatric syndrome often involving random violence and self mutilation, suicidal behaviour, a lot of real agitated, fearful and confusional kind of symptoms'*[ii]

Dr Stuart Grassian, also says that the most shocking thing is that those who end up in padded cells

> *all tend to be ill in very similar kinds of ways and they are so frightened of what was happening to them that they do not exaggerate their illness. They tend to minimize it, to deny it. They are scared of it.*[iii]

IPRT believes that the prison system tends to respond to the disruptive behaviour of mentally ill prisoners with further punishment. But the punishment often makes things worse and people tend to get into vicious cycles of disruptive behaviour and punishment.

The inhumanity of strip cells

A strip cell (known also as padded or isolation cell) is a place of solitary confinement. It is an empty cell -furnished only with a thin mattress on the ground and a blanket. In Irish prisons a few of these cells have walls that are padded in order to protect the prisoner from self-damage, others do not. The latter cells are called strip cells, i.e. the walls are usually concrete and thus potentially dangerous. A few cells within the Irish prison system do not even have a call-button. IPRT found that in one prison mentally ill prisoners have to 'shout through the heating vent to their mates who then call an officer'. In another IPRT was told that a prisoner would 'have to hammer on the door' if he wanted help etc. In one prison new, very hard but easy washable material covered the walls. It appears that ease of washability was given priority over softer and more protective wall material because mentally ill prisons can defecate the cells. The windows are always sealed, thus the cells are inevitably stuffy. Many of the padded cells are dark and dank. If there is a slopping out buckets in the cell it is very smelly. In the words of an expert who examined one prison on behalf of IPRT these cells are 'dreary smelly single cells'. While in a strip cell a prisoner is allowed to wear only underpants or night dress. No books, radio or any personal belongings are ever permitted. People in strip cells are usually locked up for 23 hours a day. Though prison rules state that every prisoner must be allowed out to exercise for one hour a day this rarely seems to happen. This means that some prisoners will be locked up for 24 hours a day. Prison rules also state that a doctor must see each strip cell occupant daily. At least some of these visits appear to be somewhat cursory.

In theory the rules about solitary confinement to the above type of cell is strict. Rule 78 of the Rules for the Government of Prisons (Department of Justice, 1947) states: "The Governor may order any refractory or violent prisoner or prisoner of suicidal tendencies to be temporarily confined in a special padded cell, but a prisoner shall not be confined in such a cell as a punishment nor for a longer period than is absolutely necessary." Reality, as shown in fig. 1 and 2 and tables 1 and 2 tell a different story.

Standards of treatment of the mentally ill prisoner

'No-one shall be subjected to torture or to cruel, inhuman or degrading treatment'.

This is a basic human right enshrined in United Nations Universal Declaration of Human Rights (Article 5) that Ireland has signed but not implemented. So far we have not ratified the Covenant against Torture, Degrading and Inhumane Treatment (CAT). This means that Ireland can avoid its international AND LEGAL obligations to adhere to basic human rights standards. The government's delay in ratifying CAT is inexcusable. The use of solitary confinement as a way of dealing with mentally ill prisoners is totally rejected by the IPRT.

IPRT Summary Findings

This IPRT Report examined 224 entries into strip cells - places of solitary confinement - in 3 Irish prisons. IPRT found that:

- solitary confinement (strip cells) is used as a regular substitute for medical care.
- 78% of prisoners put into strip cells were found to be mentally ill (Fig 1, p 9).
- some mentally ill prisoners are *repeatedly* put into strip cells. For example one person spent 25 out of 30 days in solitary confinement (Table 2).
- the longest stay in a strip cell at any one given time was 18 days (p 11).
- solitary confinement makes sick people sicker. Yet even those who are certified insane are put in strip cells (Table 1, p 11)).
- some prisoners are kept naked while in solitary confinement (p 13)
- some cells have no call button; prisoners have no means to call for help and
- some cells have slopping out buckets (p 4).
- IPRT believe these figures to be conservative: 40% of entry/exit dates to and from these strip cells are missing (p 10)).
- reliable sources have witnessed mentally ill prisoners eating paint off walls and defecating in strip cells (pp 4 & 11)

IPRT Summary Recommendations

IPRT calls for the:

- immediate ratification of the United Nations *Covenant against Torture, Degrading and Inhumane Treatment* (CAT)

- immediate implementation of all recommendations from the *European Committee for the Prevention of Torture* (CPT)

- radical overhaul of the entire prison health system including

    - immediate setting up of suitable in-service psychiatric clinics, at least three appropriately placed geographically

    - immediate replacement of the use of strip cells for mentally ill and suicidal prisoners by well-lit observation wards

- full time inspector of prisons

- an ombudsman for prisoners

- consideration of the idea of mental health courts (see policy paper no 2)

IPRT Report:

The abysmal failure to build adequate and appropriate community psychiatric and psychological services for mentally ill and unwell people has resulted in mental illness becoming hugely criminalised in this country. People who urgently need medical attention go unnoticed in society and are left unattended for years on end. Many become homeless. Some commit suicide. Many become lawless and end up in prison. The Irish Penal Reform Trust estimates that almost 40% of the prison population may be suffering from some level of psychiatric or psychological illness or disturbances. The mentally ill prisoner should be treated in an appropriately secure psychiatric/psychological setting. The prison environment is detrimental to their mental health. As currently structured, prisons do not allow for adequate observation, medical or otherwise, of mentally ill prisoners. Many are locked up for as long as 23 hours a day in solitary confinement in strip cells.

The internationally respected psychiatrist Professor Anthony Clare of St Patrick's Hospital, Dublin stated,

> *the mentally ill are now the most systematically stigmatised group in our society. They …are the true lepers of today*[iv]*.*

This stigmatisation, combined with the lack of appropriate care while in detention, means that mentally ill prisoners are the most discriminated against in Irish society. Their human rights are denied on an ongoing basis – by the state.

John Gunn, Professor of Forensic Psychiatry at the Institute of Psychiatry, London, writes,

> *Not only do prisons generate psychiatric problems but they also collect them inappropriately and act as unofficial mental hospitals for individuals who should be in health care.*[v]

That observation summarises the challenge facing the Irish Government in relation to their failure to recognise and respect the human rights of mentally ill prisoners.

What type of individual ends up in a padded cell?

Prison records (summarised below) clearly show that those who end up in solitary confinement in padded cells are not ruthless offenders. This is because the most ruthless of prisoners are usually the most calculating. They tend not to commit the kinds of infractions that would result in them being confined to padded/strip cells.

In reality, the people who end up in padded/strip cells are there as a result of impulsive or chaotic types of behaviour. They may have some type of psychiatric disturbance such as attention deficit disorder, mood instability or affective instability. In short, most people who end up in padded cells are mentally ill,

illiterate or cognitively impaired - people who at times cannot manage to contain their behaviour. This view is supported both by research and by the governors and relevant staff interviewed by IPRT for this project. The most common comment went like this: 'most prisoners who are in these cells are really very depressed' or 'they ought not to be in prison in the first place'.

The facts about solitary confinement and the mentally ill

IPRT visited three prisons, Mountjoy, Cork and Limerick between 20th February - 20 March 2001. IPRT wishes to sincerely thank the Governors and staff of all three prisons for their co-operation. IPRT would also like to acknowledge that in all three prisons individual efforts by staff to act consistently in a humane way to those mentally ill was more than evident. Our criticisms here are of the prison *system* and in particular, the lack of political will to demonstrate humanity.

In total 224 official entries into strip cells were examined. Although the dates of entry ranged from November 1999 to March 2001, the majority of recorded entries fall in the later half of the above time period. The last date of entry recorded was March 6th 2001. The data was used with two main purposes in mind. Firstly, to establish a link between use of strip cells and mentally illness. Secondly, to highlight the inexcusable length of time certain prisoners are detained in these cells, the majority of whom are can be generally defined as having mental health problems. This report concentrates on those reasons for entry that are explicitly psychiatrically/pscyhologically sourced only.

Reasons for detention

It is recognised that the data available citing the 'reasons' for the detention of an individual in a padded/strip cell, firstly, is not comprehensive, (rarely does the 'reason' cited exceed a few words) and secondly, is reliant on the subjective opinion of prison staff. However despite this, it does allow us to determine the general reason or reasons for detention and, in most cases, a distinction can be made between prisoners with mental health problems and those without (Fig. 1). For example, it is clear that a prisoner detained for reasons such as 'suicidal' or 'self-inflicted wound' can be classified as having problems related to mental health (Tables 1& 2). IPRT conclude that the information available goes a long way toward establishing a relationship between the use of padded cells and the mentally ill.

Figure 1 highlights the reasons for detention in strip cells. 78% of those detained in a strip cell suffer from some form of mental illness/disturbance (actual categories of mental illness: tables 1 & 2). 5% are put into strip cells for substance related (drugs usually) reasons, 13%are put in for punishment reasons and 4% for reasons that do not fall into categories above.

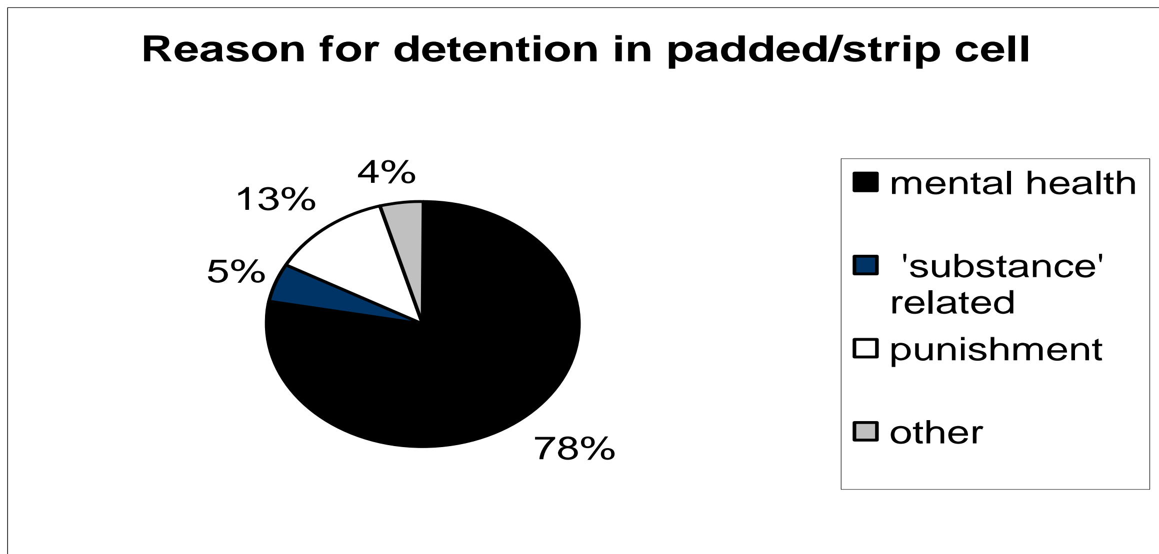

Figure 1: 1) Percentages are based on the 224 entries.
2) 'Mental Health' category includes all those who can be generally defined as having mental health problems, it ranges from those who are 'depressed' to those 'certified insane'. Regarding reasons such as 'own request'. it has been pointed out by all three governors that in almost all cases they refer to a mental health problems. While it is acknowledged that this may cause some overstatement in this category, if more specific records were available it is unlikely that the result would deviate to any substantial degree to the figures shown here. Again a more comprehensive categorisation and recording system would be useful here.
3) Other' includes missing data and reasons that do not fall into categories above.

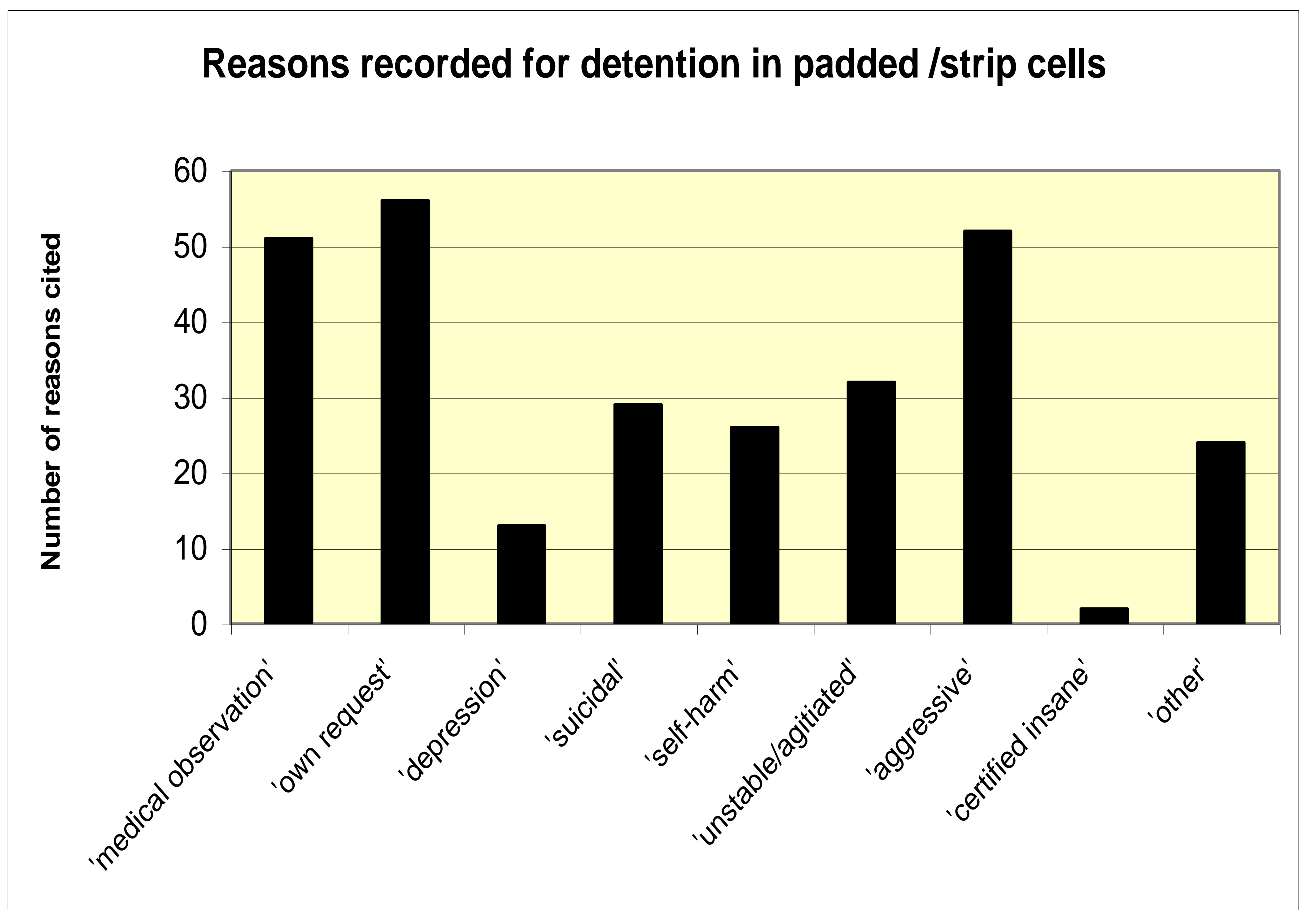

Figure 2 highlights the recorded reasons for entry into strip cells. This table also provides the number of times these reasons were cited.

1) Where prisoners were confined in padded cells for multiple reasons e.g. “highly agitated, unstable acting aggressively toward staff”, each reason was entered separately on the table.
2) The reasons cited are the subjective view of the prison officer, there is a personal style to the explanations given. Officers variously use the words ‘erratic behaviour’, ‘agitated’ and ‘unstable’. Similar reasons have been grouped together.
3) It is useful to note that for many individuals there are more than one reason for detention cited. Where reasons for detention include ‘own request’ and/or ‘aggressive’ these words were usually coupled with other reasons such as ‘depression’, ‘self- harm’ etc. For example ‘own request, depression’ or ‘unstable and agitated, assault on ….’ are examples of frequent reasons cited.

IPRT has quoted fully all the recorded reasons for entry into padded/strip cells. We have categorised the reasons for entry into padded/strip, and since some of the entries have multiple reasons, the number of reasons given will exceed the number of actual entries. It is important to note two things: firstly, that all three governors in the above prisons believe that many of the mentally ill people in prison ‘*should not be in prison in the first place*.’ Secondly, all three governors believe that *the majority of those who go to the padded cell ‘at their own request’ are actually suffering from various forms of depression.*

Approximately 78% of entry into padded/strip/isolation cells are clearly associated at some level with psychiatric/psychological disturbance. To use these cells as a substitute for appropriate medical and para-medical services is scandalous. Most of all is an absolute denial of human rights. IPRT concurs with Dr Smith of the Central Mental Hospital for the Criminally Insane, who has said that the gross overuse of padded cells for psychiatric disability ‘is a grotesque way of storing a human being’ [vi]

Table 1 (p. 11) provides the number of consecutive days spent in strip cells that are over 4 days duration. IPRT believes that, at the very least, these stays are damaging to the mental health of prisoners. The longest stay recorded at any one time was 18 days. Table 2, however, shows that some mentally ill prisoners are repeatedly put into strip cells. The longest of repeat entries recorded was 25 days out of 30 days (prisoner F). This is a conservative estimate because on two occasions prisoner F, for example, left the strip cell without his exit being recorded. The second longest stay was that of prisoner J: 21 days out of 33.

Table 1: THE LONGEST NUMBERS OF DAYS IN A STRIP CELL

	DAYS	REASON GIVEN	IPRT COMMENT
Prisoner A	18	own request	This term is used when a prisoner asks due to depression
Prisoner B	15	no reason given	
Prisoner C	14	highly agitated violent behaviour	
Prisoner D	12	unstable, aggressive toward staff	
Prisoner E	12	certified insane	
Prisoner F	12	Depression, self-mutilation	This prisoner spent a total of 25 days out of 30 in a padded cell (Table 2)
Prisoner G	11	distressed state, for observation	
Prisoner H	10	own request	
Prisoner I	8	Rule 78 (breaking prison rules)	
Prisoner J	7	medical observation	This prisoner spent a minimum of 20 days out of 33 in a strip cell. The records are not complete therefore only the minimum can be calculated. (Table 2)
Prisoner K	7	own safety	
Prisoner L	7	refusing to comply with rules and regulations	
Prisoner M	7	unstable	This prisoner was certified insane on the 7th day and moved to a 'special cell'. It is likely that the 'special cell' was another type of padded/strip cell.
Prisoner N	6	self-mutilation	
Prisoner O	6	unknown	
Prisoner P	5	self-inflicted wounds	
Prisoner Q	5	For observation, drug intake.	
Prisoner R	4	assault staff, violent behaviour, medical observation	

Of the 224 recorded entries, which include repeat entries (one individual for example was recorded on seven separate occasions - Table 2) 86 or nearly 40% had either *missing* entry or exit dates. One prison, in particular, had relatively few recorded dates of exit from cells. This makes it impossible to determine the

actual length of time these individuals had spent in the strip cell. IPRT spoke very briefly to one extremely unwell prisoner in a padded cell but noted that his name was *not* recorded in the official entry book also. IPRT believes therefore that the findings to be a very conservative estimate of how long some prisoners stay in solitary confinement. Of the records available the length of time that many individuals spend in strip cells is damming indictment of the use of strip cells both for mental ill and other prisoners. The incomplete nature of the records only serves to demonstrate the lack of thought given to this issue. It suggests that no proper procedure regarding the use of strip cells is in operation.

Table 2: REPEAT DETENTION IN A STRIP CELL

	DAYS	REASON GIVEN	IPRT COMMENT
Prisoner F	**12**	**Depression, self-mutilation**	**This prisoner spent**
Prisoner F	7	self-harm	
Prisoner F	unknown	own request, agitated	**25 out of a 30 day**
Prisoner F	unknown	own request	
Prisoner F	2	own request, had glass in mouth	**period in a strip cell**
Prisoner F	2	own safety, suicidal	
Prisoner F	2	self-harm	
Prisoner I	**8**	**Rule 78**	
Prisoner I	3	Rule 78	**16 days**
Prisoner I	2	Medical	
Prisoner I	2	Medical	
Prisoner I	unknown	Rule 78	
Prisoner J	**7**	**medical observation**	**This prisoner spent a minimum of 20 days out of 33 in a strip cell. Note: prisoner was transferred to Dundrum Hospital.**
Prisoner J	6	medical observation	
Prisoner J	unknown	medical observation	
Prisoner J	7	medical observation *(to Hospital for the Criminally Insane)*	
Prisoner O	**6**	**unknown**	**8 days**
Prisoner O	2	suicidal	
Prisoner S	**3**	**Medical observation**	**7 days**
Prisoner S	2	Medical observation	
Prisoner S	2	Rule 78/ Very Violent	

Table 2 gives an indication of repeat detentions. Although the entry/exit dates are not given below it was found that frequently less than a week might pass before repeat detention occurred. It is clear that many of the prisoners cited in both Table 1 and Table 2, those who spent inhumane periods of time or were detained repeatedly in the padded cell, suffer from mental health problems.

IPRT comment

The majority of stays in padded cells were 1-3 days. Table 1, however, lists stays of 4 days or longer, with an accompanying comment[vii]. Putting sick people in padded/strip cells only serves to make them sicker. Bearing in mind that there may be up to almost 40% of people in prison who need support and treatment we find it an abomination that the Irish state is facilitating the possibility that prisoners may well be leaving prison in a worse condition that when the entered. If this is true then our prison system must inevitably be both facilitating the denial of human rights and helping to increase crime.

Anecdotal evidence

These facts and figures from the official records of the prison are of serious concern. Anecdotal evidence from other sources intensify this concern. They include:

- disturbed prisoners held in padded cells resorting to eating the paint off the walls - evidence from reliable sources working in prisons.
- some prisoners claim to have been kept naked in a strip cell - the IPRT has seen a private statement from the prison authorities acknowledging this which states: 'it is management policy that offenders should wear their underwear while confined in an unfurnished room, however, this is not always possible depending on the mental condition of the offender'.
- mentally ill prisoners have reported that they were deprived of essential medicines while in the strip cells.
- a mentally ill prisoner released back into the prison, after a week in a strip cell, without any medical treatment in the intervening period
- a prisoner found hanging in a strip cell was saved and transferred to the Central Mental Hospital for the Criminally Insane. On being returned to prison he was quickly returned to a strip cell where he attempted to hang himself again.

These reports are anecdotal in nature but they cannot be dismissed- the persistent nature of these statements is deeply worrying.

Are there consequences for the prison staff?

The system is not only failing prisoners particularly the mentally ill, it is also failing prison staff. There are no procedures in place to deal with or to help those who suffer from mental health problems, as a result prison staff are essentially *forced* to deal with the mentally ill in the most inhumane and unsympathetic way possible, forcing people into strip cells. Experts have found that over time prison staff experience

a kind of brutalising effect….the really sobering fact is that the people who work in these setting day after day have seemed to, over time, lose their capacity to be shocked by the kinds of things they see … if you live in these environments too long, you start losing some of your own humanity … you stop experiencing the shock of brutality and inhumanity that those of us outside the system never thought could exist in this country'.[viii]

This may explain the response of Irish officers when asked how they felt about looking after sick people in padded cells. Several officers, when interviewed, said, 'you get used to it after a while'. In one prison, officers are 'especially handpicked' for this job - perhaps in implicit recognition of the dehumanisation process? This possibility of dehumanisation is also serious matter of concern to the IPRT.

IPRT comment

The IPRT greatly regrets that the lack of community service in Irish society for the mentally ill has resulted in the criminalisation of mental disturbance. The above sample of official records for entries into solitary confinement or strip cells clearly show that many individuals in these cells have displayed symptoms that may be a manifestation of mental dysfunction. There is evidence that the use of strip cells further damages mental health. It is equally clear that normal non-medical facilities within a prison system are not a suitable environment to treat the mentally ill. Irish prison authorities must recognise that in many cases they are dealing with clinical problems that need treatment and not punishment. It is sad reasoning to say that if you put sick people in a tight enough cage they will not hurt themselves or anyone else. Sooner or later mentally ill prisoners will be released into the community. What chance has either this person or society got unless proper treatment is made available?

The IPRT believes that the policy of entry into strip cells is:

- an absolute denial of the human rights of mentally ill/disturbed prisoners
- this government is therefore in breach of both UN and Council of Europe human rights standards
- this treatment is deeply inhumane for both prisoners *and* staff
- it may even contribute to increasing crime, as offenders are likely to leave prison in a worse condition than they went in and therefore be more disruptive in society.

- given that the above data incorporates entry into strip cells of February and March 2001, the very recent improvements within the overall medical prison services clearly have not made a substantive difference to this situation. They are merely elasto-plast remedies. It is more than clear that approximately 40% of prisoners may be mentally disturbed on entry into prison. At the very least all governments are morally and legally obliged to make sure prisoners do not leave Irish prisons in a condition worse than they went in. Something has to be done. Why do we need prisons built with bricks of shame? Why not have prisons built with bricks of pride? How many reports have to be written before change occurs?

IPRT calls on the government to implement the following recommendations.

IPRT Solutions To The Problem Of Medical Human Rights

Model of a medical service for mentally ill offenders

Mental illness is both discriminated against and needlessly criminalised in this country. For real change to happen, it must occur first and foremost at society-wide level. By society-wide changes we mean massive diversion schemes combined with some form of reformative justice for mentally ill offenders, particularly for those who have committed non-violent crimes. (Please see IPRT policy paper no 2 *Community Solutions for Mentally Ill Offenders.*) At the prison level appropriate and separate medical in-services, general rehabilitation and educational services need to be established; a radical overall of the system is essential. In other words two distinct but co-ordinating systems need to be established: one outside prison, the other inside prisons. This policy paper deals with solutions within the prison system only.[ix]

Inside prisons

If a mentally ill person is obliged to go to prison, then in order to acknowledge his/her illness a radical overhauling of the entire prison medical and para-medical system is essential. This would include the setting up of in-service clinics as well as the setting up of a community re-integration programme for ex-offenders. Before that, however, the IPRT calls for the immediate abolition of padded cells. Unmanageable behaviour by the mentally ill should be seen for what it is, behaviour to be medically treated rather than to be punished.

All padded cells must be abolished immediately. They are degrading, inhumane and seriously destructive places in which to exist.

Observation wards

All strip cells should be replaced by small observation wards. These wards must only be used when a person is an immediate threat to him/herself or to those immediately around him and as a very short-term measure. These wards should be well lit and have a well-designed window from which all parts of the room can be observed. It should have 2 or 3 simple beds, possibly secured to the floor and some basic furniture that could not be used for self-harm, e.g. a foam armchair. A simple toilet must be part of the ward facilities also.

Basic code of practice[x]

- Physical restraint should be used as little as possible.
- Restraint, which involves tying prisoners to either the furniture or some part of the building, must never be used.
- A definite number of staff should be fully trained in the management of aggression.
- One of these members of staff must make a balanced judgement between the need to promote an individual's autonomy by allowing him/her move around the room at will and the duty to protect that person from self-harm.
- A detailed record for each prisoner must be kept.
- Any prisoner who has been put into an observation ward should be seen by a GP within the hour and a psychiatrist within 3 hours. Nurses should observe the prisoner at all times.
- Prisoners must never be put naked into an observation ward.
- At all times the prisoner should have continuously explained what is happening to him, why he is in an observation room and who is coming to see him. A doctor must always introduce her/himself to the prisoner.
- All complaints by the prisoner should be recorded and addressed as appropriate.
- All observation rooms need to be in a quiet place and as part of the in-service medial clinics (see below) where possible.

A radical overall of the prison health system

The Whitaker Committee 15 years ago, and, more recently (1996), the European Committee for the Prevention of Torture (CPT) recommended the setting up of a small psychiatric clinic within the Irish prison system to be staffed by Health Board personnel. The Whitaker Committee also recommended that psychiatrists should have direct clinical responsibility for all prisoners suffering from mental illness, disorders of personality, problems of addiction, and for those prisoners of sub-average intelligence with associated behavioural problems.

The same inadequate form of intermittent, visiting psychiatric care exists today as in 1985 - only this service is now, given the increased presence in the system of

various categories of vulnerable prisoner, more than ever obviously inadequate. The IPRT is thus calling for the implementation of the Whitaker Committee recommendations in relation to both the establishment of a clinic and the definition of psychiatric responsibilities.

In-service Clinics

In recognition of both the increased intake of mentally ill prisoners as well as the need to place prisoners geographically, the Trust believes that as a basic minimum, 3 in-service clinics - in Mountjoy, in the New Cork Prison and in Castlerea - must be set up immediately. All these in-service clinics must have at least 6 beds. These particular in-service clinics would serve the more short-term or less seriously mentally ill prisoner. The Mid-western Health Board might be encouraged extend the community Unit 5 Psychiatric Unit, Limerick to include secure beds for mentally ill prisoners from Limerick. This community practice is not uncommon in European countries.

Three clinics and the immediate opening of a facility in Dundrum is the minimum required to provide a secure but essentially therapeutic facility for the numbers of mentally ill prisoners or prisoners in an acute suicidal crisis, who presently languish untreated in special cells or unnoticed in the ordinary cells of Irish prisons.

As well as the provision of in-service facilities, there is a need for a radical overhaul of the provision of all general medical services. A well-planned and co-ordinated plan of action, which would embrace all medical and para-medical services and management, is now most urgent. Part of any mental health programme must also have explicit professional links with the psychology service and the probation service. The number of mental health care professionals within the prison system needs to be greatly expanded. There should be a dedicated, full-time forensic psychiatric consultant in the prison health service itself.

Prison nurses must not be prison officers as the crossover between punishment and therapy is regrettably inevitable when a conflict of interest exists. Sessional psychiatrists working with full-time psychiatric nurses would staff the smaller clinics. The sessional psychiatrists, employed in the in-service clinics would none the less be dedicated to the service and would spread their time in a regular and predictable manner over one clinic and nearby prisons, in this way developing professional familiarity and relevant population-based expertise.

Most urgently, liaison with the general medical service must be put on a structured and formal basis. The primary medical care service must ensure the efficient screening of all prisoners when they enter the prison system and at regular intervals thereafter and whenever they come to special attention such as

through an act of self-harm/depression. Appropriately trained nurses must be available. There must be an efficient system for rapidly referring potential cases on for specialist assessment and subsequent treatment. There should be no evident but undiagnosed cases of psychiatric illness in the prisons and a system of referral and screening must be in place to ensure that this will be the case.

There is a need for a committee, accountable to the chief forensic psychiatrist, to examine, oversee and monitor the mental health care needs of the prison population and there is a need for structures to co-ordinate the delivery of medical and psychiatric health care and physical and mental health promotion. These initiatives would expressly acknowledge the multi-disciplinary nature of the enterprise. It is also essential to co-ordinate the variety of relevant services such as psychology, education, work training and social work with the psychiatric mission. The role of prison officers both in assisting in the screening of the prison population for mental problems, in health promotion and in the support of vulnerable prisoners is also essential and must be placed on an organised and integrated basis.

Pre-release Re-Integration Programme

Even mentally ill prisoners get released sometime. Many of these prisoners are homeless. A pre-release re-integration programme is essential.

In order to prevent recidivism and for humanitarian reasons a 'half-way-house' is essential before those who are homeless, in particular, are released into the community. This facility could also serve those recovering from substance abuse. There needs to be a closely supervised residential programme where participants will continue to receive treatment while developing the skills necessary for successful community participation after release. This faculty would not be locked although residents will be closely monitored and expected to follow their agreed terms of participation. Upon entry into the programme the residents would not be allowed to leave the facility without an escort. However, they might earn the right to leave for specific needs such as employment. The programme would depend on the active participation of all residents in all daily activities. Staff members would serve as guides to the programmes and as role models for successful personal change. Education, training and other therapeutic activities would occur through individual treatment, groups, meetings, job functions and recreation. The average length of stay would be 4-6 months. As residents progressed in the programme, they would have increased responsibilities and the opportunity to fulfil a variety of social roles, including that of friend, peer, co-ordinator and tutor. The relationships formed while in this programme are essential toward the formation of the social network that is necessary to maintain recovery after treatment. Communications with the appropriate community/public medical services should be formally established well before the resident leaves.

Conclusions

Ever since the closure of mental hospitals in recent years and the failure to build subsequent adequate mental health services, mental illness has been hugely criminalised.

- The use of padded cells and the lack of appropriate mental health care exacerbate prisoners' underlying mental disorders, and increase the risk of suicide.
- The use of strip cells is deeply degrading and inexcusable. It is an absolute denial of human rights of the mentally ill. Their use must be abolished.
- A radical overall of the entire health system inside prison is essential and long overdue.
- 3 in-service psychiatric clinics should be opened, throughout the prison system, beds made available in the Hospital of the Criminally Insane, Dundrum, Dublin and a pre-release residential programme needs to be set up.
- Ireland is breaking its international obligations. CAT must be ratified.
- Changes limited to prison mental health programmes *only* will not result in major improvements. Therefore a major diversion programme, using the CCRP programme in Alaska as a model, perhaps, needs to be implemented,
- The above programme includes the setting up of mental health courts and an independent monitoring

IRISH PENAL REFORM TRUST LTD
Iontaobhas Éireannach Teo Um Leasú Pianúil

Community Solutions to the Criminalisation of the Mentally Ill in Ireland

A Position Paper of the Irish Penal Reform Trust April 2001

IPRT
Dominick Court
41 Lower Dominick St
Dublin 1
Ireland
Tel: 01 872 0344
Fax: 01 872 0399
e-mail: info@penal-reform.ie
www.penal-reform.ie

IPRT Summary Recommendations

IPRT calls for:

- the government to consider the idea of Mental Health Courts (page)

- the government to consider the idea of Mental Health Courts as part of a planned and co-ordinated and service provider programme, something similar to the Court Co-ordinated Resources Project (CCRP) in Alaska (page)

- this means a pilot scheme, rather like the Jail Alternative Scheme (JAS) in Alaska is also worth considering. Participants in this scheme would work directly with the offenders and service providers to create and monitor individualised treatment plans, which the offenders must follow as conditions of probation

- immediate ratification of the United Nations *Covenant against Torture, Degrading and Inhumane Treatment* (CAT)

- a full time Inspector of Prisons

- a full time ombudsman for prisoners

Introduction

Mental illness is needlessly criminalised in this country. The abysmal failure to build adequate and appropriate community psychiatric and psychological services for mentally ill and unwell people has resulted in mental illness becoming criminalised in this country. People who urgently need medical attention go unnoticed in society and are left unattended for years on end. Many become homeless. Some commit suicide. Many become lawless and end up in prison. The Irish Penal Reform Trust estimates that almost 40% of the prison population may be suffering from some level of psychiatric or psychological illness or disturbances. A considerable number of these offenders are in prison for very minor crimes which are highly likely to be related to mental or psychological disturbances. The mentally ill prisoner should be treated in an appropriately secure psychiatric/psychological setting. The prison environment as currently structured do not allow for adequate observation, medical or otherwise, of mentally ill prisoners. Many are locked up for as long as 23 hours a day in solitary confinement in strip cells.

The internationally respected psychiatrist Professor Anthony Clare of St Patrick's Hospital, Dublin stated,

> ***the mentally ill are now the most systematically stigmatised group in our society. They …are the true lepers of today[xi].***

This stigmatisation, combined with the lack of appropriate care while in detention, means that mentally ill prisoners are the most discriminated against in Irish society. Their human rights are denied on an ongoing basis – by the state.

John Gunn, Professor of Forensic Psychiatry at the Institute of Psychiatry, London, writes,

> ***Not only do prisons generate psychiatric problems but they also collect them inappropriately and act as unofficial mental hospitals for individuals who should be in health care.[xii]***

That observation summarises the challenge facing the Irish Government in relation to their failure to recognise and respect the human rights of mentally ill prisoners.

For real change to happen, it must occur at society wide level as well as within the penal system. By society wide changes we mean massive diversion schemes combined with some form of reformative justice for the mentally ill offenders, particularly for those who have committed non-violent crimes. In other words two distinct but co-ordinating systems need to be established, one outside prison, in the community, the other inside prisons. This policy paper considers community solutions.

IPRT calls for immediate action to deal more appropriately with psychiatric illness before it comes criminalised. We recommend serious consideration be given to the idea of establishing a mental health court system. These courts would be an inherent component of a planned co-ordinated monitoring and service provider.

Mental Health Courts:
There are several mental health courts established in USA which have yielded very positive results. The mental health court system in Alaska provide a useful example of what could be established in Ireland. In 1999 the Alaska Court System established a mental health court project which have five broad objectives: 1) to preserve public safety 2) to reduce inappropriate incarceration of mentally disabled offenders and promote their well being 3) to relieve the burden on the Department of Justices/correction by inmates with mental disabilities 4) to reduce repeated criminal activity among mentally disabled offenders (legal recividism) and 5) to reduce psychiatric hospitalisation (clinical recidivism) of mentally disabled offenders. Mental health courts address both a) the need for a more humane approach which diverts the offenders with mental disabilities from overcrowded prisons or being 'treated' in padded cells and b) the need for a planned co-ordinated treatment strategy which makes good hospital costs, reducing needless incarceration and suffering among low-risk mentally disabled offenders. All offenders with a history of mental illness would appear before these courts. Specified judges would need to be trained in mental health issues and resources. This would entail some training in co-occurring alcohol and substance abuse disorders. These judges would be specifically assigned to hear mental health court cases only. These judges (and their offices) would also be primarily responsible for co-ordinating the role of the court with law enforcement, prosecuting agencies, defence agencies and mental health agencies.

Since these courts were established in USA offenders can now have the option of following a carefully monitored individualised plan of mental health treatment and services instead of going to prison. However, a mere court system will never be sufficient if this court system is not an inherent part of a well planned, co-ordinated monitoring and service provider programme.

The Court Co-ordinated Resources Project

In Alaska, for instance, this type of co-ordinated and service provider programme is known as the Court Co-ordinated Resources Project (CCRP). As its name suggests the CCRP depends upon a centralised co-ordination of court, agency and mental health resources. IPRT would envisage the court system, the Department of Justice, Equality and Law Reform, particularly the probation service, the Health Boards and hospitals for the mentally ill, the Department of Social Services all functioning in partnership with each other. There would also need to be explicit co-ordination between the mental health courts and the

present drug courts. The chief role of the CCRP is to expedite and maximize responsible alternatives schemes to prison for those who are judged to be fit to live in the community. A programme, similar to this one, which addresses both the need for humane treatment of the mentally ill via suitable community schemes and the largely wasteful and ineffective financial and administrative burden presently placed on the Dept. of Justice must be seen as a better way of reducing crime. Within this programme a specific co-ordinating and monitoring agency exists in Alaska. It is called the Jail Alternative Services (JAS).

Jail Alternative Service (JAS)

The function of the JAS programme is to co-ordinate, monitor and operate a pilot scheme. In Alaska, this pilot programme was set up in 1998 for up to 40 eligible defendants. There, the JAS Case co-ordinator works directly with the offenders and service providers to create and monitor individualised treatment plans, which the offenders must follow as conditions of probation.

Do mental health courts and the CCRP (JAS) programmes work?

The pilot studies, so far, indicate that mentally ill offenders who participate in the CCRP mental health system and comply with a treatment plan through JAS are far less likely than non-participating offenders to be arrested again or be admitted to a psychiatric institute. Community service providers also report that JAS monitoring and oversight have significantly increased their clients' motivation to comply with treatment plans. The CCRP/JAS programme is proving to be effective in preventing crime, expediting the legal process, protecting victims, providing humane alternatives to sentencing, reducing clinical and legal recidivism, and finally, lowering prison population. At the very least, the above ideas merit consideration.

Health Warning notice!

As a general rule, when public mental health services in the community, such as the above, are sufficiently funded and capable of supplying adequate, caring services, very few people refuse to comply with treatment. On the other hand, where funding is so deficient that all the client receives is perhaps a brief monthly appointment with a psychiatrist and a prescription for medication that may cause disturbing side effects, a significant proportion of clients refuse to comply with treatment are lost to follow up (many end up behind bars).

END

Endnotes

[i] Draft paper by Bonnie Kerness, Coordinator Prison Watch, American Friends Service Committee, p1
[ii] These comments are taken from an Interview titled: Psychological destruction Due to Isolation pp 61-67, Survivors Manual, published by American Friends Service Committee, November 1997
[iii] IPRT particularly note Dr Grassian's comments in several others articles also concerning prisoners in isolation for two weeks or thereabouts. IPRT believe that as a rule of thumb any isolation longer than 4 days may be potentially damaging to a mentally ill/distressed individual
[iv] In address to the Royal College of Psychiatrists in U.C.C. (Quoted by Bishop Dermot Clifford in 'The Care of the Mentally Ill in Our Community. Messenger Publications. 1995. Quoted in Working Notes, April 1999, Issue 34, Facing up to Mental Illness.)
[v] Coid, J.W. 1991, *Editorial*, 'British Medical Journal', 302, 16 March, pp603-604.
[vi] Dr. Charlie Smith. Mountjoy Prison Visiting Committee Annual Report. 1997
[vii] -All days of entry and exit are counted as 1 day. According to the governors of the three prisons, most, if not all prisoners put into padded cells at their 'own request' are suffering from some type of depression.
-Where prisoners were confined in padded cells for multiple reasons, e.g 'highly agitated, unstable and acting aggressively towards staff', each reason was entered separately on the table.
-There is obviously a personal style to the explanations given. For e.g. officers variously use the words 'erratic behaviour', 'agitated', and 'unstable'. Similar reasons have been grouped together.
-Days of leaving padded cells were not always recorded in 2 of the 3 prisons visited.
[viii] ibid p 65
[ix] See IPRT policy paper, 'Community Solutions to the Criminalisation of the Mentally Ill in Ireland'.
[x] This code of practice was adapted from the UK *Mental Health Act 1983, Code of Practice, published March 1999* pursuant to Section 118 of the Act.
[xi] In address to the Royal College of Psychiatrists in U.C.C. (Quoted by Bishop Dermot Clifford in 'The Care of the Mentally Ill in Our Community. Messenger Publications. 1995. Quoted in Working Notes, April 1999, Issue 34, Facing up to Mental Illness.)
[xii] Coid, J.W. 1991, *Editorial*, 'British Medical Journal', 302, 16 March, pp603-604.