



TO BE, OR NOT TO BE, **IN OBSERVATION CELLS?**

A discussion paper on the introduction
of observation cells for mentally ill
and suicidal prisoners

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“No one truly knows a nation until one has been inside its jails. A nation should be judged not by how it treats its highest citizens, but its lowest ones”

Nelson Mandela

Explanatory note

Observation room and observation cell — the difference. An observation room is a room situated within a prison or community hospital. It is only one aspect of an overall therapeutic strategy and is always underpinned by a therapeutic ethos and medical/para-medical staff.

An observation cell is a cell-like room situated within a prison and generally speaking is used for disciplinary purposes only. It appears that this is the type of cell that fits the description of the new ‘observation cell’.

Acknowledgements

I would like to thank Dr Justin Brophy, Irish Psychiatric Association, who read the penultimate draft of this document. Any mistakes are my own. I sincerely thank the Irish Prison Service (IPS), the Prison Officer’s Association (POA), the Department of Justice, Equality and Law Reform and the Director of Medical Services for their willingness to meet, or to talk and convey information on matters relevant to the introduction of the new observation cells. Thanks also to the Board of IPRT and its Director, Rick Lines, for their contributions to this paper. To Paula, (IPRT’s Administrator) for her immense formatting patience — many thanks!

IPRT caveat

At time of writing the guidelines for the construction of the new observation cells have not yet been finalised. Therefore our findings and recommendations are pertinent to the official information given to us only. This paper deals only with those mentally ill patients within the prison system and not with those in the Central Mental Hospital.

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IPRT summary findings

The Minister for Justice, Equality and Law Reform, Michael McDowell, has instructed that the Irish Prison Service (IPS) ‘replace as soon as possible all traditional padded cells with new safety observation cells’ (see IPRT letter Appendix 1).

Unless a radical change is instituted at the same time as the building of these observation cells, IPRT concludes that *despite obvious good intentions, it is likely that the new observation cells and their occupancy will turn out to be but a cleaner version of the old padded/strip cells.*

IPRT believes that the same cohort of mentally ill people are likely to end up in observation cells because:

- The absence of the Director of Prison Health Care Services from the Implementation Committee (currently drawing up the guidelines for the structure of and appropriate admission to observation cells) means that international standards of good medical practice are unlikely to be acknowledged (p. 10).
- The restricted admission procedure and limited number of beds in the Central Mental Hospital [CMH] means that it is likely that some mentally ill people who deserve hospitalisation will be obliged to remain in prison (p. 10).
- Community hospitals will not admit any mentally ill prisoners (p. 10).
- There appears to be a serious misunderstanding of what a medical facility within a prison is meant to be. This misunderstanding is due in part to two things: the commonly expressed perception that patients returning from CMH are ‘over-medicalised’ or ‘drugged up to the gills’ phenomenon¹ and the issue of legally enforced medication (p. 10).
- The present shortage of appropriate staff within the overall prison system exacerbates the problems and means that those in observation cells are unlikely to receive adequate treatment.
- Crucially, and despite considerable advances, there still appears to be no official recognition that suicidal prisoners should never be put into isolation of any sort.

¹ These are the two most common expressions used over several years and many conversations with IPRT.

- In Irish prisons suicidal prisoners are frequently put into padded or strip cells.² For example, one suicidal prisoner spent a total of eight days in a padded cell. One report to IPRT notes that one very young successful suicide had not been deemed at risk although he spend most of the day in bed.

Therefore the replacement of padded cells by observation cells will probably not greatly facilitate the right of all prisoners to adequate medical care unless other radical changes occur simultaneously. Absence of these changes means that IPRT believes that these cells may well not adhere to international standards of best practice. Mentally ill offenders should not be held in any type of prison cell unless there is a medical/para-medical automatically in attendance.

² *Out of Mind, Out of Sight, Solitary Confinement of Mentally Ill Prisoners*, Valerie Bresnihan, IPRT (2001).

IPRT summary recommendations

It is worth noting that, in general, prisons in Europe do not house mentally ill offenders/patients. Mentally ill patients are placed in either designated psychiatric hospitals or else in a hospital within a prison. Ideally even holding cells should be situated within a separate medical structure of a prison. Accordingly, IPRT takes its recommendations from appropriate medical settings.

Structural recommendations

IPRT believes that the new observation cells are unlikely to remain as holding cells unless a radical medical overhaul is introduced into the prison system. This must include:

- the recommendations from the *Report of the Group to Review the structure and organisation of prison health care services* regarding observation rooms and other health care services need to be urgently implemented (p. 9).
- CMH needs to broaden its admission policy and increase the number of its beds for admitting mentally ill prisoners (p. 10).
- There will always be some patients who will need short-term medical care within the prison. Therefore observation rooms/wards — as against observation cells — also need to be built within the prison system (p. 10).
- Community hospitals need to admit patients who need medium to low security, difficult as this might be (p. 10).
- Irish attitudes towards mentally ill patients/prisoners need to change (p. 9).
- Those who campaign for better community services need to put emphasis on the double discrimination of mentally ill prisoners.
- Much more updated and consistent research is needed regarding prison suicides (p. 14)

Observation cells recommendations

- The Director of Medical Health Care Services needs to sit on the implementation committee.
- At least some observation cells need to be converted into observation rooms. They must be set apart from the ordinary prison (pp. 6–7).
- Ideally *all* observation cells need to be situated within a separate medical section of every prison.
- No patient should ever be left in an observation cell for longer than twenty four hours. This should be specified in writing by a medical officer.

- Clear medical guidelines derived from international standards of good practice need to underpin the ethos of both observation cells and rooms (pp. 1–2, 7).
 - The use of observation cells for suicidal prisoners should never be allowed.³
 - Specific human rights and CPT recommendations need urgent consideration (p. 7 and App. 2).
-

³ *Suicide Prevention in Scottish Prisons*, John Gunn, University of London, (1996).

1 Terms of reference

International standards of good practice

I PRT sets down below a small sample of the international rules, regulations and standards of good practice that we feel ought to underpin all policy associated with mentally ill prisoners and with the construction of the new observation cells (even though they are expected to be holding cells only).

Inhumane treatment

Inhumane treatment is treatment that causes intense physical and mental fear, anguish and inferiority capable of humiliating and debasing the victim and possibly breaking his or her moral resistance (Article 3 of the *European Convention for the Protection of Human Rights and Fundamental Freedoms*). *Soliday's study showed that two thirds of secluded [or isolated] patients saw it as a punishment and half found it humiliating.*⁴

International standards of best practice

Prisoners as patients

The United Nations Principles of Medical Ethics place on all health personnel, and particularly physicians, a duty to provide prisoners with protection of their physical and mental health and treatment of disease. Their first priority, therefore, is the health of their patients and not the management of the prisons. The *Oath of Athens* (ethical code of health professionals working in prison settings) further makes it clear that medical judgements should be based on the needs of patients and take priority over any non-medical considerations.

Human Rights in the Administration of Justice: protection of persons subjected to detention or imprisonment.

Standard minimum rules for the treatment of prisoners

Adopted by the *United National Congress on the Prevention of Crime and the Treatment of Offenders*, 1995, and approved by the Economic and Social Council by its resolutions 663 C (XXIV) in July 1957 & 2076 in May 1977. These rules seek to set out what is generally accepted as being good principle and practice in the treatment of prisoners and the management of institutions.⁵ Relevant to this paper is:

⁴ 'A Comparison between Patient and Staff Attitudes Towards Seclusion' in *Journal of Nervous and Mental Disease*, 173, 282–6. *Soliday SM* (1985).

⁵ *Human Rights in Prisons, Training Manual for Prison Staff*, International Centre for Prison Studies, p. 145, (no date).

“Treatment of Insane and Mentally Abnormal prisoners”:

- 22 (1) At every institution there shall be available the services of at least one qualified medical officer who should have some knowledge of psychiatry. ...[The medical services] shall include a psychiatric service for the diagnosis and, in proper cases, *the treatment of states of abnormality*. (IPRT’s italics)
- 82 (1) Persons who are found to be insane shall not be detained in prisons and arrangements shall be made to remove them to mental institutions as soon as possible.
- (2) Prisoners who suffer from other mental diseases or abnormalities shall be observed and treated in specialised institutions under medical management
- (3) During their stay in prisons, such prisoners shall be placed under the special supervision of a medical officer.
- (4) The medical or psychiatric service of the penal institutions shall provide for the psychiatric treatment of all other persons who are in need of such treatment.⁶

IPRT endorses the 1998 World Health Organisation (WHO) consensus statement that deprivation of freedom is intrinsically bad for mental health and that prison has the potential to cause significant mental harm.

IPRT has also been guided by CPT recommendations for mental health services in Irish prisons, some of which are laid out in Appendix 2.

Summary

All IPRT recommendations are underpinned by the above principles and rules. IPRT believes that in many prisons a significant proportion of prisoners suffer from some form of mental illness/disturbance. We know that prisoners who are severely mentally ill should not be in prison, they should be hospitalised. However, there will always be a number of patients who will not need in-patient treatment (CMH) but still need appropriate medical treatment. This treatment may dictate that a patient needs a special therapeutic environment such as an observation ward or room in a hospital prison.

⁶ *Human Rights in Prisons*, Training Manual for Prison Staff, International Centre for Prison Studies, p. 145, (no date).

2 Overall context

Introduction

This paper deals only with those mentally ill patients *within* the prison system. There will always be a definite number of patients who will suffer from short term mental illness and who may, or may not, become severely mentally ill in due course. We include in this discussion those waiting to be admitted to CMH.

Mentally ill patients should be entitled to the same rights as the physically ill. If a man or woman breaks her/his leg in Mountjoy, s/he needs to be taken to the Mater hospital for immediate treatment. If a prisoner's mind breaks, s/he needs to be taken to an appropriate environment where s/he can be treated. Part of that treatment may be admission to a small prison ward/room or prison/community hospital.

Screening and monitoring the mental health of prisoners helps to identify those with mental disorders and who should not be in prison. It is important to distinguish between prisoners who intentionally disrupt the order of the prison and prisoners who are mentally disordered and whose behaviour is disruptive. Though, as regards the former, IPRT regards the existence of padded cells for punishment as equally inappropriate.

In Ireland, the treatment of mentally ill people is increasingly a process of criminalisation. It has been publicly acknowledged by politicians, the judiciary and those involved in prisons that the majority of mentally ill offenders are imprisoned for minor, usually public order crimes, but primarily as a result of their mental illness.⁷ One might thus argue that since mentally ill people are stigmatised by society in general, mentally disordered offenders are thus doubly stigmatised.

If the safety of society is to be paramount, if the human dignity of both victim and offender is to be respected, then mentally ill offenders are in need of greater than ordinary protections. This is because prisoners will almost always return to society. They are a vulnerable group in a particularly stressful environment. For instance, prison populations are normally distinguished because of their drug and alcohol problems, family disruption, institutionalisation, educational failure and stigma. The findings from a report by the UK Office for National Statistics, 'Non-fatal Suicidal Behaviour Among Prisoners', suggests that the levels of psychiatric disturbance in suicides are higher than average in prison. *One morbidity survey indicated that only 10% of the prison population were free from any form of*

⁷ The lack of access to appropriate resources in the community leads by default to the use of prisons as a form of alternative housing for those incapable of living independently and without some support. For these mentally ill people, prison functions as means of control for those who ought instead to be receiving treatment. See also *Politics of Prison Medicine*, Valerie Bresnihan, IPRT (2002).

mental disorder at all.⁸ From that perspective, ‘prisons are stressful and from a psychiatric point of view, toxic’.⁹ Due to lack of data, it is unclear what the true picture regarding prison suicides relative to Irish society actually is. This is truly regrettable.

IPRT’s previous findings

In a previous IPRT report, *Out of Mind, Out of Sight, Solitary Confinement of Mentally Ill Prisoners* (2000), it was found that 78% of those detained in strip/padded cells (solitary confinement) were mentally ill/disturbed. These cells had become a substitute for appropriate medical treatment. The longest number of consecutive days in solitary confinement recorded was 18 days. One prisoner spent 25 days of a 30 day period in a strip cell (solitary confinement).

In terms of preparing for the intended observation cells and relative to international standards of good practice, the report also found that *both the official procedure and record-taking for admission to solitary confinement was seriously wanting. 40% of entry/exit dates were found to be missing. In the main, chief officers rather than a medical officer made the decision regarding entry into a padded/strip cell. Visits to those in solitary confinement, although reasonably frequent, were usually of a cursory nature.*

IPRT immediately called for the abolition of solitary confinement as a means of ‘treatment’ for mentally ill prisoners.

In a following IPRT report, *Politics of Prison Medicine* (2002), it was pointed out that there were considerable institutional difficulties between the prison system and the health system regarding the existence — or non-existence — of clearly defined sets of responsibilities. The end result is that mentally ill offenders are not treated adequately within the prison system. This situation still pertains today although genuine attempts have been made to solve the relevant issues.

Some agencies appointed by Government, such as the *Group to Review the Structure and Organisation of Prison Health Care Services* and the *National and Economic and Social Forum* accepted IPRT’s findings and subsequently carried forward IPRT’s recommendations.¹⁰ Both the *Politics of Prison Medicine* and the Review Group (above) stated that it was regrettable that there still exists the automatic assumption that all prisoners suffering from psychiatric illnesses are dangerous. It needs to be pointed out again that this is not the situation in most cases and the majority of such prisoners require low to medium security levels only.¹¹ Regarding padded cells, the Review Group recommended that ‘in the longer term, padded and strip cells should be replaced by observation wards for prisoners experiencing short term mental crises... the duration of such a facility should not exceed twenty four hours, the aim being to keep to a period considerably shorter than this’.

⁸ Other relevant figures quoted in *Suicide is Everyone’s Concern, A Thematic Review*, HM Chief Inspector of Prisons for England and Wales, (May 1999).

⁹ Dr Harry Kennedy, *Human Rights and Mentally Ill Prisoners*, Central Mental Hospital, Paper delivered at the 6th Annual conference of the Irish Penal Reform Trust, December 14, 2002.

¹⁰ See report of the Group to Review the Structure and Organisation of Prison Health Care Services (May 2001) and the Economic and Social Forum report, *Re-integration of Prisoners* (January 2002).

¹¹ IPRT is neutral on the issue of whether it is best to have hospitals in prison or in the community. The Group in their Review state their preference: that ‘appropriate therapeutic units which could be used to treat prisoners as well as other persons in the community, to be made available or established’ p. 44.

In November 2002 at a meeting with a delegation from IPRT, the Minister for Justice, Equality and Law Reform, Michael McDowell, agreed to replace padded or strip cells with observation cells. IPRT wishes to thank the Minister for Justice for his invitation to write a submission to the implementation committee subsequently set up to consider the design of these new cells. IPRT completed this project in April 2003.

IPRT's current findings

Structural findings

Since observation cells do not exist in isolation, it is necessary to identify specific structural problems which we feel would be bound to increase the inappropriate use of observation cells.

Firstly, if observation cells are to be short-term holding cells only, then these cells can only legitimately exist if the cells themselves are underpinned by a therapeutic ethos.

Secondly, the shortage of appropriate therapeutic staff within the prison system generally is bound to exacerbate this problem. If there are not enough hospital beds, and not enough medical and para-medical attendees to deal with mentally ill patients, then inevitably these patients will have to remain in the new observation cells for an undue length of time.

Thirdly, there is only one hospital in this country, the Central Mental Hospital (CMH) Dundrum, that will admit mentally ill offenders. In general however, CMH will only admit those who are psychotically ill. The management of this hospital do not wish to cater for those who are mentally ill with severe personality disorders (unless they are 'treatable' with medication). CMH may well be adhering to the letter of the law with regard to the *Mental Health Act 2001* but bearing in mind the United Nations principles of medical ethics (p. 7) we feel such a narrow admission policy fails to recognise the medical human rights of mentally ill prisoners.

Fourthly, despite several CPT recommendations, community hospitals will not admit mentally ill patients/prisoners even though the majority of ill patients need low to medium security only. We fully accept that the 1945 Act as it stands complicates the implementation of the CPT recommendations. We also realise that there are very few mental hospitals in the country with appropriate security surroundings. But serious consideration needs to be given to the remarks of the Group Review quoted previously. (p. 9)

Fifthly, the Irish Prison Service (IPS) itself appears to be determined not to 'medicalise' the prison system (see appendix 3 for numbers of medical staff in prisons). The IPS is reluctant to introduce observation wards or rooms — as against observations cells — as this would 'over-medicalise' the system even though this is clearly recommended by the CPT as an option.

One of the reasons for not medicalising the prison system is the common perception that patients returning from CMH are over-medicalised or 'drugged up to the eyeballs'. If the prison system is medicalised then there appears to be the fear that this could happen in prison too. IPRT makes no comment on the validity of this perception except to say that it is extremely common. However, IPRT feels that there appears to be a serious misunderstanding of what a medical facility within a prison is meant to be. A medical facility means a separate hospital-like structure, but within the prison grounds. It also seems that the common perception of being 'drugged up to the eyeballs' refers mainly to the patients who are diagnosed as criminally insane which in effect facilitates legally enforced medication.

Sixthly, the present implementation committee set up by the current Minister for Justice to establish guidelines lacks the presence of the Director of Prison Health Care Services. Thus a medical ethos is unlikely to exist.

IPRT's perspective on observation cells

IPRT's has two basic premises regarding the placing of any mentally ill prisoner in cells.

Firstly, this serves as a punishment, however unintentional, and even if inadequate medical services or absence of appropriately trained staff are the primary reasons for a prisoner being placed in isolation/solitary confinement. Therefore, all international standards regarding a denial of human rights relative to punishment apply.

Secondly, as noted and according to international standards of good practice, isolation [observation cell] must have a medical infrastructure.

There are several definitions of 'observation'. Many of them overlap with 'isolation' or 'seclusion'. From our conversations with the relevant agencies it appears that seclusion is the nearest to what is meant by the introduction of observation cells. Seclusion means 'the placing of a patient in any room alone with the door or exit locked or fastened or held in such a way to prevent the egress of the patient'.¹² However, seclusion is used as a *part* of an authorised treatment intervention only when all other interventions have failed, when the patient is in grave danger to self or others, where it is essential and it is certified as so essential by a medical officer.¹³ (IPRT italics)

The probable structure of observation cells

We caution that final decisions have not been made by the implementation committee regarding the use of observation cells, but from our conversations our findings are as follows:

On the positive side, and very much an improvement from the former padded/strip cells:

- The new cells will have fixed beds on plinths (normal bed height).
- All walls will be soft surfaced so as to protect the prisoner from self-harm.
- There will be a call button in every cell.
- Toilets will exist in or adjacent to each observation cell.
- A rather heavy green gown will be provided (patients will no longer be naked).
- Three cells of varying types are to be built for demonstration purposes in Cloverhill prison by September 2003. Further consultation is to then take place.

¹² The above quoted recommendations are taken also from *Mental Treatment Regulations 1961* (Mental Treatment Regulation: Part 2 Section 6), *Principles and Practice of Forensic Psychiatry*, Bluegrass R & Bowden P, Mental Health Services Policy/Best Practice Guidelines Eastern Health Board, Reports of the Inspector of Mental Hospitals.

¹³ Central Mental Hospital Seclusion Policy (April 2001).

3 IPRT recommendations

Structural recommendations

- If standards of good practice are to be applied then it is essential that resources are put into the prison medical system in order to prevent undue detainment of mentally ill patients in observation cells. More medical and para-medical staff, as well as observation rooms and wards, are needed.
- The Medical Director needs to sit on the implementation committee.
- CMH needs to change its admission policy.
- Community hospitals need to admit patients who need medium to low security.
- The IPS needs to accept that some patients need short-term care in particular; observation rooms/wards need to be built.
- Public attitudes towards mentally ill patients/prisoners need to change.
- Those who campaign for better community services need to put emphasis on the double discrimination of sick prisoners.

Observation cell/room recommendations

Our main recommendation is that the new observation cells must be converted into observation rooms i.e. *they must be underpinned by a medical ethos*:

- Observation rooms must be used as a part of authorised medical treatment intervention only, where it is essential and it is certified as so essential by a medical officer.
- No patient should remain in an observation cell for more than 24 hours.
- Seclusion may be initiated by a staff member but it must be medically authorised. In the event of it being initiated by a staff member, a doctor must be asked to review the patient within one hour.
- The doctor prescribing seclusion must sign the Register and print their name underneath their signature.
- The medical officer shall review the patient within 1 hour after the commencement of seclusion and if a further period of seclusion is warranted, after 3 hours and at such intervals as they deem appropriate thereafter. The seclusion book must be signed for each extension of seclusion.
- A consultant psychiatrist shall review the patient every 24 hours while in seclusion.
- All patients should be observed at least every 15 minutes and each observation must be recorded in a special observation book.
- While carrying out observation, staff members should attempt to re-engage in a therapeutic way with the patient.

- Those in isolation should be observed only by a member of staff with psychiatric training and at all times.
- The green gowns, while an improvement, seem especially heavy. Gowns used in the CMH, for instance, would be preferable.
- Suicidal patients should never be put in observation cells (see Section 4).

The room (cell) itself should:

- Be properly heated and ventilated.
- Have connecting cameras installed. These should only exist as an ‘eye’ to view the patient when s/he cannot be seen from the window. They should never be a substitute for face to face intervention.
- Have access to toilet and washing facilities at all times.
- Have clear evidence of daylight.

The IPRT believes that the introduction of the new (non-medical) observation cells, in particular, will not help those who are suicidal.

4

Suicide

Introduction

Suicide can be regarded as the tip of an iceberg, i.e. the bit that shows. Underneath the tip is the large body of psychological distress and frank despair that leads to suicidal behaviour. The prison suicide problem is one which runs deep in society and extends far beyond the prison walls.

Prisons collect individuals who find it difficult to cope, they collect excessive numbers of people with mental disorder, they collect individuals who have weak social supports, they collect individuals who, by any objective test, do not have rosy prospects. ... Prisoners suffer the ultimate ignominy of banishment to an uncongenial institution ... where friends cannot be chosen, and physical conditions are spartan. Above all they are by the process of imprisonment separated from everything familiar, including all their social supports and loved ones, however unsatisfactory. This is what is supposed to happen, this is what the punishment of imprisonment is all about. This collection of life events is sufficient in any individual to make him or her depressed. The depressive feeling ... may include a wish to die.¹⁴

Sometimes a prisoner makes this wish come true.

Relative to the Irish context, in particular, all international evidence suggests that a high proportion of patients who feel suicidal have a significant depression. This is a treatable illness. Other factors associated with prison suicides are also legitimate medical matters, such as anxiety, low self-esteem, substance and mental handicap'.¹⁵ IPRT reluctantly concludes that the selection process for admission to CMH and the non-medicalisation of Irish prisons greatly hinders any pro-active suicide prevention strategy despite the introduction of recent suicide prevention strategies.

Further, there is universal agreement that the safe/observation rooms are largely an irrelevance to the problem of suicides. A ligature environment is not the main issue. Suicidal prisoners identified as needing isolation rarely kill themselves in isolation. The real problem is identifying and supporting those who want to kill themselves¹⁶.

¹⁴ *Suicide in Scottish Prisons — a brief review* (unpublished report), J Gunn (1996).

¹⁵ *ibid*, p. 81.

¹⁶ *ibid*.

Prison staff and suicide

There is no doubt that suicide has a profound effect on all people who are in contact with such an event. It is not something that can be shrugged off. Prison officers and other staff may even develop their own psychiatric symptoms as a result of being in contact with a successful suicide. It is certainly the case that a prison who has recently had a successful suicide has a lot of members of staff who are left feeling guilty, ill understood, impotent and to a small extent fearful of the future. To successfully protect staff from such trauma is a characteristic of a healthy prison only.¹⁷

Further, in prisons where both idleness and poor medical services exist (unhealthy prisons), there is always the danger that prison staff who become used to the prison environment fail to understand the impact it has on prisoners who are entering it for the first time and they may lose sight of the fact that prisoners are individuals with human needs.

Prison staff should not be left to take the blame for society's failures.

'In its widest sense suicide prevention policy must be about creating a climate in which suicidal thoughts and feelings are less likely to take root. Inmates will normally be less prone to suicidal behaviour in the establishment where regimes are full, varied and relevant; where staff morale is high and relationships with inmates positive; where good basic living conditions are provided; where every effort is made to encourage contacts with family and the community'.¹⁸ In other words, a 'healthy prison'¹⁹ is the best preventive of suicide.

The essence of suicide prevention is that staff are given more help to help the helpless.

Suicide data in Irish prisons

In Irish prisons, suicidal prisoners are frequently put into padded or strip cells. For example, one suicidal prisoner spent a total of 8 days in a padded cell. One report to IPRT notes that one very young successful suicide had not been deemed at risk although he spent most of the day in bed.²⁰

The following are the most up to date figures available from the IPS on suicide and para-suicide (attempted suicide).

¹⁷ *ibid* — See also *Suicide is Everyone's Concern*, Bibliography.

¹⁸ *Prison Reform Trust*, (1996).

¹⁹ *Suicide is Everyone's Concern, A Thematic Review*, HM Chief Inspector for England and Wales, (1999), ch 7.

²⁰ Overall IPRT concurs with Professor John Gunn: 'Modern psychiatry is narrowing its focus, becoming pre-occupied with labels as opposed to functional analyses and with the rejection of people who have behavioural disorders. This narrowing tends to mean that [forensic] psychiatry is concentrating on psychotic disorders at the expense of neurotic ones. ... Within a prison, symptoms are more difficult to evaluate than within the domestic environment. For example it is natural to feel depressed by imprisonment, yet such depression may still have pathological significance and be treatable the commonest disorders are substance abuses of various kind, personality disorders and other neurosis, which include depressive disorders. Substance abuse and depressive disorders are known to be particularly predisposing to suicidal behaviour'.

Statistics

No. of suicides in Irish Prisons

| | |
|-------------------|---|
| Year 2000 | 3 |
| Year 2001 | 1 |
| Year 2002 | 4 |
| Year 2003 (April) | 1 |

No. of parasuicides in Irish Prisons

| | |
|-----------------------|----|
| Year 2000 | 73 |
| Year 2001 | 73 |
| Year 2002 | 93 |
| Year 2003 (to May 23) | 37 |

In short, suicide has no single cause. There is no doubt that suicide has a profound effect on all people who are in contact with it. Specifically related to the issue of observation cells, there is universal agreement that the safe/observation cells are largely an irrelevance to the problem of suicides. Good preventative suicidal strategies are characteristics of a healthy prison only.

5

IPRT suicide recommendations

- The use of daytime seclusion for suicidal prisoners, whether it be an observation room or cell, should be abandoned.
- Suicidal people should be managed by closer supervision and support instead of seclusion, combined, if necessary, with medical care and sedation.
- A psychiatric nurse needs to be exclusively responsible for the daily care of suicidal patients.
- They should be allowed keep their standard (safe) clothes and a few personal possessions as directed by the psychiatric nurse responsible for their care.
- Every prison and remand centre needs to have an observation ward, staffed 24 hours a day. Perhaps this could be designed in a way that it could function as a day care vulnerable prisoner unit.
- Acutely suicidal prisoners who remain in prison at night should be nursed in a place which can be fully supervised by psychiatric nurses. There **must** be someone in attendance and able to spend time with them, if necessary, at all times.
- Serious consideration needs to be given to the idea that inmates could be involved in suicide prevention. The Listeners scheme, where an older prisoner is trained by the Samaritan's is useful. The Edinburgh listener scheme provides a good model.
- Suicide prevention need not be considered as solely a medical issue and medical resources should be revised and attuned to the needs of the prisoners at risk.
- There needs to be a second medical examination for prisoners after the first week of their sentence.
- All staff, including medical staff and prison chaplains, need to be trained in giving counselling and support.
- A personal officer scheme should be developed in all prisons. Each prison should develop its own local arrangements for staff management and counselling following a suicide.
- The nature of the prison community is such that, in addition to ensuring the availability of a full range of medical services, prison administrators should also recognise that all prison staff need to have an understanding of basic health matters. Very often when an incident occurs in a prison of a medical nature it will be a non-health care staff who will be first on the scene and who will be required to administer immediate care.
- All cost implications related to the above recommendations should be assessed alongside an economic analysis of **not** implementing the proposals. This would include effects outside the prison system. (e.g. the legal and other social costs as well as costs within the prison system.)

- All Irish sentencers should have some instruction in psychiatry so they are better able to understand the implications of some of their decisions. Prison rehabilitative resources are largely static and this situation should be monitored by the courts.
- An independent review board should be established which would undertake a clinical audit after each suicide. A delegation of this review board should meet with the close relatives of those who have successfully committed suicide.²¹
- Mental Health Courts should be established (see IPRT report: *Out of Mind, Out of Sight*).

IPRT will be publishing extensive research, The Case for Mental Health Courts, in the Autumn.

²¹ See *Suicide in Scottish Prison — a brief review*, (unpublished report), J. Gunn (1996).

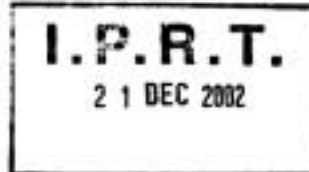
Appendix 1

Letter from Mr Michael McDowell, T.D., Minister for Justice, Equality and Law Reform 11/12/02



OFFICE OF THE MINISTER FOR JUSTICE, EQUALITY AND LAW REFORM
OIFIG AN Aire DLÍ AGUS CIRT, COMHIONANNAIS AGUS ATHCHÓIRITHE DLÍ

11 December, 2002



Dear Valerie,

At our recent meeting I promised to write to you regarding the use of padded cells, particularly in relation to mentally ill prisoners.

Let me say at the outset that, while prisons must have suitable accommodation for prisoners at risk of self-harm, I regard the use of traditional padded cells, which I have personally inspected during visits to prisons, as unacceptable. I have therefore directed the Director General of the Prison Service to replace as soon as possible all traditional padded cells with new safety observation cells which, while soft-surfaced so as to protect the prisoner from self-harm, will fully meet the needs and respect the dignity of the prisoner in every way consistent with his or her safety. In no circumstances will such cells be used as a punishment or deterrent; they will be used only where the safety of the prisoner absolutely requires such use. It is also the case that new Prison Rules are nearing finalisation, and I will give careful consideration to the provisions to be included in the Rules relating to these circumstances. I will also personally monitor the provision of the new safety observation cells.

As regards mentally ill prisoners, I should first of all say that an increasing number of vulnerable and mentally disordered people are being committed to prison, and in this regard it is very important for a clear picture to be developed of the extent of mental illness among the prison population. To this end, the Irish Prison Service is currently facilitating a research project being undertaken by a psychiatric team based at the Central Mental Hospital which is examining the prevalence of mental illness among the prison population, and I will be glad to share the findings of the research with you when it becomes available.

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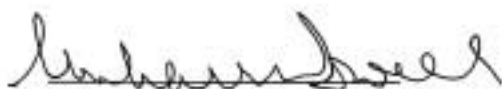
I want to say also that both the Irish Prison Service and I are completely committed to a policy of equivalence of health care for prisoners with that available to the general community. Indeed, successive Governments have taken the view that if a prisoner is psychiatrically assessed as in need of in-patient psychiatric treatment then that treatment ought to be provided in a psychiatric hospital. The Report of the Group to Review the Structure and Organisation of Prison Health Care Services published in 2001 concurred with this view in recommending that "the development of prison psychiatric units and prison hospitals should be avoided". This Report contains many recommendations relating to prison health care services, including mental health services. Arising from the publication of the Report, a Working Group was established involving representation by this Department, the Department of Health and Children, relevant Health Boards and the Irish Prison Service. This Working Group is currently exploring means of implementing the core recommendations of the Report.

Turning to the specific issue of the holding in padded cells of mentally ill prisoners, it is undoubtedly the case that there have been occasions when a mentally ill prisoner has been held in a padded cell, sometimes for a lengthy period, while awaiting transfer to the Central Mental Hospital. In response to that unacceptable state of affairs, and as an immediate measure pending the wider changes to padded cells which I have signalled, I have requested the Irish Prison Service to ensure that no mentally ill prisoner who is awaiting transfer to the Central Mental Hospital will be held in a padded cell, unless this is unavoidably necessary as an immediate and time-limited measure for the protection of the prisoner or others from harm. I have also given a direction to the Director General of the Irish Prison Service to make available additional special observation cells in Mountjoy and Cork Prisons (which have experienced delays in transfers to the Central Mental Hospital), and any other prison where the need arises, for the holding of mentally ill prisoners awaiting transfer from those prisons to the Central Mental Hospital. More fundamentally, I recognise the urgent need to tackle the underlying issue of delays in the provision of in-patient psychiatric care to mentally ill prisoners, and in this regard I have made arrangements for the Irish Prison Service and the East Coast Area Health Board to

draw up a Service Level Agreement, to be concluded by the end of this year, on the admission to the Central Mental Hospital of mentally ill prisoners and their treatment there. The Working Group charged with drawing up this Agreement has been meeting on a weekly basis since early October in order to achieve this aim.

I hope that this gives you an understanding of my position on these issues. Once again can I say that I am sorry that I was unable to accept your kind invitation to attend your conference, and that I wish it every success.

Yours sincerely,



Michael McDowell, T.D.,
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Appendix 2

CPT recommendations from their report on Ireland 1999

We reiterate the recommendations of the CPT in their last published report on Ireland:

‘In comparison with the general population, there is a high incidence of psychiatric symptoms among [Irish] prisoners. Consequently, a doctor qualified in psychiatry should be attached to the health care service for every prison, and some of the nurses employed should have had training. A mentally ill prisoner should be kept and cared for in a hospital facility which is adequately equipped and possess appropriately trained staff. That facility could be a civil mental hospital or a specially equipped psychiatric facility within the prison system. ... The transfer of a mentally ill prisoner to a psychiatric facility should be treated as a matter of the highest priority.....

A number of inmates being held in prison were found to be suffering from conditions which required treatment in an in-patient psychiatric setting (e.g. serious post-traumatic cerebral sequellae). Further, apparently due to the shortage of beds at the Central Mental Hospital, a number of prisoners who had been placed there were found to have been returned to prison before their conditions had fully stabilised.....

The CPT recommends that the provision of prison psychiatric services be reorganised as a matter of urgency. The aim should be to ensure that it is always possible to transfer mentally ill inmates to an appropriate psychiatric facility without delay.....

The CPT recommends that the level of in-house care in the male accommodation areas at Mountjoy Prison be further reinforced. In so doing, efforts ought to be made to enhance the continuity of care delivered to inmates (for example, by employing a smaller number of psychiatrists for longer periods of time)²²

²² *Report to the Irish Government on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 31 August to 9 September 1998*, p. 37.

Appendix 3

Number of doctors by institution

| | |
|--------------------------|----------------|
| Mountjoy Prison | 3 |
| Dochas Centre | 1 |
| Wheatfield Prison | 1 |
| Cork Prison | 1 |
| St Patrick's Institution | 1 |
| Limerick Prison | 1 |
| Castlerea Prison | 1 |
| Arbour Hill Prison | 1 |
| Training Unit* | 2 |
| Shelton Abbey | 1 |
| Portlaoise Prison | Vacant |
| Cloverhill Prison | 3 (one vacant) |
| Midlands Prison | 2 |
| Curragh* | 2 |
| Fort Mitchel* | 2 |
| Loughan House* | 2 |

Doctors at prisons marked * are job-sharing

Statistics provided by the Irish Prison Service to the Irish Penal Reform Trust 2003.

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