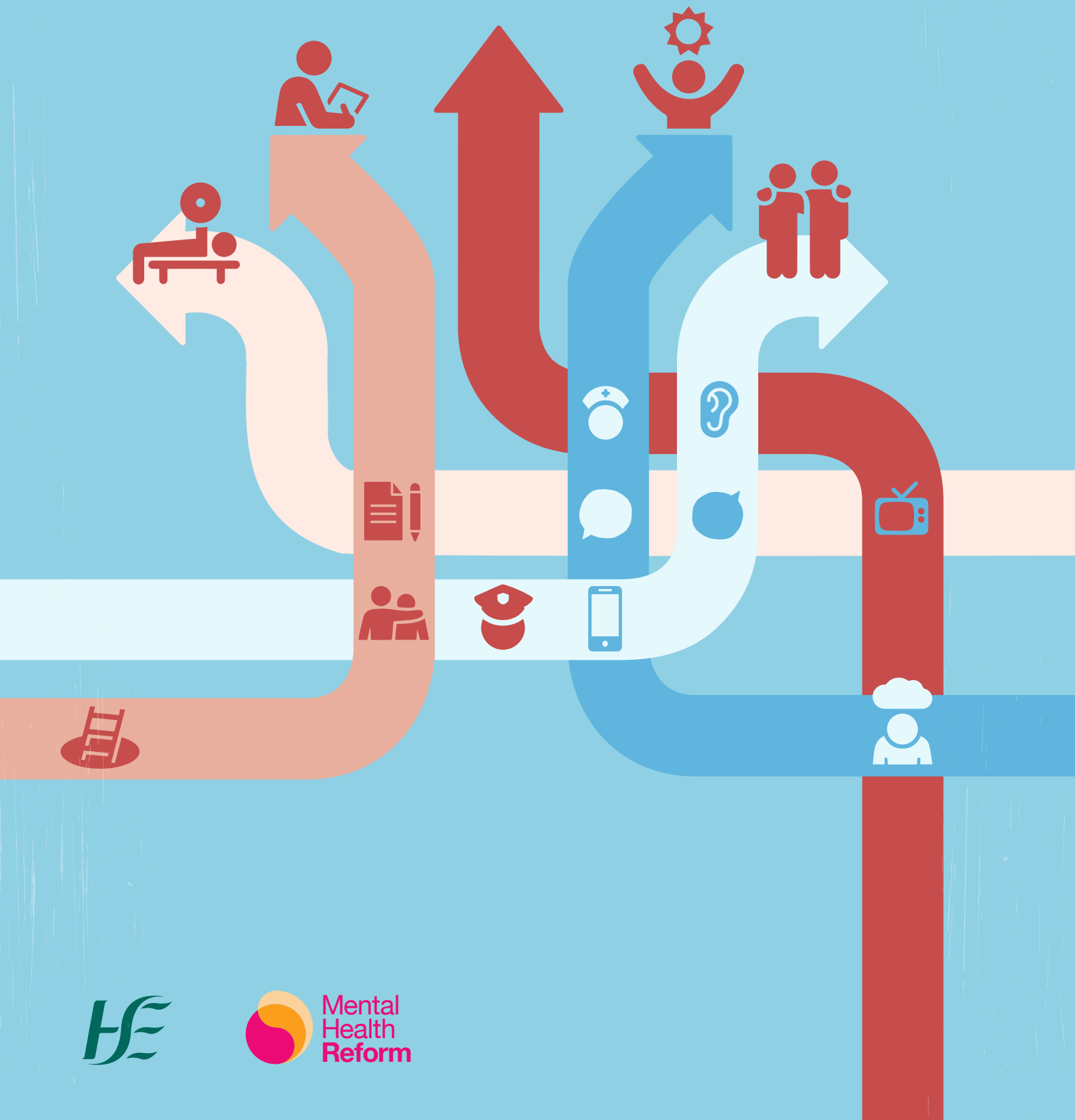
# MENTAL HEALTH SERVICES & SUPPORTS IN PRISONS:

## Service Mapping and Reflections from Lived Experiences



HSE

Mental Health Reform

# CONTENTS

# ABBREVIATIONS

| | |
|---|---|
| **A&E** | Accident and Emergency |
| **AA** | Alcoholics Anonymous |
| **ACEs** | Adverse Childhood Experiences |
| **CAP** | Care After Prison |
| **CMH** | Central Mental Hospital |
| **CSS** | Community Support Scheme |
| **DBT** | Dialectical Behaviour Therapy |
| **DSS** | Decision Support Service |
| **FGDs** | Focus Group Discussions |
| **GPs** | General Practitioners |
| **HLTF** | High-Level Task Force |
| **HSE** | Health Service Executive |
| **IASIO** | Irish Association for Social Inclusion Opportunities |
| **IPRT** | Irish Penal Reform Trust |
| **IPS** | Irish Prison Service |
| **ISM** | Integrated Sentence Management |
| **MBT** | Mentalisation Based Therapy |
| **MFL** | Master Facility List |
| **MHR** | Mental Health Reform |
| **MBSR** | Mindfulness Based Stress Reduction |
| **NA** | Narcotics Anonymous |
| **NFMHS** | National Forensic Mental Health Service |
| **OCD** | Obsessive-Compulsive Disorder |
| **PCTS** | Psychology Case Tracking System |
| **PICLS** | Prison In-reach and Court Liaison Service |
| **PIPS** | Progress in the Penal System |
| **PIMS** | Prisoner Information Management System |
| **RAC** | Research Advisory Committee |
| **UNCRPD** | United Nations Convention on the Rights of Persons with Disabilities |
| **VCS** | Voluntary and Community Sector |
| **WHO** | World Health Organisation |

# FOREWORD

It is with immense privilege that I introduce this pivotal report on mental health within the Irish prison system. In an era where global awareness of mental health continues to expand, it is imperative that we illuminate the unique challenges faced by people in prisons. Despite national and international guidance that individuals with severe mental health difficulties should be diverted from the criminal justice system, we know that this is not the reality for many individuals.

This report represents a significant stride towards comprehending and addressing the mental health needs of this key group. It is the culmination of extensive research, collaboration, and dedication, having embarked on its journey since initial discussions began in 2019.

Within these pages, you will discover a distinctive perspective on mental health within the prison environment. While there are often reports spotlighting specialised care for people in prison, this report ventures into the day-to-day realities for both prison staff and persons detained in closed, adult prisons.

I would like to express thanks to the Health Service Executive (HSE) for their generous support and funding, which made this project possible. Additionally, I extend sincere gratitude to the Irish Prison Service (IPS) for their invaluable support throughout this endeavour. The collaboration and insight of both have been instrumental in shaping our research and ensuring its relevance to the realities faced by both persons in custody and staff within the prison environment. Mental Health Reform (MHR) looks forward to continuing our engagement with both agencies as we move to implement the recommendations outlined in this report.

I would like to extend my appreciation to the individuals who shared their stories and experiences, despite the inherent challenges and vulnerabilities involved. As always, I hope that we at MHR have handled these stories and experiences with care, respect and compassion.

Addressing mental health requires a whole-of-government, multi-stakeholder approach, and nowhere is this more evident than in meeting the mental health needs of people in prison. Ireland's commitment to a tiered approach to mental health, as outlined in our policy "Sharing the Vision," underscores the importance of strategic investment. This report emphasises the crucial role played by Voluntary and Community Sector (VCS) organisations in delivering services within prisons, highlighting their positive impact on the daily lives of people in prison with mental health difficulties.

To achieve a coordinated approach demands comprehensive investment across all services to ensure individuals receive support at the earliest possible juncture. This entails investing in early intervention and prevention services, investing in general mental health services accessible to all, as well as providing specialised services for those in need.

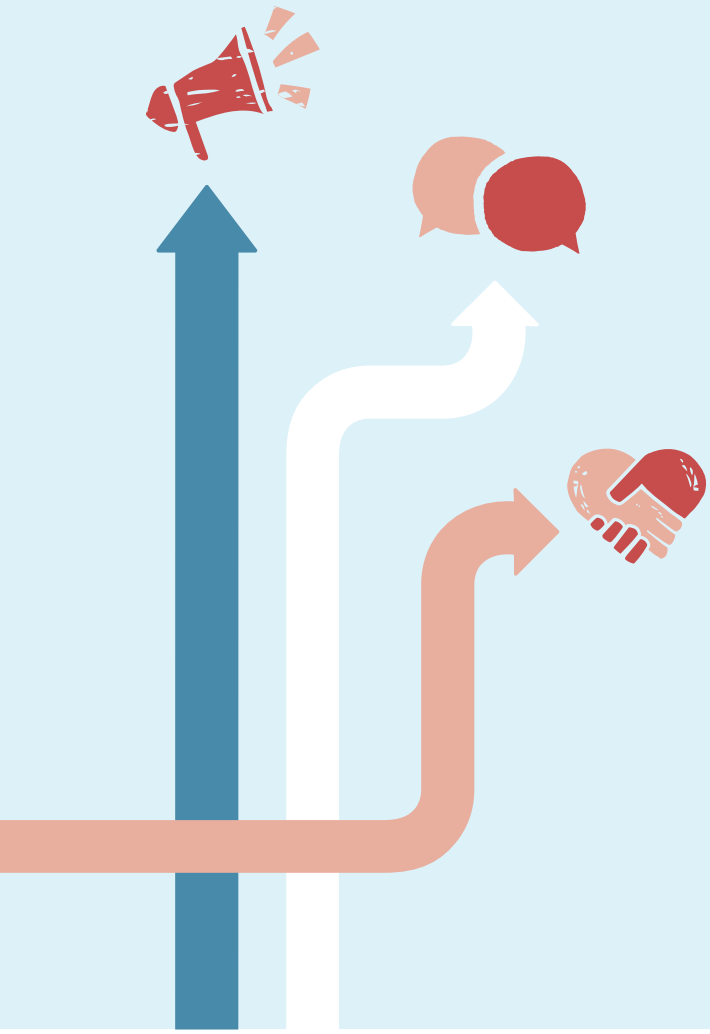
Finally, I urge policymakers, stakeholders, and communities alike to heed the findings presented in this report and take proactive steps towards fostering a more compassionate and inclusive society. Together, we can forge a future where mental health is prioritised, stigma is eradicated, and every individual has the opportunity to thrive.

Warm regards,

***Fiona Coyle*,**
**CEO of Mental Health Reform**

## Who We Are

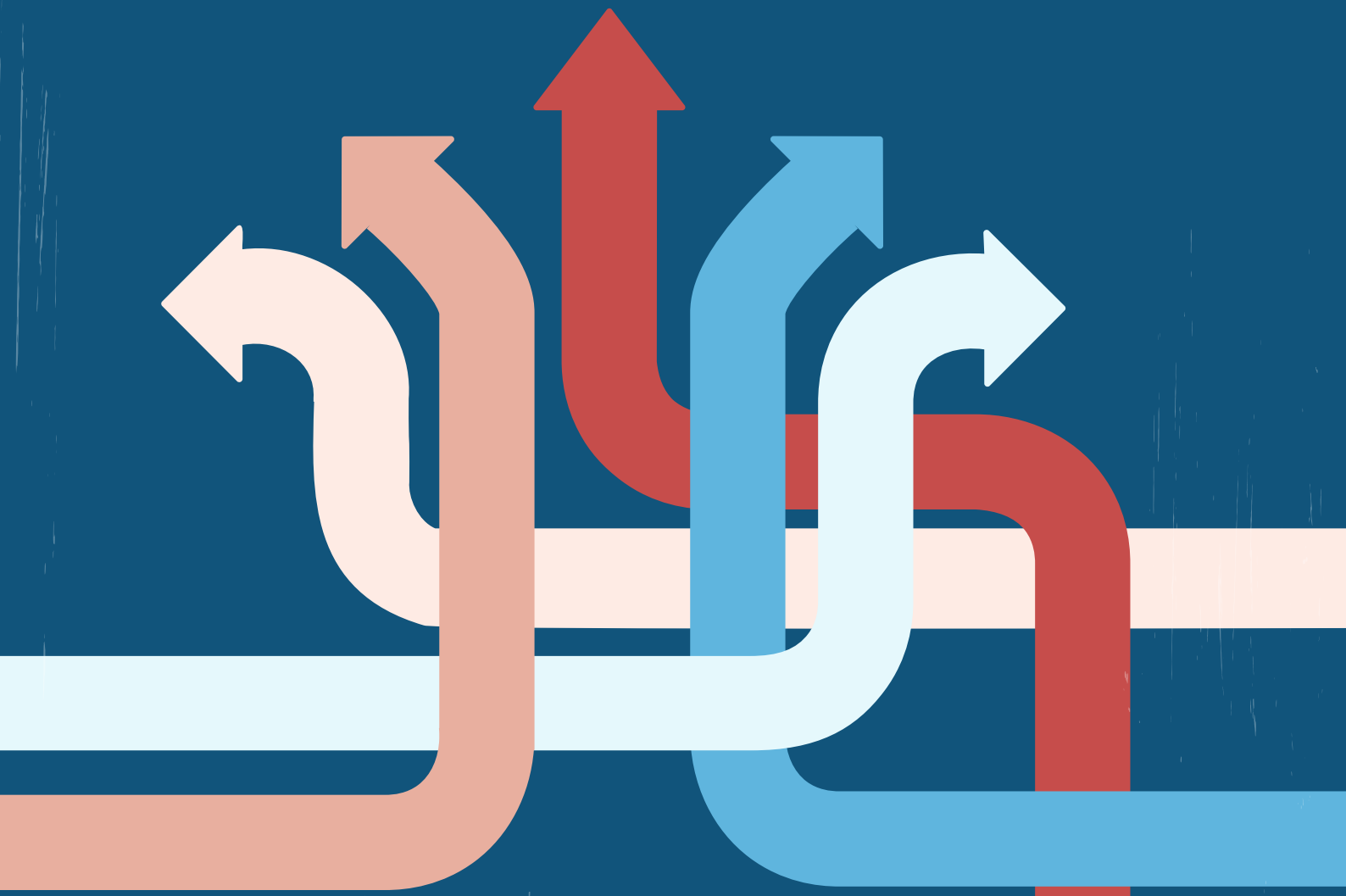
Mental Health Reform (MHR) is Ireland's leading national coalition on mental health. Our vision is of an Ireland with accessible, effective and inclusive mental health services and supports. We drive the progressive reform of mental health services and supports, through coordination and policy development, research and innovation, accountability and collective advocacy. Together with our 85 member organisations and thousands of individual supporters, MHR provides a unified voice to the Government, its agencies, the Oireachtas and the general public on mental health issues. MHR would like to thank our members for their continued insight, input and work.[1] Further information on our members can be found on the MHR website.



## A Note on Language

While our national mental health policy, *Sharing the Vision: A Mental Health Policy for Everyone*, uses the terminology 'mental health difficulties', the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which Ireland ratified in 2018, uses the term 'psychosocial disabilities' when referring to people with mental health difficulties or people who self-identify with this term. The UNCRPD clearly states that the protections and rights set out extend to those with psychosocial disabilities. Mental Health Reform (MHR) advocates for the choice of the individual in how they prefer to describe their experience and acknowledge that *"it is an individual choice to self-identify with certain expressions or concepts, but human rights still apply to everyone, everywhere."*[2]

This is not about a medical diagnosis; it is about the interaction between someone with a mental health difficulty and their social environment. Psychosocial disability refers to the functional impact or barriers that those living with enduring mental health difficulties experience every day. People in prison with enduring mental health difficulties/ psychosocial disabilities also have rights under Ireland's Equal Status Acts.
This report strives to use person-first language throughout. In cases where the term 'prisoners' is used it relates to direct quotes from people or is the official terminology used by service providers. Other quotes contain language that may not otherwise be published in a research piece; however, to keep the authenticity of the lived experience, direct quotes have not been changed.



# MENTAL HEALTH SERVICES & SUPPORTS IN PRISONS:

## Service Mapping and Reflections from Lived Experiences

EXECUTIVE SUMMARY

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## INTRODUCTION

It is increasingly acknowledged globally and in Ireland that many individuals in prison experience mental health difficulties and have a range of needs that are often complex. Despite an increased focus on this issue in recent years, in Ireland there remains an inadequate understanding of the services and supports available.

In 2019, Mental Health Reform (MHR) and the Health Service Executive (HSE) initiated a crucial study to map mental health services and supports in prison settings. Despite ethical approval and initial momentum, the study faced a pause in 2020 due to the global pandemic, resuming in 2022.

Since the project's inception, the landscape has evolved significantly. There has been a new mental health policy published and a High-Level Task Force (HLTF) established. The HLTF examined the mental health and addiction challenges faced by individuals who come into contact with the criminal justice sector, and has made 61 recommendations.[3]

Adapting to these developments, this research set out to contribute valuable insight, drawing from the lived experiences of individuals within Irish prisons, to support key stakeholders in bringing transformative change in addressing the mental health needs of the prison population.

Focusing on adult closed prisons in Ireland, the study not only identifies mental health services and pathways to access support but also integrates the nuanced perspectives from those who have lived experiences. *Sharing the Vision: A Mental Health Policy for Everyone*, Ireland's national mental health policy, commits that all persons with mental health difficulties encountering the forensic system should have access to tiered mental health supports. While much of the previous focus on mental health supports in prisons has been on specialised services, this study reflects the broad range of services and supports available across tiers, in line with *Sharing the Vision*.

> .. this research set out to contribute valuable insight, drawing from the lived experiences of individuals within Irish prisons ..

# NARRATIVE: MENTAL HEALTH & THE PRISON POPULATION

As of February 2024, more than 4,500 persons are detained in the Irish Prison Service (IPS).[4] Both mental health difficulties and drug and alcohol dependency are very common among the Irish prison population.[5,6] A 2019 systematic review of the literature estimated 50.9% of persons in custody in Ireland have a substance use disorder, 28.3% an alcohol use disorder, 4.3% have been diagnosed with an affective disorder and 3.6% with a psychotic disorder; most of which are significantly higher than rates found in the general population.[7]

Rates of **dual diagnosis** are also high among prison populations,[8,9] and women[10] and persons with adverse childhood experiences (e.g. abuse, neglect, household substance misuse, domestic abuse, etc.) are at increased risk.[11] The Health Needs Assessment for the IPS reported that "the prevalence of prisoners with a dual diagnosis was notable."[12] Despite the high prevalence and high risk among the population,[13] this has been recognised as an under-resourced area in Irish prisons.[14]

> .. the prevalence of prisoners with a dual diagnosis* was notable ..

The **prison environment** itself can also contribute to or exacerbate mental health difficulties. In Ireland, it is estimated that of detained persons who have ever used heroin, 43.0% initiated use while in prison. A study by Nurse et al[15] found that feelings of isolation and boredom, drug misuse, reduced contact with family, and negative relationships with peers or prison staff all contributed to poor mental health while in custody.[16]

**Overcrowding** in prison environments has also been found to negatively impact mental health.[17,18] With overcrowding often comes reduced privacy, sanitation, and out-of-cell activities, as well as increased violence, all of which contribute to and exacerbate mental health difficulties among prison populations.[19] Overcrowding may also contribute to increased waiting times to access services and supports.[20] Mental Health Reform's member organisation, the Irish Penal Reform Trust (IPRT), highlight overcrowding as a significant issue in their recent Progress in the Penal System (PIPS) – A Framework for Penal Reform 2022 report.[21] As of February 2024, 11 out of the 12 closed-prisons in the IPS were at full capacity or over-capacity.[22]

Similar to the broader mental health system, **voluntary organisations** are involved in the delivery of mental health related services and supports in prisons and fill important gaps in the provision of these services. Indeed, the IPS Healthcare Standards relating to mental health specifically state that "appropriate use will be made of voluntary agencies such as the Samaritans or a counselling service."[23]

** Dual diagnosis refers to individuals who are co-presenting with mental health difficulties as well as substance and/or alcohol use disorders. They may also be experiencing homelessness or housing insecurity as a result.*

### Research Aims

This project sought to identify what mental health services and supports are provided across adult closed-prisons in Ireland and the pathways, or steps, detained persons must take to access these services, including:

- What services and supports are available?
- How do detained persons become aware of what services and supports are available?
- How do detained persons become aware of the steps needed to access such services and supports?
- What are the steps detained persons must take to access each service and support?
- What are the potential barriers to accessing each service and support?

## METHODOLOGY

This study used a mixed-methods approach. A ten-part **survey** was distributed to staff across adult closed-prisons in the IPS, covering general prison information and various mental health programmes, services, or supports in the prison. Descriptive analysis was used for survey data. Qualitative **focus group discussions (FGDs)** or **one-to-one in-depth interviews** with key stakeholders explored their experiences providing or accessing mental health services or supports in adult closed-prisons. A total of 21 prison staff, five voluntary and community sector staff, and 12 detained men took part in FGDs or one-to-one interviews. Audio recordings of interviews and FGDs were anonymised, transcribed, and analysed using thematic analysis, informed by Braun & Clarke.[24] **Desk-based research** was used to contextualise and supplement data from surveys and qualitative interviews and FGDs. Where desk-based research was used, appropriate sources are referenced. For more detailed information on methodology used, please refer to the full report.

> .. feelings of isolation and boredom, drug misuse, reduced contact with family, and negative relationships with peers or prison staff all contributed to poor mental health while in custody ..

# SETTING THE SCENE

This section presents contextual factors highlighted by participants regarding the current prison landscape, including prison officers, the committal process, Integrated Sentence Management (ISM), Probation Services, and the impact of COVID-19 on prisons.

## Prison Officers

**Class officers** are prison officers who are in charge of a prison landing (e.g. a prison unit). Class officers typically can provide information about various services and supports within the prison, and can initiate referrals to services (e.g. GP, school, psychology, etc.).

## Committal Process

Individuals entering custody typically spend their first night in a committal unit. The following day, a series of **committal interviews** take place, including with medical staff, the prison governor, chief officer, ISM, and, in some cases, a peer-listener from the Samaritans Listener Service. Some prisons may also provide a **small booklet**, listing available services.

## Integrated Sentence Management and Probation Services

**Integrated Sentence Management (ISM)** was described as a service providing support to individuals with sentences of a year or longer. ISM Officers hold periodic check-ins to help manage their sentence, engage with services, and plan for release. **Probation Services** were described as offering tailored support, based on individual needs. Those on short sentences typically link in with the service toward the end of their sentence, or upon release. Persons with life sentences engage with probation throughout their time in prison.

## Protection Landings

**Protection landings** are units with a restricted regime, that includes being locked in cells for up to 23 hours per day, with meals handed in to persons. Those on protection have very limited access to the school, employment, and mental health services and supports in the prison.

## Impact of COVID-19

COVID-19 mitigation measures implemented at the onset of the pandemic included frequent lockdowns, isolation of positive cases and close contacts, and restricted in-person visitations – the majority of which were lifted by early 2023. Several prisons introduced **in-cell phones** for contacting family, friends, and services such as the Samaritans Listeners. **VideoLink** services also became widely used for visitations and mental health service provision.

## Policy Context

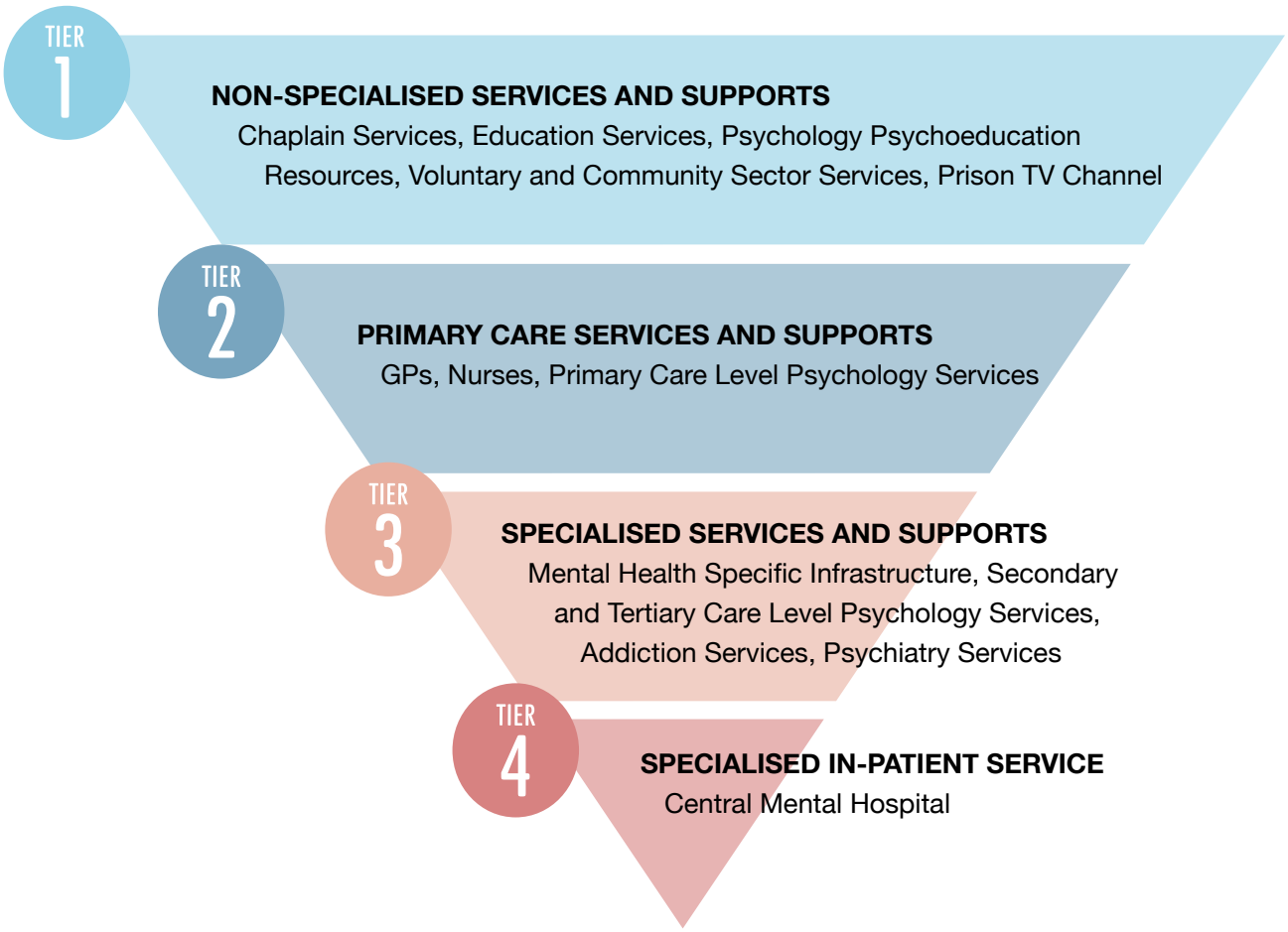
Ireland's mental health policy, *Sharing the Vision: A Mental Health Policy for Everyone* outlines a tiered approach to mental health services nationwide. Recommendation 54 of Sharing the Vision states that all persons with mental health difficulties encountering the forensic system should have access to tiered mental support. Therefore, findings of this research are presented using a similar tiered approach framework.

# MAPPING MENTAL HEALTH SERVICES AND SUPPORTS

Study participants were asked about the mental health services, supports, and resources that are available to persons in prison. This section provides an overview of mental health services, supports, and resources that were identified. This overview is presented by service or support, rather than by prison. The availability of some services, supports, and resources may differ from prison to prison.

Drawing inspiration from Sharing the Vision's "Stepped Care Approach," each service or support identified was categorised into one of four tiers, based on the level of mental health support provided. Tier 1 includes services or supports that are low-level and non-specialised, Tier 2 includes primary care mental health services and supports, Tier 3 includes specialised mental health services and supports, and Tier 4 includes specialised in-patient mental health services and supports, as illustrated in **Figure 1.**

***Figure 1.*** *Tiered model of mental health services and supports in the IPS*



## Tier 1: Non-specialised Services and Supports

**Tier 1** services and supports in prison are available to the whole population and are generally best suited to support persons experiencing 'mild' mental health difficulties. Services identified include: Chaplain Services, Education Services, Psychology Psychoeducation Resources, Voluntary and Community Sector Services, and the Prison TV Channel.

### Chaplain Services

Prison chaplains, trained in pastoral care, were described as providing informal emotional support for detained persons on a day-to-day basis.

### Education Services

Prison schools offer general academic courses and life skills workshops. In some prisons, mental health adjacent courses, such as yoga, mindfulness, sleep management, and mood management were reported as available. Additional courses may also be available via the prison TV channel, local universities, and online through Open University.

**Spotlight: Red Cross Programme**

The Red Cross programme, accessed via the prison schools, offers Red Cross volunteer training to detained persons. Volunteers raise awareness of prison activities and supports, and lead health promotion events such as suicide prevention or overdose prevention.

**Spotlight: Mental Health Week**

Interview and FGD participants spoke highly of Mental Health Week, hosted by prison schools annually and open to the whole prison population. The programme includes a week full of workshops, speakers, and events that focus on mental health and well-being.

### Psychology Psychoeducation Resources

Psychology-led once-off psychoeducation workshops, sometimes co-offered with education or addiction services, are open to the whole prison population. These workshops cover various topics, for example grief, trauma, or self-esteem. Additional psychoeducation resources may be available through the TV channel, library, and leaflet distribution.

### Prison TV Channel

The **prison TV channel** provides information about available services and how to access them**. In-cell televisions** may also share education and mental health resources.

### Additional Non-specialised Resources

Additional non-specialised resources that may indirectly support mental health were identified, including informal peer-to-peer support, the prison gym, and the phone service.

### Voluntary and Community Sector Services

A number of voluntary and community sector services that provide support to persons in custody, recently released, or affected by imprisonment were identified, as presented in *Table 1* on page 15.

*Table 1. Further information about each service can be found in the full report.*

| Voluntary and Community Sector Services Identified | | |
|---|---|---|
| * Anna Liffey Drug Project | * Grow Mental Health | * Peter McVerry Trust |
| * Alcoholics Anonymous Ireland | * Irish Association for Social Inclusion Opportunities | * Rape Crisis Centre |
| * Bedford Row | * Merchant's Quay Ireland | * Society of St. Vincent DePaul |
| * Care After Prison | * Narcotics Anonymous Ireland | * St. Nicholas Trust |
| * Churchfield Community Trust | * National Traveller Women's Forum | * Smyly Trust |
| * Cork Alliance Centre | * New Directions | * SAOL Project |
| * Exchange House | * One in Four | |
| * Fusion CPL | * PACE | |
| * Guild of St. Phillip | * Pathways Centre | |

**Spotlight: Samaritans Listener Service**

Samaritans Listeners offer confidential, active listening services 24/7. Listeners provide a non-judgemental ear and can signpost to further support. They are trained not to intervene or stop self-harm. Both face-to-face listening services provided by trained peers and over-the-phone listening services provided by trained volunteers in the community were described.

"

.. Services include: Chaplain Services, Education Services, the Prison TV Channel ..

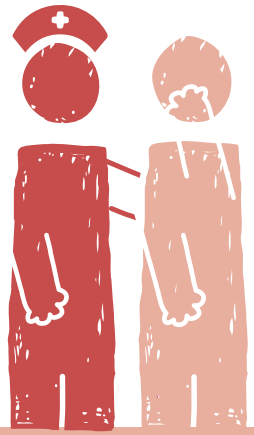
## Tier 2: Primary Care Services and Supports

**Tier 2** service and supports should be provided for persons needing additional supports beyond Tier 1. This Tier, **Primary Care Services and Supports**, supports persons experiencing 'mild to moderate' mental health difficulties. Identified services include: Primary Care Health Services and Primary Care Psychology Services.

### Primary Care Health Services

GP and primary care nursing services are provided via the prison health clinic. **Prison GP Services** provide primary healthcare services, including clinical care for persons experiencing mild to moderate mental health difficulties, prescription medications, and referrals to further mental health supports, where appropriate. GP services are generally available on a daily basis, typically by appointment.

**Primary care nursing services** can provide general health assessments, triage for clinical care, and referrals to the GP or additional mental health supports, where appropriate. Primary care nurses also provide risk assessments and supports following self-harm incidents, and pre-transfer care to in-patient psychiatric services. Nurses are available on prison landings daily, including weekends, to distribute medication to detained persons.



### Primary Care Psychology Services

**Primary care level psychology services** offer support for individuals experiencing mild to moderate difficulties such as anxiety, depression, obsessive-compulsive disorder, and panic disorder. These are typically short-term interventions. Examples participants gave included interventions for sleep disturbance, mood, and anxiety.

## Tier 3: Specialised Services and Supports

**Tier 3** services and supports provide specialised support for persons experiencing moderate to severe mental health difficulties. This tier also includes addiction services in the IPS. Services identified include: Mental Health Specific Infrastructure, Secondary and Tertiary Care Psychology Services, Drug and Alcohol Addiction Services & Dual Diagnosis, and In-reach Psychiatry Services.

### Mental Health Specific Infrastructure

Mental health specific infrastructure identified included mental health specific landings, high support units, and safety observation cells.

### Secondary and Tertiary Care Psychology Services

**Secondary and tertiary level psychology services** offer support for more pronounced or enduring mental health difficulties, such as personality difficulties, trauma, and psychosis recovery. These interventions may include group-work or longer-term individual work.

> .. Primary care nurses provide risk assessments and supports following self-harm incidents ..

### Drug and Alcohol Addiction Services & Dual Diagnosis

Upon committal, persons are screened for substance use and offered **detox or drug maintenance** (e.g. methadone) as needed. Additionally, **addiction counselling** services via **Merchant's Quay** can help individuals struggling with addiction develop positive coping strategies. Some prisons may also have **Narcotics Anonymous (NA)** and **Alcoholics Anonymous (AA)** support groups, and **addiction-focused workshops run through local universities**. The **Medical Unit in Mountjoy Prison** offers community living and an eight-week intensive support programme for individuals to become drug-free.

### In-reach Psychiatry Services

Psychiatry services, provided by the **National Forensic Mental Health Services (NFMHS)** or HSE, offer specialised treatment for more severe mental health difficulties, such as psychosis or suicidal thoughts. The NFMHS also operates two dedicated areas for persons experiencing mental health difficulties and at risk of harm to themselves or others, located in Cloverhill and Mountjoy prisons.[25] Additionally, the NFMHS **Prison In-reach and Court Liaison Service (PICLS)**, a multidisciplinary psychiatric service, helps courts identify defendants experiencing significant mental health difficulties and facilitates access to appropriate mental health care.[26] The service provides in-reach clinics in Cloverhill, Mountjoy, Wheatfield, Midlands, Portlaoise, Arbour Hill, and Castlerea prisons.[27]

### Tier 4: In-Patient Mental Health Services and Supports

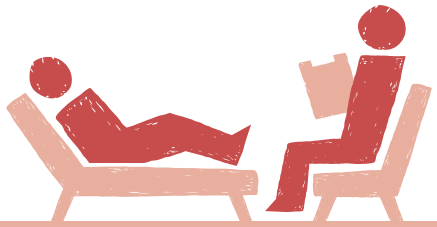
**Tier 4** services should be provided to persons experiencing severe mental health difficulties and in need of specialised in-patient mental health care. The Central Mental Hospital was identified as the key provider of Tier 4 care.

### The Central Mental Hospital

The Central Mental Hospital (CMH), now located at the NFMHS in Portrane, is the only approved centre that can provide **in-patient mental health care** for detained persons experiencing significant mental health difficulties. Care is provided under the Mental Health Act, 2001 and Criminal Law (Insanity) Act 2006.

## PERSPECTIVES OF PERSONS WITH LIVED EXPERIENCE

Study participants shared their reflections of the available services and supports in closed-prisons, and the ways in which persons may become aware of each service or support and how it is accessed. Challenges to accessing each service or support, along with potential solutions identified by participants, are also highlighted in this section. For a detailed exploration of pathways, experiences, challenges, and opportunities, please refer to the main report.



> .. Psychiatry services offer specialised treatment for more severe mental health difficulties ..

| Pathways to Accessing Services and Supports | | | |
|---|---|---|---|
| **Service or support** | **How persons become aware of service or support** | **How persons become aware of steps needed to access service or support** | **Steps one can take to access service or support** |
| **Chaplains** | On committal; Noticeboards; TV Channel; Word of mouth; Prison staff | | • Meet on committal<br>• Ask class officer<br>• Referral via prison staff, family, friend, or supporter<br>• Via phone service<br>• Approach on landings |
| | Visible on landings | | |
| **Education services** | On committal; Word of mouth; Red Cross volunteers; Prison officers; Prison staff; Chaplains; Addiction services; Governor; ISM; Noticeboards; TV channel | | • Ask prison officer, governor, or peer to put name on list<br>• Self-refer via application or speaking with teacher<br>• Referral via Prison Information Management System |
| **Samaritans Listener Services** | Noticeboards; TV channel; Leaflets; Prison staff | | • Approach peer listener<br>• Ask staff member to get Listener |
| | T-shirts worn by peer listeners; Stickers outside of Listeners' doors | | |
| **Primary care services** | On committal; Governor; ISM; Leaflets; Information books | | • Present to daily nurse triage<br>• Self-refer to surgery, GP<br>• Ask officer, chaplain, or other staff<br>• Ask peer to call nurse<br>• Call bell at night<br>• Referral from multi-disciplinary team meeting |
| | Daily nurses triage | | |
| **Psychology services** | On committal; Information books; Leaflets; Noticeboards; TV channel; School newsletter; Annual review meetings; Probation services; Voluntary staff; GPs; Nurses; Prison officers; Operational staff; Chaplains; Psychiatry; Governors; Addiction services; Word of mouth; Red Cross volunteers; Mental Health Week; Lifers Forum | | • Open access to whole-population workshops<br>• Referral for clinical services may be made by anyone: prison officers, GPs, nurses, chaplains, addiction services, teachers, Governor, peers, family, solicitor, resettlement coordinator, or self-referral.<br>• Automatic referral for priority groups |
| **Addiction services** | ISM; Court mandated reports; Prison officers; Word of mouth | | • Offered detox on committal<br>• Referral via GP, nurses, ISM, class officer<br>• Ring addiction services via phone |
| | Screened on committal | | |
| **Psychiatry services** | Nurses; Chaplains; Class officers; Prison staff | | • Referral via GP |

*"To be honest with you, it was the prisoners overall that helped me with my mental health, by being able to talk to one another, by being there for one another, by looking out for me when I first came in, and introducing me to other people"* **– Man in custody**

*"The teachers were the best of the services that I ever used in jail. The teachers taught me more about myself in terms of manners and respect, and I suppose I see the work they put in because they… really care about their students and they really care about our progression in education…"* **– Man in custody**

*"You'll do anything to pass the time. People say, 'Go to the gym.' That would be great if the gym was on every day."* **– Man in custody**

*"I think the Red Cross programme in particular is well supported because staff can see the benefits, not just to prisoners, but to themselves as well. I mean, the Red Cross programme has made prisons a safer place for everybody."* **– Prison Officer**

*"I think the school is brilliant, they try to empower prisoners to find themselves, be the best version of themselves."* **– Prison Officer**

*"It's all short-staffed every week. It's either there's no school or there's gym or there's no gym or there's school or there's half of the schools open or half the school closed. It's always something. Every week it's always something."* **– Man in custody**

*"Where before I came to prison… there was no way that I would talk to anyone about my mental health. I'd always bottle it up and try to be strong and put on a face or put on whatever, maybe like a mask. Now, since I came to prison and got access to the [Mental Health Week] workshop with the psychologist and the school, I feel like I can really talk about my mental health."* **– Man in custody**

*"[Committal to prison] can be quite sudden, really abrupt for some people, and just not knowing basics, like what can I bring in with me? What's it going to be like when I'm in there? Will I have contact with my family?"* **– Voluntary service staff member**

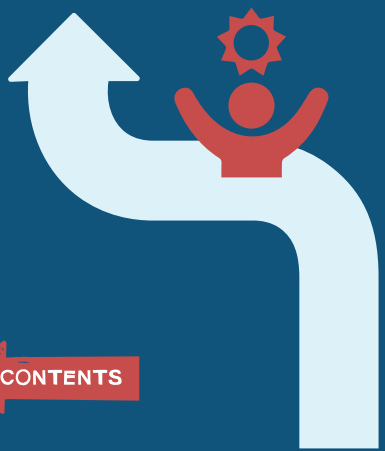
*"[Addiction services] are compassionate as well. Because you're there for an hour with one person and you're starting to build a relationship. I find that works."* **– Man in custody**

*"I'd say, there's a running joke at the jail that you have to be doing a life sentence to get a psychology appointment."* **– GP**

*"Another thing I think works well is the psychiatric input. It's slow and it's not always available because of the shortage, but the ones that are being seen receive very good care and you see them improve..."* **– Nurse**

*"I would also encourage people to come in and speak to Travelling people about the mental health and the Romanian population, and the Polish and the Lithuanians, have something for them as well."* **– Man in custody**

*"[Chaplains] talk to you like a human being."* **– Man in custody**



*"I'm here for a full year, and I've seen psychology once. It's understaffed, as far as I'm concerned. Obviously, you need a prison officer or two out there waiting. That's understaffed as well. People have sick days. There doesn't seem to be a proper staff and a system put in-place..."* **– Man in custody**

*"But the stigma of mental health is just like you wouldn't be telling people that you're going to addiction counselling or anything, which I don't think there's a problem with. Because you're actually doing a good thing, but people would like to keep that hush."* **– Man in custody**

*"[The Samaritans] works quite well. The beauty of that, I suppose, is there's capacity built in the prison community. It tends to sustain itself with limited input from any of the official services really other than when the training comes around."* **– Psychologist**

*"They should have basically NA meetings, AA meetings, they should have these inside because they're in other prisons around the country. They're not inside here."* **– Man in custody**

| Key Challenges and Opportunities Identified by Study Participants | | |
|---|---|---|
| **Service/ Process** | **Key Challenges** | **Key Opportunities** |
| **Committal process** | Persons, families, friends, supporters underprepared, unsure what to expect | Provide pre-sentencing information where possible |
| | Too little information provided | Resume information pack distribution |
| | Too much information overwhelming | Review information in weeks following committal |
| **Education services** | Limited access for those on protection | Increase access for those on protection |
| | School closures due to security and operational staff shortages | |
| **Samaritans Listener Services** | Language barriers | Purposeful recruitment of peer-listeners with multiple languages |
| **Primary care services** | Long GP wait lists for non-emergency care | Increased GP coverage for permanent staff leave |
| | Understaffing of overnight nursing as safety concern | Increased overnight nursing coverage |
| **Psychology services** | Long waiting lists | Increase whole population workshops to increase visibility, referrals, and support |
| | Understaffing of psychologists and operational staff to facilitate | |
| | Lack of awareness | Increase group therapy sessions to reach more persons and reduce stigma |
| | Stigma | |
| **Addiction services** | Long waiting lists | Increase operational staff and addiction counsellors |
| | Understaffing of addiction counsellors and operational staff to facilitate | |
| | Lack of awareness | Increase workshops and support groups for addiction |
| | Stigma | |
| | | Dual Diagnosis model of care |
| **Psychiatry services** | Long waiting lists for CMH | Collaborative approach between IPS and NFMHS for persons in need of care in approved centre |
| | Lack of facilities and security to care for violent and disruptive persons in CMH – leaving person in IPS | |

## CONCLUSION

This research sought to better understand the mental health services and supports available to adults detained in closed-prisons, including the pathways to accessing these resources and potential barriers. Findings highlight a number of mental health services and supports available that can be categorised into four tiers, ranging from low-level to specialised in-patient care. A number of pathways to learning about, and accessing these services and supports were identified. Often, persons learned about resources via informational material (e.g. leaflets, posters, TV channel), staff interactions, or peer interactions. While the steps needed to access each specific service or support varied, they were often reported as being accessed via both formal and informal referrals by staff or peers.

Qualitative interviews and FGDs revealed that, once accessed, the overwhelming majority of services and supports are viewed positively by both staff and men in custody. Tier 1 emerged as particularly impactful, with educational services and other resources such as the prison gym frequently cited as beneficial to mental health.

Some barriers to accessing services and supports were identified. The most common challenges related to short-staffing, long waiting lists, limited awareness, stigma, and language barriers. However, potential solutions were also identified by study participants. Across stakeholder groups, there was a strong desire to continue and broaden Tier 1 supports, such as psychoeducation workshops. The demand for increased addiction services was also evident, along with the perceived value of workshops and addiction support groups led by persons with lived experience of addiction or incarceration.

Finally, this research underscores the importance of diverting persons with mental health difficulties away from prison and into mental health services, where appropriate and feasible – findings of which align with the HLTF Report.[28] Where diversion is not possible, it is crucial to mitigate the negative impact of incarceration on mental health and ensure access to tiered mental health services and supports within the prison.

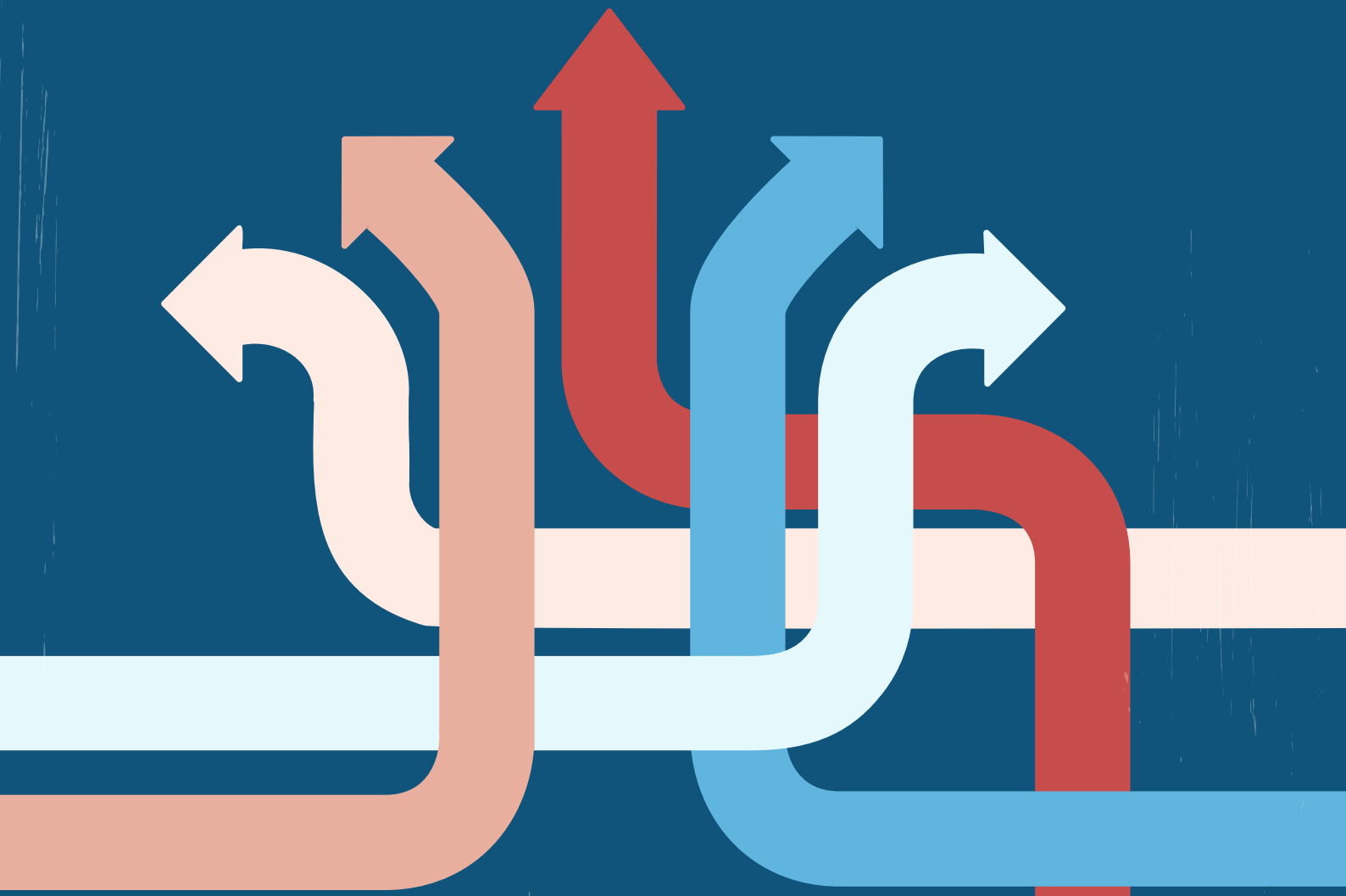
> .. once accessed, the overwhelming majority of services and supports are viewed positively by both staff and men in custody ..

# RECOMMENDATIONS

| Policy and Legal Recommendations | |
|---|---|
| **Align the Irish Prison Healthcare Standards with UNCRPD** | Ensure compliance with human rights standards for persons with disabilities, including mental health difficulties, within the criminal justice system by aligning the IPS Healthcare Standards with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). |
| **Ensure that legal rights, including those afforded under the Assisted Decision-Making (Capacity) Act 2015 are extended to people in prison** | It is essential to extend legal rights to individuals in prison, including those provided under the Assisted Decision-Making (Capacity) Act 2015. |
| **Ensure all prisons are implementing learnings from the COVID-19 lockdowns** | Improving indoor air quality in prisons to meet the updated Health and Safety Authority Indoor Air Quality Code of Practice will reduce illness among both detained persons and staff. The UN recognises access to sanitation, including showering facilities, as a fundamental human right. Infectious disease isolation measures must respect human rights, be based on scientific evidence, non-arbitrary, non-discriminatory, of limited duration, and respectful of human dignity. |

| Operational Recommendations | |
|---|---|
| **Formulate a comprehensive framework for tiered mental health support in Irish Prisons** | This study has outlined the different types of supports available at an overarching level, and will be complemented by a research project exploring the mental health status and needs of the prison population due to be undertaken in 2024. There is a need to develop a clear framework specific to the prison context. This study has shown that Tier 1 supports are highly impactful but are often not directly considered when looking at mental health support and services. |
| **Increase resource allocation across all tiers** | To effectively deliver a wide array of essential supports and services, increased resourcing and funding is imperative. |
| **Enhance the role of the Voluntary and Community Sector** | Improve awareness and engagement with the Voluntary and Community Sector (VCS) by providing accessible brochures detailing available VCS offerings in each prison. Periodic visits from VCS services, akin to the success of Mental Health Week, could enhance awareness and accessibility. Ensure the provision and expansion of VCS services through sustainable, sufficient, and multi-annual funding. |

| | |
|---|---|
| **Implement the Dual Diagnosis model of care in prisons** | In line with the recommendations of the HLTF, a National Clinical Programme for Dual Diagnosis should be resourced and piloted within the prison setting with a view of scaling up across the prisons. |
| **Distribute tailored information booklets in each prison** | Standardised information booklets for each prison should be distributed within 48 hours of committal. Tailor the content to the specific offerings, services, and opportunities available in each prison, ensuring individuals have adequate time to review and seek clarification. |
| **Provide information in multiple languages** | Enhance accessibility by translating essential information into multiple languages, ensuring that individuals in prison can readily comprehend the provided materials. |
| **Provide pre-sentencing guidance on what to expect in prisons** | There are opportunities within the criminal justice process to provide pre-sentencing guidance on what to expect in prisons. This information should be provided in an accessible way and translated into relevant languages. The impact of imprisonment and the shock of being in prison are reported to be detrimental to mental health. Preparedness will reduce anxiety levels about what to expect. |
| **Implement a second mental health screening** | A second mental health screening should be conducted in the days following reception, when someone may be better placed to engage in discussion and the immediate stressor of being imprisoned is not as acute. This should be done by a trained mental health professional. |
| **Peer support model** | Explore and implement a peer support model within Irish prisons to enhance mental health and well-being, leveraging the unique benefits of shared experiences and mutual understanding among the prison population with lived experience of mental health difficulties. |
| **Purposefully recruit multi-lingual peer-Listeners** | Training Samaritans peer-Listeners who speak additional languages will improve access to the service for non-English speaking persons. |
| **Increase awareness and reduce stigma** | Increasing frequency of Mental Health Week and similar lived experience workshops and events may increase mental health awareness and reduce stigma among the population. |
| **Develop Population-Centric Modelling for Tailored Prison Health Services in Ireland** | Establish a modelling framework for the prison population as Ireland shifts towards population-based health budgeting. This modelling initiative should inform service provision, considering the distinct demographic and social characteristics of each prison population. Recognising that individuals often originate from communities facing multiple deprivations, have experienced adverse life events, and present with diverse and complex needs, the model should aim to tailor services accordingly. |



# MENTAL HEALTH SERVICES & SUPPORTS IN PRISONS:

## Service Mapping and Reflections from Lived Experiences

FULL REPORT

# 1. INTRODUCTION

It is increasingly acknowledged globally and in Ireland that many individuals in prison experience mental health difficulties and have a range of needs that are often complex. Despite an increased focus on this issue in recent years, in Ireland there remains an inadequate understanding of the services and supports available.

In 2019, Mental Health Reform (MHR) and the Health Service Executive (HSE) initiated a crucial study to map mental health services and supports in prison settings. Despite ethical approval and initial momentum, the study faced a pause in 2020 due to the global pandemic, resuming in 2022.

Since the project's inception, the landscape has evolved significantly. There has been a new mental health policy published and a High-Level Task Force (HLTF) established. The HLTF examined the mental health and addiction challenges faced by individuals who come into contact with the criminal justice sector, and has made 61 recommendations.[3]

Adapting to these developments, this research set out to contribute valuable insight, drawing from the lived experiences of individuals within Irish prisons, to support key stakeholders in bringing transformative change in addressing the mental health needs of the prison population. Focusing on adult closed prisons in Ireland, the study not only identifies mental health services and pathways to access support but also integrates the nuanced perspectives gained from those who have lived through these experiences. *Sharing the Vision: A Mental Health Policy for Everyone,* Ireland's national mental health policy, commits that all persons with mental health difficulties encountering the forensic system should have access to tiered mental health supports. While much of the previous focus on mental health supports in prisons has been on specialised services, this study reflects on the broad range of services and supports available across tiers, in line with *Sharing the Vision: A Mental Health Policy for Everyone*.

> .. this research set out to contribute valuable insight, drawing from the lived experiences of individuals within Irish prisons ..

# 2. NARRATIVE: MENTAL HEALTH & THE PRISON POPULATION

As of February 2024, more than 4,500 persons are detained in the Irish Prison Service (IPS).[4] Both mental health difficulties and drug and alcohol dependency are very common among the Irish prison population.[5,6] A 2019 systematic review of the literature estimated 50.9% of persons in custody in Ireland have a substance use disorder, 28.3% an alcohol use disorder, 4.3% have been diagnosed with an affective disorder and 3.6% with a psychotic disorder; most of which are significantly higher than rates found in the general population.[7]

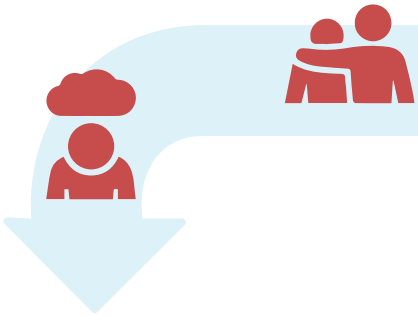
Numerous factors contribute to poor mental health of persons in custody.[8] Detained persons are more likely to have a history of trauma,[9,10] including adverse childhood experiences (ACEs), defined by Kalmakis and Chandler as "childhood events, varying in severity and often chronic, occurring within a child's family or social environment that cause harm or distress, thereby disrupting the child's physical or psychological health and development."[11] Examples of ACEs include any kind of abuse or neglect, household substance misuse, domestic abuse, or criminal behaviour.

Rates of **dual diagnosis** are also high among prison populations[12,13] and women[14] and persons with adverse childhood experiences (e.g. abuse, neglect, household substance misuse, domestic abuse, etc.) are at increased risk.[15] Persons with dual diagnosis are at a higher risk for suicide.[16] The Health Needs Assessment for the IPS reported that "the prevalence of prisoners with a dual diagnosis was notable."[17] Despite the high prevalence and high risk among the population, this has been recognised as an under-resourced area[18] In Irish prisons, this has been recognised as an under-resourced area.[19]

The **prison environment** itself can also contribute to or exacerbate mental health difficulties. In Ireland, it is estimated that of detained persons who have ever used heroin, 43.0% initiated use while in prison. A study by *Nurse et al*[20] found that feelings of isolation and boredom, drug misuse, reduced contact with family, and negative relationships with peers or prison staff all contributed to poor mental health while in custody.[21] Persons who are on remand, unsentenced, or serving a life sentence self-harm at higher rates than the rest of the prison population.[22]

**Overcrowding** in prison environments has also been found to negatively impact mental health.[23,24] With overcrowding often comes reduced privacy, sanitation, and out-of-cell activities, as well as increased violence, all of which contribute to and exacerbate mental health difficulties among prison populations.[25] Overcrowding may also contribute to increased waiting times to access services and supports.[26] Mental Health Reform's member organisation, Irish Penal Reform Trust (IPRT), highlight overcrowding as a significant issue in their recent Progress in the Penal System (PIPS) – A Framework for Penal Reform 2022 report.[27] As of February 2024, 11 out of the 12 closed-prisons in the IPS were at full capacity or over-capacity.[28]

Similar to the broader mental health system, **voluntary organisations** are involved in the delivery of mental health related services and supports in prisons and fill important gaps in the provision of these services. Indeed, the IPS Healthcare Standards relating to mental health specifically state that "appropriate use will be made of voluntary agencies such as the Samaritans or a counselling service."[29]



## 2.1. Research Aims

This project sought to identify what mental health services and supports are provided across adult closed-prisons in Ireland and the pathways, or steps, detained persons must take to access these services, including:

* What services and supports are available?
* How do detained persons become aware of what services and supports are available?
* How do detained persons become aware of the steps needed to access such services and supports?
* What are the steps detained persons must take to access each service and support?
* What are the potential barriers to accessing each service and support?

> .. feelings of isolation and boredom, drug misuse, reduced contact with family, and negative relationships with peers or prison staff all contributed to poor mental health while in custody ..

# 3. METHODOLOGY

**This research project used a mixed methods approach, combining desk-based research, surveys, and qualitative one-to-one interviews and focus groups with key stakeholders. Ethical approval was obtained from the IPS Research Ethics Committee. This section will give a brief overview of the methodology used.**

## 3.1. Surveys

The survey design was informed by the World Health Organisation's (WHO) 4Ws approach[30] and their guidelines on constructing a Master Facility List (MFL) of healthcare facilities.[31] This is considered best practice, and has previously been used by the HSE to map other health services, such as Dementia Specific Services in the Community.[32]

With the help of 14 assistant psychologists volunteering as project liaisons, a ten-part survey was distributed to staff working in 12 adult closed-prisons in the IPS. Section 1 covered general information about the prison (e.g. catchment area, operational capacity), questions in Sections 2 to 6 focused on key stakeholders that provide (or may provide) mental health specific programmes, services, or supports in the prison (e.g. GPs, Nurses, Prison Officers, Psychology), and Sections 7 and 8 covered the mental health facilities in the prison and in-reach psychiatry services in the prison. Section 9 covered education services, and Section 10 gathered information about any additional mental health programmes or supports in the prison that respondents may be aware of. The survey distributed was developed in consultation with the project steering group and MHR's Research Advisory Committee (RAC).

Each survey section was completed by the staff member within the prison best placed to answer relevant survey questions (e.g. psychology section completed by psychology staff, education section completed by teachers, etc.). Participation was voluntary, and participants were asked only to provide their job title at the start of each section to give consent for participation and ensure they were best placed to answer the questions in that section. Completed surveys were then returned to their respective project liaison person, who sent the relevant survey sections to the appropriate authority for data verification and validation (e.g. Psychology Service data was validated by the head of Psychology Services, Nursing data was validated by head of Nursing Services, etc.). Surveys were returned by each of the 12 prisons, though not all sections were fully completed in every survey due to the voluntary nature of the research.

### 3.1.1. What did we do with the survey data?

A descriptive analysis of the data was carried out in order to provide an overview of the existing mental health related programmes, services, and supports available in the IPS, and how persons access them. This data has been integrated throughout the results section in order to support qualitative findings from the individual interviews and focus groups and, where appropriate, has been presented using data tables.

## 3.2. Qualitative Interviews and Focus Groups

Key stakeholders were invited to take part in semi-structured in-depth one-to-one interviews or focus group discussions (FGDs). Frontline health and mental health professionals operating in the IPS, Prison Officers, and staff working in voluntary organisations involved in the delivery of mental health related services and supports in the IPS were invited to take part in online focus group discussions. In order to facilitate schedules, some participants engaged in one-to-one interviews in place of FGDs. A total of five one-to-one interviews and four FGDs took place with a total of 21 prison staff across nine prisons, including prison officers, psychologists, nurses, and GPs. An additional five participants from four voluntary and community sector services took part in one focus group discussion. One-to-one interviews lasted between 44 and 134 minutes, and focus groups lasted between 73 and 161 minutes.

Persons in custody in adult male prisons were invited to take part in one-to-one in-depth interviews exploring their experiences accessing, or attempting to access, mental health services or supports while in closed prisons. The decision to hold these conversations in a one-to-one format rather than a focus group format was made in order to safeguard the privacy of conversations that may relate to their own experiences of mental health difficulties. A total of 12 men across five prisons took part in one-to-one interviews. The majority of these interviews took place in person; however, a small number were held via telephone. Interviews lasted between 17 and 78 minutes.

### 3.2.1. What did we do with the interview and focus group data?

Audio recordings of the one to one interviews and focus groups were anonymised by removing all identifiable information (e.g. names, place names, etc.) before transcription. Thematic analysis, informed by Braun & Clarke,[33] was carried out whereby the common themes, topics, and ideas were identified and examined.

## 3.3. Desk-based Research

Desk-based research was used to collect important additional or contextual information to supplement findings from surveys, one-to-one interviews and focus groups. Where desk-based research was used to support data in Chapters 4 and 5 of the report, this is noted using footnotes, and appropriate sources referenced.

## 3.4. Contextual Information for Methodology Decisions

It is important to note some contextual information that informed decisions regarding the methods used for this study. First, the decision to exclude persons in custody in female prisons from participating in one-to-one interviews was made due to a similar piece of research being carried out by a PhD candidate at University of Limerick, focusing solely on female prisons. However, staff working in female prisons were invited to participate in surveys and focus group discussions. The research team also visited the Dóchas Centre on the Mountjoy Campus, for a tour led by an Integrated Sentence Management (ISM) officer and met with an Assistant Governor. Additional limitations of the research can be found in Chapter 8, Limitations.

# 4. SETTING THE SCENE

**This section introduces contextual factors related to the current prison landscape that study participants highlighted, including prison officers, the committal process, Integrated Sentence Management (ISM), Probation Services, and the impact of the COVID-19 pandemic on prisons.**

## 4.1. Prison Officers

Participants in one-to-one interviews and focus group discussions often spoke about the important role and significant impact that prison officers, and in particular class officers, have with persons in custody. **Class officers** are prison officers who are in charge of a prison landing (e.g. a prison unit). Participants explained that class officers are able to provide information about various services and supports within the prison, and can initiate referrals to services such as the GP, school, psychology, etc.

## 4.2. Committal Process

Participants in one-to-one interviews and focus groups spoke about the **committal process**. Individuals coming into custody are typically housed on a committal unit for their first night, where they are due to be checked by prison officers every 15 minutes to monitor their well-being. The following day, a series of **committal interviews** will take place. Within 24 hours, the person will be met by a doctor or a nurse, who will go over their medical history, substance use, and psychosocial background. The person may also meet with the prison governor, chief officer, and ISM. During these interviews, staff generally provide the person with information about the available services and how to access them. Referrals may be made throughout this process to services such as psychology, psychiatry, or addiction by the staff member, or individuals may self-refer by expressing interest in engaging. While one interviewee noted that every person coming into custody receives a small **booklet with a list of the services** available to them, other men in custody reported not receiving these booklets. Several participants in custody suggested that COVID-19 related restrictions may have interrupted distribution of these materials. Some interviewees spoke about peer-listeners from the Samaritans Listener Service meeting individuals coming into custody to offer a non-judgmental ear and signpost to services. While one man in custody noted this as available at his prison, another shared it was unavailable due to an unfilled post at his prison.

## 4.3. Integrated Sentence Management and Probation Services

**Integrated Sentence Management (ISM)** was described by interview and focus group participants as a service that individuals with sentences of one year or longer will meet with on committal and have periodic check-ins with throughout their sentence. ISM officers help individuals to manage their sentence, engage with appropriate services, and plan for release, for example by connecting them with housing or addiction supports.
**Probation Services** were described as offering various services, depending on the needs of each person. For those on short sentences, probation typically links in with persons nearing the end of their sentence, or upon release. Persons with life sentences engage with probation throughout their time in prison.

## 4.4. Protection Landings

Several one-to-one interview and focus group participants spoke about **protection landings**, where individuals are locked in cells for up to 23 hours per day, with meals handed in to them. Individuals on protection landings have a very restricted regime, and therefore receive very limited access to the school,

employment, and mental health services and supports in the prison. Participants shared that individuals will typically self-refer to these landings if they feel unsafe being among the general prison population. In general, participants agreed that protection landings were a last resort, and prison staff indicated that they would often work with individuals to provide alternative options, such as transferring to a different prison where they may feel safer among the general prison population.

## 4.5. Impact of COVID-19

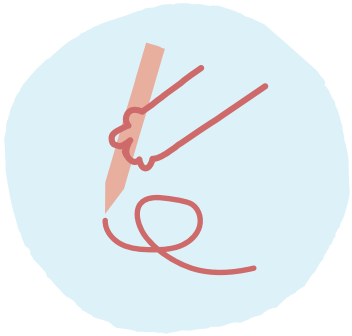
One-to-one interview and focus group participants described the impact the COVID-19 pandemic has had on services and supports in prisons. Mitigation measures that were put in place included lockdowns, isolation and quarantine for positive cases and close contacts, and restricted in-person visits – the majority of which were lifted by early 2023. Men in custody noted that lockdowns were frequent, particularly prior to vaccine rollout, due to the close proximity in which the population lives.

With the pandemic restrictions came the introduction of technology in prisons. Several prisons introduced **in-cell phones** to facilitate contact with family, friends, and significant others, as well as with support services such as the Samaritans Listener Service. While these phones are not yet available in all prisons, it was noted by several participants that in-cell phones would be rolled out across the IPS in the near future. **VideoLink** services became widely used in place of in-person visits and mental health service provision. This technology continues to be an option for individuals in custody and their family, friends, and significant others.

## 4.6. Policy Context

Much has been written on mental health policy, penal policy and human rights at an international and national level. In the interest of brevity and non-duplication of information, it was decided not to re-iterate the fullest policy context relating to this study.

Instead, however, we would like to note that this research was undertaken with the State's obligations under the UNCRPD in mind and the paradigm shift taking place internationally relating to disability rights. As mentioned earlier, this relates directly to the rights of persons with psychosocial disabilities, as the rights of the UNCRPD explicitly extend to this cohort also. "The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) is an international human rights treaty, which exists to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all disabled persons."[34] All of the Articles in the UNCRPD, such as Article 13 – Access to Justice, Article 16 – Freedom from exploitation, violence and abuse, and Article 25 – Health, extend to disabled people in prison. In this regard, as highlighted in 'a Note on Language', this means that people in prison with mental health difficulties have rights under the UNCRPD. The State is working on realising these rights for disabled people in the community and therefore, this should be reflected across the prison services.



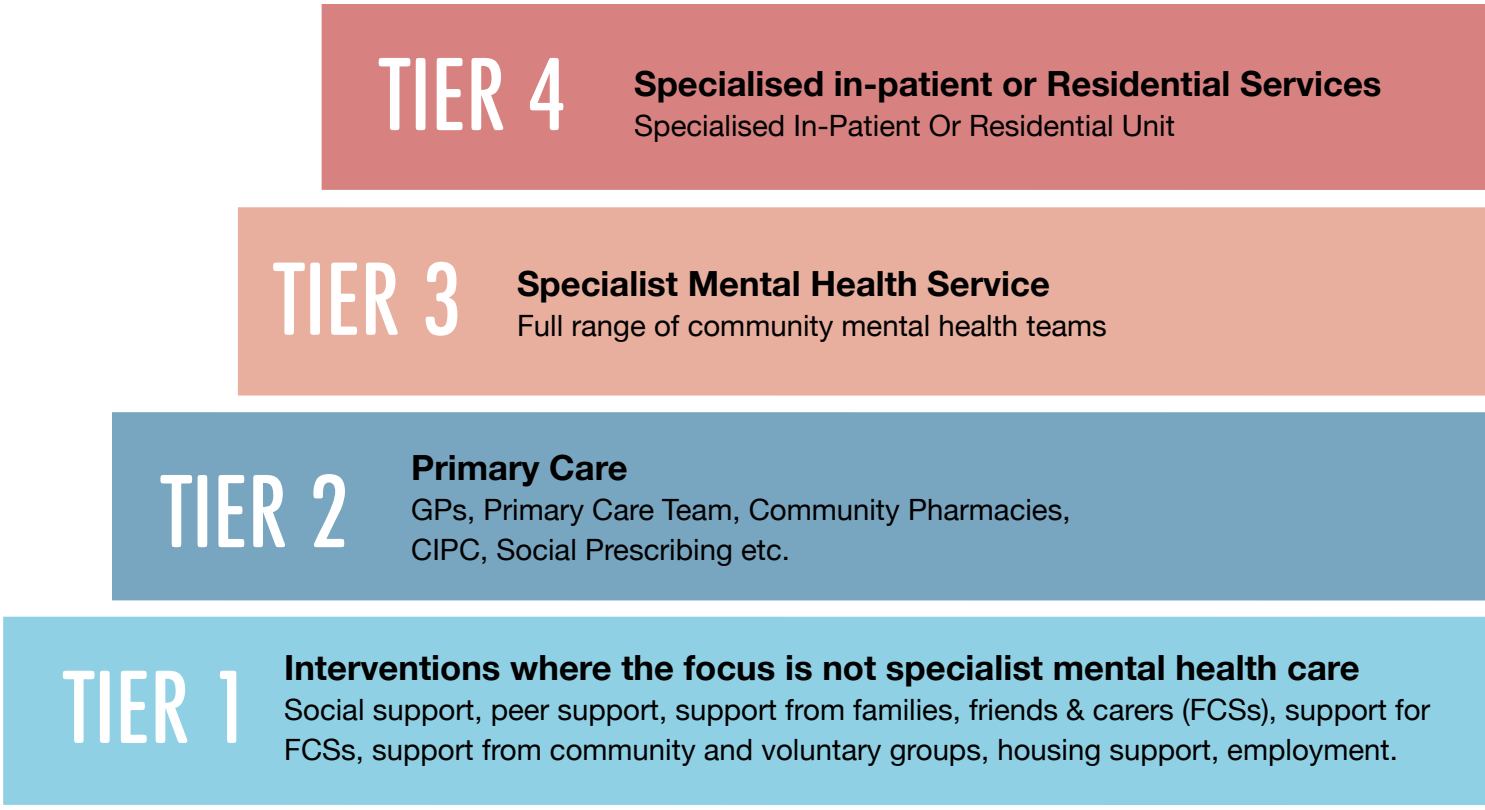
Articles 12 and 14 of the UNCRPD relate to recognition before the law and to a person's capacity. In order to realise these rights, Ireland brought forward the Assisted Decision-Making (Capacity) Act[35] and is working on legislation on the Protection of Liberty Safeguards, the draft of which has not been published at the time of writing.[36] People in prison should also be aware of the changes in their rights to supported decision-making, which have been in place with the Decision Support Service (DSS) since April 26th, 2023.

Following the delays related to COVID-19 lockdowns, this study was updated to align with Ireland's most recent mental health policy, Sharing the Vision: A Mental Health Policy for Everyone. This policy sets out the tiered approach to mental health services across the country, as outlined in **Figure 1**. Therefore, it was decided that the vast information garnered in this study would also be most useful if presented using a similar, tiered approach framework.

Recommendations 54, 55, 56 and 87 of Sharing the Vision all relate specifically to mental healthcare and the criminal justice or forensic systems. MHR notes the ongoing work in relation to the Sharing the Vision: A Mental Health Policy for Everyone recommendations, including the follow-up from the HLTF recommendations.

Policies and procedures relating to imprisonment of disabled people, including persons with mental health difficulties, need to be updated and in line with disability rights nationally and internationally.

*Figure 1. Sharing the Vision: A Mental Health Policy for Everyone – Stepped care approach*

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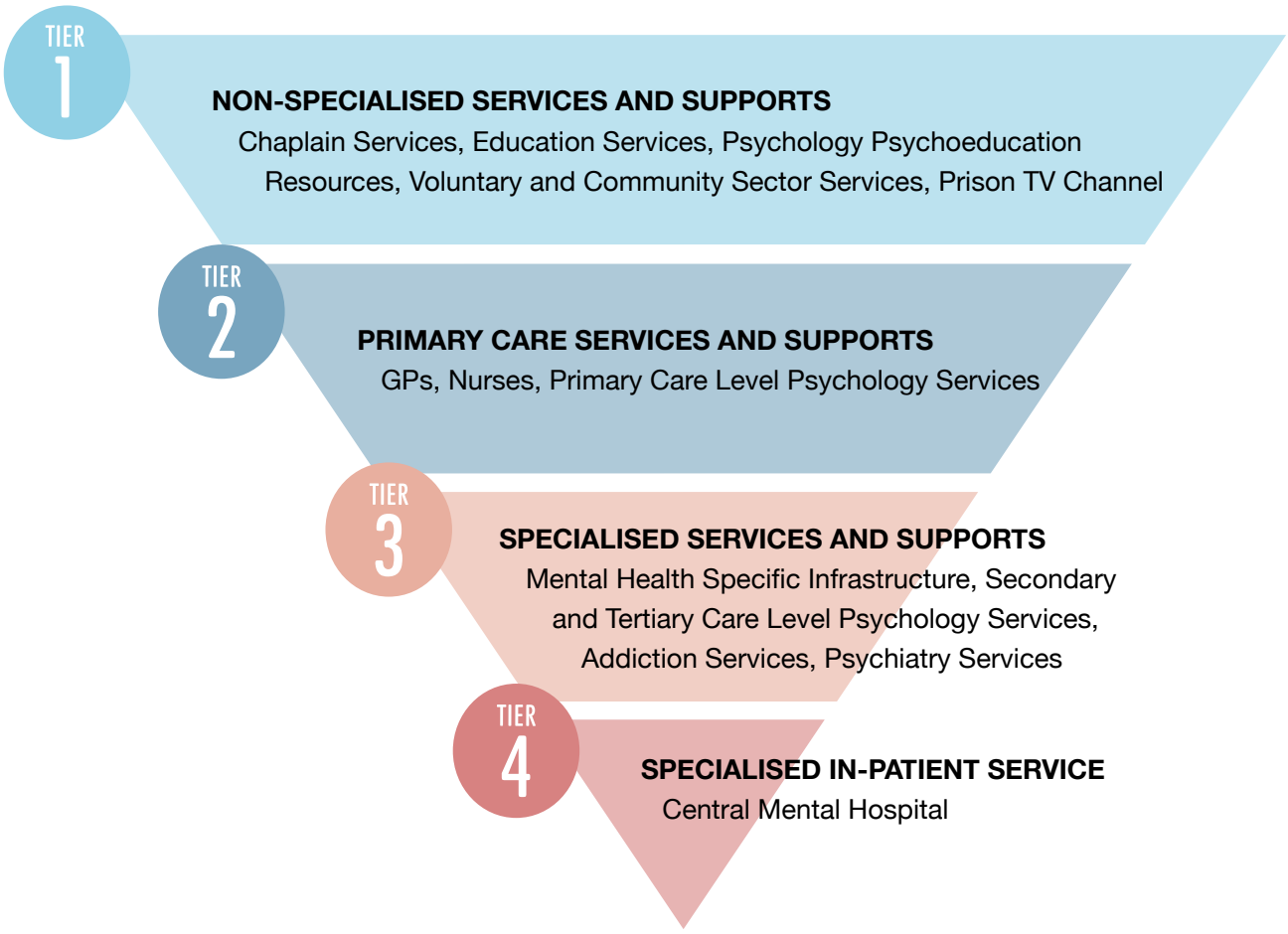
# 5. MAPPING MENTAL HEALTH SERVICES AND SUPPORTS

One-to-one interview, focus group, and survey participants were all asked about the mental health services, supports, and resources that are available to persons in prison. This section provides an overview of mental health services, supports, and resources that were identified. Importantly, to protect the anonymity of participants, the decision was made to present this overview by service or support, rather than by prison. The availability of some services, supports, and resources may differ from prison to prison.

Drawing inspiration from Sharing the Vision's "Stepped Care Approach", this research is presented using a tiered model. Recommendation 54 of Sharing the Vision states that all persons with mental health difficulties encountering the forensic system should have access to tiered mental support. In order to achieve this, we first must understand what exists and what needs to be strengthened. Therefore, each service or support identified was categorised into one of four tiers, based on the level of mental health support provided. Tier 1 includes services or supports that are low-level and non-specialised, Tier 2 includes primary care mental health services and supports, Tier 3 includes specialised mental health services, and Tier 4 includes specialised in-patient mental health services, as illustrated in **Figure 2.**

***Figure 2.** Tiered model of mental health services and supports in the IPS*



## 5.1. Tier 1: Non-specialised Services and Supports

Tier 1 services and supports in prison mirror those at community level. As indicated in Figure 1 and Figure 2, services and supports within this tier are available to the whole population and are best suited to helping manage mental health difficulties which might be described as 'mild'.

### 5.1.1. Chaplain Services

Prison chaplains, trained in pastoral care, were described by one-to-one interview, focus group, and survey participants as providing informal emotional support for persons in custody on a day-to-day basis. They may also be a source of support following a crisis, or while waiting to access other mental health services and supports in the prison. Chaplains were also described as being able to liaise between persons in custody and their families, friends, or supporters outside of the prison. Chaplain services are available in the prison every day, including weekends.

### 5.1.2. Education Services

The prison school was repeatedly highlighted as a mental health resource throughout focus groups and interviews. Through the school, detained persons are able to take **general academic courses** (e.g. Maths, English, Irish, etc.), **life-skill workshops** (e.g. cooking, industrial cleaning, physical education, first aid, etc.), and **electives** (e.g. music, woodworking, arts, etc.). **Mental health adjacent classes** such as yoga, mindfulness, sleep management, and mood management were also noted as available in some prisons. Additional courses available through **local universities** or online through **Open University** were also noted.

Teachers who participated in the survey noted that all courses are delivered in-person, however more than 150 additional courses were also available through the prison TV channels, which persons now have access to in their cells. Courses in the school are offered in both the morning and the afternoon, with morning classes running from 9:30 AM to 12 PM, and afternoon classes running from 2:15 PM to 4 PM. Some detained persons avail of classes in the school full-time, while those who have jobs in the prison are limited to five sessions per week.

***Spotlight: Red Cross Programme***

Participants in many of the focus groups and one-to-one interviews spoke about the Red Cross programme in the prisons. This programme was described as a course that is accessed through the school, during which persons learn about the history of the Red Cross and receive training to become Red Cross volunteers in the prison. Volunteers regularly engage with prison staff to help raise awareness of events, workshops, and other supports that are available in the prison, for example by dropping leaflets under cell doors and spreading the word among peers. In addition, Red Cross volunteers lead health promotion events in the prisons throughout the year. Some examples of past events participants shared included suicide prevention, overdose prevention, and weapons amnesty. These varied from prison to prison, with workshops and activities tailored to the needs of each prison.

> .. Chaplain services are available every day, including weekends ..

***Spotlight: Mental Health Week***

Mental health week was described by many interviewees and focus group participants as a programme that happens once a year across all of the prisons. It is hosted by the schools and open to the whole prison population. The programme includes a week full of workshops, speakers, and events that focus on mental health and well-being.

### 5.1.3. Psychology Services

**Once-off psychoeducation workshops** for the wider prison population were also described as being available from time to time. These workshops may be co-offered with the school or addiction services, and facilitated by either an assistant psychologist or qualified psychologist. These workshops are typically once-off group sessions, lasting about one-and-a-half to two hours. Some examples of past workshops included seminars related to healthy sleeping habits, grief, trauma, self-esteem, and managing mood.

Additional informational resources about mental health, developed by the psychology team, are made available to the wider prison population through prison TV channels, prison libraries, and leaflets dropped under cell doors from time to time.

### 5.1.4. Voluntary and Community Sector Services

Voluntary and community sector services providing support to persons in custody, persons recently released from custody, and persons affected by imprisonment were identified through interviews, focus groups, and surveys. Services identified and the type of support offered are outlined in **Table 3**.

Not all identified services and supports were discussed in-depth, and as such the information outlined may not be comprehensive. Where services were named but not discussed, a brief description of available supports has been added using publicly available information, with relevant sources cited.

***Spotlight: Samaritans Listener Services***

Many participants brought up the listening services provided by the Samaritans. Listeners are trained by the Samaritans to provide confidential, active listening services, and are available 24/7. The Listeners provide a non-judgemental ear to individuals who wish to speak to someone, and signpost to further support. They are trained not to intervene or stop self-harm. Two services were described by interview and focus group participants: face-to-face listening services provided by trained peers, and over-the-phone listening services provided by trained Samaritan volunteers in the community outside of prisons. Calls to the Samaritans in the community from in-cell phones may be made at any time, and are not limited in time or frequency. Participants shared that Samaritans from the community come into the prisons on a weekly or fortnightly basis to provide support and ongoing training to peer-listeners. Samaritans recruit new peer-listeners two to three times per year and provide a five to six-week training course. Persons in custody may express interest in attending this training, or be invited directly by prison staff. Those who are selected to become peer-listeners were described by one prison officer as persons who are stable, focused, and “not here to mess around and they want to do good for themselves and do good for others”.

*Table 3. Voluntary and Community Services Identified*

| Voluntary and Community Sector Services Identified | |
|---|---|
| **Ana Liffey Drug Project** | A national addiction service that was noted as available by one survey participant. The organisation website indicates there is a prison in-reach service, however at the time of writing it notes these in-reach services are suspended due to the COVID-19 pandemic.[38] |
| **Bedford Row** | A Limerick-based service that supports persons in prison and families affected by imprisonment with the aim of breaking the cycle of offending and imprisonment.[39] |
| **Care After Prison (CAP)** | A peer-led support service that trains individuals more than two years out of their last sentence to become mentors for others in their transition out of prison. These mentors support individuals to re-integrate into the community and access supports. CAP also provides a Community Support Scheme (CSS), which enables some individuals with short sentences to serve part of their time in the community. |
| **Churchfield Community Trust** | An adult education service[40] in the Cork area that can be accessed through referral, for example through the Irish Association for Social Inclusion Opportunities (IASIO). |
| **Cork Alliance Centre (CAC)** | A probation funded project that provides a Desistance & Integration Support Programme for persons recently or soon to be released from prison, to facilitate re-integration into the community and access to supports. Individuals may access the service via referrals from probation or other service providers, family members, friends, or self-referral. CAC also provides a CSS. |
| **Exchange House Ireland** | A national Traveller-specific frontline service provider that offers a wide variety of supports across the country, and provides family and addiction support to persons in prison.[41] |
| **Fusion CPL** | An addiction project in Cherry Orchard, Dublin, which works with people who are drug-free or stable. The project links in with individuals in prison who have about two years left in their sentence to ensure they are accessing services and supports in prison, and ensure they have a plan for housing and addiction supports upon release. |
| **Guild of St. Phillip** | A probation-funded organisation that provides befriending and visit services in the Dublin area for persons in prison who otherwise would not have visitors, as well as persons who have left custody.[42] |
| **Grow Mental Health** | Provides Mental Health Education Programmes in the general community and in workplaces.[43] Some funding is also received from Probation Services to provide in-reach services to prisons.[44] |
| **Irish Association for Social Inclusion Opportunities (IASIO)** | Provides information, linkages, and resettlement support for persons in prison and upon release, including addiction, housing, training, and employment support. IASIO also provides a CSS. |

| | |
|---|---|
| **National Traveller Women's Forum** | A forum that engages with Traveller women in the Dóchas centre to provide peer support.[45] |
| **New Directions** | A free, confidential service that provides information and emotional support for families affected by imprisonment.[46] |
| **One in Four** | Provides professional counselling to adult survivors of childhood sexual abuse and support for families. The organisation also works with persons who have sexually abused children to provide interventions. These interventions are open to those in prison, released from prison, or who have never been convicted.[47] |
| **PACE** | A Probation Services funded organisation that provides targeted interventions for persons with convictions to reduce re-offending.[48] One survey participant specifically highlighted the Circles of Support and Accountability (CoSA) intervention for persons convicted for harmful sexual behaviour.[49] |
| **Pathways Centre** | Provides information, education, counselling, support and referral services to persons recently released from prison in the Dublin area.[50] |
| **Peter McVerry Trust** | A housing and homelessness support service that provides early stage prevention services for those at immediate risk of becoming homeless, including persons in prisons.[51] |
| **Rape Crisis Centre** | Provides listening and support services for individuals who have experienced rape, sexual assault, sexual harassment, or sexual abuse. These services were referenced as being available in the Dóchas Centre1as well as Limerick Women's' Prison. Individuals wishing to access this support may ask a prison officer to put their name down for the service. |
| **Society of St. Vincent DePaul** | Provides support to children and families visiting loved ones in prisons.[52] |
| **St. Nicholas Trust** | A Cork-based service that supports families of persons who are incarcerated. Supports provided include a support group for persons affected by imprisonment, practical guides and tips for supporting a loved one in prison and upon release, and support for in-person visits.[53] |
| **Smyly Trust** | A Child, Youth and Family Service that offers residential care for boys and girls up to age 18, and an Aftercare Service for young males leaving residential services or foster care.[54] |
| **SAOL Project** | BRIO is a two-year programme run by SAOL and Probation Services to provide education and training for women who have experienced criminality and addiction.[55] |

* While the Rape Crisis Centre was noted as available by two participants in IDIs and FGDs, during a site visit MHR was informed that the service was absent from the Dóchas Centre for some months.

### 5.1.5. Prison TV Channel

The **Prison TV Channel** was described as a resource that provides people with information about what services and resources are available, and how to access them**. In-cell televisions** were used to share education and mental health resources with individuals during the COVID-19 lockdowns, when persons were confined to their cells for long periods. Given their success, these resources have continued to be provided following the lifting of restrictions. It was noted, however, that not all prisons offer the same resources on the TV channel.

### 5.1.6. Additional non-specialised services and supports

Additional non-specialised services and resources that support mental health were identified through interviews and focus groups. Examples participants described included informal peer-to-peer support, the prison gym, and the phone service. As these services and supports were described as having a more indirect role in supporting mental health, as opposed to being a mental health specific service or support, further information and reflections on these additional services and supports are presented in section 6.5.5: Reflections on Additional Non-Specialised Services.

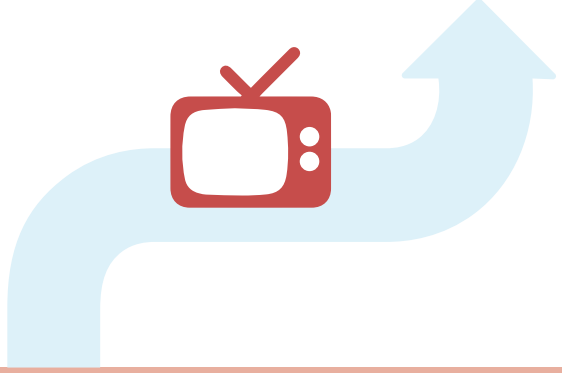
## 5.2. Tier 2: Primary Care Services and Supports

Tier 2 supports and services should be provided when people require additional supports to those available in Tier 1. Again, Tier 2 supports in prisons should mirror the types of supports available in the community. This tier is referred to as primary care services, and is designed for people experiencing 'mild to moderate' mental health difficulties.

### 5.2.1. Primary Care Health Services

All prisons that participated in the research had primary care health services available onsite for persons in custody. Through these services, provided via the prison health clinic, individuals are able to access GP and primary care nursing services.

**GP services** provide primary healthcare services to the prison population, similar to GPs in the community. Additional healthcare services such as A&E, hospitals, and secondary healthcare services outside of the IPS are available via prison GP referrals. For mental health care, GPs provide clinical care for persons experiencing mild to moderate mental health difficulties, provide prescription medications, and refer onwards to other mental health services and supports in the prison. GP services are generally available on a daily basis. In large prisons, appointments may be offered to different landings (e.g. prison wings) on specified days of the week. However, it was noted that urgent cases will be prioritised regardless of prison landing.



> .. The Prison TV Channel was described as a resource that provides people with information ..

**Primary care nursing services** were described by survey participants as offering primary care support such as general health assessments, triage for clinical care, and referrals to the GP, psychiatrists, addiction counsellors, or psychologists. Primary care nurses were also described as providing risk assessments and supports following self-harm incidents, and pre-transfer care to in-patient psychiatric services. It was also noted that nurses may be involved in pre-release planning for persons leaving custody, to help re-establish community supports for continuation of support upon release. Nurses are available on prison landings daily, including weekends, to distribute medication to detained persons.

### 5.2.2. Primary Care Psychology services

All prisons that participated in the research had psychology services available onsite for persons in custody. Psychology services provided by the IPS offer mental health support at various levels, including at the primary care level. Psychology records in the IPS are managed by the Psychologist Case Tracking System (PCTS), an electronic health record accessible only to staff within the psychology services.

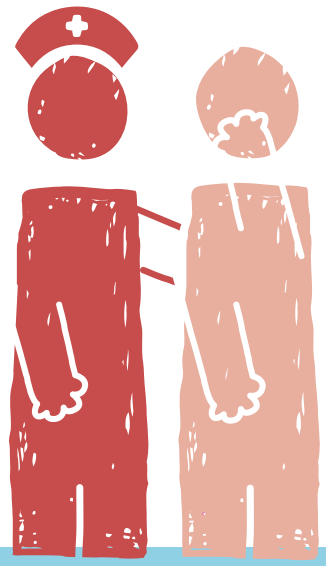
**Primary care level psychology services** provide support for individuals experiencing mild to moderate difficulties such as anxiety, depression, obsessive-compulsive disorder (OCD), and panic disorder. Persons accessing this level of services generally engage in short-term interventions, up to 12 one-to-one sessions lasting about 50 minutes each. These sessions are often provided by assistant psychologists working under the supervision of qualified psychologists. Primary care interventions discussed in interviews and focus groups included interventions for sleep disturbance, mood, and anxiety.

## 5.3. Tier 3: Specialised Services and Supports

Tier 3 services and supports can be described as specialist services and supports. People accessing tier 3 services and supports are typically experiencing moderate and severe mental health difficulties and may have a mental health diagnosis. This tier would also include specialist addiction services in the IPS.

### 5.3.1. Mental Health Infrastructure in Prisons

Survey participants were invited to provide information as to the mental health specific infrastructure available in each prison. **Table 1** provides an overview of such infrastructure in each closed adult prison.



> .. Primary care nurses provide risk assessments and supports following self-harm incidents ..

*Table 1. Mental Health Specific Infrastructure in the IPS*

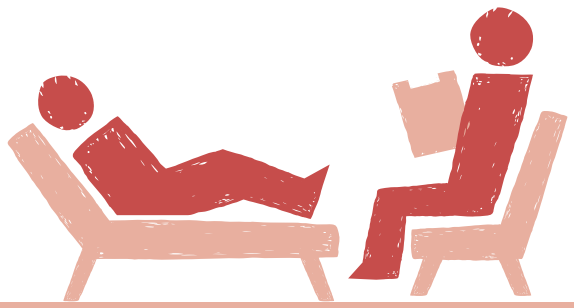
| Prison | MH Specific Landings | | | High Support Units | | | Safety Observation Cells | | |
|---|---|---|---|---|---|---|---|---|---|
| | Available | Capacity | Avg Stay | Available | Capacity | Avg Stay | Available | Capacity | Avg Stay |
| Arbour Hill | Data not available | | Data not available | Data not available | | | Data not available | | |
| Castlerea | Yes | 7 | Varies, but avg 3 months | No | | | Yes | 1 | Data not available |
| Cloverhill | Yes | 31 | Med to long term | No | | | Yes | 2 | 4 days |
| Cork | Yes | 9 | 1 day to full time | No | | | Yes | 2 | 1-5 days |
| Dóchas | No | | | Yes | 1 | Varies | Yes | 1 | 1-2 days |
| Limerick Male | No | | | No | | | Yes | 4 | 1 day |
| Limerick Female | No | | | No | | | Yes | 1 | 2 days |
| Midlands | No | | | Yes | 11 | | Yes | 4 | 2 days |
| Mountjoy | Yes | 17 | Data not available | Yes | 9 | Data not available | | | |
| Portlaoise | No | | | No | | | Yes | 2 | As required |
| Wheatfield | No | | | Yes | 10 | 7 days | No | | |

### 5.3.2. Secondary and Tertiary Care Psychology Services

For persons with more pronounced or enduring mental health difficulties, secondary and tertiary level psychology services were described as being available across all prisons. Examples provided by one-to-one interview, focus group, and survey participants included personality difficulties, trauma, and psychosis recovery. These interventions are provided by a qualified psychologist, and may include group-work or longer-term individual work. More details and descriptions of specific psychology interventions can be found in Appendix 1.

### 5.3.3. Drug and Alcohol Addiction Services & Dual Diagnosis

Several addiction services were described by one-to-one interview and focus group participants as being available across the IPS. The most commonly referenced service was **addiction counselling**, which was described as providing support to persons struggling with addiction, and helping them to develop positive coping strategies. **Merchant's Quay** was repeatedly noted as providing many of the addiction counsellors for the IPS. Clinical support for persons using substances was also discussed. When an individual enters prison, they are screened for substance use and offered **detox or drug maintenance** (e.g. methadone) by the primary healthcare services, based on their needs.



Some participants also spoke about **Narcotics Anonymous (NA)** and **Alcoholics Anonymous (AA)** support groups in prison. It was noted, however, that not all prisons are currently running the support groups. Participants also spoke about **courses and workshops run through local universities** that focus on the topic of addiction. Some interview and focus group participants also spoke about the **Medical Unit in Mountjoy Prison**, a unit that offers community living and an eight-week intensive support programme for persons struggling with addiction to become drug-free. The programme is provided by prison staff and the community and voluntary sector.[56] One prison staff member added that some individuals who complete the programme will progress to an open centre, progression unit, or be released, as appropriate.

When preparing for release, GPs or addiction services may be able to facilitate links with pharmacies and treatment centres in the community to continue drug maintenance, addiction counselling, or other addiction services.

### 5.3.4. In-reach Psychiatry Services

Psychiatric services were generally described as caring for persons experiencing more severe mental health difficulties, such as psychosis or suicidal thoughts. While the majority of psychiatric services for the IPS are provided through the National Forensic Mental Health Services (NFMHS), in some prisons, these services are provided by local Health Service Executive (HSE) teams. Prisons working with the NFMHS described having in-reach psychiatry services provided through the Central Mental Hospital (CMH), in addition to having psychiatric nurses working daily on site in some prisons.

### *5.3.4.1. Desk-based research on psychiatry services*

Psychiatric services play a crucial role in the delivery of mental health services in the IPS. Unfortunately, psychiatric services did not engage in data collection for this study. Nevertheless, as a key provider of mental health services and supports in the IPS, the research team made the decision to capture additional information on the services and supports provided by psychiatric services to supplement information provided by other study participants. This was achieved through undertaking desk-based research, outlined in this subsection and subsection 5.4.5.1.

Forensic psychiatry is a sub-speciality of psychiatry which provides specialised treatment to persons experiencing significant mental health difficulties with a history of offending, in therapeutically secure hospitals, in prisons, and in specialised consultations within general adult mental health services.[57] Forensic psychiatrists also liaise with court services to provide expert opinions on fitness to stand trial and criminal responsibility.[58]

A number of psychiatric in-reach services are available within the IPS. In collaboration with the IPS, the NFMHS operates two dedicated areas for vulnerable persons experiencing mental health difficulties who are at risk of harm to themselves or to others. These areas are separated from the general prison population, and provide increased access to care and regular review by prison in-reach teams.[59] The D2 wing in Cloverhill Prison has 22 cells, including two special observation cells, which can accommodate persons on remand (e.g. those awaiting court proceedings). Persons who have received a sentence may be accommodated in Mountjoy Prison's High Support Unit – which has facilities for up to nine persons.[60]

The Prison In-reach and Court Liaison Service (PICLS), provided by the NFMHS, is a multidisciplinary psychiatric service that helps courts to identify defendants experiencing significant mental health difficulties and facilitates access to appropriate mental health care in safe environments, based on individual needs and risk assessments.[61] The service provides in-reach clinics in Cloverhill, Mountjoy, Wheatfield, Midlands, Portlaoise, Arbour Hill, and Castlerea prisons.[62] Since 2006, the service has helped to divert more than 1,000 persons experiencing significant mental health difficulties from custody to healthcare services.[63]

> .. Since 2006, the service has helped to divert more than 1,000 persons experiencing significant mental health difficulties from custody to healthcare services..

## 5.4. Tier 4: In-Patient Mental Health Services and Supports

Tier 4 services and supports should be provided to persons experiencing severe mental health difficulties and in need of specialised in-patient mental health care.

### 5.4.1. The Central Mental Hospital

The CMH, now located at the NFMHS in Portrane, was also described as the only approved centre that can provide hospital or in-patient mental health care for persons in custody who are experiencing significant mental health difficulties. In linking with the Sharing the Vision tiered-approach, the CMH falls under Tier 4.

#### *5.4.1.1. Desk based research on the CMH*

The CMH is an Approved Centre under the Mental Health Act, 2001,[64] meaning it is registered by the Mental Health Commission to provide in-patient care to persons experiencing mental health difficulties.[65] It is also a designated centre under the Criminal Law (Insanity) Act 2006, meaning that it can receive, detain, care for, or treat, where appropriate, persons committed or transferred into the facility.[66] The NFMHS, located in Portrane, operates the CMH, which consists of five units including a Medium Security Unit, High Security Unit, Mental Health Intellectual Disability Unit, Female Unit, and Pre-discharge Unit.[67] Persons receiving care in the CMH may also access health, vocational, recreational, and social opportunities through the site's 'Village Centre'.[68] In addition to in-patient care, the NFMHS also provides community and prison in-reach services.[69]

In November 2022, the CMH moved from Dundrum to the new state of the art NFMHS facilities in Portrane.[70] Once fully operational, the new CMH within the Portrane campus will have an operational capacity of 130 beds[71] – an increase from the 96-bed capacity at Dundrum.[72] As of February 2024, the CMH at Portrane is operating at a capacity of 112 in-patient beds.[73]

Persons who are experiencing significant mental health difficulties and have serious charges against them or pose a high risk to others will be transferred to the CMH for care under the Mental Health Act, 2001 and Criminal Law (Insanity) Act 2006. All persons in prison requiring psychiatric treatment in the CMH are assessed and triaged by the NFMHS admission panel to ensure each individual receives care at the appropriate level of therapeutic security.[74] Each triage is assisted by the use of the Dundrum Toolkit,[75] a collection of professional judgement instruments that facilitate decision-making about admission, transfer, and discharge from forensic mental health and psychiatry services.[76] Between November 2022, and November 2023, 50 persons were admitted to the CMH.[77] According to the High Level Task Force (HLTF) report, the NFMHS reviews the waiting list for admission to the CMH weekly. Between 2020 and the publishing of the HLTF report in September 2022, the number of persons awaiting transfer to the CMH has ranged from 20 to 25 persons.[78] As of September 2023, 22 persons in prison were awaiting transfer to the CMH.[79] Persons awaiting transfer are managed within the IPS; however, the HLTF notes, "*this care is not comparable to what is provided in the CMH and represents a significant patient safety issue.*"[80]

# 6. PERSPECTIVES OF PERSONS WITH LIVED EXPERIENCE

This chapter presents the perspectives and reflections of survey, one-to-one interview, and focus group participants on the services and supports available to persons in prison. It also highlights the ways that persons become aware of each service or support, and how it is accessed. In some cases, challenges to service delivery or accessing supports were discussed by participants. These challenges are also highlighted in this section, along with potential solutions that participants offered, from their own perspectives.

## 6.1. Reflections on Prison Officers

Prison and voluntary sector staff spoke positively about prison officers, and emphasized the important role that they play in the day-to-day running of the prison, service delivery, and in building rapport with persons in custody. Staff felt that the amount of time prison officers spend with persons in custody enabled them to get to know individuals well and build positive relationships.

> *"Look, psychology, we have our hour a week with the men we work with. [They're] on the ground with them 12 hours a day. The impact they can have in positive ways is huge."* ***– Psychologist***

In particular, prison staff highlighted the many ways in which prison officers can help to identify needs and direct persons to resources for support. Some prison officers gave examples of how they might support someone who they see experiencing mental health difficulties.

> *"If you know a guy is not going to get to see a psychologist for two or three years because his issue is not really on the radar for them as being top priority, the staff will often point him in other directions, whether it's getting him into a workshop where they get their head around what problems they're having, whether it's getting them into the school programme, getting them involved with the Red Cross, or putting them in touch with what other services and resources are available… These are the things that are not seen by other services, is the resourcefulness of staff to come up with solutions where solutions are not easily found. An awful lot of it as well… is the relationship between the prisoner and the officer… you realize that the effect that your positive relationship has on prisoners can be hugely influential to their outcomes. It's something that we need to ourselves recognise, but also other professionals within the services need to recognise as well."*
> ***– Prison Officer***

Men in custody reported a mix of both positive and negative relationships with prison officers. Positive interactions generally consisted of feeling respected and supported as a human being, whereas negative interactions were characterised by a lack thereof. Overall, men in custody felt that when they gave their respect to prison officers, they would be treated respectfully in return.

*"Now, I have to say from my experience with the staff, the prison staff, they're 110%. There's the odd one that can be a bit of a whatever, but everybody has a bad day. I think if you give, for 99.9% of the people in here, the staff, the IPS staff, they'll treat you with the same dignity and respect you treat them."* – ***Man in custody***

*"Most of the officers are all right… You treat them nice, and they treat you nice."* – ***Man in custody***

## 6.2. Reflections on the Committal Process

Men in custody reflected on the committal process, sharing that the experience was often overwhelming, intimidating, and isolating. This was particularly the case, they shared, for those coming into prison for the first time.

*"When I first came to prison, I knew that the only thing I got handed was a phone number list under the door, and at the time my head was spinning… everything gone…I couldn't even think of my mother's number properly, and I was left sitting in isolated walls around me… not knowing what to do. Banging on a door, looking for a priest to talk to. Banging on a door, looking for a governor. Being told to sit down, being told not to bang the door, and you're confused, you're looking around and you saying, "How did I end up here?"* – ***Man in custody***

Prison and voluntary sector staff also noted that many persons coming into prison will experience loneliness. These feelings were especially heightened during periods of COVID-19 restrictions, when individuals coming in would be kept in quarantine for extended periods of time before joining the general population.

*"During COVID [restrictions], they literally were put into solitary confinement for 14 days or something. It was ridiculous. The Listeners would ask, could they go down just to talk to somebody to say, 'Oh look, this is just because of COVID. It won't be like this all the time. You will be up--,' but again, inconsistency. Some prisons gave that assurance to the person being committed. Other people were just thrown into solitary over the quarantine period, which must have been horrendous."* – ***Voluntary service staff member***

A few of the men in custody shared experiences or interactions they had with staff during their committal process that negatively impacted their mental health.

*"At the very beginning, I think it even happens to this very day, anyone that comes on to [block name], at the beginning, they get a really hard time off the officers. People are saying that their mental health is all over the place, and they're probably doing a little bit too much banging or they're probably doing whatever, but then the officers grow on that as well, then they're more aggressive. It's making the problem worse."* – ***Man in custody***

Once detained persons enter the general prison population, meet their peers, and develop a routine, both staff and men in custody shared that individuals' mental health would often stabilise or improve. This was particularly the case, they shared, for those coming into custody for the first time.

> *"When I came in, as I said, I was in isolation for 10 days. Even after I got off isolation, I went to the general population in the prison. To be honest with you, it was the prisoners overall that helped me with my mental health, by being able to talk to one another, by being there for one another, by looking out for me when I first came in, and introducing me to other people. Gradually then, my mental health started to get a bit better."* **– Man in custody**

### 6.2.1. Challenges and opportunities for change identified

Interview and focus group participants identified challenges related to the committal process, as well as potential opportunities or solutions to overcome these challenges. Participants in the voluntary sector felt that many individuals going into custody, and their families, friends and supporters, are under-prepared. They felt that, wherever feasible and appropriate, persons would benefit from being provided with information prior to their committal, which they could review with their families, friends and supporters, to help them to prepare and know what to expect.

> *"It can be quite sudden, really abrupt for some people, and just not knowing basics, like what can I bring in with me? What's it going to be like when I'm in there? Will I have contact with my family?"* – **Voluntary service staff member**

Several prison staff and detained men felt that there was a missed opportunity during the committal process for persons to meet a member of the psychology services and receive a consultation or general mental health assessment. Participants felt that more individuals could receive earlier interventions if they were made aware of psychology services and referred early on in their sentence.

> *"If I could wave a magic wand, I would implement the suggestion I made earlier that everybody has a committal interview with a psychologist so that they can ascertain who would benefit from early intervention… If I could change one thing, it would be that, because there's a lot of people who are crying out for mental health help that is just not available to them."* – **GP**

> *"When you come in, you're sent off. You don't get asked, 'Have you any mental health problems?' I don't know now, now if they do, but I came in I wasn't asked. I was asked was I on medication."*
> **– Man in custody**

Regarding the amount of information received at the committal stage, some prison and voluntary sector staff, as well as men in custody, felt there was not enough information about mental health services, supports, and what to expect in prison. However, others felt that the large amount of information individuals receive was overwhelming.

> *"They're absolutely bombarded with information. They're in the height of it. They don't remember anything, so much so, often, when I meet new referrals, I will start talking about stuff that they should know about and they have no idea, no recollection of ever being told. They're flooded with this information and then they're just left, and they have to go and ask. It's a big communication problem."* – ***Voluntary service staff member***

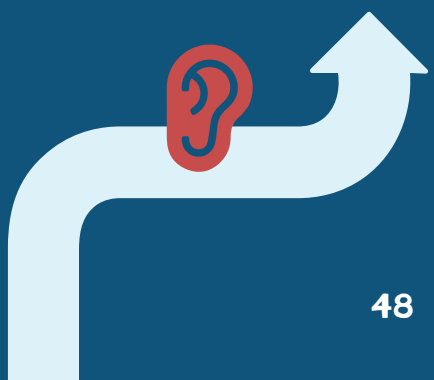
Both prison staff and men in custody felt that resuming distribution of information packets with information about mental health services and supports in the prison on committal would help to overcome some of the awareness gaps, and serve as a resource they can refer back to for information about what is available. Participants also recommended that within the first few weeks of coming into prison, persons are given more information about services and supports that are available. They felt that re-providing this information once individuals have started to settle in and develop a routine would help to overcome the information overload that many people experience in their first few days.

> *"It takes two or three weeks that it takes to get your bearings. I find that if you get too much stuff in the first day, it's too much to take in. It should be left to the end of the month or whatever… Whereas if you get a wee bit, then you'll say you remember."* – ***Man in custody***

> *"I think what would improve it would be, when they come through [prison name] is give them a brochure or whatever, a leaflet or whatever it may be, to let them know that there's help available. That would also take half the weight by just knowing that there's help there. Now, we know that there's a big-time waiting list, even if you're outside, but I think, overall, just by knowing there's help there, that would take a lot off their chest."* – ***Man in custody***

## 6.3. Reflections on Probation Services

Some study participants reflected on their experiences with Probation Services. Men with life sentences who spoke about their experiences engaging with the service throughout their sentence spoke highly about their interactions. They felt that the non-judgmental ear Probation Services provided supported their mental health, and helped them to understand their background and upbringing.



*"Probation helped me a great deal to understand my background, where I came from and the role I played in my own criminal endeavours and the opportunities I took, and also I missed, and the ones I took were often more criminal led than the ones I missed."* ***– Man in custody***

## 6.4. Reflections on COVID-19

Interview and focus group participants described the impact the COVID-19 pandemic has had on the mental health and well-being of persons in custody. The frequent lockdowns prior to vaccine roll-out contributed to feelings of isolation and loneliness. Even with the widespread lifting of restrictions, men in custody shared how the virus continues to impact their well-being. Several of the participants in custody reported testing positive for the virus during the 2022-23 winter, and being isolated for more than 10 days. While none disagreed with the principle of isolation to protect others, many reported being denied access to showers while isolating, and reflected on the negative impact that had on their mental health.

*"I'm thinking, 'Jesus, there's a shower across the landing. Why don't they let me in there?' I could have put on a mask. I could have put on gloves. I wouldn't have touched any of the surfaces. If I did, I would have wiped them down. Just like when anyone else would get the COVID. They wouldn't give me a shower for 10 days. My mental health deteriorated big time. I lost two stone in weight."* ***– Man in custody***

## 6.5. Reflections on Tier 1: Non-specialised Services and Supports

### 6.5.1. Reflections on Chaplain Services

The prison chaplain services were seen as an important source of mental health support across conversations with both men in custody, and prison and voluntary sector staff.

*"It's a way that prisoners can communicate with somebody outside of the prisoner population, but also outside of the direct staff situation as well. It's a listening ear for them that is very important in times of a crisis."* ***– Prison Officer***

Both prison staff and persons in custody spoke positively about their experiences and interactions with chaplain services. Staff felt that the chaplains knew persons in custody well, and were able to sense when individuals needed support, and communicate this to senior prison management as needed.

*"They get underestimated, I think with services there. They're really excellent because they've got much more patience for their job, I reckon. They're just there to be a kind ear. Note some stuff down. They're just normal. They don't necessarily have any of the medical jargon or any of that. It's just good for a chat. They're really good at picking up on who are struggling."* ***– GP***

> *"They also tend to be, in many cases, a voice that can go to the senior management in the jail about a particular prisoner situation and say, 'Look, we may need to look at this in a different way or some other way of helping somebody out.'"* **– Prison Officer**

Some staff shared that chaplains would be one of the first services that they would speak with if they were concerned about an individual in their care.

> *"Chaplains would be my first point of call if I'm genuinely worried about something. I'll say 'Just please check in on so-and-so.'"* **– GP**

Men in custody valued the chaplains, and felt that they were really able to listen to them. As one man succinctly described, "They talk to you like a human being."

> *"They honestly, just one or two of them down there, and they really do just bring that little bit of calmness or understanding and listen. In five years or four years, I'm here and it's the first time I've reached out to somebody who has listened."* **– Man in custody**

#### *6.5.1.1. Pathways to chaplain services*

Participants in interviews, focus groups and surveys identified several ways in which a person in prison may become aware of chaplain services, and how to access them. Persons may learn about chaplain services through various informational resources, including leaflets received on committal and posters on noticeboards on the prison landings advertising services in the chapel. Chaplain services are also made visible, along with other mental health supports, through the prison TV channel.

Prison staff and peers may also provide information about chaplain services to detained persons. Individuals coming into prison may be automatically met by chaplains within 24 hours of committal as part of the committal process, or be offered a chance to meet with the chaplains. Those who accept the offer will have a referral made on the Prisoner Information Management System (PIMS). During these meetings, chaplains will provide information about their services and how they can be accessed. On the landings, persons in custody may hear about chaplain services through word of mouth from peers or prison staff.

Chaplains are also visible on the landings daily, walking around and available for persons to approach for a conversation. Chaplains may also initiate conversations with persons by stopping by their cells for an informal check-in.

> *"They actually just walk around the landings. They'll actually knock on their cell door and say, 'Hey, what's up?'"* **– GP**

Other ways in which persons may access chaplain services include asking a prison officer to refer them, or to call chaplains using the prison phone service. During busy periods, it was noted that phone calls may be diverted to chaplains at other prisons where another chaplain will be available to take a call.

In general, participants agreed that chaplain services were an accessible and visible service throughout the IPS.

#### *6.5.1.2. Challenges and opportunities identified*

Only one challenge related to chaplaincy services arose throughout interview and focus group discussions. Some prison officers expressed concern that approval for compassionate phone calls (additional phone calls to families, friends, and supporters due to extenuating circumstances) had recently shifted from going through class officers to now going

through the chaplains. Concerns related to the increased pressure this would put on chaplains, which might take time away from their other services.

> *"The chaplain now, I think there's chaplains in the whole prison, they have to listen to [hundreds of] people getting on to them about getting compassionate phone calls."*
> ***– Prison Officer***

### 6.5.2. Reflections on Education Services

The prison education services were repeatedly highlighted as an important resource for individuals' mental health throughout one-to-one interviews and focus group discussions with prison and voluntary sector staff, as well as men in custody. Study participants agreed that individuals attending classes and workshops through the prison school helped to get persons off of the prison landing and develop a routine, which in turn benefitted their overall mental health and well-being. Learning and developing new skills was also seen as a way of empowering persons and helping to build self-esteem.

> *"I think the school is brilliant, they try to empower prisoners to find themselves, be the best version of themselves."* ***– Prison Officer***

Participants who had accessed courses through local universities or online through Open University spoke highly about these programmes. In particular, the Open University degree in criminology was discussed by several of the men in custody, who shared that the course opened their eyes and helped them to better understand their own upbringings, life circumstances, and criminal backgrounds.

Overall, participants across stakeholder groups who spoke about education services within the IPS spoke overwhelmingly positively about the prison schools and the teachers. Teachers were described as an invaluable resource for persons in custody, as they were able to provide a kind ear to students and generally had a more nurturing relationship to persons in custody than other prison staff.

> *"The teachers teach you with a little bit of normality. They treat you the way they want to be treated."*
> ***– Man in custody***

> *"The teachers were the best of the services that I ever used in jail. The teachers taught me more about myself in terms of manners and respect, and I suppose I see the work they put in because they… really care about their students and they really care about our progression in education if we choose that role, and they were absolutely amazing in terms of helping me, often going out of their way to make sure my assignments were in and on time, especially during COVID [restrictions], which was an absolutely nightmare because they weren't allowed on site in [prison name], but they just did. They go out of their way a great deal for the lads to help the lads, and they were just fantastic."*
> ***– Man in custody***

*Spotlight: Reflections on Red Cross Programme*

Every participant who spoke about the Red Cross Programme in the prisons spoke positively about it. Prison Staff and men in custody felt that there was a lot of trust between Red Cross volunteers and both prison staff and their peers. For persons in custody, the reputable name of the Red Cross, and the programme being run separately from the IPS, instilled trust among the prison population. Prison staff felt that volunteers played a significant role in helping to keep the prison safer and healthier.

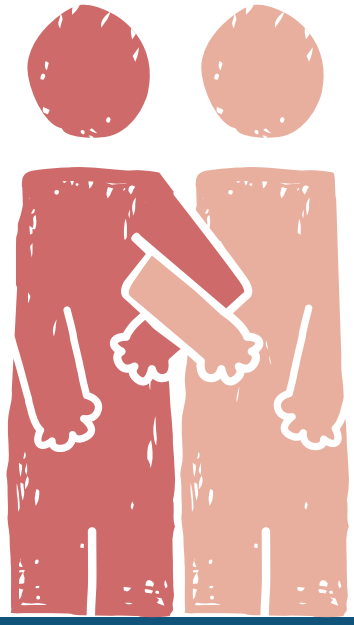
> *"I think the Red Cross programme in particular is well supported because staff can see the benefits, not just to prisoners, but to themselves as well. I mean, the Red Cross programme has made prisons a safer place for everybody." – Prison Officer*

One of the men in custody shared just how impactful the weapons amnesty programme run by the Red Cross had been:

> *"Once every month, you invite people to throw any knives or slashes that they have. What we got from it, I think it was 70 or 80% less cutting on landings because of the Red Cross." – Man in custody*

The Red Cross programme was also valued by volunteers themselves – many of whom see benefits to their own mental health and well-being, as the programme has helped them to build self-esteem and create a sense of purpose.

> *"It's time to pay back something to society, that's the way I look at it, you know what I mean? I know we're in prison, we're classed as criminals, but there's the good and the bad for it." – Man in custody*



*Spotlight: Reflections on Mental Health Week*

Every interview and focus group participant who spoke about Mental Health Week in the prisons spoke positively about the programme. Several of the men in custody shared that their peers had really enjoyed the programme, and discussed how interpersonal conversations about mental health continued amongst the population for weeks following the conclusion of the programme.

> *"Everybody was talking about it and really enjoyed it after it finished. For weeks later, they were talking on the landing about the psychologists. We're all getting a different picture from it. It was a really good hour to spend." – Man in custody*

They felt that Mental Health Week had helped to break down the stigma of mental health, and break down other barriers to accessing mental health supports.

> *"Where before I came to prison… there was no way that I would talk to anyone about my mental health. I'd always bottle it up and try to be strong and put on a face or put on whatever, maybe like a mask. Now, since I came to prison and got access to the workshop with the psychologist and the school, I feel like I can really talk about my mental health." – Man in custody*

In fact, one of the men shared that the workshop he attended as part of Mental Health Week prompted him to seek psychology services for the first time.

> *"[The psychologist] done a workshop in Mental Health Week and that was the most powerful-- …I got a lot from that, very, very powerful. I've told a lot of people about it, and then it was at that stage that I put my name down to see the psychologist."*
> ***– Man in custody***

Workshops with persons who had previously been incarcerated were highlighted as particularly powerful, with many of the prison staff and men in custody specifically giving the example of The Two Norries visit. Participants felt that having someone with lived experience share their story helped to engage more of the population, and reduce the stigma around accessing supports.

> *"They brought in the mental health people. They're actually brilliant and The Two Norries were in there as well. They were good to get out and see them. They were talking about their own lives, their past, and how they came away from the drugs." – Man in custody*

Many of the men in custody felt that the programme was so well received, that it should be run more frequently. When asked how frequently they would like to see it run, recommendations ranged from every month, to four times per year. One of the men said that increasing frequency "…will be good and they'll continuously get numbers. Because people will continuously go over to them." Another added, "I think every week should be Mental Health Week, to be honest with it."

#### *6.5.2.1. Pathways to accessing the school*

Survey, one-to-one interview and focus group participants identified a number of ways that persons in custody may become aware of the prison school, and how to access it. Word of mouth was the most frequently reported way that persons would become aware of the school, what courses are available, and how to access it. Individuals may be informed through conversations with their peers, Red Cross volunteers, prison officers, chaplains, drug counsellors, or other prison staff members. Persons may also learn about the educational services during the committal process, during interviews with the prison governor, ISM, and Work Training Officers.

Informational resources such as posters and brochures posted throughout the noticeboards of the prison were highlighted as another way that persons might become aware of the school. The prison TV channel was also noted as hosting information and advertisements about the educational services.

Individuals interested in attending school must add their name to a list to be called for an interview. This may be done by self-referring and filling out an application form, or by asking a class officer, assistant chief officer, prison governor, school officer, or peer to add their name to the list. Referrals to the school may also be made via PIMS. Once on the list for the school, the head teacher will call individuals to school for an interview, during which time the teacher will ask about their interests and create a course schedule. These interviews are typically offered once per week to allow students to be enrolled on an ongoing basis.

> *"When the prisoners are going off to the landing you can tell them, will you put my name down to see the principal for an interview. They'll write, they'll go over there, they'll give their name to the principal. Then they'll come back on to the landing, they'll go back over at half two. You could be called over by an officer for an interview. They bring you over for an interview and then from there on out, then you'll get your timetable. You start going over every week."* ***– Man in custody***

#### *6.5.2.2. Challenges and opportunities identified*

While the school was generally seen as an accessible resource, interview and focus group participants did identify some challenges.

On the service level, one of the biggest challenges that was noted by several participants was school closures due to security staffing shortages. When officer detail is short, participants shared that the school is often one of the first services to be cut.

> *"We've seen in [prison name] where the school has had to be closed down for days and days at a time because the teachers are all there, but there's no officers to have that service up and running."*
> ***– Prison Officer***

These school closures were seen as having a negative impact on individuals' mental health, and overall morale.

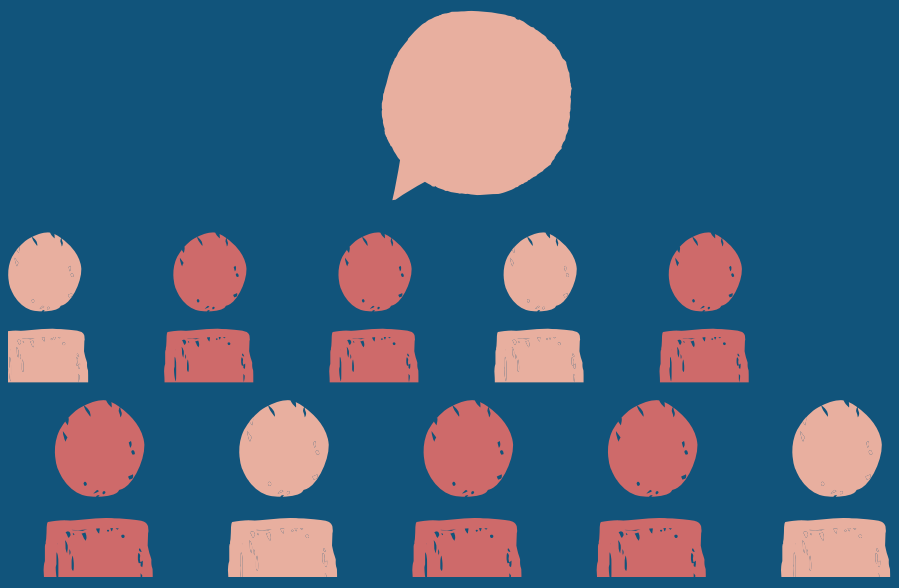
> *"That's a massive problem in terms of guys progressing with education, if you're in the middle of your leaving cert and you can't get to the school for a week or two weeks because there's no staff. That has a real stressful impact upon you knowing that you've an exam coming up, and you're not getting up to the teacher."* ***– Man in custody***

For some participants, it seemed that courses available through education services varied from prison to prison, with some offering more courses than others. In addition, it was noted that individuals who are on protection landings had very limited access to the school, due to their restricted regime. Both prison staff and men in custody felt that increasing access to the school for people on protection would be beneficial for their mental health and well-being.

While seemingly uncommon, a small number of participants mentioned anecdotes where prison staff did not facilitate enrolment in the school.

> *"I have a lot of people coming to me and asking me, 'How do I put my name down for school?' I'm telling them talk to the officer in the morning and he'll do it for you. Some days the officers would say, 'No.'… They're not getting to go to school."* ***– Man in custody***

On the individual level, some prison staff and men in custody felt that self-confidence was a barrier to some individuals engaging with the school and education services. Peer encouragement was seen as a valuable way to help individuals overcome this barrier. Men in custody felt that once individuals were engaged in courses in the school, most would enjoy the courses and the routine, and their self-esteem would improve



### 6.5.3. Reflections on Voluntary and Community Sector Services

*Spotlight: Reflections on Samaritans Listener Services*

The vast majority of interview and focus group participants who reflected on voluntary and community sector services and supports in the prisons spoke about the Samaritans Listener Services. Many participants felt that the peer-to-peer Samaritans Listener support was invaluable, as persons in custody were generally more open with their peers than with IPS staff.

> *"I think it's actually really good because they tell their colleagues things that they wouldn't dream of telling us." – GP*

Prison staff also acknowledged that the service was an important resource that provides ongoing support for persons experiencing mental health difficulties outside of the main IPS mental health services.

> *"That works quite well. The beauty of that, I suppose, is there's capacity built in the prison community. It tends to sustain itself with limited input from any of the official services really other than when the training comes around." – Psychologist*

Men in custody who had received volunteer training from the Samaritans staff spoke highly of the training they received, and about the Samaritans staff they engaged with. Peer-listeners also highlighted that phone lines to the community Samaritans Listener Service were also available to them if needed, to debrief their own emotions and support them as supporters, following difficult conversations.

#### *6.5.3.1. Pathways to accessing Samaritans Listener Services*

Participants described several ways that persons in custody might become aware of the Samaritans Listener Services. Peer-trained listeners are given Samaritans t-shirts they can wear around the prison, and have stickers outside of their cell door to indicate that a listener lives there. This helps to increase visibility of the service amongst their peers. Advertisements run on the prison TV channel and flyers and leaflets on noticeboards and slid under cell doors or provided on committal also help to increase visibility and awareness of the service. Staff may also recommend the listener services to persons experiencing mental health difficulties.

To access face-to-face listening services, persons in custody can approach one of the listeners wearing a Samaritans t-shirt to ask for a private conversation, or persons can ask a staff member to connect them with the listener on duty. At night, individuals have a call-light in their cell that they can turn on to ask their class officer to speak with a listener. Depending on the prison, individuals may be brought to a private room to speak with a listener, or the listener may be brought to the individual's cell.

*"When you're in a cell… you have a switch inside the room, which when you push it puts on a light and an alarm outside your door, the alarm is down where the officers sit. I suppose it'll tell them number 15 on B2 or whatever has a bell on, and once they come to your door, then you can ask, request for a listener… they generally should go and get you a listener and then you're brought out of your room into a listener suite, which is separate to both cells and kind of facilitate the call." - **Man in custody***

### *Challenges and Opportunities Identified*

A few challenges related to the Samaritans Listener Services in the prison were raised by interview and focus group participants, as well as potential opportunities and solutions to overcome some of these challenges. The most frequently cited challenge was language barriers. It was noted by several staff and men in custody that peer-listeners were predominantly white-Irish, and only spoke English. These language barriers, participants shared, meant that many non-English speakers would be unable to communicate with a listener. Both staff and men in custody felt there was an unmet need for peer-listeners able to speak more than one language, and recommended purposeful recruitment in the future to fill this need.

*"We were all handpicked by the governors, by the officers, and there was lots of Romanians down in there, suffering with mental health, and they're having nobody to talk to… there was nobody in the listeners' course that was suitable to talk to. Many Romanians talk to Polish, talk to Lithuanians. We were all Irish, none of us can speak their language."*
***– Man in custody***

While many prison staff felt persons in custody would trust a peer more than a prison staff member due to the authority relationship, some men in custody felt that they might actually be less open with peer-listeners than with prison staff. A few of the men explained that, because professionals have a duty to keep confidentiality, some persons may be more inclined to trust them than a peer-listener, who some perceive as having less to lose, and therefore may be more likely to disclose anecdotes of their confidential conversations.

*"They're alright, but you don't feel comfortable telling them much information because they are prisoners like yourself like me inside. You don't feel comfortable explaining much to them." – **Man in custody***

The pandemic restrictions presented additional challenges for the Samaritans Listener services. During the lockdown period, men in custody explained that one-to-one chats with peer-listeners would often take place through cell doors, which acted as a barrier to building trust and raised privacy concerns. Additionally, because the Samaritans Listener phone service line goes directly to the same Samaritans Listener helpline available across the country, some persons in custody struggled to connect due to the increased demand for the services in the community.

While the Samaritans Listener service was the most frequently discussed voluntary and community sector service in the prison, participants also reflected on other voluntary services they had accessed or were aware of. Post-release support services (e.g. IASIO, Churchfield Trust, Care After Prison, etc.) were seen as invaluable by prison staff not just for those who access them when they leave prison, but also for those still detained to consider when reflecting on mental health outside of prison.

> *"We work with IASIO with post-release and homeless services, and different people to really try and have a good plan outside as well because I think often with sessions, you're really working on that as well. You're not just talking about mental health in the prison. You're talking about mental health outside of the prison also."* ***- Psychologist***

Men in custody felt that voluntary sector services were often understanding of what they were going through. Many appreciated the connections they were able to facilitate in the community through these services.

> *"They're there and people trust them, the Cork Alliance Centre, because they're at it now years and people are understanding why a lot of people in here are homeless. Things like that. They get all that in place and they get them schemes as well and link them in with different counsellors and are able to get them treatment and things like that."*
> ***– Man in custody***

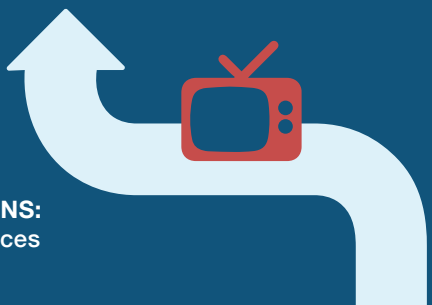
Men in custody, as well as voluntary and prison staff especially valued peer-led voluntary and community support services. They felt that persons who had lived experience of being in prison were well-placed to give advice on how to prepare for release and give advice for recovery.

> *"What I felt with him, he was a prisoner before. He was in an old prison. He turned his life around. He knows what's going on inside… I was able to go in and trust what I was going through and he could see what I was going through."*
> ***– Man in custody***

> *"Even that shock factor of, right, you're out the door. I know that's the regime and that's how it works. Especially with overcrowding. It's not as planned as we'd probably like it, but I would imagine if you had a heads up of exactly what it's going to be like from people perhaps who have walked that walk as well, it would make that transition easier."*
> ***– Voluntary sector staff***

#### *6.5.3.2. Challenges and opportunities identified*

Some challenges related to voluntary and community sector services were highlighted by interview and focus group participants, as well as potential opportunities. In some cases, participants also noted instances where the resources advertised on the TV channel were inaccessible.



*"With the [voluntary services], all they do is show you numbers on the outside where you can't actually reach them. They're showing you 086 numbers and 01 numbers but they can't be reached, where they should have free numbers."* ***– Man in custody***

Several participants shared that partnerships with additional voluntary and community services experienced in working with key populations may be beneficial, both to persons in custody and to inform prison staff training and education. Specific examples included organisations working with Travellers and LGBTQ populations.

### 6.5.4. Reflections on Prison TV channel

Both persons in custody and staff members felt that the prison TV channel was a valuable informational resource, and gave examples of how the TV channel was used to help individuals to visually see where they can access services in their prison:

*"We've developed a video that goes on the channel where we just took the video camera to a landing and walked up to where the rooms are. The guys can see, 'This is the way you go up and this is what the rooms look like.'"* ***– Psychologist***

*"That's another good thing. There's a channel on the television that showed what things were there. When you come in, what you'll do, where you go, how you get to see and things like that."* ***– Man in custody***

In-cell televisions were seen as a vital resource, particularly during the COVID-19 lockdowns, when people were confined to their cells for long periods.

*"They ran an education channel. You're in your cell and you can see what's on the telly. I know it's not the same as interactive education, but they still got to see. If you wanted to tune in and if you wanted to try and do something, you could do something."* ***– Prison Officer***

*"They were teaching during COVID [lockdowns]. There were classes on the screen, so the education unit here and teachers doing bits, classes on the television screen to the cells."* ***– Psychologist***

### 6.5.5. Reflections on additional non-specialised services and supports

Participants in interviews and focus group discussions reflected on additional supports and resources for mental health.

#### *6.5.5.1 Peer-to-peer support*

Informal peer-to-peer support was seen as invaluable across focus groups and one-to-one interviews. Several of the men in custody shared that they would often help to spread the word about resources that might indirectly support others' mental health, such as the school or the gym, and encourage others to attend. In some cases, they might even invite someone new to the prison or someone they see struggling to join them.

*"With me, there, I'd go back. I'd see a few fellas. I'd say, 'I heard there's a group on Thursday, it's brilliant.' You'll get an understanding of it…I says, 'It worked for me.' I'm not afraid to fucking say that. You know what I mean?"* ***– Man in custody***

Additionally, while mental health is often stigmatised in the prisons, some of the men in custody shared examples of how they would speak openly and casually about the mental health services they were accessing to their peers. Men felt that by doing so, they were helping to raise awareness of what is available, normalising seeking help, and setting an example that others could follow.

*"Word of mouth is probably the best way-- people that have been here before. I'm here [number] months now, and I'd happily tell someone else. If I was there, 'Oh, what are you doing?' 'Oh, I'm going down to the addiction counsellor' and hopefully, they'd get the lightbulb in their head, but I wouldn't be pushing them and say, 'Come on, go on.' It's up to them. I'd like to, but at the minute the stigma there is you're not supposed to, and plus you don't know whether they're going to get on it because there's a waiting list, but it's a good service… I think once you push with that road, other people know that you're probably seeing the counsellor and then they probably see you with mental health, or they can see other things, so you know more or less all about that."* ***– Man in custody***

A few participants also spoke about peer mediation – either a programme that was already in their prison or a programme they felt would be beneficial to introduce.

*"There's also a mediation service that they [Red Cross] run, where there's conflicts or feuds and stuff as well. That's quite successful because the mediators don't have to give what they feed back to us, don't have to give details of who, what and when, it's slightly anecdotal, but there's a lot of, I would say there's a lot of physical harm that's been avoided by those interventions. There is that peer-to-peer support."* ***– Psychologist***

#### *6.5.5.2. Prison Gym*

Across one-to-one interviews and focus groups, participants agreed that the gym was an important resource for people in custody. This was a particularly common theme among many of the men in custody who were interviewed. Interviewees felt that going to the gym helped both themselves, and many others, to cope with mental health difficulties and build self-esteem.

*"It was when I came to realise when I was suffering with the paranoia and the depression and all, I was taking loads of drugs. When I'm suffering now, I try to go the gym, do something, feed your problems by doing fitness, or do a couple of laps walking in the yard."* ***– Man in custody***

> *"I do a lot of running and I think that's the big trick for me, sort of to keep the mind busy. The first thing I'd do with someone with mental health issues is advise them to go for a jog with me."* ***– Man in custody***

> *"That's one of the few opportunities for men, especially, to actually release their pent-up aggression, if I could say it that way, or pent-up aggravation. They can take it out on the weights and do it inside the gym, having a bit of a boxing session now, whatever it might be there."* ***– Man in custody***

The most common challenge participants identified in relation to the gym was understaffing. When prison security detail was short staffed, the gym, alongside the school, are often the first resources to be closed. Prison staff and men in custody who discussed this challenge described the negative impact gym closures have on mental health in the prison, particularly given how frequently it seemed to occur.

> *"It's all short-staffed every week. It's either there's no school or there's gym or there's no gym or there's school or there's half of the school open or half the school closed. It's always something. Every week it's always something."* ***– Man in custody***

> *"You'll do anything to pass the time. People say, 'Go to the gym.' That would be great if the gym was on every day."* ***– Man in custody***

Additional challenges participants raised included limited access to the gym for persons on protection landings, as well as an absence of knowledge on gym equipment or low self-confidence.

> *"A lot of people don't know how to use the gym, so they stay away because they're not the size, they're not masculine enough."* ***– Man in custody***

#### *6.5.5.3. Phone Service*

Participants also spoke about the phone service in the prison. Some participants shared that the main office of the prison could be reached by using the landline phones on each landing and dialling a designated number. Once through to the main office, persons in custody can request to speak to a service, e.g. addiction counsellors, chaplains, etc. However, participants shared that there was a lack of awareness of how to reach the main office, with many persons in custody unaware of the number that they should dial.

In-cell phones were brought up by participants, who were welcoming of their introduction. Participants also welcomed the introduction of VideoLink services, which have helped persons in custody to remain in contact with their family, friends and supporters. These were introduced during the COVID-19 lockdown period, when visits were restricted. While in-person visits are now back, participants shared that there is still an option for VideoLink visits. Participants felt that having the option to engage in virtual visits was beneficial, as persons were able to see their home, speak to more people, and it saved families and friends from long commutes every week to visit in person.

> *"In the video call, I think it worked really well, because all of a sudden, you can have a mommy talk to their child and the phone could be passed around to everyone in the house. If the auntie or the uncle is in the house, they get to see more and it means the person doesn't have to travel any distance to come up there."* ***– Prison Officer***

## 6.6. Reflections on Primary care services and supports

### 6.6.1. Reflections on Primary Care Health Services

Throughout the one-to-one interviews and focus groups, primary care nurses were seen as a vital resource. The visibility and small interactions these nurses have with individuals daily during medication distribution was seen as important to helping the nurses to build rapport and trust with the persons in custody. Participants felt that the nurses knew persons in custody well, and could often provide a kind ear to individuals who are experiencing mental health difficulties.

> *"The nurses know the guys really well because they see them every day. The nurses are very good at picking up when one of them is a bit off. A lot of the nurses are quite motherly. So sometimes they just say, 'Listen, let's go down to the surgery [prison health clinic] and we'll have a chat up to you just to see what's up with them.'"* ***– GP***

#### *6.6.1.1. Pathways to Primary Care Health Services*

One-to-one interview, focus group and survey participants identified a number of different ways that persons in prison may become aware of primary care health services and the pathways, or steps they can take, to access them.

One of the most commonly reported ways of becoming aware of primary care health services, and how to access them, was during the committal process. Study participants shared that during the committal health assessment, both a nurse and GP will inform individuals about the healthcare services available, and the steps they should take if they need to access them during their sentence. Several participants also shared that this information would be provided again during committal interviews with prison governors and ISM. Leaflets or booklets with this information may also be provided to persons on committal, or available at reception. However, as previously highlighted, booklet distribution was paused by some prisons during COVID-19 restrictions, and many have not been resumed across every prison. Once settled, persons might also become aware of primary care services through observation, for example seeing nurses distributing medications and providing triage on landings daily.

Several pathways to accessing primary care services were identified by study participants.

One of the most commonly reported pathways was to speak to the nurses during their daily triage and medication distribution on the prison landings. Nurses triage, provide assistance where they can, and refer onwards or schedule an appointment with the prison GP, as appropriate. While some participants indicated that persons had direct access to the prison health clinic during the day, where

they could stop by to self-refer, it was unclear if this was the case in all prisons. Persons in custody may also self-refer to the GP, if they see them walking around the landings. Detained persons may also request access to healthcare services by asking their class officer, a chaplain, any other prison staff member, or even a peer, who may then call a nurse. Additionally, multi-disciplinary team meetings, with prison staff representative of sectors such as chaplaincy, GPs, nurses, psychology, psychiatry, prison officers, etc. in attendance, provide a forum for discussing individuals in custody who may be in need of support. The nursing team can follow up with persons based on agreed actions.

When the prison health clinic is busy, individuals may be asked to outline the nature of their concerns to a staff member in order to help the services triage and prioritise appointments with the prison GP. At night, individuals can use the call bell in their cell to inform an officer that they require nursing support. Officers will then call a nurse. An on-call nursing team is available for emergencies, and can dispatch persons to the hospital, where necessary.

#### *6.6.1.2. Challenges and opportunities for change identified*

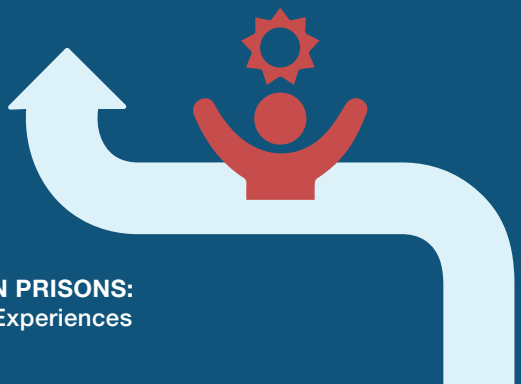
While primary care health services were generally viewed as an accessible service throughout the IPS, some challenges related to accessing the service, and opportunities to overcome these challenges, were identified. One challenge that was raised was under-resourcing of the service – particularly in relation to staffing levels. Outside of medical emergencies, some of the men in custody felt that the waiting list to access GP services was too long. Additionally, while prison staff and detained participants felt that permanent doctors were important to building rapport and trust with persons in custody, additional coverage was needed when permanent staff are on leave.

> *"We had a doctor recently and he was on two weeks holidays, and for the two weeks on holidays that he was gone for, I'd say probably 10 out of the 14 days we didn't have any doctor at all. That could lead to issues in terms of if you have committals in particular, if you have committals that have requirements like methadone or whatever that it is, get it prescribed."* ***– Prison Officer***

In terms of primary care nursing services, some prison staff shared that onsite nursing services were not always available overnight in each prison. One prison officer described the challenges that posed in regards to staff and resident safety.

> *"I can think of two incidents where a prisoner's life was saved by a nurse just being there on the spot then and there. If staffing levels sometimes means there's no nurse at all, which it's very much an essential service. It's just dumb, blind luck that that hasn't gone badly wrong so far, I think. The more it continues to run down the staffing levels like that, the more likely a prisoner or a prison officer is going to be injured and don't receive the help they need."* ***– Prison Officer***

Prison staff emphasised that consistent coverage of these positions was critical for safety.



Language barriers also arose as a challenge or barrier that some detained persons may experience while trying to access mental health support from primary care health services. Prison staff shared that often, other persons in custody will help to interpret for their peers who were unable to communicate in English. However, the stigma associated with mental health difficulties may act as a barrier to reaching out for help. As one GP succinctly explained, "Guys will very easily go to a friend of theirs with good English and say 'I have a sore back', but they're unlikely to go to their friend with good English, and say, 'you know, I'm feeling low.'"

## 6.7. Reflections on Specialised Mental Health Services and Supports

### 6.7.1. Reflections on Psychology Services

The wide array of interventions, programmes and supports that IPS psychology services offer was seen as a strength of the service by psychologists who participated in one-to-one interviews and focus groups.

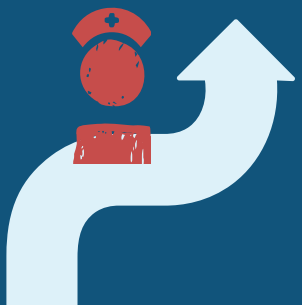
> *"I think the breadth of things that we provide. Because the remit of actually having to help people with both their mental health and like such a broad range of mental health problems, whether it's eating disorders, anxiety, depression, trauma, psychosis, or post-acute psychosis episodes. Then offence-focused needs, I think our specialisms are really broad. I think the fact that we're able to cater for both of those needs is really good."*
>
> ***– Psychologist***

Specifically, psychologists felt the Building Identity Programme for persons aged between 18 and 24 was particularly beneficial for those who decide to engage with the programme. Psychologists felt that the intervention being provided by the assistant psychologists, as opposed to qualified or senior psychologists, was beneficial because the assistant psychologists tend to be younger in age, facilitating them to build more trust and rapport throughout their sessions.

> *"Anyone who's 18 to 24 years old gets referred to ourselves. We offer them six sessions with the assistant psychologist where they formulate themselves up and come up with a care plan from that. The great thing is… the assistant psychologists tend to be younger as well, so often they find it easier to connect or their cultural references might be more appropriate than maybe mine."*
>
> ***– Psychologist***

Group-based interventions and programmes provided by psychology services were largely viewed positively. Group sessions, several psychologists felt, helped to reduce the stigma surrounding mental health difficulties in the prisons.

> *"Especially when you want to break down the barriers to help, one of the big things prisoners face is stigma, guilt, and shame… group therapy sessions, I think, can be very successful when they're available."*
>
> ***– Psychologist***



Overall, prison staff and persons in custody who participated in one-to-one interview and focus group discussions viewed psychology services favourably. Participants felt that, once the services were accessed, they were very beneficial.

> *"A lot of the guys who would go in psychology really, really enjoy it because they can see they're making progress. It's almost like going to the gym. You're on a training regime, and you can see the benefits of this. Once they get in the door of psychology, it's excellent. Guys really, really enjoy it and really, really like the fact that they are going somewhere."* **– GP**

> *"They're brilliant. They're understanding. I think the best thing now is the meetings that they're having in the school. People get to understand them. I think they are good when they do but there's not enough."* **– Man in custody**

> *"When I was getting with them, I found them all very helpful. They do their best with what they can."* **– Man in custody**

Some of the men in custody reflected on how the psychology services helped them to come to an understanding of themselves, their emotions, their past, and equip them with the tools needed to look after their own mental health in the future.

> *"And with the last 12 months, I'm more into it anytime I get called I get into it more and I love it. I'm getting something out of it now and they're after explaining to me what it's about and how to deal with your emotions."* **– Man in custody**

#### *6.7.1.1. Pathways to Psychology Services*

One-to-one interview, focus group and survey participants identified numerous ways in which persons in custody may become aware of Psychology Services, and the steps they must take to access them.

Individuals may become aware of psychology services through informational resources throughout the prison over the course of their sentence. Coming into custody, persons serving life sentences will receive information about psychology services within the booklet of resources that they each receive. Additionally, information leaflets and advertisements for psychology services and workshops were described as being available across most prison noticeboards and TV channels, and being dropped under cell doors periodically, including as part of the response to serious incidents such as a death in custody, or COVID-19 lockdowns. In some cases, information about psychology services may also be included in the prison school newsletters.

People in prison may also learn about psychology services through interactions with prison or voluntary sector staff, including teachers, GPs, nurses, prison officers, governors, chaplains, psychiatry, addiction services, IASIO, and other operational staff. This information may be provided not only at the committal stage during committal interviews and meetings with ISM officers, but also throughout their sentence, during

their annual review, meetings with Probation Services, or in their day-to-day interactions with staff. If staff members notice a person is experiencing mental health difficulties, either during the committal process or during their sentence, staff may inform them of the services available and offer to make a referral.

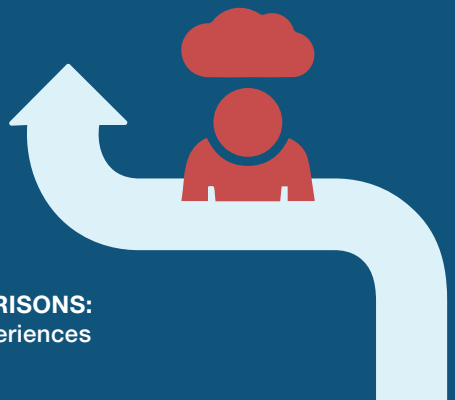
Word of mouth through peers and Red Cross volunteers in the prison was also highlighted as a powerful way that persons in custody become aware of the psychology services. Persons in custody may also learn about psychology services through engaging with programmes such as once-off workshops, Mental Health Week, and Lifers' Forum, which may prompt them to engage further with the service.

Once aware of the services available, interview, focus group and survey participants described many ways that persons may access psychology services. Whole-population workshops are open to all individuals and can be attended by any person who expresses interest and signs up. For formal counselling or clinical psychology work, persons must be referred to the psychology services. In order to remove as many barriers to referral as possible, the IPS psychology services operate an open-referral system, meaning that anyone can open a referral to the service. Persons may self-refer into the psychology services by approaching a psychologist, or they may be referred by any member of prison staff by requesting their name be put down to see psychology. Prison staff and men in custody who participated in one-to-one interviews and focus groups most often mentioned approaching prison officers, nurses and GPs to request a referral. The chaplain, addiction services, school teacher and the governor were also mentioned. Detained persons seeking psychological support may also be referred to psychology services by their peers, or by someone in the community, such as a family member, friend, solicitor or resettlement coordinator.

> *"There was another lad called to me. He said, 'Will you be going to the school?" I said, 'I'll be going over sometime later, yeah.' He said, 'Will you put my name down to see the psychologist?'"* ***– Man in custody***

In some cases, individuals may be referred to psychology through the courts as part of their sentence management. Additionally, individuals in some priority populations receive automatic referrals to the service upon committal, though they are free to decline engagement. These populations include persons aged 18 to 24, those with a life sentence, those in on a two-year sentence or longer who do not have post-release supervision, and those in on a sex related crime or violent offence.

Once a referral form is completed and received by a member of the psychology team, it is reviewed by a senior psychologist who will then add the name to the waiting list for triage assessment. Following triage assessment, the person's name will be added to the waiting list for the agreed intervention. Persons are called to receive interventions when their name reaches the top of the waiting list, or per prioritisation criteria. It was noted by several prison staff that those who are more unwell will receive priority.



*"The other thing is also just to say that we prioritise people for triage. We have a waiting list meeting every month, and when we're looking at the people who are up next for triage, if we've had lots of concerns being raised, so say if the MDT [Multi-Disciplinary Team] have been contacting us going, 'Look, can you see so and so sooner?' and that might be because they are at risk, risk of harming themselves, risk of harming others, if their behaviour is quite erratic and that there's a lot of concern around them in the MDT, we will prioritise those people, so they will skip the queue, and we'll see them a lot sooner."* ***– Psychologist***

After accessing psychology services, individuals may re-refer back into the services as needed. It was also noted that, whenever possible, referrals are kept open for six months after a person is released from prison. One psychologist explained that this was to ensure that, should someone return to prison shortly after release, they are not put back to the end of the waiting list.

#### *6.7.1.2. Challenges and opportunities for change identified*

Participants in one-to-one interviews and focus groups discussed challenges individuals may face when accessing or attempting to access psychology services in prison, as well as potential opportunities and solutions to overcome some of these challenges.

The most frequently discussed challenge in relation to accessing psychology services was the waiting lists. While the length of waiting lists varied from prison to prison, and by intervention required, both prison staff and men in custody shared that many individuals could be waiting months to years before accessing psychology services. For those serving shorter sentences, this means that many will not access psychology services prior to being released. This was a challenge not only for those who were already referred to the services and on the waiting list, but also discouraged both persons in custody and staff from initiating new referrals.

*"I'd say, there's a running joke at the jail that you have to be doing a life sentence to get a psychology appointment."* ***– GP***

*"The waiting list is just at the point where I don't really bother referring to psychology much anymore because if somebody's only doing a one-year sentence, the waiting list is 20 months, there's really no point."* ***– GP***

*"So far, I'm in here say 12 months and I'm waiting to see the psychologist 12 months. There's a big waiting list. I don't know, I probably will be released before I even get to see the psychologist."* ***– Man in custody***

*"I put my name down in 2020 for [intervention name], and I only got called seven weeks ago."*
***– Man in custody***

Psychology staff shared that the waiting list for triage was particularly long, as assessments must be carried out by a qualified psychologist. The majority of those who referenced a specific timeframe that

a person might be waiting for triage, shared that the wait could be anywhere from six to 18 months. In a minority of prisons where waiting lists were shorter, this was noted as an exception, rather than the norm.

> *"That's our benchmarking, that's what we aim for, is within 12 weeks of the referral being accepted. I would say we're probably about 12 months, if not more [for triage]."* **– Psychologist**

Following triage, persons are put on a waiting list for their agreed intervention. Those who were waiting for primary care level services that could be provided by an assistant psychologist were typically waiting less than those who were waiting to access secondary or tertiary level care with a qualified psychologist.

> *"At the moment, if I was seeing someone for a triage and I recommend that they do some work with an AP [assistant psychologist], they could be seen within four to six weeks. They have to wait to see me for the triage. That's the bit that slows them up. It's the amount of time it takes from referral for them to get the initial assessment."* **– Psychologist**

Interview and focus group participants identified several factors that contributed to the long waiting lists for psychology. The most commonly cited factor was understaffing – both of psychologists and operational staff. Prison staff highlighted that despite several drives to improve recruitment and retention of psychologists in the IPS, posts have remained unfilled. This in turn has increased the workload on those already working in the service, and increased the waiting lists for both triage and secondary and tertiary care.

> *"There was a lot of funding came to try and increase the number of psychologists in prisons and other mental health professionals, and we weren't able to fill all those positions."* – **Psychologist**

Several psychology staff acknowledged that recruitment and retention of psychologists was not a challenge unique to the IPS. Given this, they felt that it was important to examine staff benefits to incentivise more persons to apply for and remain in these positions.

> *"What are the push and pull factors? If we want quality people working in our prisons, delivering our mental health services, the reality is they have options... It's an international labour market. We're competing with… everywhere else. If we're going to recruit and retain people, we need to think about how they can access their life more readily while they work."* **– Psychologist**

The understaffing of prison officers was also seen as a significant barrier to accessing psychology services. Prison staff described several instances where psychologists were present in the prison clinic, but unable to meet people for scheduled appointments because security detail was unavailable to supervise the area or escort persons to and from appointments.

*"For two years I worked with the in-reach programme in [prison name], and I would say a close estimate would be that approximately 40% of clinics would have been cancelled because of the lack of availability of an officer. This is what I mean about under-resourcing. It's not just the resource of having an assistant psychologist or a qualified psychologist there, it's about having sufficient staff to allow these services to take place. An assistant psychologist can go in and have a clinic, one-on-one with a prisoner, but you need to have an in-reach officer outside that door for their safety. When staff numbers are reduced or when staff allocation is placed elsewhere, these services don't happen. It's right across the board. It's all in-reach services are affected. Every day in the prison, there's a shortfall in staff numbers. In every prison in the country, there's a shortage of staff."* **– *Prison Officer***

This was seen as having a negative impact on persons in prison – not only due to missed appointments and further delays for those still on the waiting list, but also by potentially discouraging people who may become uninterested in engaging as a result.

*"It's very unusual that people don't come. They really want to access the service, which is good, but it's just when you don't have enough staff to provide what they need, and that's sad, actually."* **- *Psychologist***

*"By session two or three, he's missed a couple of weeks because the clinics have been cancelled. They just drop off. They lose interest."* **– *Prison Officer***

Another factor both prison staff and men in custody felt contributed to the long waiting lists was the backlog from COVID-19 related lockdowns. Even after restrictions were lifted, however, staff illness has continued to impact access to psychology services.

*"The other piece was that even when we weren't in lockdowns, often the staffing levels were significantly impacted through staff illness, which meant that we couldn't get in to do our job. We're reliant on staff to take us into prison. That's probably, that was a big impact as well… I would say last year, even after COVID [restrictions], for the last few months of last year, our access was really poor. The services corridor was being shut really, really frequently. That's incredibly frustrating when you're trying to go in and do therapeutic work with people that need consistency."* **– *Psychologist***

*"I'm here for a full year, and I've seen psychology once. It's understaffed, as far as I'm concerned. Obviously, you need a prison officer or two out there waiting. That's understaffed as well. People have sick days. There doesn't seem to be a proper staff and a system put in-place. Obviously, COVID kicked in which drove everything haywire."* **– *Man in custody***

While one-to-one interview, focus group and survey participants highlighted numerous ways that persons may become aware of psychologist services, these varied from prison to prison, and lack of awareness about the service was cited by some participants.

> *"There's no in-your-face leaflets where, again, the leaflets, if they were left on the wall and people is waiting to go to get their dinner and they look and they can say, 'We can gain access, we can make calls or we can ring people.' Nobody seems to know anything about what goes on in this prison. There's no one helping. There's no information. There's no nothing about absolutely what goes on in the prison with psychologists, with psychiatrists, with the school."*
> ***– Man in custody***

Some prison staff felt that, even once persons were aware of the services, many individuals do not have enough information and may be hesitant to trust and engage psychology services because they are employed by the IPS. However, it was noted that this barrier will come down for many persons after speaking with psychology staff and learning what information is and is not shared with other prison staff.

> *"I think that's another issue, the fact that we are employed by the prison service and often people are cautious about sharing their information with us. I find that that barrier comes down once they meet one of us and we're able to talk to them about what we share, what we don't share, and what our agenda is in terms of being there for them as opposed to the prison service. People find a way to be much more open with us once they get in, but before they get in, it might be something that puts their guard up a little bit."* ***– Psychologist***

Stigma and self-stigma were also highlighted as challenges that might prevent individuals from seeking or accessing services, or make it more difficult for them to do so.

> *"I suppose, from my own observation, stigma is a huge thing with younger people. They don't like to say or indicate they need the support of psychology."* ***– Prison Officer***

While some of the men in custody were not ashamed to share their experiences of accessing mental health services, they acknowledged that this was not the case for everyone. One man discussed the need for operational staff to be more discreet when calling persons for appointments, as the fear of stigma may discourage some from attending their appointments.

> *"Half the fellas they're not even being put forward or even want to go up there with this-- I don't know the word now but being called out of the yard, like '[Name], yeah, you're wanted here!' Do you know what I mean? What is a psychologist doing…? They have an image of them so they just say fuck off. Do you know what I mean? But they wanted to see them."*
> ***– Man in custody***

Some psychologists felt that group-work and open workshops helped to break down some of this stigma, and that shifting to more group-based interventions may also help to work through the long waiting list, and ensure more people are able to access some level of support prior to release.

> *"When we do things like the workshops that we do this week, people realize that we're human, and we're relatively normal and the whole lot. We always get referrals from things that we wouldn't otherwise get. I think more of that assertive outreach or visibility."* ***– Psychologist***

### 6.7.2. Reflections on Drug and Alcohol Addiction Services

Across nearly every interview and focus group discussion with prison and voluntary sector staff, and men in custody, drug and alcohol addiction was seen as an important issue in prisons, and something that many persons in custody have struggled with, or will struggle with at some point.

The overwhelming majority of participants in custody who had accessed addiction services during their sentence reported positive interactions with their addiction counsellors. Men described the addiction services as helping to turn their addiction and their life around. One participant even shared that he wished he could delay his release from prison, as he was finally engaging with the services and working toward recovery.

> *"The services here are brilliant. I told [name] that I didn't want to get out."* ***– Man in custody***

Several men in custody felt that the relationships and trust that were built through the addiction counsellors were a meaningful and important resource.

> *"He's very good. He'll call you over maybe twice out of the month. He'll call you over for a meeting. He'll have you in the room. He'll just talk away with you. He's actually good. I find [counsellor's name] good. Now, he takes your mind off things. If you had a bad week, when you talk to him, you'll come out smiling."* ***– Man in custody***

> *"They're compassionate as well. Because you're there for an hour with one person and you're starting to build a relationship. I find that works."* ***– Man in custody***

While the majority of participants in custody described positive experiences with their addiction counsellors, a few negative interactions were raised. One detained participant felt that in his experience, while the staff were kind, the appointments he had were brief and there was no follow up. Another man shared that he felt stigmatised by his addiction counsellor.

> *"He sort of gives you, 'You again?' He looks at you. He shouldn't look at you like that. The fucking doors should be open, 'Come in.'"* ***– Man in custody***

Participants in custody who had accessed courses about addiction through local universities spoke overwhelmingly positively about their experience.

Some of the detained participants had previously accessed the Medical Unit in Mountjoy Prison. Those who did spoke very positively about their experience.

> *"I can honestly say when I did the medical unit… it was brilliant."*
> ***– Man in custody***

#### *6.7.2.1. Pathways to Drug and Alcohol Addiction Services*

Participants in interviews and focus groups described a number of ways that individuals in custody become aware of and access addiction services. Persons coming into custody may become aware of addiction services during the committal process, when they are screened for substance use and placed on maintenance or detox as appropriate. Individuals who wish to avail of further addiction support may request a referral during this time. Persons may also become aware of addiction services through ISM officers, or through court-mandated reports where they will be required to engage with the services as part of their sentence management. In prisons where NA and AA are available, officers will announce when the group is happening, so that any individual who is interested may attend. Participants also shared that word of mouth was a powerful way that persons learned about addiction services.

> *"Word of mouth is probably the best way-- people that have been here before. I'm here nearly seven months now, and I'd happily tell someone else. If I was there, 'Oh, what are you doing?' 'Oh, I'm going down to the addiction counsellor' and hopefully, they'd get the lightbulb in their head."* ***– Man in custody***

To access addiction counselling services, referrals may be made through prison staff members, including GPs, primary care nurses, ISM Officers, or Class Officers. Some men in custody also noted that the addiction counsellors could be reached through the phone service.

> *"You can press number [redacted] on the phone, and you get through to the main office. You can be linked in with a certain person."* ***– Man in custody***

Linkages to pharmacies and treatment centres in the community upon release was valued by persons who wished to continue accessing addiction support. One man in custody shared how much he was looking forward to accessing a treatment centre upon his release, as he had tried to access one several times on his own before entering prison, but had faced barriers.

> *"I tried to get into treatment for years. I couldn't get it. I met [counsellor's name] and I was talking away to him. I said I want to go to treatment when I get out. I know I'm drug-free now, but when I go to the outside, it's going to be different because you're in an open environment. You could be around anything. If you have a bad day, you could turn back to drugs. I said, 'I'd like to go to that treatment centre.' He started to write my name down. He said, 'Look, when you have nearly two weeks left,' he said, 'I'll have you over the treatment centre' I tried for years on the outside to get it. It took me to come into jail to talk to this person to get me for that treatment centre. He got it for me straight away. It was quick."* ***– Man in custody***

#### *6.7.2.2. Challenges and opportunities for change identified*

Participants in interviews and focus groups spoke about challenges that persons in prison might face in regard to accessing addiction services within the prison, as well as potential opportunities and solutions to overcome some of these challenges.

One of the most commonly cited challenges at the service level was the long waiting list to access addiction services, in part due to under-resourcing of the services. The waiting time to access services varied based on prison, but the overwhelming consensus across one-to-one interviews and focus groups was that the waiting lists were too long. Several prison staff and men in custody felt that the waiting lists would likely continue to grow longer as the prison population increases and becomes overcrowded.

> *"We have addiction services. We've two counsellors, but they will also tell you their list is endless. It just takes so long to get through it because there's so many people coming in that had some sort of substance abuse before they came in."* ***– Nurse***

Participants in custody shared some of the ways that they or their peers had overcome the long waiting list to become prioritised. One of the men felt that it was only for his repeatedly asking prison staff to be seen quickly that he was able to access addiction counselling within a month of coming into prison. Prison Officers shared that in some cases, individuals may increase their substance use to get the attention of staff and be prioritised.

> *"When you have to wait to be so sick and ill to actually get treated, nearly everybody can say, 'Well, I get treated if I do more drugs, if I do more stuff, or if I do more of this, if I do more of that, or if I play up more,' then they're like a bored child. No disrespect to any of the prisoners, if it's the only way you can get attention and service, that's what they have to do."* ***– Prison Officer***

Some prison staff and men in custody shared that there was a need for a dual diagnosis model of care (e.g. receiving addiction counselling and psychology services in tandem) in prison. In some prisons, this model was unavailable, while in others the length of waiting lists delayed access to one of the services.

> *"It's the dual diagnosis. It is addiction and mental health. You can only have one or the other, and that is a serious problem in jail and outside of jail. It's ridiculous. Your addiction counsellor will deal with your addiction, and once you have that dealt with, you can then see psychologist and then work on your mental health…"* ***– Man in custody***

> *"[The addiction counsellor] knew that I needed to see a psychologist. He said, 'Look, I'm referring you to a psychologist. In the meantime, I'm going to continue seeing you,' he said… he put a letter in underneath the psychologist door to come and see me urgently. It's gone 12 months now and I still haven't seen him."* ***– Man in custody***

Additional service level challenges identified included language barriers and the need for interpreters, as well as the time it takes for security detail to accompany persons to and from appointments, which may reduce time spent with the addiction counsellor.
At the individual level, several interview and focus group participants shared that there was a general lack of awareness about addiction services among the prison population. Men in custody felt more persons would avail of the services and supports if they were aware of what was available, and how to access it.

> *"There's not enough awareness about mental health or also about the services that's available. Nobody knows them. The numbers, they haven't a clue. I was talking to the young lads there, I was saying, 'Have you thought about drug counselling?' They're like, 'How do you do that? How do you go about that' You're thinking, 'That's wrong that you haven't a clue about anything' I think the awareness is the big problem right now. They need to get awareness about that."* ***– Man in custody***

The stigma associated with both addiction and mental health difficulties was seen as another challenge for many people in custody. For some people, the fear of stigma prevented them from seeking support altogether, while others who are accessing the support may try to keep it a secret from their peers.

> *"But the stigma of mental health is just like you wouldn't be telling people that you're going to addiction counselling or anything, which I don't think there's a problem with. Because you're actually doing a good thing, but people would like to keep that hush."* ***– Man in custody***

Several men in custody spoke about the nature of addiction itself being both a challenge to engaging with services, and an obstacle in their recovery journey. One of the men described how his addiction to drugs prevented him from wanting to engage with addiction services during his previous prison sentence.

> *"I just wanted to be on the landings taking drugs, drugs, drugs. I did [more than seven years]. Just drugs, drugs, drugs and throwing out the gate. I just didn't want to know about anything that was happening up around there."* ***– Man in custody***

For some, even after deciding to seek mental health or addiction services, the difficulties they might experience along the pathways to accessing care may be exacerbated by their substance use.

> *"You try to work your way, weave your way through all the obstacles and the mental obstacles. I can only imagine what it's like for people with drug addictions, and that are not able to think clearly, but they must be desperate."* ***– Man in custody***

Men in custody also shared that even once addiction supports have been accessed – be it counselling, open workshops, or courses – the nature of addiction can make it difficult for an individual to continue engaging.

> *"The first week, everyone, as addicts go, we're all there to see what's it about. From half past nine in the morning to quarter to 12. It's a long time for an addict to stay still in the room and listen to a person talking or going through slides… It's very hard for an addict to stay there, now when you're in the height of addiction."*
> ***– Man in custody***

Several participants felt that there was a need for more addiction counsellors, as well as addiction nurses, to overcome the service-level challenges. A few prison staff members felt that there was also a need for more in-house addiction services, as opposed to relying heavily on voluntary and community sector in-reach services.

> *"The services here are brilliant… but they need more drug counsellors. There's only two here."* ***– Man in custody***

> *"If there is an addiction nurse or addiction services there in-house, they could follow them up and see how they are doing and encourage them, counsel them to really motivate them to come off their addiction when proper follow up is given. Because it's just the [primary care] nurses, they just give the methadone as the doctor prescribed, counsel them, but it doesn't really make so much impact."* ***– Nurse***

Several study participants also stated a need for more workshops or support groups for addiction. Men in custody felt that holding group sessions one to two times per month would be beneficial. They felt that many persons in custody would be interested in attending – initially out of curiosity or to get off of the landings, but once in the door, many of the individuals would likely find value in the group session. Participants in custody felt that group discussions with persons who have lived experience of addiction or incarceration would be particularly impactful.

> *"What would be good for that particular group [young men] would be if you had ex-prisoners come into prison and talk to them about the dangers of drugs, the cocktails of drugs, how you mix the drugs. Also, explain to them that they were once like them and spent so many years in prison. Talk to them about the prison life, and what's the best way."* ***– Man in custody***

Participants who had accessed NA and AA within their prison also felt these support groups were valuable. However, they were not available in some prisons and some men felt they should be present in every prison.

> *"They should have basically NA meetings, AA meetings, they should have these inside because they're in other prisons around the country. They're not inside here."*
> ***– Man in custody***

Finally, one study participant was concerned by the absence of clinical support for persons experiencing crack or cocaine addictions, and felt this service was needed.

### 6.7.3. Reflections on Psychiatry Services

Participants in focus groups and interviews reported both positive and negative views of psychiatry services in the prisons. Those who viewed the services positively cited good rapport, and being a witness to the benefits and improvements individuals see once they access the services.

> *"Another thing that works well I'd say is like [prison name] there, is when prisoners are doing the right things, they are taking their medication, and they are interacting with the services that are there, they seem to get back on a more even keel, and the system itself seems to be able to handle them. They are able to live normal lives nearly within the system once they're taking their medication, and they're doing what they're supposed to be doing medically."* ***– Prison Officer***

> *"Another thing I think works well is the psychiatric input. It's slow and it's not always available because of the shortage, but the ones that are being seen receive very good care and you see them improve. The major problem is getting to access it, but when they do, they are very, very good. They have good rapport with those prisoners as well, and they are able to stabilise their mental health. You could see it works when they get it."* ***– Nurse***

Unfavourable opinions of the psychiatric services generally consisted of disagreements with the use of seclusion, restraint, and some medications for mental health difficulties, with some sharing anecdotes from years past from those who had used the services.

#### *6.7.3.1. Pathways to Psychiatry Services*

To access psychiatry services, persons in custody will typically receive a referral from the prison GP. It was noted by several participants that referrals to the GP could be made by anyone, including nurses, chaplains, class officers, or other prison staff members. Once the referral is made by the GP, individuals are placed on a waiting list to see a psychiatrist. Prison staff reported a range of waiting times, ranging from a few days to several months, depending on the prison and severity of the individual's needs.

Follow-up psychiatric care in the prisons was described as similar to what one would receive in the community, where persons are discharged from the psychiatrist to the GP, with periodic check-ins from psychiatric services.

#### *6.7.3.2. Challenges and opportunities identified*

Some challenges related to psychiatric care in prisons were discussed by interview and focus group participants. All of the challenges that participants spoke about related to long waiting lists and under-resourcing of the service.

## 6.8. Reflections on Specialised In-patient Services

### 6.8.1. Reflections on the Central Mental Hospital

Unfortunately, the researchers were unable to speak directly with anyone with lived experience of accessing or providing specialised in-patient services through the CMH. Therefore, the research team is unable to present reflections on experiences of engaging with this service. However, some challenges related to accessing the service were discussed, and presented in subsection 6.8.1.1. below.

#### *6.8.1.1. Challenges and opportunities identified*

Prison staff shared that despite the opening of the new CMH in Portrane, the CMH was still under-resourced and did not always have the capacity to care for some of the persons in custody in need of the service – both due to a shortage of beds, and not having the capacity to care for violent or disruptive persons in IPS custody. These resourcing challenges contributed to a long waiting list for transfer to the CMH. Prison staff shared that persons could be waiting from weeks to a year or longer for admission to the CMH.

> *"We have guys who are on the waiting list to go there for weeks and months, in the meantime, they stay in prison and it's really not an appropriate place for them because they're being looked after by people who are not, they're trained to deal with criminals, not people who are psychiatrically unwell."* ***– GP***

One psychologist described what the day to day might look like for someone awaiting transfer to the CMH.

> *"Now if somebody's waiting for transfer to the CMH, they're probably quite unwell. Healthcare would be involved on a day-to-day basis. They'd be seen on a daily basis. They'd see the psychiatrist at least once a week. The CPN [community psychiatric nurse] would be involved. We wouldn't necessarily be involved with everyone at that level. We do work like CBT [cognitive behavioural therapy] for psychosis stabilisation work. If somebody's quite unwell, they're usually on a different wing. There is a smaller, quieter wing."* ***– Psychologist***

Prison staff also expressed safety concerns related to persons who are awaiting transfer to the CMH. These safety concerns were regarding the well-being of the person waiting, of the staff, as well as of others in custody.

> *"They have said that he's… on their violent, disruptive prisoner list for Portrane, but they can't take him because they don't have the facilities to deal with him. This prisoner has been, I suppose, left to certainly not get better, but he's getting worse over the last number of months…The CMH on the one hand say that they can't take him because they don't have the facilities or the staff to deal with him, but on the other hand, he can't be medicated, and he's left with us for us to deal with on a daily basis."* ***– Prison Officer***

Several prison staff members felt there was a need for more joined-up thinking and a collaborative approach to caring for detained persons in need of mental health services within an approved centre.

> *"We don't work in a joined-up way or a collective way in terms of dealing with the issues that are arising with prisoners. Now, I know that their health and safety of staff in Portrane is very important as well, but our health and safety is important. The prisoner's health and safety are important as well. The fact the he's been left to more or less rot, I suppose, in [prison name] is putting everybody's health and safety at risk from what I can see."* ***– Prison Officer***

## 6.9. Participants' Closing Reflections

At the conclusion of each interview and focus group discussion, participants were asked to share what they would say if they were given one minute to talk to key decision makers, (e.g. Director of Prisons, Minister for Justice, HSE, etc.) about mental health in prisons. Both prison staff and men in custody shared that they would use their minute to emphasise the need to divert persons away from prison to mental health or addiction services where possible and appropriate. Where persons are unable to be diverted from the prison system, they felt that plans should be put into place to ensure access to appropriate treatment and support while in custody. Some also felt that opportunities to work towards re-integration into communities while still in custody would be beneficial.

> *"Locking up people isn't really the answer. They should be doing something or giving them a chance or letting them out to work in the community. Obviously, everyone's not going to succeed. Someone's going to fuck up or break rules or do stuff, so they put them back at the start. If they don't break the rules and they're doing everything right, you should be entitled to some sort of chance." –* ***Man in custody***

> *"There needs to be more alternatives before going to prison rather than just going to prison. Just facilities. There's drug treatment in prison, but it's very little beforehand."* ***– Prison Officer***

> *"I'd say to them that they need to look at us as human beings more than- - not just prisoners and numbers… People with mental health problems that commit crime...I'm not saying… 'Let them off. Give them a fairer sentence.' But if they're going to send them to prison rather than send them to… a mental health hospital, then make sure that there's a thing place where you can say right, I want them seen within a certain amount of time, when he goes in, I want them to give him his medication if he's needing medication or something like that…. It's compulsory that they address the issue when they're in court, so they're made aware of it, and then the officers here are made aware of it, and they could be doing it straight away instead of just being left in here."* ***– Man in custody***

Prison staff and men in custody felt that young detained persons should be prioritised for early interventions, to stop the cycle of offending.

> *"There's a real opportunity there to intervene with younger guys and to crush a second offense before they get into this vicious circle, before they get hardened, before they start to close off to any help that would be available later on. Can we please try and do more for those guys, younger guys, on their first or second offense to stop the cycle. Whatever they need to reduce the cycle of harm."* ***– GP***

*"With the young lads… I would encourage ex-prisoners to come in and also professional help to have workshops and stuff available for the likes of the young kids as well."*
***– Man in custody***

Several men in custody in particular felt there was a need for increased awareness of mental health, and the services and supports available among the prison population.

*"I would say, again, I'm back to advertising the mental health and I would spill it all over the landing, and be in anybody's face about it so then people know if they need help, it's there. That would be the first thing I'd do."* ***– Man in custody***

*"I think that's what they should do, get more involved with the people that are coming in these days… They're suffering bad from mental health issues. And there's no one for them to talk to… Only if they put down their name and they're called, and then they're half afraid, they're not aware of what they're going through. [There needs to be] someone nice explaining to them, we're about this, and blah blah blah. You tell them what it is, a half an hour every person, when they come in. So, that's what I'd say to them."* ***– Man in custody***

Both prison staff and men in custody felt that both exisitng mental health services and indirect supports could have signficant positive impacts on individuals' mental health. They felt that these services should be considered a priority. Several psychology staff reiterated that they were eager to work with people, but need regular access to the population in order to do so.

*"I think get us access. You're paying for us. We're at some level an expensive resource for you to be paying for, relatively speaking. Get us access so you can get your money's worth out of us, because there's more we can do than what we're doing currently. This isn't a recent problem… Every day and every week there's inefficiencies there, so do your best to get greater access. That'll be it. That'd be the one thing I'd say."*
***– Psychologist***

Prison officers and men in custody shared throughout interviews that the prison post censor services, which screens mail for security, is often one of the first to be cut when the prison is shortstaffed. This can lead to a backlog in post, which participants shared was often stressful for both detained persons and their loved ones. Some felt that this service, along with other non-specialised services, should be considered essential.

*"I think I would say what I've said already is make censors a post that cannot be taken away. Make gym a post that cannot be taken away and make in-reach a post that cannot be taken away, that it cannot be touched. These are things that must be implemented regardless of what's going on in the prison. That'd be one."* ***– Prison Officer***

Prison and voluntary staff, as well as men in custody, also shared that additonal support groups, psychoeducation workshops, and non-specialised resources would be beneficial for mental health.

*"One of my main things as well would be NA, Narcotics Anonymous, and AA, they'd be brilliant to have inside the prison. Just to have people to come in and have a chat with. That's all they need, telling their story. They tell you their story and they will-- You build up a little relationship with them and then, hopefully, they came in every month. You'll be looking forward to going out and seeing them."* ***– Man in custody***

*"If they could do anger management classes a lot more. All stuff to address yourself. I know cooking is nice and I know making teddies for the kids are nice, but more looking after us."*
***– Man in custody***

*"I don't think it's a bad thing when prisoners get a few nice things, as in not all the time because you don't want them spoiled, but what I'm saying, when they get something every now and then, like a soccer match, whatever… but I think if you can make a prisoner smile in any way, shape, or form, they can bring that positivity elsewhere."* – Prison officer

*"More sports therapy, hot and cold therapy would be a big thing. Even a cold shower, if you could have a cold shower, could make a difference."*
***– Man in custody***

*"[Prison name] had a mental health week at the end of February there and it was brilliant, but the conversations that were happening should be happening on a daily basis."*
***– Voluntary sector staff***

Participants also spoke about the role of voluntary sector services – both the opportunities for more to become involved, and the need for multi-annual funding to support the work they do.

*"You have a psychology service, you have an addiction service, but is it fit for purpose? Is it working the way it should to be more open to community agencies and value the support that they can bring?"* – ***Voluntary sector staff***

*"I would also encourage people to come in and speak to Travelling people about the mental health and the Romanian population, and the Polish and the Lithuanians, have something for them as well."* ***– Man in custody***

*"I would ask them, I suppose, to look at the funding and stuff because, for example, projects like ours every year have to apply again for funding, essentially. If there's no-- A lot of time and energy is spent on that, justify the money you got, et cetera."* ***– Voluntary sector staff***

Some participants also spoke about improving the overall environment of prisons, both in the short term and in the long term.

*"Getting people off the floors. If you're wanting to do something right now, get them off the floors."* ***– Man in custody***

*"I guess my leaning would be to make prisons themselves more trauma-informed and more therapeutic. That's improving the environment significantly. Broader access to meaningful activity and get to improve people's sense of self-esteem and self-worth for everybody in prison. I think everyone should be either in school or working or doing something that has meaning for them to give them skills when they get out, but also training the staff to equip them to feel empowered in their role, to feel supported in their role so that what they're doing is bringing people in a more positive direction, not a negative one."* ***– Psychologist***

Prison staff in particular shared that they would use their minute to emphasise the need for increased access to inpatient mental health care for those with severe and enduring mental health difficulties.

*"[We need] a better way of dealing with prisoners that need to go to the CMH. I cannot understand why after building a new facility, that there's now 18 prisoners in the Irish Prison Service that should be in the CMH and are not there. It's obvious that the CMH either needs greater resources or better services or more staff or whatever it is, or better training in terms of dealing with these violent, disruptive prisoners who have severe mental health issues, that all this needs to be looked at."* ***– Prison Officer***

*"I would say that something needs to be done about the availability of hospital beds. That the way in which people with chronic, and enduring mental health… and acute mental health problems. Things like people who are in the midst of a psychotic, or a schizophrenic episode. It's a real human rights issue that they are languishing in prisons, as opposed to being able to get a bed in a hospital where they can get appropriate treatment. That's what's happening at the moment because there isn't for various resourcing issues, Portrane… isn't set up to be able to facilitate the people in our custody. That makes me desperately sad, because we can't help them. The prison service isn't a specialized setting where people can be injected against their will, which that's another subject for ethical debate anyway. Some people… are really, really suffering, need treatment, and they're not able to get it in a prison. They're stuck there for months, for years, sometimes at a time."* ***– Psychologist***

Some participants also spoke about the mental health of prison staff.

*"I think the staff's mental health needs to also be looked after because you can't give what you don't have. We're working in a very stressful condition and short-staffed, and it adds a lot of stress. If your mind is not in order, it might affect also, because something would have to give. We need to be looked after as well."* ***– Nurse***

*"I think officers are vulnerable as well, just in terms of mental health… It'd be nice if there was… just a little room for officers if they wanted to either do some music [during lunch]… and then other times people could go in and do a bit of guided meditation or like the creative room, like just a hub where you can go in..."* ***– Prison Officer***

*"You need to consider the people working in the prison and support them in their role in terms of family-friendly policies."* ***– Psychologist***

*"Definitely to put time and more effort into supporting the prison officers as well and their mental health."* ***– Voluntary sector staff***

Participants in custody, voluntary sector and prison staff felt that the prison service should ensure that persons in custody are prepared for their eventual release, and that linkages to services in the community are supported.

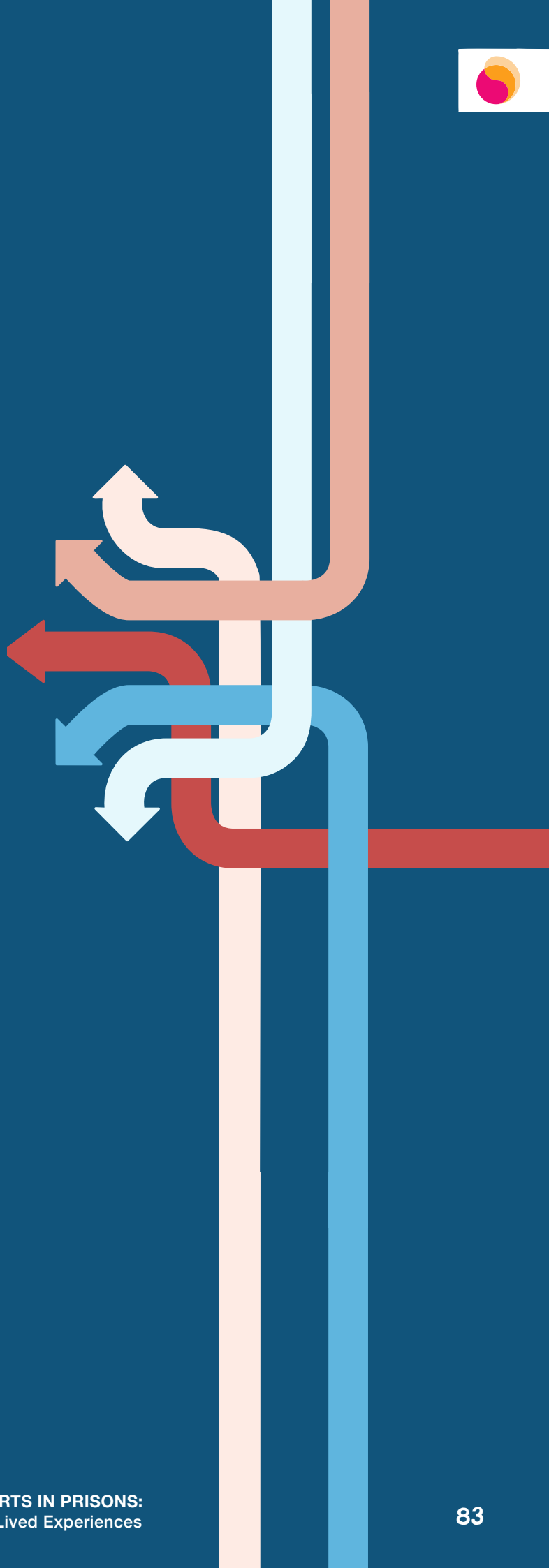
*"When people are being released from here…a lot of guys are homeless. They go out that gate, with a bag in their hand and they'll go out the road. They're looking left, right, which way do I go? There's a lot of that happens here as well. They're saying you come in the gate on your own, you go out the gate on your own. But I think there should be a bit more-- I suppose all they can do is what they can do, I don't know. But with this homeless craic, the lads are going out and they have no support, you know what I mean? They have their bag in their hand. All of a sudden they're on the other side of town, and they're sleeping in doorways, doing heroin and stuff."* ***– Man in custody***

*"There has to be more options. I know there's a lot organisations and volunteers, community organisations that come into the prison, but there's a lot more that would come into prison. There's a lot more former prisoners, former prisoners are probably the best in the position to come and help out prisoners, especially when it's based on release and the anxieties about going home and… former prisoners are in the best position to advise prisoners. It's as simple as that."*
***– Man in custody***

*"People get released from prison, suddenly all the structure is gone. They're just left on their own. They're not necessarily going to have the family supports or the social supports that they need. Then that just leads into a revolving door to prison service. Just better resources, I think before, during, and after, really."* ***– Prison Officer***

*"It's supporting the transition and the transition out of prison, having that multi-agency coordinated approach to things."*
***– Voluntary sector staff***

*"I remember speaking to someone in psychology in the prison and they said they can't make referrals into the community because they're Department of Justice funded, and other psychologists in other services that have psychologists are HSE funded… Psychology in a prison should be able to have direct pathways to refer into psychology into the community."*
***– Voluntary sector staff***



# 7. SUMMARY AND CONCLUSION

This research sought to better understand the mental health services and supports available to adults detained in closed-prisons, the pathways or steps one must take to access them, and potential barriers or challenges related to accessing each service or support. Findings highlight a number of mental health services and supports that are available to persons detained in Irish prisons. By categorising services and supports into four tiers, ranging from low-level to specialised in-patient care, this study provides a comprehensive overview of the mental health services and supports within adult closed prisons in Ireland.

A number of pathways to learning about and accessing these resources were identified. Broadly, persons in prison often learned about services and supports via information material (e.g. leaflets, posters, TV channel), staff interactions, or peer interactions. While the steps needed to access each specific service or support varied, they were often reported as being accessed via both formal and informal referrals by staff or peers. **In particular, prison officers arose as a key resource for both awareness of services and for facilitating access**.

Qualitative one-to-one interviews and focus groups elicited a range of lived-experience perspectives from persons who have accessed, attempted to access, or provided mental health services or supports in prisons. Findings indicate that, once accessed, the overwhelming majority of services and supports are viewed positively by both staff and men in custody. **Tier 1 services and supports, encompassing low-level, non-specialised services available to the whole prison population, emerged as particularly impactful, with educational services and other resources such as the prison gym frequently cited as beneficial to mental health.**

While services were generally received positively once accessed, a number of barriers to accessing services and supports were identified. Some of the most common challenges included short-staffing due to recruitment challenges and illnesses, long waiting lists, limited awareness, stigma, and language barriers. However, discussions surrounding these challenges also revealed potential solutions. Across stakeholder groups, there was a strong desire to continue and broaden Tier 1 supports, such as psychoeducation workshops, to increase awareness, reduce stigma and provide a level of mental health support – a measure that could prove particularly beneficial for those awaiting access to Tier 2 or Tier 3 supports. In addition, the demand for increased addiction counselling and a dual diagnosis model of care was evident, along with the perceived value of workshops and addiction support groups. This was especially the case for those led by persons with lived experience of addiction or incarceration, presenting an opportunity to broaden the availability of these lower-level addiction supports in the short-term while also planning for more comprehensive changes in the medium and longer term.

Finally, this research underscores the importance of diverting persons with mental health difficulties away from the prison system and into mental health services, where appropriate and feasible. This aligns with the findings and recommendations of the HLTF Report.[81] Where diversion is not possible, it is crucial to mitigate the negative impact of incarceration on mental health and ensure access to tiered mental health services and supports within the prison. Preparing individuals and their families, carers and supporters with information, both prior to incarceration and again on committal, could also help to increase awareness and reduce the negative impact. A comprehensive list of recommendations arising from this study is available in Section 9, Recommendations.

# 8. LIMITATIONS

As with any research piece, there are a number of limitations and caveats to this study. Regrettably, the NFMHS and psychiatry did not take part in data collection. Completion of the surveys was voluntary and therefore the fullest picture of service provision cannot be provided. There are some learnings about the framing of the questions and the data availability within the IPS. Data regarding the numbers of persons presenting to the GP or Psychology services in each prison with specific mental health difficulties (e.g. anxiety, depression, PTSD, etc.), for example, was not readily available. This limitation is not unique to this study and has also been a limitation to other reports including the Crowe report on the Health Needs Assessment of the Irish Prison Service.[82] The recent Crowe report also highlighted the lack of interoperability of IT as a limitation.

MHR undertook all possible measures to ensure inclusivity of the voices of lived experience in the prisons, including recording a short video to be shown on the TV channels explaining the study in order to overcome potential literacy barriers. While the majority of detained interview participants were proactive in requesting to participate in the study, a small number of men shared with the researchers that they had been handpicked by prison staff to speak with the researchers. This was unexpected, as it was not part of the study design. To minimise risk, the consent form was reviewed with each participant prior to commencing interviews, and participants were given time to ask any questions they had prior to commencing the interviews. They were also reminded that participation was voluntary, and they were free to decline to answer any questions, or end the interview at any time. However, the opinions expressed may not necessarily be a true representation of all experiences in prison.

It is also important to note that all study recruitment materials were distributed in English, as interviews were conducted in English. Given this, this study may not be representative of the lived experiences of persons unable to communicate in English. As mentioned in the study, one-to-one interviews and focus groups were open to all prisons; however, due to a similar piece of work being undertaken on the experiences of women in prison, it was decided not to duplicate work and so one-to-one interviews did not take place with women in prison. The research team did, however, visit the Dóchas Centre on the Mountjoy Campus, and received a tour from an ISM officer and met with an Assistant Governor. Additionally, surveys, interviews and focus groups pertained to adult closed-prisons, and thus findings cannot be applied to adult open prisons or to youth detention centres.

Finally, of note is the inclusion of sex offenders in the study undertaken by Porporino in the 'New Connections' Report.[83] This was not an area examined in detail in this study, nor are the survey responses available in such a way as to categorise the men in prison.

".. MHR undertook all possible measures to ensure inclusivity of the voices of lived experience in the prisons .."

# 9. RECOMMENDATIONS

## 9.1. Policy and Legal Recommendations

### 1. Align Irish Prison Service Healthcare Standards with UNCRPD

Align the Irish Prison Service Healthcare Standards with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) to safeguard the rights and dignity of individuals with disabilities, including mental health difficulties, within the criminal justice system. This alignment ensures adherence to international human rights standards.

### 2. Ensure that legal rights are extended to people in prison, including those afforded to them under the Assisted Decision-Making (Capacity) Act 2015

In line with the principles of human rights, it is essential to extend legal rights to individuals in prison, including those provided under the Assisted Decision-Making (Capacity) Act 2015.

### 3. Ensure all prisons are implementing learnings from the COVID-19 lockdown periods

Improving indoor air quality in the prisons to meet the updated Health and Safety Authority Indoor Air Quality Code of Practice will reduce the spread of airborne pathogens such as COVID-19, influenza, rhinovirus, RSV, and measles among both detained persons and staff. The UN recognises access to sanitation, including showering facilities, as a fundamental human right. During infectious disease outbreaks, necessary isolation measures must respect human rights, be based on scientific evidence, non-arbitrary, non-discriminatory, of limited duration, and respectful of human dignity.

## 9.2. Operational Recommendations

### 1. Formulate a comprehensive framework for tiered mental health support in Irish prisons.

This study has outlined the different types of supports available at an overarching level, and will be complemented by a research project exploring the mental health status and needs of the prison population due to be undertaken in 2024.There is a need to develop a clear framework specific to the prison context. This study has shown that tier 1 supports are highly impactful but are often not directly considered when looking at mental health supports and services.

### 2. Increase resource allocation across all tiers

To effectively deliver a wide array of essential supports and services, increased resourcing is imperative. Adequate funding and resources are necessary to ensure the comprehensive provision of these vital services.

### 3. Enhance the Role of the VCS

Improve awareness and engagement with the Voluntary and Community Sector (VCS) by providing accessible brochures detailing available VCS offerings in each prison. Periodic visits from VCS representatives, akin to the success of Mental Health Week, could enhance awareness and accessibility. Ensure the provision and expansion of VCS services through sustainable, sufficient and multi-annual funding.

### 4. Implement Dual Diagnosis Model of Care in Prisons

In line with the recommendations of the HLTF, a National Clinical Programme for Dual Diagnosis should be resourced and piloted within the prison setting with a view to scaling up across the prisons.

### 5. Distribute Tailored Information Booklets in Each Prison

Standardised information booklets for each prison should be distributed within 48 hours of committal. Tailor the content to the specific offerings, services and opportunities available in each prison, ensuring individuals have adequate time to review and seek clarification.

### 6. Provide information in multiple languages

Enhance accessibility by translating essential information into multiple languages, ensuring that individuals in prison can readily comprehend the provided materials.

### 7. Provide pre-sentencing guidance on what to expect in prisons

This study has highlighted the lack of preparedness for people entering prison. There are opportunities within the criminal justice process to provide pre-sentencing guidance on what to expect in prisons. This information should be provided in an accessible way and translated into relevant languages. The impact of imprisonment and the shock of being in prison are reported to be detrimental to a person's mental health. Preparedness will reduce anxiety levels about what to expect.

### 8. Implement a second mental health screening

A second mental health screening should be conducted in the days following reception, when someone may be better placed to engage in discussion and the immediate stressor of being imprisoned is not as acute. This should be done by a trained mental health professional.

### 8. Peer support model

Explore and implement a peer support model within Irish prisons to enhance mental health and well-being, leveraging the unique benefits of shared experiences and mutual understanding among the prison population with lived experience of mental health difficulties.

### 9. Purposefully recruit multi-lingual peer-listeners

Training Samaritans peer-listeners who speak additional languages will improve access to the service for non-English speaking persons.

### 10. Increase awareness and reduce stigma

Mental Health Week was repeatedly cited by men in custody as reducing stigma and promoting help-seeking behaviour. Increasing frequency of the events, and similar psychoeducation and lived experience workshops may increase awareness and reduce stigma among the population.

### 11. Develop Population-Centric Modelling for Tailored Prison Health Services in Ireland.

Establish a modelling framework for the prison population as Ireland shifts towards population-based health budgeting. This modelling initiative should inform service provision, considering the distinct demographic and social characteristics of each prison population. Recognising that individuals often originate from communities facing multiple deprivations, have experienced adverse life events, and present with diverse and complex needs, the model should aim to tailor services accordingly.

# 10. ACKNOWLEDGEMENTS

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We are grateful to the all of the participants of this study, whose willingness to share their experiences has shed light on the complexities of mental health issues within the prison system. Their contributions have been integral to the development of this research. It was important for us to get as much insight as possible into the daily reality of life in prison in Ireland. We would like to acknowledge the trust of the men in custody for talking to us. We really appreciate the solution-focused ideas they put forward.

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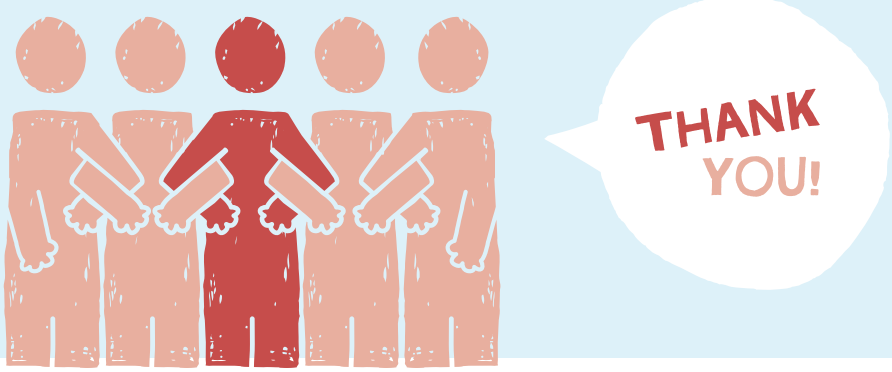

# APPENDIX 1: PSYCHOLOGY SERVICES AND INTERVENTIONS

| Intervention Name | Description |
|---|---|
| Alexithymia | This programme aims to help participants to learn, identify and name emotions; to introduce the idea that emotions can be useful in solving problems; and to prepare them for future interventions where they will talk about their emotions. Offered in a group format for 1.5 to 2 hours, every week, for four to seven weeks. |
| Building Better Lives (BBL) | The aim of this programme is to support men to live safer lives and build healthy relationships in the community. This national programme for the treatment of sexual violence addresses mental health, relationships, and past traumas. It is typically offered in a group format for two hours, every week, for nine to twelve months. The programme can also be adapted to a one-to-one format if clinically indicated. |
| Mindfulness Based Stress Reduction (MBSR) | This programme aims to help participants develop awareness of the present moment, and skills to help them to reduce overall arousal and emotional reactivity. It is offered in a group format for two hours, every week, for nine weeks. |
| Psychoeducation Workshops | Whole-population wellness programmes, open to anyone in custody interested in attending, are held from time to time, and are sometimes co-offered with the school or addiction services. These workshops provide psychoeducation around a broad range of mental health related topics, and may be facilitated by either an assistant psychologist or qualified psychologist. These workshops are typically once-off group sessions, lasting 1.5 to 2 hours. Examples included: Improving Your Sleep; Grief; Trauma; Social Anxiety; Self-Esteem; ASD/ADHD; Exam Stress; Preparing for Release; Managing Your Mood. |
| 1-to-1 support | One-to-one interventions are provided for a broad range of individual intervention work across levels of intensity and diagnosis. They are typically offered via 50-minute weekly sessions over the course of 10 to 12 weeks for primary care interventions, or longer for more intense interventions. |
| Primary Care Interventions | These interventions aim to provide brief, low intensity psychological support for persons who are experiencing mild to moderate mental health difficulties. They can be provided by an assistant psychologist under the supervision of a qualified psychologist. They are typically offered via 50-minute weekly sessions over the course of 10 to 12 weeks. |
| Secondary/ Tertiary Interventions | These interventions are tailored to the needs of the client, but typically treat active symptoms of trauma or complex trauma. They may also provide one-to-one offence-focused work which could not be completed in a group setting. These interventions are provided in the one-to-one format by a qualified psychologist weekly for 50-minute sessions lasting from 12 weeks up to two years. |

| | |
|---|---|
| Dialectical Behaviour Therapy (DBT) Skills/Emotion Regulation Group | This programme provides intervention to support improved emotion regulation skills and awareness. It is provided in a group format for 50 to 90 minutes per week, for 12 to 14 sessions. It was noted that this programme may expand to 29 sessions. |
| Mentalisation Based Therapy (MBT) | This programme aims to improve interpersonal functioning, emotional regulation, and psychologist insight for those with personality disturbance and/or where collaborative formulation has identified strengthening mentalisation skills may support improved functioning. This is achieved by broadening participants' understanding and experience of emotion, increasing focus on the internal self, making thoughts and feelings more explicit, recognising rigid patterns of relating, and increasing empathy for others. It is provided in a group format, weekly, for 75 to 90 minutes. The introduction group (MBT) lasts for 10 to 12 sessions, while the secondary programme (MBTg) lasts for 42 sessions. |
| Triage Assessments | These assessments are a brief clinical intake, during which a psychologist will meet with the person in custody to identify needs and put together a treatment plan. Triage assessments are carried out over two to six weekly one-to-one sessions, during which they can signpost to other services and supports, and work with the person to identify tools and healthy ways of coping while they are on the waiting list for their agreed intervention. |
| Metacognitive therapy for psychosis | This programme aims to reduce positive symptoms of psychosis. It can be provided in a group format or one-to-one, and is typically offered for 30 to 50 minutes weekly over the course of 12 weeks. |
| Pathways to Change | This programme is an introductory offence-focused intervention, with the objectives of: supporting men with violent histories to develop a solid understanding of their violent offending and their unique risk factors for violence, early in their sentences; increasing the number of men with a violent history being seen by psychologists for preliminary offence-focused work; promoting exploration of personal risk factors and, when willing, sharing this information within the group context; helping people link their unique risk factors for violence with the rehabilitative possibilities and opportunities within the IPS and beyond (on release); and motivating and empowering people to take a more active role in their sentence management to reduce their risk of violent recidivism. The programme takes place over 12 weeks with sessions lasting for 1.5 hours. It is held in a group format. |
| Psychological First Aid | This programme was piloted in one prison following a death in custody. This was an open access, once off support group to the population. |
| Building Identity Programme | This programme is targeted to individuals ages 18 to 24 and aims to improve insight into their own risk factors and set up a care plan. Individuals meeting criteria are automatically referred to the programme on committal, though they are free to decline the opportunity. Participants attend six weekly one-to-one sessions with assistant psychologists, lasting 50 minutes each. Monthly check ins continue for six months. |

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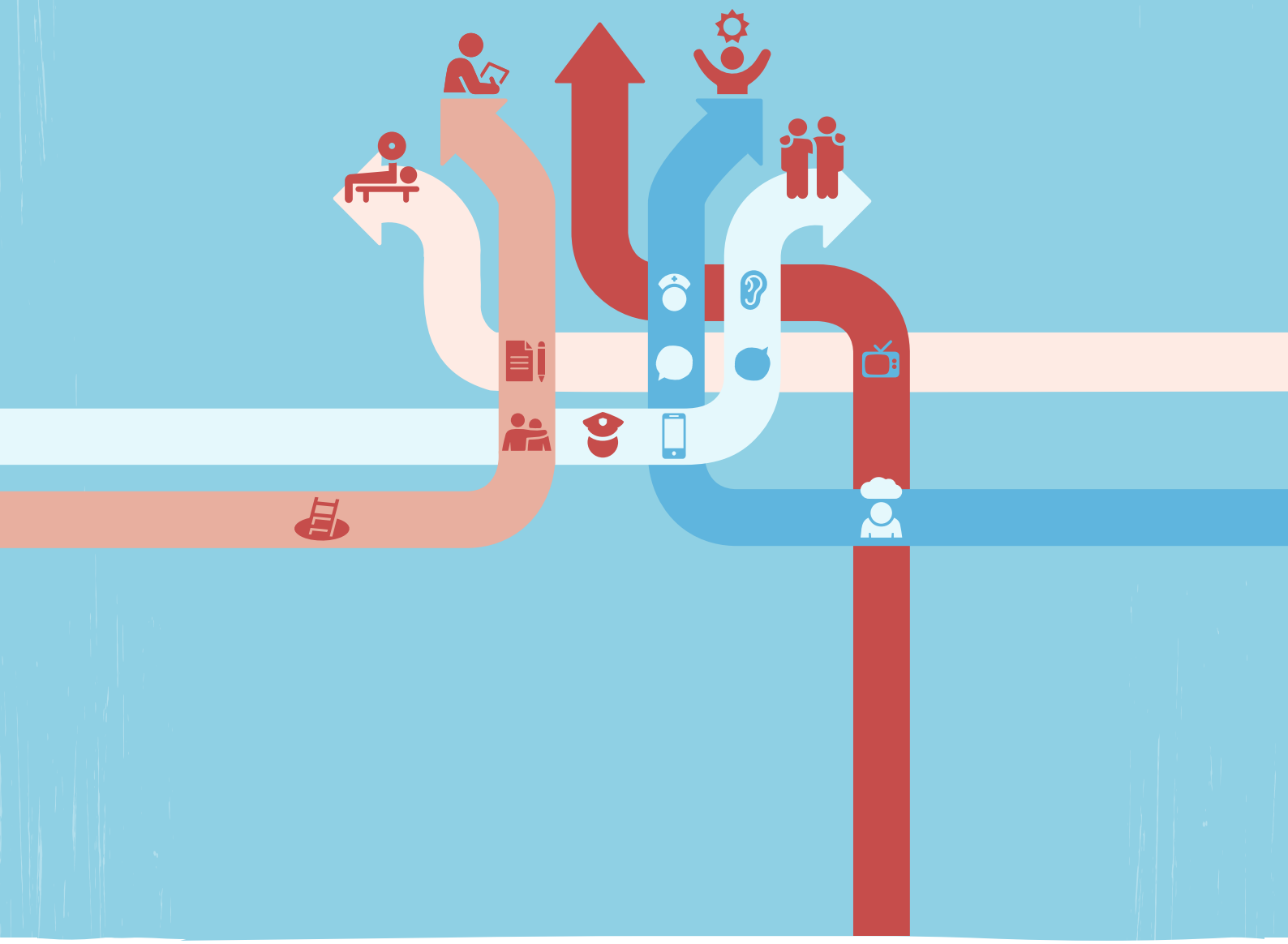
# MENTAL HEALTH SERVICES & SUPPORTS IN PRISONS:

## Service Mapping and Reflections from Lived Experiences



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