Crowe

Seirbhís Phríosúin na hÉireann

IRISH PRISON SERVICE

Health Needs Assessment for the Irish Prison Service

Final Report

March 2022

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1 Introduction

1.1 Background to the Irish Prison Service

Similar to many organisations, the Irish Prison Service (IPS) operates according to a multi-year strategic plan, with this strategic plan providing guidance and direction to the activities and ambitions of the organisation. Underpinning the ambitions and objectives contained within all strategic plans is the IPS mission to "provide safe and secure custody, dignity of care and rehabilitation for safer communities". In order to ensure that the underlying objectives within this mission are upheld, the IPS regularly conducts reviews of the care and services provided to prisoners.

This mission of the IPS with its corresponding values, refers not only to ensuring that prisoners are kept safe and treated with dignity through secure custody, but also in terms of the health services and resources they are provided with. As per EU and UN guidelines, the IPS seeks to ensure that prisoners receive the same standard of healthcare as members of the public, with care provided through a combination of doctors, nurses, and other in-reach healthcare professionals. The IPS is also cognisant of the fact that prisoners can often be more likely to have certain health needs than the wider population, and so has specific initiatives on issues such as mental health services, addiction services and care of older prisoners.

The current strategic plan – *Irish Prison Service Strategic Plan 2019 – 2022*[1] – sets out the ambitions and purpose of the Irish Prison Service (IPS) within five distinct pillars:

- **Staff Support** – creating a more supporting working environment with a more engaged workforce.
- **Prisoner Support** – further supporting the integration of prisoner support services to deliver more effective rehabilitation to prisoners.
- **Safe and Secure Custody** – creating a safer and secure custodial setting in the IPS estate, making prisons a safer place for staff, prisoners, and visitors.
- **The Prison Estate** – investing in a prison estate that provides safe, secure, and humane custody, that upholds the dignity of all users and that reflects and supports a modern and progressive penal policy.
- **Governance** – ensuring an open, transparent, and accountable prison service.

The IPS Strategic Plan provides a compelling narrative for the improvement and further development of all facets of healthcare during the prisoner experience. This identifies areas of focus within the *Strategic Priority 2: Prisoner Support* for improving healthcare, enhancing psychological wellbeing, increasing rehabilitation support, and resettlement and integration. The Strategic Plan delivers an explicit requirement for a review of prison healthcare through a Health Needs Assessment (HNA).

Crowe Ireland was commissioned in late 2019 to conduct a Health Needs Assessment, both for the IPS as a whole and for the 12 individual prisons within the IPS estate. In the following paragraphs, we describe how we undertook this assignment, while subsequent

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1 Irish Prison Service Strategic Plan 2019 – 2022 https://www.irishprisons.ie/wp-content/uploads/documents_pdf/Document 5_IPS-Strategy-2019_2022.pdf

main sections of the report present our findings, analysis and recommendations for the optimal development of IPS healthcare services.

1.2 Overview of the Health Needs Assessment Process

1.2.1 Terms of Reference

The terms of reference for this Healthcare Needs Assessment required that it should take account of the health needs of prisoners, the demands for health care services and the level of healthcare provided. In this regard, the views of key stakeholders must be considered. The overall purpose of the exercise is to enhance the quality of healthcare provided in prisons and to secure service improvements as required. The HNA was tasked to take account of the efficiency and effectiveness of services and consider the following actions:

- Analysis of international best practice in the provision and resourcing of health and care services to the prison population.
- Review and reporting on the provision and resourcing of health and care services currently available to the prison population in Ireland.
- Identification of the generic and specialist health care needs of the current prisoner population and estimate the future requirements.

The key elements of the HNA were identified as the following:

- **Description of Prisons** – requiring site visits to each open and closed prisons for adult male and female prisoners.
- **Description of the healthcare services provided** – primary care, mental health, pharmacy and access to specialist services, and an explanation of how IPS health services interact with the broader prison services and the range of services provided externally by the Health Service Executive (HSE).
- **Organisation of healthcare resources and services at prison level** – clinical facilities, pharmacy, other facilities, healthcare staffing (GPs, nursing, healthcare assistants, allied health professionals), working arrangements, including out-of-hours cover, approach of primary care services and the integration with community services, and health promotion and prevention services within the prison.
- **Description of health issues and health status at the prison level** – minor illness, infectious disease, chronic disease, disability, mental health, self-harm, substance misuse, dental health, lifestyle related behaviours, and prescription data.
- **Description of healthcare needs** – based on current and future requirements.

It was also anticipated that the HNA would involve:

- Close consultation with IPS stakeholders, including prisoners and their families, at all levels of the organisation, and wider keyholders external to the IPS, such as professional health care bodies.
- Consideration of effective interventions, involving an analysis of national and international best practice.
- Identification of recommendations for consideration by the Steering Group on healthcare services and interventions addressed across the IPS estate.

- Development of implementation proposals for the Steering Group on priority actions and a means to monitor progress.
- Delivery of a final report providing a qualified narrative for all findings, conclusions and recommendations.

This assignment was conducted through a mixed methodological approach, with site visits to each prison complemented by a stakeholder engagement process and comparative research. The following subsections detail each aspect of this methodological approach. All of work was conducted so as to generate a rounded and evidence-informed understanding of healthcare services and prisoner needs, with a view to developing this report containing our findings and recommendations for the Irish Prison Service.

1.2.2 Site Visits

Crowe collected comprehensive data regarding health needs and services within each prison, with a site visit conducted to each prison. During these site visits, Crowe personnel met with representatives and staff of each prison, including governors, medical staff, nursing staff, psychologists, prison officers and external providers of in-reach services to prisoners. Where possible the team engaged with prisoners so as to ensure that their voices were considered. However, this became increasingly challenging due to Covid-19 restrictions.

The Crowe team for each prison visit included consultations with both healthcare management and clinical skills (medical and nursing).

The first site visit was conducted during March 2020. The emergence of Covid-19 and subsequent suspension of prison visits by the IPS necessitated the postponement of the planned schedule and process until later in the year, with the remaining eleven site visits conducted from late August to early October 2020. Further detail regarding the structure and format of these site visits is presented in Section 1.3 of this document.

1.2.3 Stakeholder Engagement Process

The site visits were complemented by an extensive stakeholder engagement process, with the Crowe project team interacting with a variety of individuals and organisations associated with the provision of health services to prisons so as to gather a wide variety of perspectives within healthcare and criminal justice. The stakeholders with whom we consulted included the following organisations:

- Department of Health
- Health Service Executive
- Sample of acute hospitals
- Inspector of Prisons
- Medical Council
- Irish Penal Reform Trust
- Mental Health Reform
- Red Cross
- Department of Justice
- Central Mental Hospital
- Royal College of Physicians in Ireland
- Pharmaceutical Society of Ireland
- Nursing and Midwifery Board of Ireland
- Chaplains
- Irish College of GPs
- Merchants Quay Ireland

The insights gathered through these interactions are included in our analysis throughout this document.

1.2.4 *Comparative Analysis*

Finally, in addition to conducting site visits across the IPS estate and engaging with a wide range of stakeholders, a key element of the HNA was the undertaking of a comprehensive literature review regarding prisoner health services. A team of researchers from Leeds Beckett University conducted an in-depth review regarding established best practice within the delivery of healthcare to prisoners across a number of jurisdictions. The findings gathered through the course of this review are presented in full in Annex I, while Section 3 of this document provides a summary of these findings.

1.3 Description of Prison Visits

1.3.1 *Background*

An essential aspect of our assignment was the schedule of site visits to each of the twelve prisons within the Irish Prison Service's estate. These visits provided us with an invaluable opportunity to speak to staff within the prisons (including governors, discipline and healthcare staff), as well as hearing the perspectives and experience of prisoners in receipt of such services. The approach chosen for the undertaking of these visits provided us with a full understanding as to the key issues and challenges facing those 'at the coalface' of delivering healthcare services within the Irish prison system.

After discussions with the IPS, it was decided that these site visits would be conducted over the course of two to three days, depending on the size of each prison. These site visits would commence with a meeting between the Crowe project team and the governors of a prison, after which we would be taken on a tour of the prison and engage with various members of staff and, where possible, prisoners. This format would enable us to fully familiarise ourselves with the operational context of each prison, as well as providing us with an opportunity to engage with as many prisoners and staff members as possible.

In order to ensure that this format was suitable in practice, it was decided to undertake two pilot visits, with Castlerea and Mountjoy prisons selected as the two sites. Though initial kick-off meetings with the governors and the pilot visit to Mountjoy Prison were conducted as scheduled during early March 2020, the rapid spread of Covid-19 and introduction of nationwide restrictions on March 12th curtailed our pilot visit to Castlerea Prison as had been planned.

Following the introduction of these restrictions on March 12th, we agreed with IPS senior stakeholders to temporarily suspend the programme of site visits, until easing of Covid-19 restrictions might enable their recommencement. In line with the easing of Covid-19 restrictions in the autumn, we conducted the remaining eleven site visits in late August and September 2020. In the interests of public safety, it was agreed that engagements with prisoners would vary according to the individual circumstances of each prison, namely the extent to which interactions could be conducted whilst complying with social distancing. Furthermore, these visits were conducted over a single day, with Crowe engaging with as many members of staff as possible via telephone and video calls in advance of our visit.

The impact of these restrictions was that we were less able to conduct detailed fact-finding on the day of the visit, with much activity having to take place by email, phone and video meetings in the following weeks and months. The workload of IPS staff as a result of the Covid-19 pandemic also meant that staff were less able to respond to our requests for information as quickly as desired.

It is also important to stress that during these site visits, Crowe team members were fully compliant with all relevant public health guidance, including wearing masks whilst in confined indoor spaces, travelling to and from the prison individually, regularly sanitising hands and adhering to social distancing whilst indoors.

1.3.2 Engagement with Healthcare Staff

Our primary contact within each prison was that with the Chief Nurse Officer (CNO). As the individual largely responsible for managing the day-to-day delivery of healthcare services within a prison, it was crucial to hear their perspectives, not least in respect to how they believed healthcare was regarded within their prison. Each site visit began with a meeting with the prison governor(s) and CNO, after which we then taken on a tour of the prison by the CNO, during which we were shown the various facilities available for the delivery of health services. These tours also provided us with an opportunity to meet with the various healthcare staff working within the prison and organise a formal interview later in the day, or subsequent to our visit, according to their availability.

Alongside the CNO, the resident General Practitioner(s) of a prison have significant responsibility in managing and delivering care to prisoners, and so each site visit included a detailed interview with the GP(s) working within the prison. We also were particularly keen to speak with the nursing staff within each prison. At the end of each tour of prison facilities, we held a group interview with all available nursing staff, and in some cases individual consultations subsequent to our visit, during which we informed staff that we would be happy to receive emails from any of their colleagues who wished to contribute but were unable to attend.

In addition to prison-based primary care staff, we also engaged with dental staff, mental health staff, psychologists, addiction counsellors and where possible, chaplaincy services. The majority of these interviews were conducted in-person during our site visits, though due to unavailability, some personnel were engaged with via video calls.

1.3.3 Engagement with IPS Senior Management

Crowe conducted extensive engagement with IPS senior management throughout the course of the assignment, ensuring that senior management were continuously kept informed as to project progress. This engagement began following our appointment, firstly with a meeting with the IPS Strategic Planning Group in October 2019, shortly after which we then met with the Director General of the IPS. During December 2019 we conducted a visit to the IPS Headquarters in Longford, during which we met with staff across the wider organisation, and were provided with an in-depth walkthrough of the PIMS and PHMS data systems employed by the IPS.

With regards to ongoing updates, Crowe and the IPS held regular update meetings as to project progress, with Crowe also formally presenting to IPS Senior Management at specific, agreed-upon intervals. These engagements ensured that despite Covid-19

restrictions and personnel on both sides working remotely, the IPS were kept fully informed as to project progress during all stages of the assignment.

1.3.4 Engagement with Discipline Staff

During our three-day visit to Mountjoy Prison we were able to conduct a semi-structured interview with prison officers, during which we discussed their interactions with healthcare staff, the training they receive in respect of prisoner physical and mental health, as well as any other issues they wished to raise. This level of engagement was very helpful, but was unfortunately not possible for subsequent site visits due to a combination of Covid-19 restrictions and our only spending one day in each prison. Nevertheless, we typically did manage to speak with prison officers on an *ad hoc* basis through the course of our site visits, and so were able to ensure that some perspectives from discipline staff were gathered for this assessment.

1.3.5 Engagement with Prisoners

As the purpose of this Health Needs Assessment is to identify and support improvements to the healthcare received by prisoners, we regarded it as important that the voices of prisoners were heard during this process. Our original project plan included a series of focus groups with prisoners in all prisons, with this format undertaken during our initial pilot site visit to Mountjoy Prison in March 2020. Unfortunately, due to the introduction of Covid-19 restrictions, we were unable to conduct specific focus groups with prisoners for all prison site visits. The restrictions on consultants interacting with prisoners were not only agreed between Crowe and the IPS, but also requested by prisoners as they were fully aware of the need to prevent the introduction of Covid-19 into the prison system.

We conducted *ad hoc* interviews and conversations with prisoners where social distancing was possible, explaining the purpose of our visit and inviting them to share their experiences, perspectives, and any suggestions for how improvements could be made to health services. This reduced engagement with prisoners, as against our original project plan, was disappointing and not ideal, although did at least ensure that prisoner voices were heard during the HNA process.

Through the course of our site visits, we were able to conduct varying degrees of engagement with prisoners in the following prisons:

- Dóchas Centre;
- Loughan House;
- Mountjoy;
- Shelton Abbey;
- Portlaoise;
- Cork.

1.3.6 Engagement with External Stakeholders

In addition to our engagements with staff and prisoners within each prison, we also undertook a series of interviews with individuals and organisations external to the Irish prison system. These included those providing in-reach services within prisons, local hospital emergency departments, as well as organisations involved in prisoner advocacy and representation. Engaging with these external stakeholders ensured that we were provided with a comprehensive picture of how prison healthcare services are delivered, while the inclusion of prisoner advocacy and representation groups was crucial in representing the voices of prisoners, particularly in light of our reduced direct interaction

with prisoners as set out in Section 1.3.5. As with our engagements with discipline and healthcare staff, the findings and perspectives from these interviews are interspersed throughout the entirety of this document.

1.3.7 Project Governance

At the commencement of this review, a Steering Group was established, composed of representatives of the IPS, the Department of Justice, the Department of Health, and the Health Service Executive. The Crowe team met regularly with the Steering Group throughout the course of the assignment, both to provide project updates and to brief the Group on key issues arising as the review progressed.

We were also requested to meet with the High Level Taskforce on Mental Health established to consider the mental health and addiction challenges of persons interacting with the criminal justice system. This meeting took place on 29th July 2021 and provided a useful opportunity for our team to brief the Taskforce on relevant issues arising from the HNA assignment.

1.4 Making Use of Information and Opinion Provided During the Review

1.4.1 Individual Prison Reports

Following each site visit, the Crowe team prepared an HNA report pertaining to each individual prison. These reports are mainly factual in nature and provide a more in-depth assessment of the healthcare services provided in each prison, and the issues and challenges specific to that establishment. The individual prison reports were shared with Care and Rehabilitation Health Leads, and the Governor and healthcare team of each prison for fact-checking purposes, and follow-up information was provided as necessary. The prison-specific reports should be read in conjunction with this main report for the IPS as a whole, which is intended to deal with the overall provision of healthcare services across the IPS and the strategic and corporate issues arising for our analysis.

1.4.2 Dealing Objectively With Information and Opinions Provided

In a review as comprehensive as this HNA exercise has been, it is natural that the Crowe team will have been presented with a wide range of information and opinion both from within the IPS and by external stakeholders. Sometimes, opinions and suggestions made by those with whom we spoke were at variance from one another; sometimes, they were subjective and based upon personal experience; in every case, without exception, they were presented from deep concern with wanting to improve prison healthcare. In that regard, we are grateful to all of our consultees for their time, their candour and their desire to see positive change.

However, it is our job as consultants to listen, to critically assess what we learn, and to reach our own, independent judgements informed by the evidence presented to us. On that basis, whilst what follows in this report is drawn from what we have seen and heard, all of the findings and recommendations we present are objective and independent.

2 Healthcare Needs of the Prisoner Population

2.1 Background to the IPS

A nation's criminal justice system is designed to identify and to hold to account those who commit crimes, and, if properly structured and resourced, can be the bedrock for a safe and secure society. In Ireland, the Department of Justice oversees the nation's criminal justice system, which its mission to "to maintain community security and promote a fairer society in Ireland". An Garda Síochána are the organisation responsible for policing within Ireland, i.e., detecting and preventing instances of crime, as well as catching those responsible for breaking the law so as to enable their sentencing in a court of law. However, once those individuals have been sentenced by the court system and placed into custody, it is then necessary to ensure that a prisoner's time in the prison system is safe, dignified, and that a pathway to rehabilitation is offered.

Operating as an executive agency within the Department, the Irish Prison Service is the state organisation which is charged with managing the day-to-day operations of prisons in the Republic of Ireland. Approximately 4,000 prisoners are within the care of the IPS, with this population distributed across the following twelve prisons:

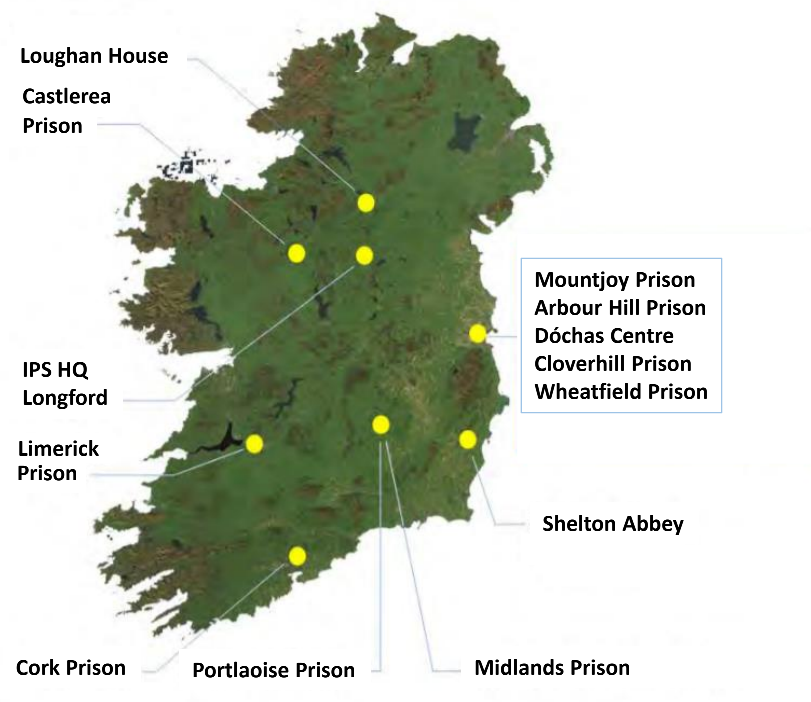

Figure 2.1: Location of IPS Prisons and HQ

- **Arbour Hill** – a closed, medium security prison for adult males, inmate profile is predominantly long-term sentenced prisoners.
- **Castlerea Prison** – a closed, medium security prison for adult males, committal prison for remand and sentenced prisoners in Connacht, Cavan, Donegal, and Longford.

- **Cloverhill Prison** – a closed, medium security prison for adult males, primary catering for remand prisoners committed across Leinster.
- **Cork Prison** – a closed, medium security prison for adult males, committal prison for Cork, Kerry, and Waterford.
- **Dóchas Centre**– a closed, medium security prison for adult females, committal prison for all females committed on remand or sentence outside the Munster area.
- **Limerick Prison** – a closed, medium security prison for adult males and females, it is the committal prison for males in Clare, Limerick, and Tipperary, and for females in Munster.
- **Loughan House** – an open, low security prison for adult males regarded as requiring lower levels of security.
- **Midlands Prison** – a closed, medium security prison for adult males, committal prison for Carlow, Kildare, Kilkenny, Laois, Offaly, and Westmeath.
- **Mountjoy Prison** – a closed, medium security prison for adult males, committal prison for Dublin city and county.
- **Portlaoise Prison** – a closed, high security prison for adult males, it is the main committal prison for those sent to custody from the Special Criminal Court and prisoners linked with subversive crime.
- **Shelton Abbey** – an open, low security prison for adult males regarded as requiring lower levels of security.
- **Wheatfield Prison** – a closed, medium security place of detention for adult males, and for sentenced 17-year-old juveniles.

2.2 IPS Duty of Care for Prisoners

It is widely accepted that the social determinants of criminality can be seen as largely comparable to the social determinants of health. In Ireland, as it appears to be across the world, the majority of people detained in prison come from communities and populations that are economically deprived, with low levels of education and employment, and living in poor housing conditions prior to their committal to prison.

The IPS has a duty of care to provide prisoners within its custody with appropriate services and supports to assist their rehabilitation and integration into society, with an underlying goal of reducing recidivism. The background of many prisoners can often mean that individuals in custody, irrespective of age, can present to the IPS with significant existing and emergent health difficulties. Therefore, ensuring prisoners have access to well-resourced and accessible healthcare resources and services is of paramount importance.

The official mission statement of the IPS is:

"Providing safe and secure custody, dignity of care and rehabilitation to prisoners for safer communities."

In line with this mission, the IPS provide prisoners with access to a range of services during their time in custody. These services include but are not limited to education classes (both basic and specialised), work experience and vocational training programmes, and a range of healthcare resources and services. With regards to the latter, as outlined in

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Section 1, the IPS seeks to ensure that prisoners are enabled to receive an equivalent level of care as those in the wider community. Ensuring that prisoners have access to high-quality and timely healthcare services is important, as prisoners typically have higher rates of morbidity and mortality than those in the wider community. Conditions of specific prevalence can include addiction, mental health conditions, chronic conditions such as diabetes and hypertension, as well greater susceptibility to infectious diseases.

It is important to note that the responsibility of ensuring prisoners have access to healthcare services lies with the Irish Prison Service, and not the Health Service Executive. In some other jurisdictions, responsibility for prison healthcare services comes under national healthcare providers, or may be shared between national healthcare providers and prison services. These differences in approaches to the delivery of prisoner healthcare across various jurisdictions are examined further in both Section 3 and Annex 1.

2.3 Health Services and Prisoner Needs

2.3.1 Service Provision

Within the Irish Prison Service, responsibility for healthcare services comes under the Care and Rehabilitation Directorate, alongside other services such as psychology services, education, work training and spiritual services. It is important to note that psychology is a standalone area within the Care and Rehabilitation Directorate and is separate from IPS healthcare services in terms of managerial reporting.

The IPS healthcare service aims to provide prisoners with access to an equivalent scope and quality of health services available under the General Medical Card scheme in the community. The IPS provides primary care services for the assessment, treatment, and support of prisoners. It also facilitates a range of commissioned and collaborative in-reach services, including stakeholders such as HSE Community Services and the National Forensic Mental Health Service. Services provided include mental health services, pharmacy services, drug treatment and addition services, dental services, and other allied healthcare provision such as opticians, physiotherapy, and chiropody (this list is not exclusive).

Within each individual prison, the ultimate responsibility for all aspects of prisoner care lies with the Governor of the prison, with the delivery of prisoner healthcare overseen by the prison's assigned doctor as set out in the Prison Rules (2017 Revision). Until very recently, the question of medical input to prison healthcare services was extremely varied and inconsistent across the IPS: a small number of prisons had permanently-assigned doctors (as IPS employees); others had locums or contracted GPs undertaking sessional commitments in the prisons, sometimes with the same doctors providing the service for several years; and others struggled to get locum GP cover, depending on agency services. This situation resulted in a lack of continuity (the doctors attending the prison being unfamiliar with the prisoner population and/or inexperienced in the demands of prison healthcare), and in considerable variability in the quality and consistency of care provided across the IPS.

In practice, therefore, the day-to-day healthcare services in most prisons are typically overseen by the Chief Nurse Officer (CNO). The CNO of a prison is responsible for managing the care provided by the prison's nursing team, which provides 24-hour cover in all of the closed prisons. It is reported that a number of CNOs have had to undertake a

wider range of duties in recent times to address the difficulties in securing the required GP capacity. The CNO and nursing team will also regularly liaise with addiction, in-reach and mental health services.

More recently, however, the IPS has made major changes in respect of the provision of medical input to prison health services. A recruitment competition has resulted in the appointment in mid-2021 of seven GPs on a full-time and permanent contract basis (as IPS employees) to the following prisons:

- Mountjoy Prison;
- Cork Prison;
- Cloverhill Prison;
- Loughan House.
- Midlands Prison;
- Wheatfield Prison;
- Limerick Prison;

(A further full-time position, at Castlerea Prison, is yet to be filled.)

2.3.2 *Structures for IPS Healthcare Services*

An outline of the structures for healthcare within the IPS is provided below, showing aspects of the IPS relevant to healthcare, not including other central directorates and functions. This presents the structural lines of reporting and does not highlight the pathways of accountability and responsibility:

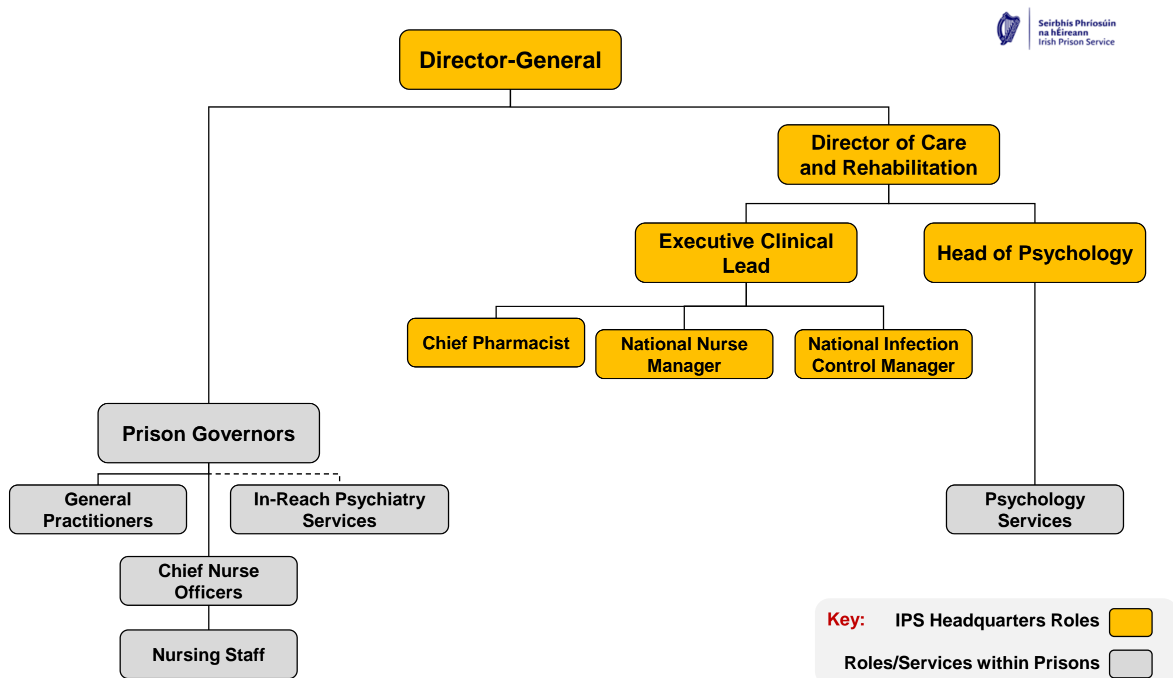

Figure 2.3.2: Current IPS Health Resources Structure

The range of health services available to prisoners whilst in custody can be categorised within the following areas.

- **Primary Care**
  - During the course of their time in custody, prisoners generally have ready access to primary care services, either GP or nurse led. Nurses are readily available on prison landings to conduct initial assessment and triage of prisoner health needs, while prisoners typically are able to access a GP within 24 hours of raising a health complaint.
- **Mental Health Service**
  - During their time in custody, prisoners have access to a range of mental health resources, including psychiatry and psychology services, counselling, access to Samaritans' phonelines, as well as 'Listener Programmes' where prisoners are provided with training to support their peers.
- **Dental Care**
  - The IPS provides prisoners with basic treatment for acute issues, with services identical to what is available on the medical card scheme. The dental care needs of a prisoner are assessed during the committal process, while in the case of emergent issues prisoners will either present to prison officers or nurses with an issue, with a dental appointment then being scheduled.
- **Addiction Services**
  - As many prisoners enter the prison system with addiction problems, or – in some cases – develop such problems whilst in custody, provision of adequate addiction services is a core element of the Irish Prison Service's healthcare services. The most visible of these services is the daily methadone clinics conducted in all closed prisons, with the proportion of inmates receiving methadone as high as a third in some prisons. In addition to heroin, the IPS also deals with other addiction issues through its multidimensional drug rehabilitation programmes. Prisoners typically have access to addiction counsellors, with some prisoners also having access to specialist addiction nurses, psychiatrists, and GPs, while drug treatment programmes are operated across a number of prisons to support prisoners wishing to halt their drug misuse.
- **Pharmacy Services**
  - The IPS ensures that prisoners in each prison are provided with access to pharmacy medicines, both over-the-counter medication and medicine requiring prescriptions. General Pharmacy Services are provided to all prisons (including Mountjoy) by way of a contract with a local community pharmacy. An Addiction Pharmacist Service is available in Mountjoy and Dóchas.
- **In-reach Services**
  - While the services listed above are regularly required by prisoners and so provided by resident staff within a prison, other services may not have sufficient frequency of demand to necessitate the posting of a full-time position within a prison. Instead, professionals from local hospitals will visit prisons, and provide services within fields such as chiropody, complex dental treatment, and sexual health. These visits can either be regular or on an as-needs-basis, with the IPS commissioning these in-reach services so as to ensure that prisoners have access to the same specialist care and treatment as in the community.
- **Local Hospital Referrals**
  - Occasionally, prisoners will be referred to a local hospital for interventions or investigations that the prison is not equipped or otherwise capable of providing,

as well as serious emergencies. Such referrals are on a case-by-case basis at the discretion of the GP, or nursing staff in the case of an emergency. Nursing staff take responsibility for any required follow-up care on the prisoner's return, where complex follow-up care is not required.

- **Public Health Programmes**
  - Access to national screening services is made available by the IPS, including the BreastCheck and CervicalCheck programmes (see Section 5.2.2 below). In addition, in 2021-22, all prisoners have been afforded access to the Covid-19 vaccination programme. The HSE designed and delivered a bespoke vaccination pathway for prisoners and staff in the IPS as part of the national Covid-19 Vaccination Programme.

2.4 IPS Prison Health Data

2.4.1 Overview

Due to the large numbers of prisoners who pass through the Irish prison system each year, it is important for the Irish Prison Service to have access to accurate, timely and detailed data. This is particularly pertinent with regards to the healthcare services provided to prisoners, many of whom may have complex health needs. The information recorded by the IPS is detailed below, along with the data systems for the management of such data.

Ordinarily, at this stage in a report such as this, we would include high-level statistics or infographics relating to the overall profile of healthcare services provided across the IPS – for example, number of GP attendances, prevalence of certain conditions, percentage of the prisoner population suffering from mental health or addiction problems, and so forth. However, as will be described in the following paragraphs, the information systems currently in use within the IPS were not developed as reporting tools and do not facilitate accurate reporting or analysis, and as a result we are unable to present any statistical data.

2.4.2 Data Systems

The IPS has two primary data systems for the storage and management of prisoner data, these being the **Prisoner Information Management System** (PIMS) and the **Prisoner Health Management System** (PHMS). The information stored and managed on PIMS refers to all aspects of a prisoner's custodial sentence, while all healthcare records are stored electronically on PHMS. These two systems are outlined below.

2.4.3 Prisoner Information Management System (PIMS)

The Prisoner Information Management System (PIMS) is the internal data management system of the Irish Prison Service. It records all general information pertaining to a prisoner, including their demographic data and information regarding their custodial sentence, including their offence, length of sentence and eligibility for parole. The recording of data enables the IPS to categorise the prisoner population by age, ethnicity, custodial sentence, offence, and any specific medical requirements.

Each prisoner is assigned a unique identifier number, so that if an individual re-enters the prison system, the IPS already have an existing profile to which information can be added. This existing profile is important, as it ensures that IPS staff – both discipline and healthcare – are provided with a detailed picture of an individual's background and history. Regarding a prisoner's history, if an individual has spent time in an Isolation Cell during a previous custodial sentence, or is deemed to require Special Observation, then this will be included on their PIMS profile. This ensures that if a prisoner is committed or transferred to a new prison, staff have as much information as possible.

Information included in an individual's background will be relevant to a prisoner's custodial sentence and where they can be housed within a prison. This includes any previous violent incidents, altercations with staff or other prisoners, gang affiliation or specific vulnerability. These latter two will be recorded through a combination of prisoner testimony and prison staff prior knowledge.

PIMS forms the foundation of all knowledge and information the IPS has regarding its prisoner population and is regularly updated by staff. Ensuring timely and detailed updating is therefore of key importance, particularly for prisoners who are scheduled to transfer to a new prison.

2.4.4 Prison Health Management System (PHMS)

The Prison Health Management System, introduced over a decade ago by the IPS, records all information regarding a prisoner's health status, healthcare needs and their interaction with health services provided by the IPS. Demographic information is populated from PIMS, with other data gathered during the nursing and GP committal interviews upon a prisoner's arrival into custody. This information gathered during committal interviews is added to as a prisoner spends time in custody, with all interactions with health services or changes to their healthcare needs updated onto PHMS by doctors, nurses and other healthcare staff.

The system itself has a variety of "tabs", recording a prisoner's personal details, medical summary, movements both within the prison itself and the Irish prison system, and clinical details. There is also the capability for notes and formal documents such as prescriptions or referral for external health services to be scanned onto the system and added to a prisoner's profile.

The system is used by all twelve prisons within the IPS estate, though only staff within an individual's current prison location can update a prisoner's PHMS profile. This ensures that a prisoner's full medical history is available to a new prison in the event of transfer, with staff in the transfer prison provided with a full overview as to the individual's history and health needs. Furthermore, each prisoner is provided with a unique identifier when entering the Irish prison system, assigned and recorded on PIMS so that in the event of an individual re-entering the prison system, their existing information is retained and accessible to staff.

As PIMS forms the foundation of all knowledge and information the IPS has regarding a prisoner's custodial sentence, so too does PHMS for a prisoner's medical history and care requirements. As with PIMS, ensuring timely and detailed updating of information onto PHMS is therefore of key importance. This is particularly pertinent for prisoners who are scheduled to transfer to a new prison, as detailed PHMS profiles will support the

healthcare staff in the prisoner's new prison in ensuring that the individual is provided with the most appropriate care and treatment.

It is important to note that whilst PHMS offers the functionality set out above, it is fundamentally a patient record system which allows data to be entered, updated and viewed by IPS healthcare staff, but does not have sufficient capability in terms of reporting or analysis (nor was this functionality included in its original specification). This is a major deficit in the system which significantly limits its usefulness at both prison and IPS-wide levels. As a result, the IPS currently lacks the ability to produce statistics or to manage aggregated data relating to the health of the prisoner population and the healthcare services provided to them.

2.5 Data Challenges

2.5.1 Strengths and Weaknesses of PHMS

Crowe's review of the data storage and management systems of the Irish Prison Service was conducted through a combination of IPS briefing sessions and demo walkthroughs, along with inviting staff to share their feedback. Feedback from clinical stakeholders was varied, with some accepting the functionality of the PHMS as being adequate, and others expressing frustration and disquiet about its limitations.

There is a range of tabs on the PHMS, apparently allowing for a significant level of detail to be added to each individual profile, providing staff with an individual's history and details of care needs. In addition, the two systems – PIMS and PHMS – operate across the entire IPS estate, allowing information to be available in the prisoners' location, and ensuring that the staff have a more detailed picture of transfer prisoners and their care needs. This latter point was frequently cited by staff with experience of working in the HSE as facilitating prisoner care to be consistently delivered to individuals across the entire Irish prison system, regardless of whether a prisoner may transfer between different prisons.

PHMS is designed in such a way to have one unique record per prisoner and moves with the prisoner as they relocate between prisons.

We observed both directly and through staff consultation a number of deficiencies in the storage and management of prisoner data. These deficiencies relate to the approach of the IPS in how data is stored and managed, rather than any systematic issues with PIMS or PHMS. In particular, we were informed that patient information can often simply be added into the 'Notes' tab of PHMS as narrative text, which makes it very difficult for the IPS to systematically review trends within patient health care.

Issues of interoperability, such as the lack of connectivity to the Psychology Case Tracking System (PCTS), data integration and migration problems, ease-of-use and user accessibility challenges, and the lack of reporting and analytics to accurately consider prisoner and prison population health needs, are considered to be significant issues that require early resolution.

2.5.2 *Absence of a Dedicated Data Manager*

A significant deficiency identified in the approach of the IPS to data management is that the organisation does not have a nominated individual whose sole responsibility is to ensure consistent storage and management of prisoner data across the IPS. We consider this to be problematic, given that the Chief Pharmacist, identified as the Business Owner of the PHMS, has a wide range of other clinical and management responsibilities. A dedicated staff member with data management expertise is required to ensure that this role is filled properly by a person with appropriate technical qualifications and experience.

Appointing an experienced individual with extensive knowledge of data management systems to this position could have great benefits for ensuring the consistency of data management across the IPS. In addition, having a designated data manager within the organisation could support greater utilisation as to the capabilities of PIMS and PHMS and ensure that IPS staff are fully aware, and confident, as to how to navigate and optimise the systems.

It is important to note that the individual appointed to this position should have data management as their sole focus and responsibility, rather than a varied portfolio of duties.

2.5.3 *Lack of Data Training Provided to IPS Staff*

During the stakeholder consultations, we were regularly informed about concerns relating to a lack of consistent, informative, and practical training made available to IPS staff regarding the utilisation of PHMS. Staff reported that a lack of knowledge regarding the capabilities of PHMS and PIMS prevents both data systems from being fully utilised, with this attributed to an absence of consistent training. Training was described as being ad hoc rather than structured. The level of detail and time provided during these training sessions was described as varying according to the work schedules of those providing training, and we were informed that many staff feel that this method of training can comprise the data input onto prisoner profiles.

IPS healthcare staff also expressed unease that medical input into the system, specifically in terms of diagnostic coding, is occasionally inaccurate, or lacking detail, due to inadequate user skills. A number of staff suggested that formal data management training sessions are required at all levels. We were told that there is poor availability of accurate condition-specific incidence and prevalence morbidity data across the IPS, which may be frustrating for those seeking to enable intelligence-led initiatives, services, and resources.

We were advised that information on PHMS updates and system enhancements is typically streamed down to staff, the PHMS users, via manuals rather than bespoke training sessions, with no framework to ensure compliance, understanding or minimum capability standards. A data management and training lead may address the training and competency shortfall through the development of an ongoing training programme, with the benefits realised from focused, informative training sessions clearly recognised by IPS stakeholders.

2.5.4 *Issue of Duplicate Records*

The challenge of duplicate records regarding the management and storage of prisoner data within the IPS was identified. Much of the information gathered for PIMS and PHMS is collected through prisoner testimony, and as some prisoners will provide a different version

of their name when re-entering the prison system (e.g. "Johnny Murphy" rather than "John Patrick Murphy"), IPS staff are somewhat reliant on prisoner cooperation. If a prisoner is known by the staff conducting the committal assessment process, the issue of alias-related duplication can be quickly addressed and rectified. When the prisoner is not recognised by staff, there is a possibility of multiple data records being created for the same individual.

This is particularly problematic regarding PHMS as it means that IPS staff are not provided with an individual's full background and medical history, with this potentially comprising the decisions made regarding the care and health services provided to a prisoner. We were informed that at present, once duplicate records are identified, the IPS staff are required to manually transfer relevant data from one record to another, rather than simply being able to merge the two records. Developing and implementing an IT update for such an action would be an effective means of mitigating this problem and ensuring that the IPS is provided with more complete data profiles for each individual.

2.5.5 Absence of Reporting and Analytics

There is a requirement for prison-based electronic record systems to deliver insights and understanding to prisoner health data and information, from both an individual and population perspective. PHMS appears to lack the functionality to enable clinicians and managers to develop accurate reports and analysis, such as disease-specific incidence and prevalence.

This must be considered to be a significant gap in the capability of IPS data systems. The prevailing lack of intelligence and evidence, such as those enabled within a dashboard function, does not support the pertinent targeting of health resources towards the management and treatment of prisoners. A full fitness-for-purpose analysis and review of the current PHMS system will be required to address this issue.

In that context, we understand that the IPS is currently reviewing and enhancing internal management processes and its operational model to provide greater clarity on decision making, responsibility, accountability and assurance required throughout the estate. Through its Data Analytics project, the IPS is aiming to enhance performance through implementation and monitoring of an operational scorecard which will support the operational and tactical management and reporting of risks. This work on data analytics will need to be co-ordinated with the specific analysis of healthcare information needs and future systems requirements.

3 Lessons from Comparative Analysis

3.1 Leeds Beckett University Research

Crowe engaged Leeds Beckett University to undertake an Evidence and Literature Review of prison healthcare services in other comparable jurisdictions, in order to identify lessons which may be worthy of consideration in the context of the further development of healthcare services within the Irish Prison Service.

The research considers healthcare across a range of relevant prison systems, providing findings and examples of current practices for the following European countries: Finland, France, Netherlands, Norway, Portugal, and the United Kingdom. The issues associated with the COVID-19 pandemic were not included in this review.

The Leeds Beckett report is presented in full in Annex 1. The key points which Crowe considers to be of most relevance to the IPS are as follows:

- **Governance**

  Governance of a prison health care system by the Ministry of Justice or the Ministry of Health remains a subject of debate in a number of countries. It is clear that no single model of health service governance in prisons exists, and despite general World Health Organization guidance on healthcare provision, there is wide variation in policy and practice of prison health across Europe. It is apparent that in some countries, health organisations advocate prison healthcare being the responsibility of health ministries, but this is not the case in all jurisdictions.

- **Improving Prison Health**

  The research highlights a range of areas that may support more effective health provision such as prison staffing levels and operational issues that may constrain prisoner access to healthcare, quality of healthcare data and intelligence, improved collaboration with community health services, early intervention services and self-management initiatives, prison healthcare workforce development needs, and more effective resource allocation. Issues of continuity of care, including risk management planning, are highlighted as particular areas of focus.

- **Mental Health**

  NICE (UK National Institute for Health and Care Excellence) guidance published in 2017 establishes evidence-based principles for assessment and management, co-ordinated care planning, and service organisation within the criminal justice system. The guidance states that prisons should commit to improving the mental health and wellbeing of prisoners through appropriate assessment, treatment, and transfer of care and it is accepted that the evaluation of prisoners requires the deployment of prison staff with the training and skills to perform this. It is noted that psychotropic medications available in the community and required by a prisoner should be available to the prisoner during detention.

- **Substance Misuse and Addiction**

  Drug services in prisons typically incorporate assessment, prevention, counselling, abstinence oriented and medication-assisted treatment, self-help groups and peer-driven interventions, harm-reduction measures and pre-release and aftercare

programmes. While capacity to respond to the health needs of drug users is often lacking in prison, time in prison provides a compelling opportunity to intervene with drug users. There are wide-ranging interventions across Europe, with best practices indicative of structured therapeutic community approaches, abstinence orientated treatment plans often supported with drug-free units, peer support and education, opioid substitution therapy, and harm reduction programmes.

- **Communicable Diseases**

  Communicable diseases, including blood-borne viruses, tuberculosis, viral hepatitis, and sexually transmitted infections (STIs) are all more common among people in prison than in the general population. Overcrowding and high risk behaviours or delays in diagnosis can result in higher prevalence within the prison population. Improving detection and management of infectious diseases may help with the response to outbreaks both within the prison and in the wider community. All prisoners should be offered testing for Hepatitis B, C and HIV on entry to prison and a Hepatitis B vaccination made available, and annual HIV testing should be offered to men who have sex with men. The review recommends active case finding and the implementation of a prison health surveillance system to monitor infectious diseases.

- **Rights to Healthcare**

  It is accepted that international standards such as the UN's Mandela Rules and Bangkok Rules affirm the *principle of equivalence*, being the responsibility of the state to ensure that people who are incarcerated are provided healthcare that is, at a minimum, equivalent to that available in the community. It is noted that the interpretation of *equivalence* is interpreted loosely across health systems with wide variations in standards accordingly. Prison health services should be able to provide medical, psychiatric and dental treatment and to implement programmes of hygiene and preventive medicine in conditions comparable to those in the wider community. Prison must therefore have staffing and facilities consistent in technical and professional expertise to which exist in the outside environment.

The research identified additional areas of focus that include the challenge of meeting the healthcare needs of older prisoners, those with special needs, the issues of self-harm and suicidal behaviour, and prisoners who present with drug-related health issues. Offering qualified scrutiny of prison healthcare practices across the range of jurisdictions, the literature review provided by Leeds Beckett University is able to provide recommendations that should be read and considered alongside the Health Needs Assessment report.

3.2 Other Lessons from our Analysis and Experience

In addition, the Crowe team has identified a number of other interesting lessons from our broad analysis of prison healthcare systems as part of this project, and from our team's previous experience of providing consulting, advisory and clinical services in other jurisdictions. The lessons which may be of particular relevance to the IPS are as follows:

- **Meaningful Use of an Electronic Health Record in the New York City Jail System**[2]

  The integration of electronic health records (EHR) technology has been a driver for improvement in US healthcare provision overt recent years. This paper explored the benefits of integrated EHR is a New York prison, to examine potential improvements in continuity of care, promotion of evidence-based practice, and a reduction of errors. The EHR is characterised in three stages, the first focusing on data capturing and sharing, the second on developing advanced clinical processes, and the third stage focusing on improving outcomes. The key findings include the meaningful use of EHR records in prison-based health systems enhances their ability to deliver co-ordinated and high-quality care, and integrated EHR may support good practice and service development such as e-prescribing, measured performance tracking, accessible clinical summaries, and the migration of health records to community-based services supporting effective release transition planning.

- ***Looking Behind the Bars: Emerging Health Issues for People in Prison***[3]

  This paper examines the health issues and challenges facing prisoners, with an acceptance that individuals detained in prison experience a higher burden of communicable and non-communicable disease, mental health and substance misuse problems than the general population and often come from marginalised and under-served groups in the community. Critically, the authors argue that prisons offer a compelling opportunity to tackle health problems and inequalities in an approach that can potentially deliver benefits to the individual and to the community. The discussion accepts that suicide is the leading cause of mortality in prisons worldwide but highlights the challenge of non-communicable diseases, such as cardiovascular disease, as an increasingly important factor in high-income countries; they represent the leading cause of mortality in prisons in England and Wales. An additional issue in focus is the ageing prison population in most high-income countries, with older people in prison typically presenting with multiple and complex medical and social care needs, including reduced mobility and personal care capabilities.

- ***Implementing Two Nurse Practitioner Models of Service at an Australian Male Prison***[4]

  This study examines the impact of two new primary and mental health Nurse Practitioner roles within an Australian prison setting, demonstrating the feasibility of the role and advocating the future career pathways for prison nurses. The benefits highlighted include improved interprofessional relationships among prison health staff,

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2 *Meaningful Use of an Electronic Health Record in the New York City Jail System.* M Martelle, B Farber, R Stazesky, N Dickey, A Parsons, and H Venters. American Journal of Public Health, September 2015.

3 *Looking behind the bars: emerging health issues for people in prison.* S Stürup-Toft, , EJ O'Moore, and EH Plugge. British Medical Bulletin, January 2018.

4 *Implementing two nurse practitioner models of service at an Australian male prison: A quality assurance study.* I Wong, E Wright, D Santomauro, R How, C Leary, and M Harris. Journal of Clinical Nursing, January 2018.

professional and clinical leadership, reduced treatment and assessment delays, improved prisoner access to health services, and increased clinical consultations and medication reviews. The initiative appears to have gained support from prison stakeholders and, building on evidence from other countries, may result in improved staff retention and ambition. The researchers conclude that implementing the role of Nurse Practitioner requires the detailed preparation of service settings, including security considerations, referral pathways and multi-disciplinary staff engagement, and education and consultations with relevant stakeholders towards the scope of practice and service goals.

- **Finding Meaningful Work in Difficult Circumstances: A Study of Prison Healthcare Workers[5]**

  This qualitative study examined the positive job attributes, such as meaningful work, stability, peer support, and variety of clinical presentations, and perceived challenges, such as organisational culture, ineffective leadership, and constraints on the ability to deliver clinical care, of a range of prison-based healthcare workers in a US prison. The research suggests that prison management and leaders improve the working experience of their clinicians by enabling a greater scope for clinical practice, supporting innovation initiatives, reducing bureaucratic redundancies, and recognising the specialist nature of prison healthcare. The study also highlights the importance of improving leadership skills across all levels of the prison health system, and strongly advocates for the provision of professional development opportunities to promote retention, the delivery of quality standards, and a culture of safety.

Whilst the above academic papers provider useful pointers to how prison healthcare is managed in other jurisdictions, they are indicative examples only of practice elsewhere: some elements may be worth more detailed scrutiny by the IPS, whilst other aspects may not be workable in an Irish context. What is of most potential benefit to the IPS is the fact that a substantial body of international research exists in the field of prisoner health and prison healthcare services. We are cognisant of the fact that senior clinicians within the IPS do access relevant academic literature and professional fora, which is beneficial and to be commended; what is needed, however, is a structured basis for this to be part of the routine governance system for healthcare management within the IPS, a topic to which we return later in this report.

5 *Finding meaningful work in difficult circumstances: A study of Prison healthcare workers.* A Stephenson and N Bell. Health Services Management Research, February 2019.

4 Provision of General Healthcare Services

4.1 Background

The IPS is responsible for the safe and secure custody of persons sentenced to prison, held on remand, or held on immigration matters. It is responsible for ensuring that convicted individuals properly serve their sentence and for providing them with opportunities to engage in a meaningful way to reduce the likelihood of reoffending and assist their reintegration into law-abiding society. The IPS deals with male and female offenders who are 18 years of age or older.

The Irish prison system comprises 12 prisons: 10 closed prisons and two open centres. The majority of female prisoners are accommodated in the Dóchas Centre, within the Mountjoy Prison campus, with the remainder accommodated in Limerick Prison.

The overall daily average number of prisoners in custody in 2020 was 3,824 compared to 3,971 in 2019. The number of prisoners in custody peaked at 4,108 in February 2020, and there were 6,340 committals to prison that year.

4.2 Overview of IPS Healthcare

Currently, the IPS Health Functions sits within the Care and Rehabilitation Services Directorate. The full list of services provided within this directorate consists of:

- Integrated Sentence Management
- Prison Healthcare Service
- Prison Education Service
- Work and Vocational Training
- Library Services
- Reintegration
- Psychology Service
- Sex Offender Management
- Incentivised Regimes Policy
- Chaplaincy Service

Health provision within prisons is delivered on a primary care basis and aims to provide prisoners with access to the same range and quality of healthcare services as that available under the General Medical Card scheme in the community. The range of services include, mental health, addiction and substance misuse, pharmacy, dental, and other allied health services such as chiropody, physiotherapy, and optometry.

Prison nursing is widely considered to be the bedrock of prison healthcare services, and the challenges associated with this workforce are addressed throughout this report.

4.3 Point of Entry: Committal Assessment

Upon arriving to prison prisoners will undergo a committal assessment regarding their general health condition and identification of specific healthcare needs. Prisoners are met by a nurse who will conduct a medical assessment, with the information collected during this assessment relating to:

- General health and wellbeing
- Medical history
- Mental health
- Addiction
- Medication

This information is then input onto PHMS. Prisoners receive a unique identifier number from their registration on the PIMS system which remains following release, so any prisoners who are re-entering the prison system will already have a profile to which information can be updated.

The committal assessment process is essentially the same for all prisoners regardless of length of sentence, although long-term prisoners may receive a violence-based assessment conducted by a psychiatrist, as do prisoners serving sentences relating to specific violent crimes. Similarly, there is little difference in the committal process for new prisoners and those transferring from other prisons, though in the case of the latter their medical information will be gathered from PHMS and particular issues may be followed up upon with staff from their previous prison.

In addition to a nursing assessment by a committal nurse, prisoners will typically meet with a GP and Governor for a face-to-face assessment and. In the case of the former, clinical assessment, diagnosis, treatment planning for all medical conditions, medication prescribing, and referral to hospitals and other medical services for urgent and specialist treatment.

Prisoners will also meet with the Integrated Sentence Management (ISM) team to discuss any lifestyle issues or social care requirements which the prisoner feels may be relevant for the duration of their time in custody. All of these engagements will typically be conducted within 24 hours of a prisoner’s committal, though this can occasionally be longer, depending on GP and/or Governor availability.

The committal assessment covers a wide range of health issues and is designed to provide the IPS with a full understanding of an individual’s health and medical. In general, the process is well-regarded by staff, although time pressures, difficulties gaining the required information, and prisoner reluctance to fully engage, raise concerns about the assessment being complete. Nurses at some prisons reported that with up to ten committals a day, they may not always be able to afford to spend as much time as required with a prisoner and so information may be missed. We were also informed that nurses are adept at using intuition to identify issues that a prisoner may be withholding. However, staff stated that there is ultimately a reliance on prisoners to be honest and open at presenting issues during committal.

Mental health and issues of risk as part of committal process will be discussed in Section 7 of this report.

The committal procedure for those prisoners transferred from within the IPS estate follows the same processes. However, transfers typically benefit from established assessments

and management plans, reducing, but not eradicating, the issues of risk and unmet need. Put simply, transferred prisoners tend to present less uncertainty, enabling prison health staff with greater knowledge and understanding of the issues at hand to facilitate forward planning.

4.4 Prisoner Engagement with Primary Care Providers within the IPS

During the course of their time in custody, prisoners generally have ready access to primary care services. Prisoners will either present to a prison officer or a nurse with an issue, with a GP appointment then scheduled. Nurses are readily available on prison landings to conduct initial assessment and triage of prisoner health needs, while we were informed that prisoners are usually able to access a GP within 24 hours of raising a health complaint.

4.5 Prison Doctors

In Section 2.3.1 above, we referred to the difficult position which has existed until recently with regard to medical input to IPS healthcare services.

The recent recruitment of seven GPs into the prison system, alongside the existing doctors working for the IPS, will provide an appropriate level of medical coverage in each prison establishment, although we note that a full-time GP has yet to be appointed to Castlerea Prison. (It is disappointing that this post has not yet been able to be filled, given that the IPS has found it challenging for some time to obtain consistent locum GP cover at that prison. The post has recently been re-advertised.)

In addition, arrangements are in place as necessary to provide weekend GP cover in larger prisons via service level agreements with external service providers, which is welcome.

The IPS is to be commended for taking a positive decision to invest in healthcare services by recruiting this new cohort of GPs to work within the prison system. In that context, it should be noted that these arrangements have only just been introduced, and there is considerable work to be done to overcome the difficulties which have existed up to now, such as inconsistent medical cover, lack of familiarity amongst locum GPs with the prisoner population or with prison health issues, absence of team-based working, and other features. Having full-time, resident doctors working within the prisons as part of a multi-disciplinary team will provide a significant platform for improvement. It is noted that the expansion of the GP role seeks to support clinical governance enhancement at prison and national levels, with potential to support prisons as medical training placements.

4.6 Prison Nurses

4.6.1 Overview

The dedication, commitment, and skills of the IPS nursing workforce was in full evidence during the site visits and the numerous post-visit interactions the Crowe team had with nurse leaders. The nursing workforce can be considered to be the driving force and leading component of the IPS healthcare system.

4.6.2 Skill Mix and Utilisation

The nursing teams across the IPS include a wide range of qualifications and skills, from theatre nursing to mental health nursing, although the typical skill mix at each prison is heavily weighted towards general nursing. The workforce includes a number of nurses with specialist or additional skills and qualifications such as nurse prescribers and advanced nurse practitioners. However, it should be noted that specialist nursing capabilities, such as nurse prescribers, are not typically utilised within the prison in the current provision of healthcare services (although the recent hiring of GPs is likely to improve matters in this regard). This leads to frustration, with nurses unable to practice according to their skillset. It appears that all members of the nursing staff have the same workload and duty profile regardless of their attainment of any specialist qualifications.

Frustration was consistently expressed by nurses in relation to the capacity to be able to fully make use of their skills and expertise to develop healthcare services, improve the overall health of the prison population, and enable cross-IPS learning and development. It is reported that creativity and innovation is lost due the rigidity and resource constraints of the health system, with condition-specific nurse-led clinics almost impossible to deliver. There was concern verbalised that the strain on staff resources leads to de-skilling of nursing staff and lost opportunities for professional, service, and systems improvement.

We were informed as an explicit issue of concern, that there is a lack of mental health training and qualifications across the nursing teams. Repeatedly, the Crowe team was advised that the lack of mental health nurses, together with the lack of opportunity for general nurses to gain qualification-based mental health training, is a major obstacle for effective service delivery. Furthermore, the IPS does not have the ability to determine skill mix on a prison-by-prison basis, or to assign staff to specific prisons based upon their skills, competencies, or other relevant factors; under current arrangements, transfers of staff between prisons are largely determined by seniority rather than matching skills and competencies to local needs.

4.6.3 Nursing Establishment and Deployment

As previously mentioned, it is not possible under current working arrangements for health managers to fully control the deployment, and therefore skills matching, of nurses according to need within the estate. It is unclear as to how the current establishment numbers are defined and set, and it is clear to the Crowe team that this requires a discrete piece of work as part of a comprehensive review of nursing in the IPS.

The pressing issue in terms of the on-site nursing presence is that of night shift cover. Whilst the two open prisons do not have a nurse present during night hours, typically the closed prisons will have one nurse on duty with responsibility for large and occasionally unsettled prison populations. The feedback from nurses is variable with regards to limited and no night-time nursing provision, but the expressions of concern for safety, responsibility, accountability, and regulatory practice were notable. An aspect of this concern relates to the apparent risk of non-compliance with the Nursing Code of Professional Conduct and Ethics, relating to safety, professional responsibility and accountability, and quality of practice. Many nurses reported feeling uncomfortable working alone at night with responsibility for an entire prison population. This issue should be seen as a priority within the future development and strengthening of IPS healthcare services.

In addition, we were also advised by nursing staff in many of the prisons that it is not uncommon for nurses to be tasked to undertake non-clinical duties by governors, including prisoner escorts and other administrative or routine tasks not directly related to healthcare services. This detracts from their ability to perform clinical functions, and also suggests that their clinical skills are undervalued by some senior staff.

4.6.4 Professional Development

Concerns and frustration were expressed by nurses with regards to their reportedly limited opportunities to gain additional training, skills, and qualifications. This is said to have a damaging impact on morale and the ambitions of nurses to further their career in prison-based care.

Many clinicians within the IPS advocate the premise of prison health, and therefore prison nursing, being regarded as a health specialism. Although we were informed that discussions have taken place with universities to develop prison healthcare modules at post-graduate levels, this is yet to be a reality. The recognition of prison nursing as a specialist area of nursing may not only provide a professional development framework for those currently working in prisons but may also support the engagement and recruitment of nurses into the IPS.

It was reported that IPS nurses feel disconnected from the Department of Health (DoH) and HSE, and as such, do not feel as though their skillset is fully recognised within the health economy. There does not appear to be any formal professional development or support pathways with the DoH currently in place for prison nurses, despite expressed ambitions on both sides. We believe that improvements are required in relation to professional development for nursing staff.

4.6.5 Leadership And Management

Chief Nursing Officers (CNOs) are an essential, valued, and experienced resource. However, CNOs are reported to be frequently conflicted in the division of time and labour between management and clinical support. An aspect of this conflict is when CNOs are advised or are actively encouraged to prioritise management commitments, when they identify a requirement for their input into clinical area. The absence of a deputy or assistant CNO results in challenges in fulfilling both practice and management aspects of the role.

There is a lack of management and leadership training for CNOs. There is also reportedly insufficient formal peer support and information exchange between the CNOs across the IPS estate. This can result in CNOs feeling unsupported and isolated at times, and is not conducive to skills development, shared learning, and the exploitation of good practice and innovation.

4.7 Provision of Specific Services

4.7.1 Sexual Health

During the committal assessment, prisoners are asked about their sexual health and made aware of the availability of sexually transmitted infection (STI) screening on request. Other than this, there is no evidence of proactive provision of services in the area of sexual

health promotion, detection of STIs, or other initiatives, such as sexual health education, aimed at improving and protecting the sexual health of prisoners.

It is currently impossible to assess if there are issues of unmet need in terms of screening, management and treatment and as such, no formal recommendations can be made within this report. However, it should be noted that innovative projects, led by qualified nurses, may provide benefits and learning if supported on a pilot-based initiative basis.

4.7.2 Physiotherapy

The assessment regarding physiotherapy and occupational therapy care during the committal process is said to be limited in its scope and application. It is noted that there is no in-house access to physiotherapy or occupational therapy services for prisoners. Prisoners can access such services through referral to HSE services outside the prison. However, we were informed that this process is not straightforward and that waiting lists for such services can be lengthy, particularly since the emergence of Covid-19 and resulting delays in the wider health system.

4.7.3 Dental Care

Prison oral health morbidity is considerably higher than that of the general population. The dental care needs of a prisoner are assessed during the committal process, and an appointment will be made with the dental team if a prisoner is found to require attention. Regarding access to dental services, as with all health services, prisoners will either present to prison officers or nurses with an issue, with a dental appointment then being scheduled.

Three prisons, Midlands, Portlaoise and Limerick, have specifically dedicated dental teams, with other prisons contracting services from local dentists working in the community. Dublin Prisons benefit from in-reach dental services from the Dublin Dental University Hospital. The frequency of dental services will depend on the size and demand of the prisoner population, with the larger prisons having multiple clinics each week, while other prisons may only provide fortnightly sessions.

The care provided to prisoners is basic treatment for acute issues, with services identical to what is available on the medical card scheme. It is noted that prisoners serving a life sentence are able to benefit from dental scraping and cleaning (to remove harmful plaque and tartar). Other than urgent complex presentations, assessed on a case-by-case basis, there is no scope for complex treatment plans or significant dental interventions. We were informed that such interventions will often have to wait until a prisoner is released from custody.

We were advised by dental health professionals that most presentations are for pain relief. The dental suite facilities are well equipped dedicated resources with x-ray facilities. However, it is reported that digital images cannot typically be sent between prisons, due to software incompatibility, resulting in delays and time constraints.

There is a facility within PMHS for recording dental health data, used by all dentists. As with other aspects of prison healthcare, no summary reports or statistics are available from PHMS in relation to dental care

4.7.4 *Chronic and Infectious Diseases*

The issues relating to chronic and infectious disease are provided in each prison-specific report.

During the course of our site visits, we were informed that there were no prisoners with infectious diseases. We were informed that the IPS had experienced an outbreak of tuberculosis a number of years previously, which had been quickly suppressed and informed a “cautious attitude”. This facilitated the development of robust protocols, leading to the prevention of similar infectious diseases taking hold within the prisoner population.

The majority of cells across the IPS estate are single occupancy with cells typically having dedicated toilets and sinks. There are designated isolation cells in all prisons which have air handling units fitted designed to prevent the spread of infection.

Our site visits took place at different stages of the Covid-19 pandemic and as such, strict infection control measures were in place throughout all prisons. A two-week long quarantine process for new committals has been introduced as the principal mechanism for the prevention of incoming infections. If a prisoner is identified as having an infectious disease, such as Tuberculosis, they are placed in isolation from the rest of the population, for further investigation.

Alcohol free hand sanitiser is available on all landings and at entrances to parts of the prison to mitigate the spread of infection by personnel moving around the prison.

We were also advised that the IPS is collaborating with the HSE on a national initiative for the eradication of Hepatitis C across the IPS estate, in line with the HSE’s community-based National Hepatitis C Treatment Programme.

4.8 Pharmacy Services

Pharmacy services are provided on a contract basis to each prison by a community pharmacy provider. Medication is prescribed by the doctor, as clinically indicated and the prescriptions are then sent to the pharmacy after each clinic. The pharmacist reviews these prescriptions and dispenses them on an individual patient basis. Dispensed medications are typically delivered on a daily basis, and to some locations twice daily.

All 12 prisons had a well-equipped pharmacy at the time of our visits, with facilities for safe and appropriate storage of medication. We found that the pharmacy facilities were compliant with requirements in respect of drug storage and security, with medication stocked and maintained by the externally contracted community pharmacy.
With the exception of Mountjoy Prison and Dóchas Centre, where contracted Addiction Pharmacists are engaged, there is no on-site pharmacy service. The Addiction Pharmacists attend both prisons daily, to dispense and administer methadone. They work closely with the Addiction Specialist GP and the healthcare team, as key members of the clinical addiction team. The pharmacists also provide overdose prevention training, including the use of Naloxone and arrange for the provision of same pre-release.

The issue of medication reviews, including prescription reviews and concordance and compliance reviews, was raised by prescribing clinicians as an area of concern across the IPS. Reportedly, these reviews are conducted internally by the GPs, and it is widely

recognised that this practice will benefit from external input or facilitation from community pharmacy resources. It is reported that this is already part of the current contract agreements with pharmacy services and is not being utilised due to an over-reliance on locum GPs. It is hoped that the recent appointment of permanent IPS GPs will facilitate the pharmacy-led medication review schedule.

All prisons, in line with IPS-wide practices, do not routinely prescribe Benzodiazepine medication for prisoners. The IPS Policy is to minimise the prescribing of benzodiazepines, but there are occasions when the use of such drugs is clinically appropriate and necessary, where the use is minimal and time limited.

The IPS Clinical Drug Treatment and Policies Manual, in line with national and international guidance, includes guidance on the treatment of alcohol withdrawals, including a regime for treatment with Chlordiazepoxide and the use of Diazepam if there is risk of alcohol withdrawal seizure, as well as guidance on the assessment and treatment of benzodiazepine addiction and the use of benzodiazepine hypnotics.

The IPS Drugs and Therapeutics Committee has also developed, validated and issued a protocol for emergency administration of Chlordiazepoxide, to facilitate access to necessary treatment without delay and a protocol for the emergency use of Diazepam in the treatment of status epilepticus.

4.9 Covid-19

The IPS has produced an outstanding response to the Covid-19 pandemic and the associated challenges for risk mitigation and the maintenance of health and safety. IPS stakeholders, including the prisoner population, are commended for the focussed and skilled approach to managing the array of difficulties presented by the pandemic.

Prisons have implemented a range of significant and highly effective controls and measures to prevent the introduction and spread of Covid-19 within the prisoner population. In addition to the fourteen-day quarantining of new arrivals, these included temperature checks before entry to the prison for all personnel, mandatory filling of Covid-19 health check forms for all personnel, as well as wearing of masks when maintaining appropriate social distance was not possible.

Hand sanitiser dispensary points were available at every doorway and entrance to units and landings within the prisons, and informative posters regarding how individuals could ensure good personal hygiene and keep themselves safe from infection were also distributed across prison sites. We were informed that the prisoner population had significantly bought into the importance of the Covid-19 restrictions and were very cooperative in working with prison staff to prevent the spread of Covid-19.

4.10 Lifestyle and Wellbeing

4.10.1 Overview

The lifestyle and wellbeing of prisoners can have a significant impact on health within the prison, both regarding physical health and mental wellbeing. Prisons are not typically conducive to good health and healthy behaviours, with access to physical activity, diet, and

sleep generally controlled by the prison regime. However, with the appropriate governance structure and resources in place, prison can be viewed as a useful environment for impactful and beneficial public health interventions for vulnerable people presenting with high levels of morbidity.

Ireland is reported to be the first country globally to implement the Community Based Health and First Aid programme in a prison setting; the prisoners act as Red Cross volunteers and peer-to-peer educators. The volunteer scheme promotes health and wellbeing in all prisons and benefits the prisoner community families of prisoners, and prison staff. Volunteers across the IPS estate provide prisoner support, wellbeing advice, health guidance and education, with the health component delivered by nursing staff. Nurses, teachers, and psychologists provide the volunteers with basic tools for delivery of peer support on the top issues identified by prisoners. The Listener Programme, with training and support from the Samaritans, is also very well regarded.

The following subsections document the range of services available to within the Irish prison system for the enhancement of prisoner health and wellbeing.

4.10.2 Nutrition and Exercise

Through nutritional consultations, the diet provided to prisoners is sufficient to support the health needs of the majority of the prison population. Prisoners with specific dietary needs or requests, such as vegetarianism, gluten intolerance or religious-informed preferences, are able to request and obtain tailored meals. Through the course of our site visits, we were informed that prisoners can often regard the prison diet as lacking variety, and that requests to improve the diet through the provision of fresh fruit and vegetables are frequently not responded to by the prisons. It is reported that the menus are refreshed every 28 days across the estate. Prisoners typically collect their meals from the kitchen dispensary and return to their cells to eat, though in some prisons such as Loughan House there is a communal area for prisoners to eat together.

Across all prisons, prisoners are provided with access to a gym and an exercise yard, with several prisons also housing football courts. As many prisoners are interested in health and fitness these activities are very popular, in particular exercise classes held in the gym. However, the large number of prisoners on protection and segregation of various gangs has a negative impact on access to these facilities, as all activities require strict timetabling so as to avoid conflict.

4.10.3 Activities Available to Prisoners

There are wide variations in access to occupational, recreational, training and education resources across the IPS. The open prisons, Loughan House and Shelton Abbey, clearly have much more comprehensive opportunities for prisoners than closed prisons. However, there are also significant differences in what is available to prisoners across the closed prisons, due to a range of factors which include physical space availability and limitations, discipline issues within complex prison populations, and the distribution of resources.

The issues regarding addiction and illicit substances within the prison system notwithstanding, the IPS has a strong emphasis on smoking cessation, and promotional material for such programmes is widely distributed across the prisons. We were informed by staff that such programmes have proved to be very popular with prisoners.

5 Women's Health Services

5.1 Background

The European Resolution on Women and Children in Prisons, ratified by the European Parliament in 1989 [6], recommended that women committed to prison should be permitted home visits to the fullest possible extent, and the restrictions of women's prisons should be reduced to the minimum. The United Nations in 2010 set a similar perspective in the Bangkok Rules [7], recommending that the generally lower risk to the community should be considered when enforcing prison sentences for women, and women's prisons should be 'open' to the greatest possible extent.

In Ireland, women typically represent just under 4% of the prison population, although it is noted that the rate of women committed to prison has increased more rapidly than for men over the past decade. It is reported that there continue to be significant numbers of women imprisoned for failing to pay court-ordered fines. For example, in 2020, 10% of all women committed to prison were as a direct result of non-payment of court-ordered fines. This is more than double the comparable figure of men.

The majority of women imprisoned in Ireland serve short-term sentences. The impact of detention on these women and their families may be considered to be profound, not just in terms of the socio-economic costs to individuals, communities and society, but also the significant costs in terms of health inequalities and morbidities.

There are currently two prison establishments in the country that accommodate female prisoners, the Dóchas Centre in Dublin and Limerick Prison. Dóchas is a purpose-built facility which houses the majority of female prisoners. In Limerick, female prisoners are housed in a separate wing of the male prison. Limerick Prison is undergoing new build work, which will increase the capacity for female prisoners from 28 to 60. Whereas Dóchas is a modern building with open spaces and green areas for exercise, the age of Limerick Prison and its cramped location mean that female prisoners have use of only a small exercise yard with high walls and no greenery.

The majority of the rooms in Dóchas are designed for single occupancy, but many now have two occupants due to capacity constraints. The women in Dóchas are given keys to their rooms. This allows them to lock the room when not present during the day or if they want some private time. Having a key to their room provides a level of normalcy and security for the women.

Similarly, in Limerick, the majority of cells are single occupancy. The female prisoners in Limerick do not have keys for their cells in the same way as those in Dóchas.

While these facilities meet the needs of female prisoners, the lack of appropriate facilities to dispose of sanitary products was raised as an issue. The lack of specific bins in rooms and cells could be an infection control risk and also has an impact on the dignity of the prisoners.

6 European Parliament Document A-2-51/89

7 The United Nations *Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders* ('the Bangkok Rules'), adopted by the UN General Assembly in December 2010

Female prisoners can often struggle to maintain a relationship with their children. This can be a particular issue where children are in care as a court order can be required before prison visits can happen. Mothers can also be concerned about the impact of a prison visit and time missed from school for children. The advent of video calls during the Covid-19 pandemic restrictions has had some benefits for women who can have greater access to time with their children.

5.2 Women's Health Resources and Services

5.2.1 Overview

In 2020, there were 649 female committals to the IPS. Women are detained in only two prisons within the IPS estate. Prior to the Covid-19 pandemic, the IPS's capacity for women prisoners was at 127%, with peak demand reportedly seeing Limerick Prison reach 196% capacity and the Dóchas Centre as high as 138% capacity.

Like men, women detained in prison present with complex health and wellbeing needs and poorer health status than the general population, and like men, prison can provide an array of new opportunities to address health inequalities and gain access to healthcare. Although definitive numbers are difficult to establish, we were advised by IPS staff that 85% of women in Irish prisons have substance misuse and addiction challenges, many with adverse childhood experiences and trauma, with a much higher prevalence of mental health issues and histories of abuse outside prison.

5.2.2 Resources and Available Services

Female prisoners are in receipt of the same level of standard care as their male counterparts. Prisoners are offered access to STI and Hepatitis C screening. On committal, female prisoners are tested for pregnancy as part of the urine screen.

Female prisoners are encouraged to participate in the screening programmes. For BreastCheck appointments, women leave the prison to attend the screening centre. In the case of cervical screening, staff in Dóchas are trained as smear takers, allowing the screening to happen inside the prison. For female prisoners in Limerick, engagement with CervicalCheck involves leaving the prison to have the smear taken. Nursing staff in Limerick have expressed interest in training as smear takers to eliminate the need for external appointments.

Based on the information available, it is apparent that the majority of female prisoners have suffered sexual violence at some point in their lives. To support the women, there is access to both on-site and telephone counselling services with the Rape Crisis Centre, for both Dóchas and Limerick. The prisoners can continue to access this service following release. This continuity of care is seen as a benefit as the women have built a relationship with the counsellor, and the service overall is perceived to work very well.

During the Limerick site visit, it was highlighted that at the time there was only one male GP covering the whole prison, whereas previously there was also a female GP. The current GP does not feel he has sufficient expertise to provide a comprehensive service. This contrasts with Dóchas, where the main prison GP is female and has experience in women's health. Given the range of women's health issues impacting on the female prison

population, having access to a female GP in Limerick would be preferable.

5.2.3 Mother and Baby Facilities

The Dóchas Centre has specific accommodation for mothers and babies. This includes access to a small amount of outside space away from other prisoners. The dedicated mother and baby rooms are larger spaces to allow for a cot. All of the mother and baby accommodation is in a single dedicated house. Babies can stay with their mothers until they are up to 18 months, or two years at the very most. After this point, it is considered to be important for the development of the child to have the opportunity to interact with other children and adults, outside the prison environment.

Maternity services are provided to women by the Rotunda Hospital and there appears to be a good working relationship between the hospital and the Dóchas Centre. Women prisoners in Dóchas also have access to public health nurses on an in-reach basis for post-natal care and child health.

5.3 Issues Impacting on the Health and Wellbeing of Female Prisoners

5.3.1 Overview

As part of this review, we have encountered a number of negative issues which impact on the health and wellbeing of female prisoners, and which create increased demand for healthcare services. Although these issues are outside the direct control of the IPS (and arguably outside the strict terms of reference for this review), we feel that they are of sufficient importance for us to mention them in the following paragraphs.

5.3.2 Accessing Appropriate Accommodation on Release

There is reported to be a significant difference in the outcomes for men and women on the Community Return Programme, with only 10% of men returning to prison, compared with 60% of women. Women prisoners are said to be over four times more likely than male prisoners to experience difficulty accessing suitable accommodation. It is critically important that safe, secure and supported accommodation is provided for women on release from prison. The risks associated with women having to endure temporary accommodation and homelessness are well established when considering not only offending behaviour, but also most notably, their health and wellbeing.

5.3.3 Absence of Open Prison for Women

It is well accepted that open prisons play an important role in the processes of normalisation and preparation for release from prison. Despite the IPS having two open prisons for men, in Ireland only medium-security prison facilities are available for women, a point worth noting in the context that many female prisoners receive short sentences. We note that a 10-bed Step Down Unit for women, jointly funded by the IPS and the Probation Service, has been introduced to meet this need.

Such facilities can often provide a valuable resource to maximise the chances and opportunities afforded to women on release, and to gain the most productive engagement with community-based health, housing, employment bodies. Continued development of

this type of facility may have positive impacts on the health and wellbeing of female prisoners, and this matter should be kept under review by the IPS.

5.3.4 Challenges and Difficulties Leading to Detention

There is a great deal of anecdotal evidence from IPS healthcare stakeholders and charitable organisations, such as the Irish Penal Reform Trust, that women present themselves within the criminal justice system with increasingly complex needs. These challenges are often related to chaotic lives in the community due to drug, housing, and mental health issues. Women in Ireland tend to be imprisoned for short sentences for repeat low-level offending, and when services become disconnected and disengaged, it may result in the continuation of this damaging cycle and exacerbation of health concerns and inequalities. A policy review with regard to the detention of women in Irish prisons may be needed to consider the development of pathways of care and support as alternatives to prison committal.

6 Provision of Mental Health Services

6.1 Background

Individuals held in custody are typically at an increased risk of experiencing a deterioration in their mental health when compared with those in the community. Poor mental health and serious mental disorders such as psychosis are more prevalent amongst prisoners than the general population, with conditions within prison widely accepted as not being conducive to positive mental health. Even for individuals with no history of mental health difficulties, the very nature of prison is likely to be a challenging and difficult experience, with the extensive rules and regulations, a closed environment, and lack of personal autonomy all likely to have a negative impact on their mental health. Many prisoners will present with more than one mental disorder, with such prisoners often having an additional drug misuse and/or addiction problem. Furthermore, prison sentences are found to have a particularly harsh impact on female prisoners' mental health, with research [8] indicating that four out of five female prisoners in England suffer from mental health problems, most commonly depression and anxiety.

A significant challenge for prison services in providing the appropriate support and care to prisoners with mental disorders, is simply identifying their needs. Prisoners can often be reluctant to share information relating to previous engagements with mental health services and without an accurate history and diagnosis, it can be very challenging to provide an individual with the required treatment and management plan. For instance, prisoners with severe personality disorders or acute psychosis may present as individuals who are 'difficult to manage' rather than in need of a specific treatment plan. Unless the prison staff – both discipline and healthcare – can readily diagnose the disorder, these prisoners are likely to follow a destructive pathway that will further exacerbate their mental health problems.

Therefore, there is a requirement, and indeed necessity, for consistency across prisons in how individuals with mental health issues are identified within the prison population. All prison staff, not just those working in healthcare, need to be able to recognise the major symptoms of poor mental health and know where to refer those individuals requiring help. It is understood that there is a prevailing Mental Health Training Package in place to support IPS staff, but evidence gathered *en passant* and in more detailed conversations with prison officers during site visits, suggests that subjectively this is not considered to be adequate (although the views expressed to us during site visits appear to be at variance with feedback received directly by the IPS from staff on conclusion of specific courses). The UK Prisons and Probation Ombudsman has stated:

> *It is crucial that prison staff have good multidisciplinary working arrangements with healthcare staff and feel able to make a referral when they have any indication that a prisoner appears to be unwell. Mental health awareness training can provide prison staff with the knowledge and confidence to act on any concerns.* [9]

This stresses the importance of ensuring that all staff are provided with the appropriate training and tools to recognise individuals suffering from poor mental health, as prisoners

8 Prison Reform Trust: http://www.prisonreformtrust.org.uk/WhatWeDo/Projectsresearch/Mentalhealth/CarenotCustody

9 Prisons and Probation Ombudsman (UK), Prisoner Mental Health, 2016: http://www.ppo.gov.uk/app/uploads/2016/01/PPO-thematic-prisoners-mental-health-web-final.pdf

with unidentified disorders can often lead to self-harming, suicide attempts or harm to other prisoners and/or staff.

6.2 Mental Health Resources and Services

6.2.1 Overview

Our site visits and engagements throughout this assessment indicated that the closed prisons within the IPS estate are generally well-resourced with accessible specialist mental health input from the Central Mental Hospital (CMH), with this input including Community Psychiatric Nurses (CPNs), Social Workers and Psychiatrists. There are clear limitations as to the support that these professionals can provide to the health function within each prison, but nevertheless they are regarded as an essential and valuable resource by IPS clinicians. It is important to note that Portlaoise Prison is an exception to this, with the Crowe team visiting Portlaoise informed that while the prison was promised CPN support, at the time of our visit the prison only had one psychiatrist-led morning session conducted each fortnight.

With regards to the physical facilities for mental health services, the Crowe team generally found that there is sufficient space and facilities for health staff to engage with prisoners for assessment and/or treatment of their mental health needs, though Shelton Abbey was an exception to this, with the consultation room used for mental health appointments lacking appropriate space, noise insulation, and privacy standards to facilitate confidential and sensitive support to prisoners.

While all of the above is very positive, we did make a number of observations regarding the resources and services supporting the mental health of prisoners within the Irish prison system, with these detailed below.

6.2.2 Lack of Primary Care Mental Health Assessment Tools

The delivery of mental health care is a service within primary care, yet we observed that there is an absence of recognised primary care mental health assessments, such as PHQ9 (used to monitor the severity of depression and response to treatment) and GAD7 (used to assess Generalized Anxiety Disorder). Including these or similar assessment tools within the Irish prison system, not necessarily solely during the committal process, may identify prisoners with mental health conditions that may otherwise be missed. These tools would also provide nursing staff with greater assurance that they are addressing the needs of prisoners and mitigating the risks of conditions not being identified.

6.2.3 Inadequate Mental Health Nursing Resources

Following our site visits and engagement across the Irish prison system, we believe that there are inadequate mental health nursing resources across the IPS. Staff across all prisons reported that they require greater mental health training for their nurses and require more formally trained mental health nurses. We frequently heard exasperation expressed at losing vital skills and resources, such as mental health nurses being transferred to other prisons.

6.2.4 Diagnoses of Mental Health on Data Systems

The issues of discrepancies and challenges regarding the input of diagnoses into the PHMS is an ongoing concern which requires early attention. This is said to result in ill-defined and often inaccessible morbidity data across the population for mental health as well as other conditions. This is extremely unhelpful for a range of treatment and care issues and may also lead to inefficient pathway management and risk assessment of prisoners.

6.2.5 Inconsistent Access to E-Health

Due to Covid-19 restrictions on physical meetings, the IPS has identified E-Health as a means to ensure that prisoners are afforded the opportunity to engage with mental health services via video call, even when those services are not generally available in their prison. While this is undoubtedly a positive development, we were informed that E-Health access had not yet been consistently introduced across the Irish Prison Service estate, with the majority of consultations with professionals outside of the prison(s) conducted via telephone rather than video call. In addition, it was reported that there is currently no formal policy, protocol or pathway provided within the prison system, other than those agreed with the National Forensic Mental Health Service, to support the health professionals delivering such consultations with prisoners.

6.2.6 Court Liaison Service

The Irish Prison Service benefits from a court liaison service, provided by the CMH, which includes criminal justice diversion based at Cloverhill Prison. The Mental Health Prison In-Reach and Court Liaison Service (PICLS) is provided on an in-reach basis by Central Mental Hospital (CMH) resources. This is said to be effective in streaming mentally disordered prisoners out of prison and into the CMH, HSE mental health beds, or community-based care. If supported with the appropriate resources, this service could be enhanced and rolled out across the State to provide an assessment and diversion service, with access to Garda detention facilities and/or Courts to prevent them from entering the prison estate.

A more comprehensive criminal justice diversion scheme, such as that in the UK, Netherlands and Germany would potentially impact on many mentally disordered people getting support from mental health services and staying out of prison.

6.2.7 Access to Central Mental Hospital (CMH) Resources

There is good and accessible specialist support from community CMH resources across the majority of prisons, with valued in-reach provision.

A common theme we observed across the site visits to all closed prisons was the Irish prison system's extremely poor access to beds in the Central Mental Hospital. This is cited as being due to a lack of CMH resources, resulting in lengthy waiting lists, a lack of appropriate treatment and effective management for prisoners suffering from acute mental health disorders, and greater demands placed on discipline staff to manage those prisoners. Though the number of CMH beds available to the IPS is set to increase with the opening of a new facility in Portrane, there are significant concerns within both the IPS and the CMH itself that the increase in CMH beds will not be sufficient to meet demand, and

that prisoners requiring access to CMH in-patient treatment, who cannot receive appropriate treatment elsewhere, will remain within the prison system.

6.2.8 *Access to Primary Care Mental Health Support*

There is very little evidence of primary care mental health interventions being delivered by the IPS health staff, beyond the prescribing practices of the GPs. The Counselling in Primary Care (CIPC) service provides primary care counselling in the community, albeit this is not an IPS provision, with the former national policy document *A Vision for Change* recommending in 2006 that "all individuals should have access to a comprehensive range of interventions in primary care for disorders that do not require specialist mental health services".[10] This appears to suggest that prisoners should have access to primary care psychological therapies, such as Cognitive Behavioural Therapy (CBT).

During the course of our site visits, we did not observe the delivery of this type of intervention to prisoners, but we did find support for this premise from nurses and medical staff, and additional backing by psychology staff. Such interventions would not require the skills of a mental health nurse or psychologist, but rather, with sufficient training and support, general nurses may be able to provide such a service.

(As part of this assignment, we reviewed the current national mental health policy, *Sharing the Vision*,[11] which superseded *A Vision for Change*. We note that *Sharing the Vision* includes many references to the needs of those interacting with the criminal justice system, and sets out a range of policy actions and initiatives, many of which will in our view benefit those in the custody of the IPS. It is not our intention in this report to provide a detailed policy assessment of how these issues are being progressed, and we assume that their continued implementation will form a major element of the work of the IPS over the coming years.)

6.2.9 *Access To Clozapine*

We understand that only one prison within the Irish prison system, Arbour Hill, has prisoners who benefit from Clozapine (a medication used for people with treatment-resistant mental disorders). This is said to be because only Arbour Hill can meet the robust monitoring protocols, required for safety protocol adherence, whereas this would be too difficult to enable in other prisons. Clozapine is the only evidence-based and licensed treatment for people with refractory schizophrenia, and clinical staff in other prisons asserted that it would be extremely beneficial to a number of prisoners across the IPS if the safety and monitoring requirements could be met.

6.2.10 *Required Diagnostics for Antipsychotic Medication Prescribing*

We were informed by IPS and CMH health professionals that prisoners being treated for psychosis may not always undergo the required blood tests and electrocardiograms (ECGs) across the IPS, despite this being an essential periodic requirement for individuals prescribed neuroleptics. It is unclear how widespread this shortfall in service provision is. There appears to be a lack of an estate-wide checking system to ensure that all investigations are completed in a timely manner. This is likely to be completed by those

10 *A Vision for Change*, Department of Health and Children, 2006, Recommendation 7.1

11 Government of Ireland. *Sharing the Vision: A Mental Health Policy for Everyone.* 2020

under the care of the CMH, but many GPs may not have systems to check that this is completed, with the potential for this to lead to unsafe practice.

6.2.11 Promotion Of Mental Health

Through the course of our site visits to prisons, we observed little direct evidence of mental health promotion and education programmes, although we been advised by the IPS that such initiatives have continued to be delivered by psychology services during the pandemic. The Red Cross and Samaritans deliver a range of positive health promotion interventions, and provide support to well-engaged 'listener' programmes, but there appears to be a lack of strategically developed and delivered initiatives to focus on positive mental health (such as how to protect and nurture your mental health), education around psychological wellbeing and mental health (identifying signs and recognising trigger points, as well as basics of depression and anxiety, etc.), and self-help interventions (such as mindfulness and anxiety management exercises).

Whilst we have been advised that psychological wellbeing initiatives are delivered by psychology services, this operates separately from IPS Healthcare and was therefore somewhat outside the scope of our site visits. Such initiatives should be developed and run as part of a wider IPS-wide strategy for health and well-being, aiming for optimum integration and cohesion between healthcare and psychology services.

6.3 Psychology Services

6.3.1 Overview

The IPS Psychology Services team provides a wide portfolio of therapeutic interventions that are recognised as very much appropriate and good practice for their target population, and they undertake both individual and group sessions with prisoners. However, there are three structural and policy issues that need to be acknowledged, as outlined in the following paragraphs.

6.3.2 Disconnect Between Psychology and Health Services

It is important to note that while it does fall within the Care and Rehabilitation Directorate of the Irish Prison Service, psychology services are separate from the healthcare function, with each reporting directly to the Director of Care and Rehabilitation. We were informed that this is the result of an historical arrangement, but results in a clear disconnect between health staff and psychology, with an over-reliance on practitioner initiative to share information, and limited formal mechanisms in place for collaboration. Although there is PHMS functionality that enables nursing and medical referrals to PCTS, across all professional groupings – psychology, medical and nursing – there was a common desire for greater integration.

Furthermore, there are limitations as to what prisoner-relevant data psychologists can access on PHMS. This, married to the similar exclusion of health staff from psychology notes, is an extremely high risk and poor practice scenario that requires urgent attention. In addition to the obvious risks of information being missed, this also leads to the potential for exacerbation of poor treatment and management pathways alignment.

6.3.3 *Limitations On Psychology Sessions*

Psychology services are limited in the number of prisoners with whom they can engage, due to the established detailing/prison rules. In practice, psychology staff informed us that they often see more prisoners through the facilitation of group sessions, though the limitations referred to above create significant restrictions in the number of prisoners they can see. This has a major impact on waiting times for prisoners, and it was indicated to us that waiting times of many months (up to one year) have been experienced, with some prisoners completing their sentences and being released without meeting a member of the psychology services team.

Group-based work presents an opportunity to support greater numbers of prisoners, though without meaningful change to the existing restrictions on daily sessions, psychology services will continue to struggle to meet demand for services and reduce their waiting lists to a more manageable level.

6.3.4 *Information Sharing Concerns*

The psychology service has its own information system, Psychology Case Tracking System (PCTS), which is said to work very well. However, the significant difficulty is that the PCTS is not integrated or interfaced with PHMS, other than a referral pathway, and consequently information cannot be shared easily. Although it is accepted that an information migratory approach that would allow sharing for information, whilst still protecting more sensitive areas, would benefit joined-up care and management, this is yet to be examined in detail. The issues of systems effectiveness and integration is further discussed elsewhere in this report.

It is acknowledged by both psychology services and healthcare professionals that the current information sharing arrangements, particularly relating to issues of risk, are too dependent on personal responsibility and practice.

6.4 Issues of Particular Concern

6.4.1 *Overview*

Through the course of our site visits to the twelve prisons within the Irish prison system, we observed a number of issues which may have a negative impact on the quality of care provided to prisoners experiencing poor mental health. These are described in the following paragraphs.

6.4.2 *Formal Risk Assessment and Recording of Mental Health Morbidity*

Both nursing and medical staff expressed concern regarding the lack of explicit rigour of risk assessments and supporting protocols, particularly with regards to self-harm and risk to others. This relates to both the committal process and also ongoing detention; the former can be a highly pressurised process that is said to rely too heavily on the judgement, experience and skills of the discipline officers and healthcare staff during this brief interaction, to elicit and recognise indicators of risk.

Although it is recognised that the IPS has a defined assessment in place for risk, we were consistently informed by IPS clinicians that there is a lack of uniformity in the approach to

risk assessment across the IPS. We did not examine the current risk assessment tool and supporting protocols in detail, but many IPS health professionals explicitly expressed an ambition to use recognised tools that enable effective and consistent decision-making processes and care planning. This is an issue of clear importance as the presence of validated risk assessments can provide assurance that staff have followed the appropriate protocols in assessing prisoners' mental health and likelihood of their committing harm to themselves or others.

We note and acknowledge the positive role played by the Self Harm Assessment and Data Analysis (SADA) Project, which forms part of the work of the National Suicide and Harm Prevention Steering Group (NSHPG) in the IPS and is supported by the multi-disciplinary teams across the prison estate who play a pivotal role in analysing the incidence and profile of self-harm in prisons. Notwithstanding the positive aspects of the SADA project, there does appear to be an issue for resolution regarding the uniformity of approach to risk assessment.

On a related issue to prisoner self-harm, due to a lack of records within PHMS, we are unable to definitively comment on mental health morbidity incidence and prevalence. We were informed that diagnoses may not be routinely recorded on PHMS to a reliable, accurate or consistent degree, and so the IPS does not have reliable information on this matter.

6.4.3 Relationship with Central Mental Hospital Services

We received numerous accounts of prisoners, typically presenting in acute phases of severe and ensuring mental disorders, waiting for beds to become available at the Central Mental Hospital. In some cases, prisoners have been assessed as requiring the specialist intervention of forensic mental health services but have remained in prison for up to 18 months. The most acutely unwell prisoners may be accommodated in areas designated as being 'medical' or 'high dependency', but do not benefit from 24-hour specialist psychiatric nursing care, instead relying on support provided to discipline officers by CMH staff and IPS doctors and nurses.

We observed a marked inconsistency across the prisons with regards to the referral of prisoners to CMH services. In many prisons, only the GP is permitted to make the referral, potentially requiring a nurse to raise it first with the GP, but in others it is the nurse or the GP who can refer to these services. The GP-only referral issue is said to result in unnecessary delays, disjointed working, and professional frustrations. There is no clear rationale provided as to why a nurse cannot routinely refer a prisoner to CMH services in all prisons.

An important issue to highlight is that of clinicians being unable to intervene during a psychiatric emergency due to a lack of legislative support when incapacitous prisoners refuse medication. We were informed that such instances, although infrequent, do occur and can result in acutely disturbed psychotic prisoners being unable to receive urgently needed medication. Despite evidence of very distressed prisoners being unable to demonstrate the capacity threshold for consent to treatment as a result of their mental disorder, clinicians are unable to intervene due to the current legal framework. This scenario results in extremely high-risk care and management from discipline officers, with the resulting damage to the health and wellbeing of the prisoner assessed subsequently by CMH and IPS clinicians.

We recognise that the issue of treatment without consent for acutely disturbed prisoners is always an ethical and legal concern, though in other European countries, such prisoners, subject to robust clinical assessments, may be treated against their will under relevant legislation. Following our interaction with both the IPS and the CMH, we were informed that this has not yet been tested in the Irish legal system.

As noted in Section 6.2.7 above, the question of in-patient capacity within the CMH, and the ability of the IPS to arrange the transfer of prisoners who required treatment for severe psychiatric disorders which cannot be adequately treated in a prison environment, is a fundamental issue for the IPS. The upcoming increase in bed capacity within the new CMH facility at Portrane is welcome, but there are concerns – not least those expressed publicly by the Director of the CMH – that this will be insufficient to meet increasing demand. We are conscious that the Government has established a High Level Taskforce to consider these issues, and as noted in Section 1.3.7 above we have met the Taskforce to share our emerging findings from this HNA review; nonetheless, the question of access to forensic psychiatric services is a major issue for the IPS, and needs to be resolved urgently.

In our view, keeping prisoners within the prison system when they require urgent access to CMH in-patient treatment is clinically inappropriate, disruptive to the smooth running of the prisons, and unsafe from the perspective of staff, other prisoners and the individuals themselves who require treatment.

6.4.4 Lack Of Specialist Dual Diagnosis Services

The current absence of specialist dual diagnosis services is viewed as an impediment to the efficacy of addiction, psychology and mental health services, and therefore an inhibiting factor in the wellbeing and progress of those prisoners. The formation of a dual diagnosis service, to deliver specialist support for those prisoners presenting with both drug misuse / addiction and mental health problems, is considered to be of paramount importance. A recommendation for the provision of specialist dual diagnosis services is made later in this report.

6.4.5 Provision of Mental Health Training to Prison Officers

Through the course of our site visits, we consistently observed a high level of demand from discipline officers for more effective mental health training. Prison officers informed us that they felt that the care they provide to prisoners could significantly benefit from a greater understanding and knowledge of mental disorders, particularly with regards to recognising when prisoners may have emergent mental health difficulties. We were informed that there is a training day provided to prison officers on mental health awareness, but the views of prison officers indicates that there is a strong desire for more detailed training on this topic.

6.4.6 Homeless Prisoners with Mental Health Disorders

With a significant proportion of the Irish prison population recorded as having no fixed abode, it is unsurprising that this prevalence of homelessness also extends to prisoners who present with mental health disorders. IPS healthcare staff regularly informed us that homeless people cannot get the help they need in the community due to a lack of engagement with local services, with the result being untreated mental illness and offending behaviours that lead to prison. The issue also presents challenges regarding a

prisoner's release back into the community, as IPS health staff typically struggle to get local community services to take responsibility for someone and co-ordinate the appropriate care and services. This often results in the person coming back into prison very soon after release with staff describing local authorities as having a "hands-off approach" to homeless people suffering from poor mental health.

We observed evidence of good practice in terms of the degree to which IPS staff will manage a prisoner's release plan so as to ensure continuity of care for prisoners with health challenges, including those with mental health disorders. We were informed that there is strong multidisciplinary cooperation to ensure community-based mental health services receive the relevant clinical and social care evidence and the individual has a medical card and relevant information. In contrast, the protocols for homeless prisoners are less clear and there are regular accounts of difficulties for released prisoners engaging with HSE mental health resources, raising the risk of prisoners potentially falling through service gaps on release.

7 Addiction and Substance Misuse

7.1 Overview of Addiction and Substance Misuse

Addiction and substance misuse are significant issues in many prisons across the globe, and represents a continuing challenge for the IPS. We note that Strategic Priority 8 in the EU Drugs Strategy 2021-2025 refers to the need to "Address the health and social needs of people who use drugs in prison settings and after release". [12]

Drug misuse is prevalent and contributes to violence, morbidity and vulnerability within prisons. As noted in the EU Drugs Strategy:

> *Prisoners are more likely to have used drugs compared with the general population, and they are also more likely to have engaged in risky forms of use, such as injecting drug use. Up to 70 % of European prisoners have used an illicit drug. Drug problems can worsen in prison settings due to the difficulties in coping with incarceration and the availability of drugs, including NPS (new psychoactive substances). At the same time, imprisonment can provide an opportunity for treatment and rehabilitation.* [13]

In order to surmount the direct and indirect problems with drug misuse in Irish prisons, a four-part approach is required:

- The restriction of supply of drug availability in prisons;
- The reduction of demand through supporting prisoners to avoid and reduce drug misuse;
- The building of recovery by providing the treatment and support to prisoners to maintain their recovery;
- The reduction of drug-related harms, including drug-related infections diseases, drug overdoses and other negative health and social effects.

7.2 Prevalence of Substance Misuse and Addiction

7.2.1 Overview

During our site visits, we were informed by senior management and healthcare staff that substance misuse is a serious issue within prisons, with the notable exceptions of Arbour Hill and the two open prisons, Loughan House and Shelton Abbey. Senior management estimate that approximately half of the prison population across the IPS estate may be using, or seeking to use, illicit substances, with a high percentage of these presenting with current or historical addiction challenges. In some prisons, the percentage of prisoners with substance misuse and addiction problems is much higher. The primary source of addiction in prisons was reported to be opiates, with, for example, Mountjoy Prison health staff estimating that over one-fifth of all prisoners are currently prescribed opioid substitution treatment.

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12 Council of the European Union, *EU Drugs Strategy 2021-2025*, p21

13 Ibid., p18

There is a range of other substance misuse and addictions within the prison such as alcohol, Benzodiazepines, and painkillers. Across the IPS, staff stated that they do not have exact figures for such drug misuse as prisoners are reluctant to share this information. The continued misuse of drugs within prisons poses a set of serious risks, not only due to the health risks directly associated with illicit substances, but also due to the potential for prisoners to go into debt and consequently fall victim to violence.

Drug-seeking behaviours are considered to be an ongoing challenge for prison GPs, with prisoners seeking to obtain various medication for personal non-therapeutic benefits, or as currency within the prison population.

It was reported to us by IPS staff that the majority of prisoners who have addiction problems also present with significant mental health difficulties. Unfortunately, there is a lack of reliable data collected within the prison system to identify those prisoners who have both mental health morbidity and substance misuse and addiction issues.

Since March 2020, the suspension of visits due to Covid-19 restrictions, together with new committal procedures, has reportedly significantly reduced the proliferation of illicit substances within the prisons.

7.2.2 Controls in Place Regarding Illicit Substances

There are a wide-range of initiatives and resources that are dedicated to the prevention of illicit substances entering the closed-prison system. Whilst this is outside the scope of the HNA review, we note that measures are actively enforced by the IPS to restrict the supply of illicit substances within prisons, and that this has an impact on the nature and scale of healthcare services required by those prisoners who continue to take drugs.

7.2.3 Addiction Services Available to Prisoners

Addiction counselling services are provided by resources external to the IPS and are subject to a Service Level Agreement with Merchants Quay Ireland (MQI). This is a well-regarded service within the prisons, although issues of waiting list challenges in some prisons, difficulties with prisoner accessibility due to challenges in availability of discipline officers, and a lack of MQI involvement in transition/release planning, were all identified as significant constraints on the service. MQI services include both individual and workshop-based interventions, with views expressed suggesting that an expansion of resources is required to meet demand.

Whilst MQI is a service provided internally within the prisons, there may be benefits to expand their input to support and influence transition and release planning more consistently across the IPS. It is suggested that greater engagement with MQI may enable a more comprehensive post-release plan system to help individuals with substance misuse and addiction challenges, employment and accommodation.

There is a degree of uncertainty regarding the provision of specialist ‘Addiction Nurse’ resources. It was reported at some prisons that there have been commitments to establish a specialist nurse post for addiction, but this has not come to fruition. There is a clear demand for this input.

Reports from psychology services stakeholders suggest that there is often a disconnect between addiction counsellors and psychology services, with a clear requirement for dual

diagnosis services. The term 'dual diagnosis' is used in healthcare as a reference to the occurrence of a mental disorder or condition alongside substance misuse. During our visits to closed prisons, the prevalence of prisoners with a dual diagnosis was notable. This can be considered to be a significant area of unmet demand and was reported by health and social care professionals as a shortfall in service provision.

7.2.4 After-Care Treatment Services in the Community upon Release from Prison

We note that the National Drugs Strategy makes reference to the need for early intervention with at-risk groups in criminal justice settings such as prisons: [14]

2.1.26	Intervene early with at risk groups in criminal justice settings.	a)	Providing training to enable the delivery of screening, brief intervention and onward referral in line with national screening and brief intervention protocols for problem substance use;	IPS, PS	AGS, HSE
		b)	Further developing the range of service specific problem substance use interventions in line with best international practice; and	IPS, PS	
		c)	Determining the prevalence of NPS use in prison settings with a view to developing specific training for staff and appropriate interventions.	IPS	HSE

There may be merit in considering the development of better linkages between the HSE dual diagnosis programme and the IPS dual diagnosis service, to ensure best practice and continuity of care after release. Ideally, people leaving prison should be able to access treatment in the community in a manner which ensures continuity of care and helps to minimise risk of drug overdose for offenders on release from prison. (As these are matters outside the control of the IPS, and therefore outside the scope of our terms of reference, we make no specific recommendation in this regard, but we would strongly encourage the IPS and other stakeholders to consider these matters seriously as part of the wider programme of reform proposed in this report.)

14 *Reducing Harm, Supporting Recovery.* A health-led response to drug and alcohol use in Ireland 2017-2025. P48

8 Prisoner Categories with Specific Health Needs

8.1 Overview

The population of prisons represent all aspects of society and, as such, present specific and specialised challenges when addressing the health and social care needs of older persons, and those with physical and intellectual disabilities. An IPS-wide formulation of policies and protocols, albeit within a real-world context of practicality, will help to strengthen the IPS response to the requirements of those with specific health needs.

8.2 Elderly Prisoners

The nature of the demand on IPS healthcare services is changing as the population in some prisons becomes increasingly elderly and therefore increasingly likely to experience ill-health and suffer from non-communicable diseases. Older people in prison typically have multiple and complex health and social care needs, which may include reduced mobility and personal care needs.

Prisons such as Arbour Hill, with more than half of prisoners are older than 50 years of age, with some over the age of 70, appear to manage well maximising the use of ground floor cells and effective care planning. The Midlands Prison also houses a large population of elderly prisoners, and on the occasion of our visit we were advised that several were in receipt of palliative care for terminal illnesses, whilst others were needing care of a nature seen in nursing homes (i.e. assistance with everyday living in addition to clinical oversight).

In this context, elderly prisoners present a greater management and risk challenge for IPS staff, particularly in the larger prisons across the IPS, and this requires strategic and operational policy development.

We were informed by prison health staff that there is no formal policy for older prisoners' care, and no dedicated resources or services, in place within the IPS specifically for such prisoners. Following the visit schedule, it was reported that there is a requirement for older prisoners to be subject to an assessment using the Care Dependency Assessment Tool, but clarity is required regarding its implementation and reach. Elderly prisoners are provided with health services as required, and prison staff will endeavour to accommodate such prisoners when being allocated a cell, for example, by housing them on ground-floor landings.

During our visit to Mountjoy Prison we were informed that a new facility, specifically catering for this prisoner cohort, was being established in the former 'Training Unit' on the campus. No other facilities of a similar nature are planned at present within the IPS, although it is likely to form an aspect of an estate-wide policy and service planning programme to address the health needs of older prisoners.

8.3 Prisoners with Physical and Sensory Disabilities

Throughout the IPS estate, prisoners are asked to self-disclose any physical and sensory disabilities on arrival and accommodations are generally only provided where prisoners have mobility issues, typically by accommodating them in ground-floor cells where possible. When this is a transfer arrangement, typically, all known requirements are planned for in advance of arrival.

Prisons appear to have the required levels of flexibility and adaptability to meet the requirements of prisoners presenting with physical disabilities. During the site visits, the Crowe team saw evidence that appropriate facilities are available, in terms of adapted cells and strategic allocation. However, we were informed that there is no formal policy within the prison system regarding care for prisoners with a disability; instead, if there is concern about disability, an assessment would be conducted for activities of daily living and a care plan set out for this.

8.4 Prisoners with Intellectual Disability

We were informed that there is no formal process within prisons for the assessment of intellectual disability. It was suggested that when a presenting challenge emerges, the appropriate referrals will be made to specialist services. Anecdotal accounts refer to prisoners seeking to mask their intellectual difficulties and disabilities, and unless there is a co-morbid presentation, they are unlikely to come to the attention of prison healthcare staff.

There are no clear recorded statistics regarding prisoners with intellectual disability. Prison staff suggest that there is likely to be a number of prisoners with intellectual disabilities in each prison, but it is impossible to estimate the extent of this population without comprehensive screening being employed. Whilst it is recognised that prisons may present specific difficulties for this group, health professionals advise that, without comprehensive screening and assessment, it is impossible to gauge the extent of the issue and to determine what measures could be taken to address the associated concerns.

9 Recommendations for Strengthening IPS Healthcare Services

9.1 Key Issues for IPS Healthcare Services

In the preceding sections of this report, we have presented our findings in respect of the current delivery of healthcare services across the IPS. From our presentation of findings and analysis, a number of salient points are clear:

- At present, the IPS provides healthcare services across the prison estate which are adequate to meet the day-to-day healthcare needs of the prisoner population. In some cases, these services are relatively basic, and delays for prisoners in accessing some services remain problematic. Some major challenges exist and need to be rectified within the context of a new model of service planning and delivery, with the need for additional resources.
- Perhaps the most challenging area for the IPS in relation to healthcare services is the question of care provided to prisoners with acute psychiatric disorders, who cannot be adequately managed within a prison setting, and for whom in-patient services at the CMH often remain inaccessible. This is not a problem which the IPS can fix on its own, and it is hoped that the work of the Taskforce will bring positive results, but for the time being the impact of these issues on the IPS is considerable.
- Healthcare staff within the IPS provide a dedicated level of care and commitment to the services they provide to prisoners, with many staff having extensive clinical experience in prison healthcare. This level of dedication is very positive, yet the current model of service delivery does not maximise opportunities for staff to develop skills or use specialist experience they have developed in fields such as mental health, addiction services, or care of patients with long-term conditions.
- Currently, the delivery of healthcare services across the 12 prisons is somewhat disjointed, with inconsistencies in clinical practice between the prisons. There are examples of uniformity, such as infection control and prescribing behaviours, but the service is not cohesive in many other areas. Much depends upon the experience and clinical decision-making of individual practitioners (medical and nursing) in each prison. A more joined-up approach is required, which calls for a significantly enhanced model for clinical governance on an IPS-wide basis, and increased resources at the centre to help plan, direct, oversee, quality-assure and audit services delivered at local level.
- Whilst the IPS will no doubt use every endeavour to optimise the quality of care it offers, it must be recognised that the IPS is only one (small) part of the overall health system impacting on the care and well-being of the prisoner population. Better continuity of care is required between care provided outside the prison system, and that delivered when prisoners are in custody. In that context, the IPS needs to continue to strengthen its relationships with outside agencies such as the HSE, individual hospitals, the Department of Health, the healthcare regulators, and the professional bodies.
- Linked to the preceding point, it is clear that there are other factors, extraneous to the design or running of healthcare services in the IPS, which impact significantly on the health and well-being of prisoners. For example, we commented earlier in Section 6 that prisoners with mental health issues who are homeless often fail to get the

services they need from the HSE or local authorities on release, with the result that their offending behaviours resume and they quickly find themselves back in prison. Whilst this issue is arguably outside our terms of reference for this HNA review, it would be remiss of us not to mention it, as a more integrated, cross-agency planning process for managing prisoner releases (involving IPS healthcare staff) might help to reduce the incidence of such situations.

It is within the context of the above critical points, and against the backdrop of the findings we have presented in the preceding sections of this report, that we now make a series of recommendations for improving healthcare services within the IPS. In the following sub-sections, we set out these recommendations, which are predominantly related to specific improvements in service design, delivery and resourcing. In Section 10, we describe the recommended governance structure which should be implemented to plan, manage and oversee healthcare services within the IPS.

It should be noted that the recommendations which follow are not presented in priority order; all of our recommendations should be regarded as part of a complete package of measures which need to be implemented in an integrated and cohesive manner.

9.2 Healthcare General Service Provision

The following recommendations are made for overall healthcare service provision within the IPS:

Item	Recommendation
1	***Completion of GP Recruitment Process*** The lack of GPs for many prisons, and the lack of full-time on-site provision, are frequently highlighted as a major area of concern for health staff, providing a compelling argument for full time dedicated GPs at most prisons. The recent recruitment exercise has proven successful in hiring 7 full-time GPs, and the IPS should work to ensure completion of the process by filling the position at Castlerea Prison. (This should be in the context of Recommendation #44 below, for the development of an Organisational and Workforce Plan for IPS healthcare staff.)
2	***Develop of Strategic Plan and Operational Plans for IPS Healthcare*** The recommendations contained in this report will provide the IPS with a firm set of foundations upon which to build a high-quality, dynamic, responsive and forward-looking healthcare service, rooted in best contemporary practice. In addition, we recommend that the IPS develop a strategic plan for healthcare services for the next three to five years, setting out the future vision and main strategic objectives to achieve in that period; and an annual operational plan, providing a more tactical set of service development and delivery objectives linked with performance targets, resource plans and budgetary projections.

Item	Recommendation
3	***Development of E-Health Resources*** There is a pressing requirement for the early development of formal e-health options, solutions, and protocols for all prisons. The pandemic has presented the basis for the operational framework to some degree, but this can now and should now be realised as a pivotal arm of prison healthcare. There are potential efficiency saving and safety benefits for the IPS, together with quality and positive experience outcomes for prisoners gaining speedy, accessible, and effective specialist clinical opinions via remote means. It is recommended that responsibility be assigned within the healthcare team for developing the service across the IPS, underpinned by a portfolio of protocols and quality standards.
4	***Development of Standard Operating Procedures and Care Pathways*** We recommend that the IPS should strengthen its existing Standard Operating Procedures (SOPs) for all aspects of healthcare services, in order to ensure consistency and uniformity of approach to designing and delivering services. This should include development / strengthening of care pathways to ensure that best practice is followed in the treatment of prisoners with a particular condition or with particular needs. (This recommendation should be considered in the context of our recommendations in Section 10 on clinical governance.)
5	***Strategy for the Management of Elderly and Older Prisoners*** Although apparently well managed on a case-by-case basis across the IPS, a new strategic plan for healthcare services, underpinned with policies and pathways, will help healthcare staff to allocate resources to best meet the needs of elderly and older prisoners. It is well recognised that prisoners over the age of 50 are likely to present with a range of health challenges, and as well as benefiting from specialised chronic disease management discussed elsewhere in this report, it is recommended that this group is subject to enhanced care planning. We recommend that the IPS develop a multi-disciplinary strategy for the management and care of elderly and older prisoners.
6	***Policy for the Management of Prisoners with Physical and Sensory Disabilities*** There is a requirement for the development of a formal policy to enable prison staff to best support prisoners who are living with a physical or sensory disability. Any existing policies should be formalised and strengthened, and disseminated this across the organisation.
7	***Screening of People with Intellectual Disabilities*** Many prisoners will not openly present with an intellectual disability, and it is recognised that the screening process may be very challenging for health staff to effectively use during committal. However, particularly when co-morbidities are presented, an opportunity arises for basic screening to be completed within a broader context, and as such, it is recommended that a screening tool be considered for use by health and education staff, aligned to care and action pathways.

Item	Recommendation
8	***Establish a Systematic Process to Ensure the Delivery of Required Medication Reviews*** It is accepted that medication reviews are likely to be performed routinely in some areas, but there is no evidence of a formal process for reviews to ensure good medicines management practice. The systematic process should be underpinned with agreed protocols and threshold markers for each level of medication reviews. This is an issue raised primarily by medical staff as being a requirement for good practice, and nurses also expressed the importance of reviews within the context of chronic disease management. Reviews will offer prisoners the opportunity to raise questions and problems about their medication and may improve the impact of treatment accordingly. For example, for medicines use review, it is important for changes to be agreed with the individual, the impact of changes duly monitored, and the review documented on PHMS. It is anticipated that community pharmacy providers can facilitate this proposal within current or amended contract arrangements.
9	***Internal Consultation and Review of Protocols Regarding the Controlled and Therapeutic Use of Benzodiazepines*** It is fully understood why Benzodiazepines are not prescribed within the IPS and we make no recommendation to the contrary. However, given the issues raised by clinicians regarding issues of 'most appropriate treatment' and with reference to NICE guidelines in the UK (which we believe are appropriate in this context), it is prudent that prison healthcare professionals should continue to monitor best practice and IPS requirements in this area.

9.3 Women's Healthcare Service Provision

The following recommendations represent issues that are specific to the health and wellbeing of female detainees:

Item	Recommendation
10	***Access to Female GP Resources for all Women Prisoners*** It is necessary for female prisoners detained at Limerick prison to be afforded the same access to a female GP, as provided at the Dóchas Centre. All women detained in the IPS should be given access to a female GP. Given the typical history and experiences of this population, it is recommended that gender appropriate resources are secured to augment the current GP offering at Limerick Prison.

Item	Recommendation
11	***Access to Prison-based Cervical Screening***
	Of the two facilities for women prisoners, currently only the Dóchas Centre is able to offer on-site cervical screening checks, with health professionals trained and qualified to administer cervical smears. This service is well used and highly regarded by prisoners. At present, health professionals at Limerick Prison are not able to provide this service due to a lack of training, resulting in a dependence on external CervicalCheck resources. It is strongly recommended that an adequate number of health professionals based at Limerick Prison benefit from the required training and certification, to enable an on-site screening service to be realised.
12	***Develop Bespoke Housing and Community Services Pathways***
	There is no current evidence of the provision of a gender-focused approach to gain good quality and suitable accommodation for released women prisoners. We recommend that a bespoke and gender-focused pathway is developed and implemented to address the planning and securing of accommodation for women leaving the prison system, on an inter-agency basis. [15]

9.4 Mental Health Services

The following recommendations represent issues that are specific to the mental health and wellbeing of prisoners and the services provided to them by the IPS:

Item	Recommendation
13	***Access to CMH In-Patient Facilities***
	As noted earlier, the lack of access to CMH beds for prisoners with acute psychiatric disorders represents a significant challenge to the IPS, and means that these individuals are unable to access appropriate clinical services with the proper setting, often for lengthy periods of time. Keeping prisoners within the prison system when they require urgent access to CMH in-patient treatment is clinically inappropriate, disruptive to the smooth running of the prisons, and unsafe from the perspective of staff, other prisoners and the individuals themselves who require treatment. We therefore recommend that the IPS continue to work with the Taskforce established by Government to consider these issues, and continue to liaise with the respective Departments in respect of the impact of the current arrangements as long as they continue.

15 The Government's National *Housing First* policy may provide a basis for the development of specific services for women leaving prison. *Housing First National Implementation Plan 2018-2021.* https://www.homelessdublin.ie/content/files/Housing-First-Implementation-Plan-2018-2021-final.pdf

Item	Recommendation
14	***Uniform Risk Assessment of Prisoners***

We are concerned regarding the lack of confidence in the current risk assessments within the IPS, particularly self-harm and risk to others, as consistently reported by IPS healthcare professionals. We were advised of a lack of uniformity across the IPS in the use of recognised tools that enable effective and consistent decision-making processes and care planning. The significant challenges of time and resource constraints which IPS staff face, particularly during committal pathways, are accepted. However, the delivery of effective and robust risk management is essential for the protection of the health and safety of the prisoner, the prison population, and the prison workforce.

We strongly recommend the IPS conduct a review of risk assessment tools, processes, and protocols with a view to establishing a robust, internationally recognised approach to effective risk assessment and management (for committal and ongoing assessments).

In addition to risk assessments, the review may include the introduction of primary care psychological wellbeing assessments such as PHQ9, supported by clear protocols and pathways. These will support staff in identifying demand, address gaps in service provision, and stream support into the most effective pathways.

15 ***Increase Mental Health Nursing Capacity***

The issue of there being an inadequate number of qualified mental health nurses across the Irish prison system requires urgent attention. Furthermore, attention is also required with regards to the mental health training needs of general registered nurses, with this issue regularly flagged to the Crowe team through the course of our site visits. A strategic approach to the development of an increase in mental health qualifications and skills within the nursing workforce, through both recruitment and training and development of other IPS registered nurses, is recommended. (Further comment and recommendations in respect of resourcing can be seen in Section 10 of this report.)

16 ***Development of Nurse-Led Primary Care Mental Health***

IPS healthcare provision will benefit from the introduction of primary care mental health interventions, such as CBT, which may be delivered to both individuals and groups. This initiative will gain the support of health professionals, with psychology practitioners also suggesting that this skill set will help to support their ongoing treatment and assessment pathways, with nurses potentially being able to add value to specialist care planning, such as Dialectical Behaviour Therapy (DBT) and Acceptance and Commitment Therapy (ACT). These interventions require a training and development programme for registered nurses, with defined protocols and supervision frameworks agreed and applied.

Item	Recommendation
17	***Simplification of Referrals to Mental Health Services***
	There is a compelling requirement for the referral process to specialist mental health services to be streamlined and simplified. Most notably, we find that the prisons who work with GP-only referrals to mental health resources create an unnecessary level of inefficiency and a barrier to good practice. We recommend that any qualified health professional within the IPS should be able to make referral to mental health services, based on their practiced judgement. Consultation with prisons who promote this referral pathway may be of benefit to those health teams who currently do not.
18	***Strengthening of Protocols that Establish and Define the Role and Presence of Clinical Staff in Areas of Specialist Support***
	Facilities within the prison system that are recognised as delivering specialist health and support provision, such as the HSU (Mountjoy) and D2 (Cloverhill), benefit from input from specialist health professional services, most notably from CMH resources. However, it is recognised that these areas are staffed routinely with discipline officers, with only visiting input, guidance, and management offered by the prison's healthcare staff. This represents a gap in service provision, with the ongoing management of prisoners, who may present with high levels of acuity, delivered by discipline officers. We recommend a review of the staffing requirements of specialist support facilities in prisons, to provide the best quality and skilled care and management possible. It is envisaged that the location of a mental health nurse during day shifts within these areas is likely to facilitate effective clinical leadership and improved practices. We also recommend the development and strengthening of protocols and care pathways to better manage prisoner morbidity and the aligned decision-making.
19	***Provision of Further Mental Health Training to Prison Officers***
	We recommend that the IPS consider the development and expansion of a specific mental health training programme for discipline officers. While we recognise that prison officers currently have a day's training in respect of mental health, we believe there would be a benefit in providing officers with a more detailed and practical course, building on the current provision. In addition, consideration may also be given to the notion of having lead prison officers for mental health (mental health champions). The training of Leads, or mental health 'champions', will evolve, through a train-the trainer approach. The Leads will facilitate an ongoing rolling programme of formal and informal staff development within the agreed framework of discipline staff development, and primarily in the workplace. This initiative may be managed largely within the current spend and will hopefully gain the input and support of CMH and HSE services.

Crowe

Item	Recommendation
20	***Feasibility Study for Criminal Justice Liaison and Diversion Scheme*** We believe there is a value in the IPS / Department of Justice / HSE / Department of Health conducting a feasibility study into the establishment of a nationwide criminal justice diversion scheme, typically populated with qualified mental health nurses, with medical support. This can begin with a pilot, with the team accessing Garda detention facilities and courts, diverting, signposting, and supporting mentally disordered prisoners towards the most appropriate health and social care support. This could reduce the burden on the prison system, improve health outcomes, provide effective and appropriate care interventions (such as supporting homeless people into accommodation), and be likely to be cost-effective. Within this review, the IPS might also consider the relationship between homelessness, mental health, HSE services, and engagement with the wider criminal justice sector. The IPS might review the numbers of homeless people coming through the system, the recidivism rates, mental health morbidity data, and the costs involved. A well-resourced and supported criminal justice diversion scheme could be of great value in this review. If the IPS is to continue to successfully reduce recidivism, then it is important that the protocols for homeless prisoners leaving prison and release planning/management are consistent across the Irish prison system.
21	***Establish Diagnostic Co-ordination for Prescribing of Antipsychotics*** We recommend that the IPS develop a consistent, organisation-wide approach to ensuring the relevant and periodic physical investigations are completed for those prisoners prescribed neuroleptic medication. Although this is the responsibility of an the individual clinician, there currently appears to be lack of an IPS-wide checking system to ensure that all investigations are completed in a timely manner. This may require input from a multi-disciplinary team to progress this initiative, with an accessible IPS register ensuring good governance and prescribing behaviours.
22	***Review of Clozapine Prescribing*** We recommend an internal multi-disciplinary review to be conducted in collaboration with the Clozaril Patient Monitoring Service. This review would examine whether a structure can be established that meets the safety requirements for Clozapine monitoring to allow increased use across prisons. Identified risks will be assessed against potential benefits, together with the right to access appropriate treatment protocol.
23	***Promotion and Visibility of Mental Health*** We recommend the strengthening and development of an IPS-wide mental health promotion and education programme, with supporting initiatives and resources. This programme should emphasise positive mental health, with this an opportunity for collaboration with the Irish Red Cross and the Samaritans. Additionally, as the utilisation of e-health provision increases within the IPS, consideration should be given to online mental health interventions (such as ACT and CBT), consultation, and assessments. Training / awareness raising should also be considered in respect of “Connecting for Life”, the national strategy for suicide prevention and the reduction of self-harm.

Item	Recommendation
24	***Legislative Review of Prisoner Rights***

We recommend that the IPS consider the case for a legislative review of the rights of prisoners who present with mental health disorders relating to:

- Right of access to appropriate treatment (such as specialised medication, e.g., Clozapine, or specialist services, e.g., forensic psychiatry hospital);
- Right to be treated during an acutely unwell phase of a mental disorder in a psychiatric facility;
- Right to receive treatment, as an urgent requirement / emergency when care in a clinical setting is not immediately possible, against the will of a prisoner deemed to be lacking capacity due to a mental disorder.

9.5 Addiction and Substance Misuse Services

The following recommendations relate to addiction and substance misuse services provided by the IPS:

Item	Recommendation
25	***Review of Addiction Counselling SLA***

Reports during the site visits regularly highlighted the pressures on the MQI addiction counselling services, resulting in lengthy waiting lists for therapeutic interventions. It is unclear as to when the contract was last reviewed in terms of the demand for their services, together with the allocation of resources to meet prisoner-facing activities. These services are well regarded by IPS health staff, but frustrations are expressed about accessibility for prisoners identified as requiring support. It is also suggested that further benefits may be gained from securing wider engagement with MQI resources in transition and release planning.

It is recommended that a review of the SLA is completed to address the array of issues, including those associated with resource allocation.

26 ***Consultation about the Role of Specialist Addiction Nurses***

As part of the recommended comprehensive review into the IPS nursing workforce, (see Section 10 of this report), it is strongly advised that consultation is completed to address the issues associated with the formation of specialist addiction nursing resources in the majority of closed prisons. It is understood that this is a proposition that has gained support previously, and it is clear that significant benefit may be gained from this role within a multi-disciplinary team approach.

It is recommended for the role of specialist addiction nurses be examined in terms of service impact and benefits across closed prisons.

Item	Recommendation
27	***Establish Dual Diagnosis Service across the IPS***

We strongly recommend the provision of a specialist dual diagnosis service, supporting prisoners presenting with mental health morbidity and substance misuse challenges across the IPS estate. This service would operate alongside established mental health and addiction services, delivering expertise and interventions to enhance healthcare provision, and also the skills and learning of the multi-disciplinary teams.

Prison health professionals widely acknowledge that the lack of dual diagnosis services currently represents a gap in service provision. The ability to target dual diagnosis resources appropriately may also benefit addiction counselling services in terms of the intelligent and most appropriate allocation of resources.

As part of this service provision, the IPS should engage closely with the HSE and other stakeholders providing care to ensure that services are more integrated between prison and community, so that people leaving prison can access treatment in the community without interruption. (This will also have an implication for the following set of recommendations regarding information systems, as it will be essential to provide seamless handover of records for ex-prisoners requiring care and treatment in the community.)

9.6 Healthcare Information and Systems within the IPS

The following recommendations are made in relation to healthcare information IT systems within the IPS:

Item	Recommendation
28	***Review of PHMS Fitness-for-Purpose***

As we have reported in Section 2.4 above, the IPS is unable to analyse data from PHMS, and so cannot produce reports with summarised statistics, trends, or meaningful projections. This may be due to the inherent lack of such functionality within PHMS, or the tendency of users to enter data in narrative fields, or a combination of the two, and it leaves the IPS in a position where it lacks basic data to plan and manage healthcare services and the related resources.

Linked to this, the challenge of duplicate prisoner records is resource intensive and may lead to unintended health outcomes and as such requires early resolution.

It is essential that the IPS has a healthcare information system that gains the confidence of healthcare staff and wider stakeholders and facilitates more effective reporting and analytical tools. It is recommended that an appropriate fitness-for-purpose review is undertaken to address these concerns. This should also cover the interface with PIMS and the supporting IT infrastructure available to healthcare staff across the IPS estate. Alignment with other systems, such as the psychology services ICT system, should be included within this review.

Item	Recommendation
29	***Appointment of a Dedicated PHMS Business Manager*** There is a compelling requirement for an appropriately qualified and dedicated individual to be appointed to lead data / systems management and information governance for healthcare across the IPS. The appointment of a PHMS-dedicated Business Manager is recommended to ensure that the necessary development, training, consistency, and support is available.
30	***Development and Delivery of a Robust Data Training Programme*** The lack of training and support to health staff in data management and information governance is said to result in ill-defined and often inaccessible morbidity data across the population. Early consideration should be given to training and protocol awareness sessions for those health professionals who input code diagnoses, and for all professionals who input and rely on PHMS for decision-making and assessments. It is recommended that an ongoing data management and information governance training programme is developed and delivered, as an ongoing mandatory requirement across the IPS, by suitably qualified resources.
31	***Resolution of the Issue of Incompatibility Regarding the Sharing of Dental Digital Images*** Currently, the issue of incompatibility presents a challenge when digital images are required to be shared between prisons. This is of particular note when prisoners are transferred. It is recommended that this is resolved with the required technology resources, and in the context of the proposed fitness-for-purpose review of PHMS as outlined above.

10 Recommendations for Improved Governance in IPS Healthcare Services

10.1 Strategic Positioning of Responsibility for Healthcare in Prisons

As we have reported within our review of the international literature (summarised in Section 3 above), approaches vary between countries in respect of the location of responsibility for the running of prison healthcare services: within some countries, it falls under the responsibility of the Ministry of Health, whereas in others, the Ministry of Justice or Prison Service has lead responsibility. In essence, there is no single "correct" path of action and the location of responsibility will depend upon a wide range of factors and on the nature of the local healthcare and justice/custodial systems.

At present, the IPS has lead responsibility for prison healthcare services, and we can see no compelling reason why the situation should change. The alternative would be for prison healthcare responsibility to be assumed by the Health Service Executive (HSE), which itself is undergoing significant change and restructuring in line with the Slaintecare programme. In addition, the HSE has had to focus its resources on the Covid-19 pandemic since early 2020, and it appears likely that this will continue to be the case for some time to come, both in terms of dealing with the pandemic as its intensity reduces, and managing large volumes of activity deferred over the last 18 months.

Furthermore, the HSE has no strategic experience of planning, managing, delivering and evaluating prison healthcare services, although individual clinical practitioners within the HSE have specific experience of providing services to prisoners.

Item	Recommendation
32	***Location of Strategic Responsibility for Prison Healthcare Services*** We recommend that responsibility for prison healthcare services should remain with the IPS. We also recommend more productive and meaningful working relationships be established between the IPS and HSE.

There is strong sense of belief and commitment across the IPS that the time is ripe for change, and that the IPS has committed itself to the HNA process with the will to transform prison healthcare. It is very much hoped that the recommendations detailed in this report will form the basis for an agenda for change.

10.2 Current Structures

Under current arrangements, the healthcare function within the IPS as part of the Care and Rehabilitation Directorate, and operates alongside psychology services, with both services reporting to the Director of Care and Rehabilitation. Other functions within this directorate include:

- Integrated Sentence Management;
- Work and Vocational Training;
- Reintegration;
- Prison Education Service;
- Library Services;
- Sex Offender Management;

- Incentivised Regimes Policy;
- Chaplaincy Service.

Two significant features stand out in relation to the optimum location for healthcare services within the IPS organisation structure. Firstly, this report recommends a substantial range of service improvements and enhancements, within an overall package of reform which is likely to take up to three years to implement in full. Additional resources will be required in relation to both clinical and support staff, and a new set of clinical governance structures will need to be put in place. All of these measures will require leadership and must operate at a level of strategic high priority for the IPS. For those reasons, we believe that healthcare should be a separate directorate reporting to the Director-General of the Irish Prison Service.

Secondly, we reported in Section 6.3 that there is a clear disconnect between health staff and psychology, with an over-reliance on practitioner initiative to share information, and no formal mechanisms in place for collaboration. Across all professional groupings – psychology, medical and nursing – there was a common desire for greater integration. We believe that these current difficulties can be overcome through having psychology services operate as part of a new directorate, with more integrated, patient-focused arrangements in place for service planning and delivery. The initiative will require significant work and input from professionals to establish, shape, and agree a series of robust protocols, policies, and pathways to ensure professional rigour and distinctions. This is of particular relevance to psychology services, which delivers a sizable area of work not directly related to healthcare.

This integration provides an opportunity to identify the facets of prison care: health, wellbeing, and psychology.

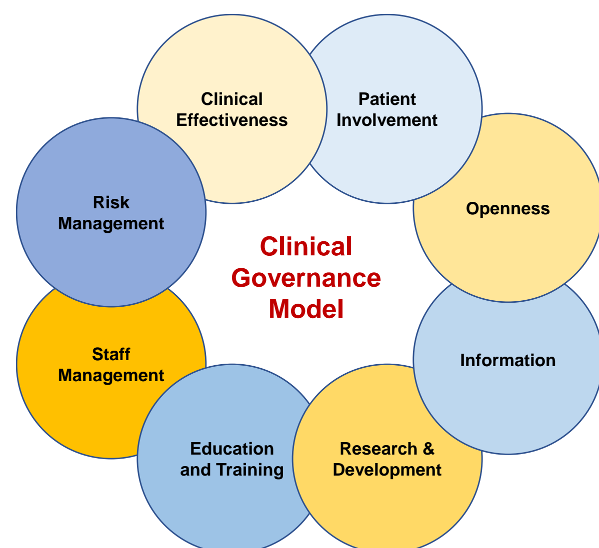
Item	Recommendation
33	***Establishment of a new Directorate of Health, Wellbeing, and Psychology Services*** We recommend that the IPS should establish a new directorate, incorporating all of the current health, wellbeing and psychology services within a common structure. The name of the new Directorate should be determined by IPS stakeholders, but for the purposes of this report it will be referenced as the Directorate of Health, Wellbeing, and Psychology Services. A position of Director of Health, Wellbeing, and Psychology Services should be established, reporting to the Director-General. The Directorate should include the following: - Primary Care Services; - Pharmacy Services; - Mental Health Services; - Psychology Services; - Drug Treatment Services; - Infection Control; - Dental Services; and - Other health professional services, such as chiropody and physiotherapy.

Careful attention will have to be given to how the recommended new directorate will work in practice. Although our brief for this review did not include very detailed assessment of IPS psychology services, we are nonetheless conscious that the professional model employed in this area within the IPS is biopsychosocial and non-medical, and that there is concern within the IPS psychology team that their inclusion in a healthcare directorate would mean a dilution of the biopsychosocial approach. On that basis, it would be imperative that the governance structures of the new directorate should ensure that IPS psychology services continue to operate a biopsychosocial approach, reflective of the broad diversity of their work, whilst also building in a more structured basis for collaboration between medical, nursing, psychology and other staff.

10.3 Clinical Governance Structures

At present, there is a lack of clear and appropriate clinical governance arrangements within the IPS – covering issues of major importance such as those illustrated in the diagram overleaf, together with elements of more general governance including staff management, workforce planning, information management and use, and patient/service user experience. For the IPS healthcare services to operate and develop effectively, all of these functions are required, but very few of them are being delivered at present in any consistent or sustained manner.

The concept of clinical governance is that it is a systematic approach to maintaining and improving the quality of patient care within a healthcare environment. It is not rigid – different clinical governance models may include components which are specific to certain services, specialties or patient needs – but typically includes a number of core elements which, taken together, go to make up an integrated model. These elements, as illustrated (right), would consist of the following within the IPS healthcare function:



- **Education and Training:** ensuring that all staff (clinical and support) are maintaining their professional skills in line with relevant regulatory requirements, and that opportunities for upskilling and career development are maximised in line with the strategic plan for IPS Healthcare Services;
- **Staff Management:** ensuring that effectiveness staff management arrangements are in place for delivery of high-quality care, that appropriate cover is provided, that services operate in an integrated and holistic manner across the IPS, and that effective workforce planning arrangements are in place;
- **Risk Management:** putting in place formal arrangements for risk management across all aspects of IPS healthcare, and resourcing this on a dedicated basis – whilst risk management should be part of everyone's job, it requires oversight and the development and implementation of effective protocols, systems, quality assurance arrangements, and oversight;

- **Clinical Effectiveness:** this aspect considers the extent to which a particular intervention works, enhanced by additional considerations such as whether the intervention is appropriate and whether it represents value for money, taking into account current evidence on contemporary best practice – leading to changes in practice where necessary;
- **Patient Involvement:** engaging with prisoners on their health status and keeping them informed as to the treatment they are receiving, and educating them in respect of health and well-being issues, and avoidance of healthcare-related risks;
- **Openness:** recognising that poor performance and poor practice can too often thrive behind closed doors, this element focuses on processes which are open to scrutiny, while respecting individual patient and practitioner confidentiality, and which can be justified openly, to assist quality assurance. Open proceedings and discussion about clinical governance issues should be a feature of the framework within the IPS;
- **Information:** information management within the IPS will be central to delivering an effective clinical governance model, centred on patient records; proper collection, management and use of information within healthcare systems will determine the system's effectiveness in detecting health problems, defining priorities, identifying innovative solutions and allocating resources to improve health outcomes for prisoners;
- **Research and Development:** this element focuses on opportunities to change clinical practice and service design in the light of evidence-led research. Techniques such as critical appraisal of the literature, engaging with clinical professionals in other prison healthcare systems outside Ireland, project management and the development of guidelines, protocols and implementation strategies are all potential tools for promoting the implementation of research practice within the IPS.

Until now, despite the best efforts of a small team of committed staff within IPS healthcare management, there has been a significant lack of resources to achieve improvements in health care delivery, to redesign services in a more cohesive and integrated manner, and to tackle critical aspects of clinical governance in a coordinated fashion. Vitally important functions such as workforce planning, risk management, development of performance information and reporting and other tasks have no dedicated resources but are part of a very broad set of responsibilities held by a small core team of busy professionals.

Item	Recommendation
34	***Clinical Governance*** We recommend that the IPS should develop and implement a clinical governance model in line with the approach described above, but further enhanced to gain explicit lines of roles, responsibility, and accountability.
35	***Consultation and Resolution of the Clinical Leadership of Healthcare*** The issue of clinical leadership within prisons goes beyond a theoretical application of governance frameworks, it requires an early resolution to enable explicit understanding within prison health teams to facilitate practical lines of leadership, accountability, and responsibility. We recommend that the IPS should adopt a solution-focussed consultation process to consider these issues, including all professional groups and input from IPS / prison management.

Item	Recommendation
36	***Development of Formal Pathways Between IPS and the Wider Health System*** It is recommended that issues of professional and service isolation be addressed with the development of a number of formalised relationships with health bodies including, but not limited to, the Department of Health, HSE, statutory regulatory bodies, universities/training bodies, and professional bodies. The current arrangements do not provide the rigour of dynamic interaction and support necessary to enable the culture and recognition of the role of prisons within the health system.
37	***Establishment of an Ethics Review and Oversight Working Group*** In order to maintain the rigour of clinical independence and person-centred care, it is recommended that consideration is given to the establishment of a multi-disciplinary working group tasked with addressing ethical issues of practice and governance, together with the oversight, from an ethical and quality perspective, of the provision of current, emergent and future healthcare practices.
38	***Multi-disciplinary Approach to Clinical Governance Review*** There is evidence of prison health professionals wanting to take a more prominent role across the range of clinical governance issues. We received representation that current clinical governance arrangements are not well-defined and established in some areas, and tend to be formed on a top-down basis. It is recommended that early planning is formed to establish site specific clinical governance groups, integrated into an IPS-wide clinical network to support innovative practice, and shared learning.
39	***Formation of a Policy and Standards Review Working Group*** IPS policies and standards are set out with the intention to align prison healthcare with the highest standards of care that are provided within the community. Although the Crowe team did not examine in detail the established portfolio of policy and standards relating to healthcare, a range of IPS stakeholders raised the issue of ongoing relevance and application of these in their practice. It was suggested that areas such as mental health, transfers and committals, screening, care of older prisoners, and medicines management will benefit from updated standards and policy enhancement. The formation of a working group across the IPS to receive evidence and information relating to health policy and standards from prison multi-disciplinary teams is therefore recommended.
40	***Formation of a Clinical Audit and Risk Committee for Healthcare*** Despite expressed interest from a number of health professionals, there is little evidence of the promotion of clinical audit initiatives. Our view is that effective clinical audit can drive high quality care and innovation in prisons. The issue of risk was widely discussed as an area of concern amongst IPS healthcare professionals, from committal processes and protocols, to the ongoing identification of factors impacting on wellbeing. There is a requirement for a committee, with representation from both executive and clinical-facing stakeholders, to provide leadership and accessible resources to address issues and challenges relating to clinical audit and risk.

Item	Recommendation
41	***Development of an Online IPS-Wide Research and Development Platform*** During site visits, health professionals, most notably nurses, talked about the apparent limitations on their professional development and the opportunities to gain the resources and authority required to undertake research and development. It is accepted that this may require clarity, but the potential outcomes of supporting research and development on practices and service delivery, together with positive cultural shifts, may be of significant benefit to prison healthcare. In order to provide support and a recognised 'point of access' for IPS health staff, the development of research and development online platform, underpinned with policy and ethical frameworks, is recommended.
42	***Engagement with Professional Bodies for Skills Development*** Prison healthcare is becoming an increasingly specialised area of practice for doctors, nurses and other health professionals, and there is consequently greater need for clinical skills to be focused on the specific needs of prisoner populations. We recommend that the IPS should formally engage with the relevant training bodies to examine the possibility of creating prison healthcare modules as part of formal training programmes. (In that regard, we have engaged with the Irish College of General Practitioners – the formal training body for GPs – and the College has indicated its willingness to discuss such an approach with the IPS.)
43	***Development of Health Impact Assessment (HIA) Policy and Protocols*** Health Impact Assessment (HIA) is a practical approach used to judge the potential health effects of a policy, programme or project on a population. Within a prison context, HIA can provide the evidence and direction to support specific initiatives, such as the identification of health benefits of capital expenditure to improve gym or recreational facilities, as well as guidance to improve planned projects to minimise risks to health. In consideration of short and longer-term benefits and detriments, the use of qualitative and quantitative evidence, and the values relating to health equity, are central features of HIA practice. It is recommended that executive-led policy and protocol development work is undertaken to recognise the areas that will benefit from HIA within agreed protocols, with training and education issues within the IPS workforce identified and addressed.

10.4 Resourcing Requirements

There is a substantial body of work involved in implementing all of the preceding 43 recommendations presented in this report, and the IPS will need to consider augmenting healthcare resources both at the centre and in individual prisons. In that context, we present the following recommendations:

Item	Recommendation
44	***Directorate of Health, Wellbeing, and Psychology Services Organisational and Workforce Plan*** With support and input from HR stakeholders, a detailed workforce plan for the development of the organisational structure and management arrangements should be prepared, covering resource requirements; reporting lines; detailed responsibilities; executive governance arrangements; team development; liaison with other parts of the IPS; and other features as necessary. Detailed job descriptions for each member of the new Directorate will need to be prepared in close collaboration with the Human Resources Directorate
45	***Central Nursing Resources*** Three full-time experienced nursing professionals should be recruited to assist the National Operational Nurse Manager in the management and oversight of nursing service delivery, in the development of the nursing workforce, and in the implementation of effective systems of clinical governance for all aspects of healthcare services. Potentially, the three posts would take lead roles for: - Mental health/addiction; - CPD / practice development and innovation; and - Policy, protocol and care pathway development. These staff members would act as part of a multi-disciplinary team to undertake regular audit and review of healthcare practices, to ensure consistent policy implementation and service provision, and to implement all aspects of clinical governance across the IPS, drawing in prison-based healthcare staff for appropriate project-based work.
46	***Additional Pharmacist Position*** An additional full-time, permanent pharmacist should be recruited to work within HQ, to cover necessary aspects of medication management including audit, policy development, drafting of standard operating procedures, research, reporting (to inform the work of the D&T Committee and for general reporting reasons), and other related duties. The post-holder would assist the Chief Pharmacist in work to develop and facilitate a formal rolling process for IPS-wide medicines management/ prescribing reviews to ensure good practice, to support and provide input to the development of nurse-led chronic disease management clinics, and to assist in initiatives to address prescribing challenges, such as the issue of equitable access to treatment, and GP prescribing behaviours. This person would also deputise for the Chief Pharmacist during periods of annual leave or other absence – at present, there is no cover. (Hiring a permanent resource would in effect formalise the existing arrangement whereby a second pharmacist has recently been engaged by the IPS on a temporary basis.)

Item	Recommendation

We recognise that the augmented staffing resources proposed in the above two recommendations represent a significant increase; however, this is in the context of the IPS starting from a very low base in his central healthcare resources. Attempting to implement the 60 recommendations in this report without increasing resources to the proposed level would significantly diminish the prospect of successful completion of this programme of change, and would inhibit the IPS from reaching the standards of clinical governance and practice which are both necessary and achievable. Substantial effort will be required in relation to development of new policies, protocols and care pathways, in medicines management, and in training and continuous professional development for staff, all of which will require additional staff resources which are not present now.

47 ***New Healthcare Risk Manager Position***

The IPS should recruit a full-time Healthcare Risk Manager – this is a growing component of all aspects of healthcare delivery and needs to be properly addressed in terms of clear risk policies, practices, training, recording, reporting and other duties which are not adequately handled at present. The post-holder would play a central role in developing and monitoring the use of a risk register within each prison and liaising with colleagues on related safety and quality initiatives and measures. We would expect this post to be held by someone with appropriate clinical or other healthcare qualifications.

48 ***New Business Manager Position***

The post of full-time Business Manager should be created to manage the development of PHMS / other healthcare information systems within the IPS, to develop appropriate reporting mechanisms, and to produce regular performance information regarding healthcare services.

49 ***Additional Administrative Resources***

The IPS should consider hiring additional administrative resources to support the above staff members (precise scale to be determined – this should be subject to a more detailed workforce planning analysis.

50 ***Skills Development for Clinical Staff***

We recommend that both medical and nursing staff members based in the prisons should develop specialist expertise in relevant fields (e.g. addiction issues, mental health, chronic disease management, etc.) and to work on a more integrated basis across the prisons within the IPS network. Such individuals could become the subject matter expert or “go to” person for such topics, providing in-reach services to a number of neighbouring prisons or to the whole of the IPS; this type of arrangement would link in well with the enhanced system of clinical governance referred to earlier, and would make best use of resources across the IPS (rather than having to recruit additional specialists at HQ) whilst also aiding integration and standardisation of services.

Item	Recommendation
51	***Psychology Services Staff Resources*** Finally, one other area where we believe additional staffing requirements exist is the IPS Psychology Service, which we understand is under considerable pressure and where waiting lists and waiting times for prisoners to access the service are considerable. As psychology is outside the IPS healthcare function and outside our terms of reference, we have not undertaken analysis of the likely additional resource requirements, but would recommend that this matter be considered as part of the development of the new Directorate of Health, Wellbeing, and Psychology Services.

10.5 IPS Nursing Workforce

The nursing workforce within the IPS currently employs around 150 staff and provides much of the front-line engagement with prisoners in relation to their health needs. In that context, we present the following recommendations:

Item	Recommendation
52	***Comprehensive Review of the Nursing Workforce*** There is an important requirement for a full and comprehensive review of the nursing workforce addressing numbers, ratios, skill mix, professional development and advancement, time utilisation, and tasks. It is recognised that this review will require close collaborative working with the IPS HR Leads, to gain the fullest possible view of the issues at hand, and the real-world challenges within the IPS. Currently, nursing in the closed prisons is restricted by the rigidity of established practices, making it difficult for the health team to deviate from the task-orientated nature of working patterns, determined by low nursing numbers and constrained time pressures, and adapt nursing to the changing needs of prisoners. It is necessary to establish a clear understanding of what is needed, in terms of skills, capabilities and capacity, and where it is best applied. There is a very small number of Health Care Assistants currently employed by the IPS on an agency/temporary basis. It may be prudent to expand this resource in order to release the registered nurses for other duties, such as service and professional development. This should be considered as part of the review of the nursing workforce.
53	***Mental Health Training for Prison Nurses*** There is an identified and compelling requirement for a focus on mental health training within the nursing workforce. This demand was expressed, almost without exception, throughout the IPS nursing and non-nursing healthcare team. Concern was frequently expressed about nurses being expected to address the mental health needs of prisoners each day, without having gained the required mental health expertise and skillset. The issue was regarded as particularly important to those registered nurses without experience and training in psychiatry and is driven by the significance of daily mental health presentations. We recommend that such training be developed and delivered by the IPS as a matter of priority.

Item	Recommendation
54	***Development of Nurse-Led Specialist Clinics***
	The ambition to develop nurse-led specialist clinics, in areas such as chronic disease management, was articulated across the IPS. The current operational challenges do not support the provision of these nurse-led programmes and result in prisoners not having equitable access to the primary care services afforded to Medical Card holders. There is widespread ambition amongst IPS nurses to deliver specialist clinics, in terms of screening, management and treatment, with expressed support from a number of GPs. A strategic approach is required to support CNOs and nursing teams to establish and deliver impactful nurse-led clinics, enabling professional development and effective prisoner management and care.
55	***Improved Control of Nursing Skill Mix***
	There is an ill-defined and poorly controlled nursing skill mix and skills matching across the IPS. This issue was highlighted as a source of frustration across disciplines and although this may be partly dealt with in the comprehensive workforce review of nursing recommended above, it also needs to be addressed within the IPS HR protocols. Leadership and ambition is required to work with staff representatives and management to seek a solution for this challenge.
56	***Support to Nurse Prescribers***
	The restrictions on trained nurse prescribers needs to be addressed. Currently, the IPS has valuable prescribing resources that are largely unable to perform to their qualification. Nurse prescribing should be considered to be a critical resource within IPS health services. The issues remain unclear around the lack of a governance structure that would facilitate prescribing practices for these nurses, although the lack of available medical supervision was identified as a key reason. This matter requires early resolution and consultation with medical staff and health leaders.
57	***Management and Leadership Training for Chief Nursing Officers***
	It was reported that there is currently no management or leadership training for CNOs. The lack of management and leadership training, formal peer support, and information exchange between CNOs must be addressed. The ad hoc nature of information sharing across the CNOs misses the opportunity to share experiences and gain support and inhibits the effective expansion of good practice and innovation. The current arrangements should be replaced by a formalised mechanism that facilitates support and information exchanges. CNOs should be supported in the development of qualifications and training for effective management and leadership.

Item	Recommendation
58	***Establish Assistant Chief Nursing Officer Roles*** There is evidence of ongoing difficulties in terms of Chief Nursing Officers being conflicted in the division of time and labour between management and clinical support. One element of this conflict was identified when CNOs are actively encouraged to prioritise management commitments, at a time when they identify a requirement for them to provide clinical support to the team. In addition, when a CNO is on leave, their management duties are typically not allocated to other members of the team, and no deputising cover is provided. CNOs and their nursing teams, at a majority of prisons, will benefit greatly from the establishment of a Deputy CNO as a bridge between the two areas of responsibility. A Deputy CNO may provide a significant resource to support effective communication pathways, and the professional development of the nursing team.
59	***Review Detailing Arrangements for IPS Healthcare Staff*** There is a requirement to address the challenges associated with changes to detailing arrangements for staff within the IPS health function. Although there is evidence of flexibility in a small number of prisons, the current rigid practices of detailing, typically presenting challenges during times of resource constraints and high demand in other areas, can result in a lack of discipline officer availability for health professionals to deliver care to prisoners. It was consistently reported that in many prisons, detailing discipline officers to healthcare is perceived to be a low priority, resulting in the loss of clinical engagement. A change to the protocols and practices is needed, with leadership and management required from senior levels, to ensure that health detailing is established as a priory area.

10.6 Infection Control

The National Infection Control Team (NICT) within the IPS advises on the prevention, surveillance, investigation and control of infection in all areas where IPS staff and detainees attend, reside and work. Whilst its role preceded the Covid-19 pandemic, the NICT played a vital role in creating and maintaining a safe environment for detainees, visitors, staff and external agencies since the emergence of the Coronavirus in late 2019, and undertook extensive preparatory work to minimise the impact of the pandemic on the IPS.

Item	Recommendation
60	***Maintenance of Infection Control Vigilance*** Although (at the time of writing) the impact of Covid-19 has reduced and public health restrictions have been relaxed, it is essential that the IPS should maintain vigilance in this area. We therefore recommend the continuation of the National Infection Control Team, both in respect of monitoring and preparing for future outbreaks / new variants of Covid-19, to deal with other infectious diseases which are prevalent in prison settings such as Hepatitis-C and TB, and to undertake a wide range of other duties including HIQA compliance, education, policy development, etc.

11 Roadmap For Change

11.1 Preamble

The preceding sections of this report have set out 60 recommendations which we believe need to be given serious consideration by the Irish Prison Service as part of its efforts to strengthen prison healthcare services.

If the IPS accepts the recommendations Crowe will be presenting in this report, the need will arise to implement a substantial change management process covering a range of dimensions – not just those outlined earlier in this report, but many more involving such matters as standard operating procedures, realignment of care pathways, upgrading some aspects of service delivery, risk management, and others. All of this will come at a time when new GPs are being introduced into the IPS and are finding their feet. All of these changes will have to be managed and resources set aside to ensure the successful conclusion of the implementation programme over a 36 month period. (Some activities will be completed within the first half of this timeframe, whereas others will take longer and/or will be dependent on external factors, such as procurement timescales.)

An important point to note is that our recommendations are presented as part of an overall package with significant inter-dependencies. In our view, selective implementation of some recommendations but not others would detract from the integrated nature of the change programme and would lead to opportunities being missed.

The implementation of new structures for healthcare in the IPS will be a multi-annual programme of work which with a number of focussed strands. The approach to the transition plan is outlined in the following subsections. This is intended to provide an overall roadmap for the IPS, rather than a detailed description of all aspects of the work to be undertaken; further detail on the transition planning will need to be examined as part of the implementation process.

11.2 Principles of Transition

The transition process within IPS Healthcare Services should be informed by a number of principles:

1. ***Phased approach:*** as this process will involve implementation of 60 recommendations, it will be important for the IPS to plan its approach so that all aspects are deliverable and receive the correct level of resource and attention. Not every task can be run simultaneously, so the total body of work involved in the change process will need to be phased over the 36 month lifespan of the implementation project.

2. ***Mapped dependencies:*** the transition of these recommendations into an implemented and successful model for healthcare services will include the identification of key dependencies and relationships within IPS healthcare, with other parts of the IPS, and with external agencies and other stakeholders.

3. ***Transition early, then transform:*** creating the Directorate of Health, Wellbeing, and Psychology Services, and putting in place the resources required, will require the IPS

to plan and enable the transition to the new model and look to transform once the new Directorate has been created.

4. ***Transformation Plan:*** a clear, multi-year transformation plan will need to be developed, to be implemented after the completion of the initial transition to the new Directorate.
5. ***Project Management / Leadership:*** Given the scale of change required in implementing 60 recommendations over a 36 month timeframe, effective and dedicated project management resources will need to be in place, with a suitable project governance structure established (e.g. a Project Steering Board), including oversight by the IPS Director-General. The structure, constituent parts, and lines of responsibility of a project steering group will need to be defined and agreed in advance of the change management initiative being realised.
6. ***Staff resources:*** the IPS will not be able to implement the 60 recommendations in this report without augmenting resources. This will involve developing role descriptions, prioritising the filling of new posts, running the necessary recruitment competitions, identifying and implementing change management initiatives within the scope of the transition plan, etc.
7. ***Service delivery continuity through transition and transformation:*** while the delivery of healthcare services within the IPS will not be compromised as a result of the change management process, continuous improvement and progress should be made through transition and transformation
8. ***Consultation and engagement:*** all parties within the IPS – healthcare staff, Governors, senior management at HQ, discipline officers, other staff, and prisoners – will be made aware of the plan for transition and transformation and what it means for them.
9. ***Continuing analysis and evaluation:*** the process of change will be kept under continuing review by the Project Steering Board, including a formal evaluation of progress every 12 months, with any necessary modifications being taken based upon evidence and feedback. Organisational change is a dynamic process which has to be capable of responding to changes in the external environment (e.g. new legislation, policy directives, regulatory issues, etc.) and the IPS must ensure that its implementation approach is sufficiently flexible to deal with such matters as they arise, whilst also ensuring that the ongoing evaluation of the initiative undertakes forward "horizon-scanning" to identify future influences.

11.3 Overview of the Transition Process

11.3.1 Overview

The proposed timeline for the Transition Plan involves preparatory work in the first half of 2022, with the majority of the implementation work continuing over a period of up to 36 months (i.e. concluding in mid-2025), although it would be expected that the vast majority of implementation actions will have been achieved during the two-year period covering late 2022, 2023 and the first half of 2024. The plan is comprised of three phases, each composed of specific tasks and activities. As well as the principles of transition outlined above, it is important to note that collaboration, collegiality and a mission focus are critical success factors for executing the transition plan.

The three phases are:

- Phase 1: Report Finalisation;
- Phase 2: Detailed Implementation Planning;
- Phase 3: Implementation.

The overall Transition Plan is illustrated graphically below, and a short description provided of each component of the work involved:

IPS Healthcare Transition Plan (Outline)

Activity	2022				2023				2024				2025	
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
	J F M	A M J	J A S	O N D	J F M	A M J	J A S	O N D	J F M	A M J	J A S	O N D	J F M	A M J
Phase 1 Report Finalisation:														
Complete and sign-off IPS-wide Report														
Complete and sign-off 12 Individual Prison Reports														
Socialisation of report findings within IPS														
Phase 2 Detailed Implementation Planning:														
Design of Directorate of Health, Wellbeing and Psychology Services														
Establishment of Clinical and Executive Governance Model														
Detailed Implementation Planning														
Establishment of Project Governance / Management Arrangements														
Phase 3 Implementation:														
Detailed workforce planning														
Recruitment of new staff														
Change Management														
Service Redesign - Processes / Workflow														
Information / Technology														
Clinical Governance														
Local Service Improvements, Infrastructure Investments etc														
Evaluation / Appraisal of New Model for Healthcare Service Delivery														

11.3.2 Phase 1: Report Finalisation

The first phase involves completion of the HNA reporting process, with sign-off of this IPS-wide report and the 12 individual prison reports, and socialisation of the findings and recommendations contained in this report across the IPS.

11.3.3 Phase 2: Detailed Implementation Planning

Phase 2 represents a focused body of work to be undertaken within a three-month period, from April to June 2022. This will involve detailed design of the new Directorate of Health, Wellbeing, and Psychology Services, along with development of the detailed model for both clinical and executive governance within the Directorate. The creation of a detailed implementation plan covering all 60 recommendations will also be required, setting out tasks / subtasks, deliverables, milestones, timescales, dependencies and resource requirements. Finally, it will also be necessary to establish an effective and dedicated project management structure (e.g. with a full-time project manager and support for the duration of the change programme), and an appropriate project governance arrangement (e.g. a Project Steering Board operating under PRINCE2 or another project management methodology).

11.3.4 *Phase 3: Implementation*

We foresee the implementation activity to commence in the second half of 2022, once the majority of the implementation planning work is complete. Some aspects may be able to make a prompt start, for example the detailed workforce planning and some elements of the recruitment process (e.g. for more senior posts within the Directorate of Health, Wellbeing, and Psychology Services, upon whom successful implementation of the recommendations in this report may depend).

Certain aspects of the overall programme of work would typically take longer and be of a more iterative nature – for example, change management activities involving culture, cohesion, team building and other tasks, or some of the service redesign activities involving review and refinement of processes and workflow.

An early start will need to be made on examining the information and technology aspects of IPS healthcare, particularly the proposed review of fitness for purpose of PHMS Clinical Governance, as the availability of reliable, timely and accurate service and performance information which is capable of analysis and reporting will be central to the success of many of the recommendations presented in this report.

We would expect the new clinical governance model to be established during 2022 and early 2023, and working effectively by the middle of 2023, with some refinements potentially required in the 12 months thereafter.

We have allowed 24 months for work on Local Service Improvements and Infrastructure Investments at individual prison level, although the relevant timescales will be subject to local constraints in respect of budgets, planning permission, procurement and other factors.

Finally, we recommend that a formal evaluation / appraisal of the proposed new model for healthcare service delivery in the IPS be undertaken annually, at a mid-year point in 2023, 2024 and (finally) 2025, and reported to the Project Steering Board and Director-General so that any refinements or change in approach can be made.

Annex I

Healthcare Needs Assessment of the Irish Prison Service: Evidence and Literature Review

Leeds Beckett University

School of Health and Community Studies

(report commissioned by Crowe as part of the HNA Project for the Irish Prison Service)

Healthcare Needs Assessment of the Irish Prison Service: Evidence and Literature Review

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1. Context and background

There are 12 institutions in the Irish Prison System consisting of 10 closed establishments and two open centres (1). There are approximately 3700 people in prison in Ireland, the majority of which (96.7%) are male. The imprisonment rate in Ireland is comparatively low, standing at 74 per 100,000 of the population (2).

The General Healthcare Study of the Irish Prisoner Population demonstrated that people in prison, compared to the general population, had lower levels of physical and mental health and had higher lifetime polydrug use, including higher levels of alcohol consumption and cigarette smoking. However, their diet was comparable and exercise patterns were better. In addition, the blood pressure readings of people in prison were lower than that of the general population (3).

One of core aims of the Irish Prison Service (IPS) are to provide prisoners with access to the same quality and range of health services as that available to those entitled to General Medical Scheme (GMS) services in the community. Priority is also given to the promotion of health through the positive intervention of staff (4). In Ireland, healthcare services in prisons, in the main, are provided by the IPS (5). This is in contrast to integrated systems adopted in Norway, France and the United Kingdom (UK) where prison medical care is contracted out to agencies equivalent to the Irish Health Services Executive (6).

Leeds Beckett University were commissioned to undertake a literature review and evidence synthesis to identify international evidence, interventions and good practice in health care service delivery in prisons and ascertain how this can be applied across the IPS estate. Specifically, the review focussed on three key objectives:

1. Review models of the provision of healthcare in other jurisdictions, focusing particularly on countries which have implemented recent changes in healthcare delivery.
2. Review recent trends and approaches in the delivery of prison healthcare, focusing particularly on mental health treatment; addiction; and communicable disease.
3. Review prisoners' rights to healthcare in other jurisdictions and focusing on the continuity of service delivery between prison and the community and between prisons themselves.

2. Methodology and approach

The identification of evidence will focus on readily available research published in journals in the UK and internationally. A Research Assistant searched six electronic databases for studies published between January 2009 to the present day. Databases included: MEDLINE; CINAHL; PsycLIT; The Cochrane Database of Systematic Reviews; CENTRAL; DARE. Websites of relevant organisations were also searched for grey literature.

3. Findings

This section organises the findings from the review against the main objectives.

3.1. Models of prison healthcare delivery

This section reviews models of the provision of healthcare in a range of jurisdictions, focusing on the key debates and evidence and highlighting countries which have implemented recent changes in healthcare delivery.

3.1.1. Context

When a state deprives individuals of their liberty, it takes on the mandate to oversee their welfare. People in prison have no choice but to rely on the state to protect and promote their health (7). In recent years, several Member States in the WHO European Region have transferred the responsibility for prison health to their health ministry, though integrating prison health into national health systems has proven to be a long and sometimes challenging process. For example, in England and Wales the process was started in 2000 and was not completed until 2006 (8).

Successful transition requires governmental commitment and support from across all levels of management in the prison and health care authorities (9). Transferring responsibility for health care from the ministry of justice to the health ministry requires careful planning and consideration of the risks as well as budgetary negotiation. Evidence shows that during implementation, there can be difficulties arising from disagreements between public health providers and penal institutions and sometimes insufficient coordination and co-operation (7).

3.1.2. Debates

KEY POINTS

Prison health and public health are recognised as interrelated.

No single model of health care governance exists.

Governance of a prison health care system by the Ministry of Justice or the Ministry of Health remains a subject of debate in a number of countries.

Prisons are settings in which the health needs of those from marginalised and disempowered groups can be addressed (10). This has the potential to improve individual health outcomes and lessen health inequalities and improve health equity. The opportunities for prisons to support those often most in need is apparent and indeed the wider impact this has for families and communities is an important secondary outcome. This is frequently why prison health and public health is seen as being intertwined.

There has been much debate recently about where prison healthcare should be located. Broadly speaking, whether healthcare should be the responsibility of health ministries or ministries of justice within countries. Much of this debate is underpinned by a series of arguments, including: impact on

the relational dynamics between staff and prisoners; practical discussions on budgetary responsibility and planning; and also ethical debates, i.e. whether healthcare staff employed by ministries of justice are compromised in maintaining patient confidentiality and more broadly in maintaining custody and security imperatives (11).

Strong arguments have been put forward by prison health commentators to have prison healthcare located firmly with health ministries (discussed later) given that fundamentally, this facilitates the transition for people between the prison and the community on release:

> *"Although prisons are likely perceived as a small component of the mandate of health ministries, their continuing responsibility for the health of individuals after their release provides a structural incentive to invest in prison health."* (11: 305)

Of course, contrary arguments propose healthcare to be located with ministries of justice. Some suggest that the separation is unhelpful and moreover by prison healthcare being located in ministries of justice, it ensures that health leaders have a prominent role in prison management (8). Other points include cultural and organisational harmony and a greater sense of professional pride that could be fostered as a result of prison healthcare being located in ministries of justice:

> *"'Outsider' health staff could be seen as 'visitors' and outside the cohesive management of prisons. It is possible for a Ministry of Justice to take a special pride in their health services, to provide extra resources and to attempt to attract the best staff, who could be enabled and encouraged to maintain their professional links while developing their unique role."* (8: 6)

3.1.3. Current evidence

KEY POINTS

Despite WHO guidance on health care provision there is variation in policy and practice of prison health care across Europe.

There is limited evidence in relation to the impact of any model of prison health care governance on health outcomes.

Prison healthcare governance varies from country-to-country. Several mapping exercises and scoping reviews have sought to understand how prison healthcare governance operates based on data gathering processes at regional levels. Much of the analysis has focused on Europe as policy and practice in prison health governance has been more forthcoming here than for other continents (12).

Pont and Harding (7) conducted a survey of 34 member states. They concluded that the separation of health care budgets from prison budgets at institutional and central administration level is strongly recommended in order to facilitate a better management of the health care needs. This would prevent any health budget being absorbed by other prison-related financial demands.

Recent descriptive analysis has mapped the current situation across Europe in regard to prison healthcare governance and management (see Table 1). Data show significant variability (13), but do show trends and patterns of healthcare organisation. In some jurisdictions, this may indicate shared responsibility; in others, however, it may reflect a transition period or arrangement between devolving responsibilities (11).

Table 1: European prison healthcare governance.

Authority for, and administration of, prison health care budgets governed by the Ministry of Health.	Responsibility for prison health care services shared between the Ministry of Health and the Ministry of Justice, Ministry of the Interior or the Health Care Department of the prison system.
Cyprus Finland France Italy Norway Slovenia United Kingdom	Albania Armenia Czechia Denmark Iceland Lithuania Malta Slovakia Spain Switzerland

The WHO's (13) interpretation of the current evidence is that jurisdictions have generally not followed the WHO guidance which advocates that governance arrangements sit within ministries of health. This assessment was largely supported by the Council of Europe (7) who noted that in most European countries the provision of health care in prisons is under the responsibility of the Ministry of Justice and the medical services are organised by the prison administration.

The WHO demonstrated that across Europe, the Ministry of Justice was the most common authority across *all indicators* regarding health care responsibilities:

- The Ministry of Justice was the authority most frequently holding responsibility for health-care service authority, administration of the health-care service budget and health-care service funding.
- Fewer than 50% of countries reported the Ministry of Health or other health-care authorities as being responsible for the assessment of prison health systems.
- Fewer than 60% of countries reported the Ministry of Health or other public health authorities as being responsible for the inspection of hygiene, nutrition and living conditions.

Based on this data, WHO were somewhat unequivocal in their view of arrangements in Europe suggesting:

> *"The lack of involvement of the Ministry of Health and other public health authorities in essential components of public health governance raises questions about the interface between prison health systems and larger public health systems in these countries, and what*

specific arrangements are in place across countries in which the Ministry of Health does not serve this role." (13: 20)

Although it was once hypothesised that prison healthcare being part of the public health service could bring improvements in delivery of healthcare to prisoners (14), the evidence is surprisingly limited in relation to the impact of various governance arrangements on health outcomes (11). There is currently no quantitative evidence linking governance arrangements and quality of healthcare or impact on individual health outcomes. A mixed-method study based on the transition of prison health services to the NHS in England and Wales concluded:

> *"The overall finding from the review was that English prison healthcare had undergone "transformation" during the ten-year period of NHS commissioning. This has led to increased quality of care through significant improvements in organisational engagement, professionalisation of the healthcare workforce, transparency, use of evidence-based guidance and responsiveness of services."* (15: 145)

The research demonstrated that there had been significant improvements in the quality of healthcare in prison settings, but highlighted areas for further improvement. These were (16):

- The relationship between the prison regime and healthcare – particularly how prison staffing levels and security/operational issues could constrain prisoner access to healthcare.
- Better links between the prison and community to support health outcomes.
- The quality of healthcare data and intelligence.
- Stronger self-management, early intervention services and peer-led services.
- Understanding the prison healthcare workforce needs and demands.
- Resource allocation.
- Increasing the responsiveness of services (recognising that 'one-size fits all model' cannot work).

Our review suggests that, to date, there is no clear evidence of effectiveness of any healthcare governance arrangement, though this is perhaps due to methodological and practical challenges relating to such a research design.

3.1.4. Examples of current practice

Examples are provided which highlight the transfer of prison governance arrangements to ministries of health. These are not 'exemplars' but offer some insight for future consideration.

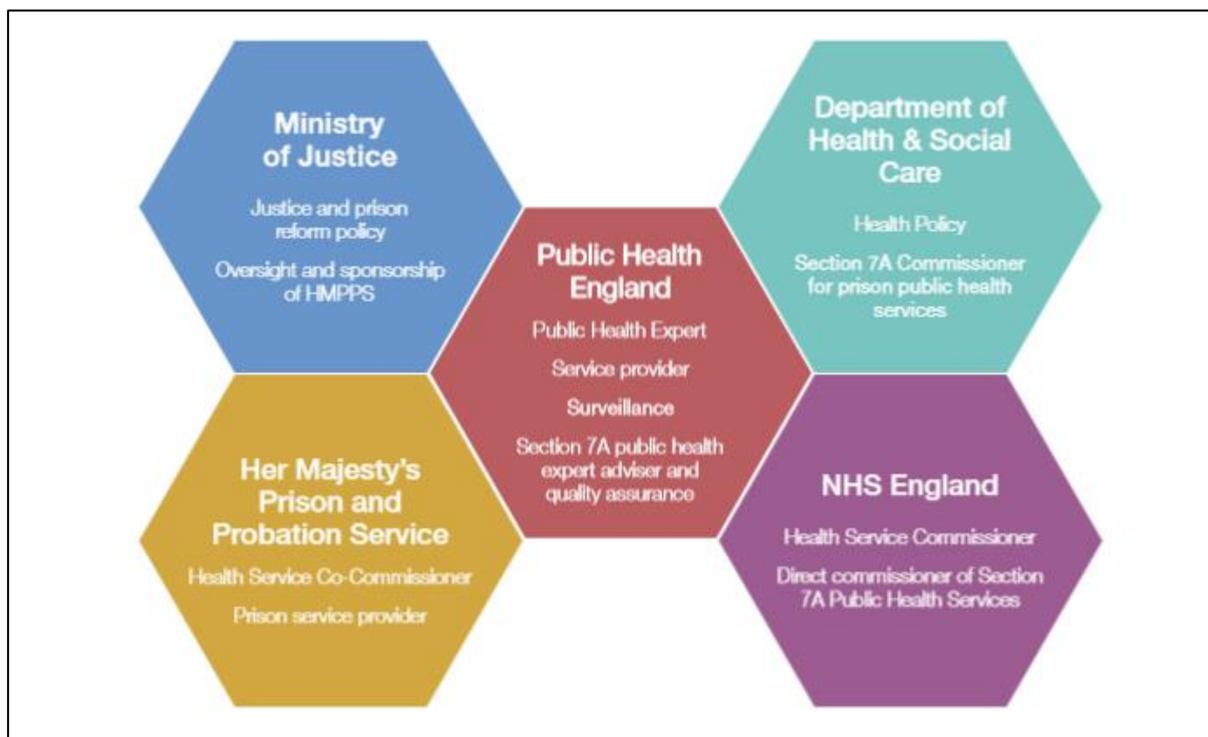
Finland

The rationale for the transfer of prison health from the Ministry of Justice to the Ministry of Health was to make improvements to health care management and quality of care and continuity of care on release from prison. This transition was completed and implemented from January 2016. Reflecting on the transition, the importance of detailed planning and organizational co-operation and ensuring that organisational roles and responsibilities were formally defined and agreed was deemed critical. In addition, staff having time to adapt to change and having mechanisms to be listened to by senior officials was valued (17).

England

Cited as an example of good practice for other European countries, the multiagency National Partnership Agreement for Prison Healthcare in England 2018–2021 is regarded as an effective collaboration. In 2018 the partnership between the Ministry of Justice, Her Majesty's Prison and Probation Service, Public Health England, the Department of Health and Social Care and NHS England was formalised (see Figure 1). The agreement aims to support the commissioning and delivery of health care in English prisons and has ten focused priority areas. The National Prison Healthcare Board has responsibility for the oversight and on-going management of this agreement and delivery of our shared objectives. Governance at establishment level is provided through the development and operation of Local Delivery Boards (LDBs), led by the Prison Governor/Director for Private Prisons and including providers of custody, healthcare, substance misuse and Local Authority leads for social care services. The work of LDBs should be underpinned by a Local Delivery Agreement to set out how partnership work is taken forward at a local level to support delivery. Organisational governance structures exist in each individual organisation, which will be used to ensure decisions that impact on organisational spending and delivery are signed off appropriately (17).

Figure 1. National Partnership Agreement for Prison Healthcare in England



Scotland

Over the last decade, healthcare in prisons in Scotland has seen a shift in its prioritisation, governance arrangements and structure. Aligned with international recommendations from WHO, the responsibility for prison healthcare services was, in 2011, transferred from the Scottish Prison Service (SPS) to the National Health Services (NHS) Scotland. The transfer followed on from recommendations of the Prison Healthcare Advisory Board (PHAB), set up by Scottish Ministers, which was established in 2007. In their report, the PHAB concluded that transferring prison healthcare services was feasible, with a key justification of equivalence of care in four key areas:

- tackling health inequalities among people who experience incarceration,
- facilitate continuity of care,
- create a sustainable service, and
- align with international recommendations and standards

Her Majesty's Chief Inspector of Prisons in Scotland supported the transfer from SPS to NHS Scotland. There were positive outcomes of the transfer including improved access to a wider range of clinical expertise. However, there was a lack of progress in the five years following transfer relating to funding allocation and resourcing (18). However, SPS are regarded exceptionally highly in their prevention agenda and health promotion policy and practice in prisons. For some time, the Scottish Prison Service has been recognised as adopting a progressive and innovative approach to health promotion in prisons (12). The reasons for this are multifaceted, but may relate to a political climate within Scotland that places emphasis on social justice as a core feature; a focus on collaboration and continuity of care between the prison system and community; and a less fragmented health care system (19). Despite this, Scotland have been at a 'cross-roads' in relation to how they seek to address and deliver health interventions in the prison setting (19) with evidence lacking in informing policy and practice decisions (20) and calls for more carefully planned health-promoting interventions in this environment (21).

Norway

Since the 1980s, local health authorities have responsibility for providing health care (22). Healthcare in Norway operates under a three tier system: the central government level; the regional level with 5 regions with responsibility for hospitals and specialist services and 432 municipal authorities to whom responsibility is decentralised. This arrangement was consolidated by the 1994 Health Care Act. Forty-two of these municipalities have a prison under their jurisdiction and are therefore responsible for providing healthcare to it (14).

3.2 Summary

This section has reviewed models of the provision of healthcare in a range of jurisdictions, focusing on the key debates and evidence, summarised in Table 2 below. Countries which have implemented recent changes in healthcare delivery were also highlighted. In short, there is no quantitative evidence which links health governance in prisons with health outcomes with people in prison. Most global health organisations advocate prison healthcare to be the responsibility of health ministries.

Table 2: Summary of potential benefits and limitations of transferring healthcare governance from the Ministry of Justice.

Benefits of transfer	Limitations of transfer
May improve continuity of healthcare in community on release. Provides a structural incentive to invest in prison health. The separation of healthcare budgets from prison budgets can facilitate better	May remove the role of health leaders in prison management. May result in negative impact on cultural and organisational harmony.

Benefits of transfer	Limitations of transfer
management of healthcare needs, and prevent monies being absorbed into other financial demands. Is compatible with WHO guidance that governance sits within ministries of health. Some evidence of improvements in healthcare delivery. May improve access to a wider range of clinical expertise.	May lose attractive and unique role for healthcare professionals within the prison service. Is not congruent with the governance arrangements in the majority of European countries. Transfer of responsibility for prison health can be a long and challenging process requiring commitment and support from all levels of management in the prison and healthcare authorities to ensure coordination and cooperation. Transfer of responsibility requires careful planning and consideration of risk. Transfer of responsibility requires budgetary negotiation and the handover of funding and resourcing can be slow. Limited evidence of improvements in healthcare delivery

4. Recent trends and approaches in prison healthcare

This section reports recent trends and approaches to the delivery of healthcare in relation to three main areas: mental health, addiction and communicable diseases. Other emerging areas are also described.

4.1. Mental health

The Council of Europe state that assessment and management of the mental health of prisoners is integral to the overall provision of prison healthcare. While the legislation operating in Europe warranted a transfer of prisoners with mental health concerns into the healthcare system, it was observed that there may still be mentally ill people held in prison.

The need for effective treatment and management of prisoners with mental health needs is linked to the concurrent physical health problems, substance misuse problems, histories of trauma, and wider social and psychological factors which continue to negatively impact on prisoners both in prison and after release (22). Furthermore, the mental health needs of different groups of prisoners such as women, older prisoners, children and young people, prisoners from minority ethnic or cultural groups and foreign prisoners, may need to be addressed differently, and may require more intensive intervention than in the wider community.

In 2016, there were 40,161 incidents of self harm recorded in prisons in England and Wales and 120 self-inflicted deaths (23). These were the highest numbers on record and are indicative of the need for health care services in prisons to be able address the mental health needs of prisoners.

Examples of current practice:

Finland: Screening for severe mental health disorders is carried out in all prisons though there is no diversion to mental health treatment following screening (see Appendix 1). Access to mental health support is available in all prisons though there are no national guidelines for the treatment of severe mental health disorders in prison (24).

France: Specially Adapted Hospital Units which operate as psychiatric institutions for treatment and detention of prisoners have been established. These operate through close co-operation with the local psychiatric care system. Eighteen prisons in France are served by regional psychological health departments which work in the prison, undertaking diagnosis and follow up of mentally ill prisoners (25). Though equivalence of care is challenging this model provides an example of successful collaboration. While the unit is part of a public mental hospital and staffed by psychiatrists, nurses, psychologists and therapists employed by public psychiatric services with the same standards of care, perimeter security, entry/exit and visits are under the authority of the prison service (25). The psychiatric team also have a role of prevention and education with multidisciplinary teams working with first aid techniques and a peer suicide prevention programme (26). Appendix 1 shows that screening for severe mental health disorders is carried out in less than half of prisons with diversion to mental health treatment following screening. Access to mental health support is available in all prisons and there are national guidelines for the treatment of severe mental health disorders in prison (24).

Examples of current practice continued:

Netherlands: Penitentiary Psychiatric Centres provide 620 places for psychiatric care within prison. The frontline staff are prison officers with two years of training in care for psychiatric patients (7). There are 12 hospitals where prisoners are transferred at the end of their sentence if they are considered too dangerous to be released into society. Their mental health in relation to being released is assessed every two years and after six years an independent court report is prepared to inform any extension to their hospitalisation (26). Appendix 1 shows that screening for severe mental health disorders is carried out in all prisons and there is diversion to mental health treatment following screening in all prisons. Access to mental health support is available in all prisons and there are national guidelines for the treatment of severe mental health disorders in prison (24).

Norway: Appendix 1 shows that screening for severe mental health disorders is carried out in all prisons though there is no diversion to mental health treatment following screening. Access to mental health support is available in all prisons and there are national guidelines for the treatment of severe mental health disorders in prison (24).

Portugal: The prison service has a psychiatric and mental health clinic where mentally ill prisoners are detained. Prisoners whose behaviour indicates mentally illness can also be kept in two psychiatric annexes for observation if their treatment does not last longer than six months (25). Appendix 1 shows that screening for severe mental health disorders is not carried out in prisons and access to mental health support is available in more than half of prisons. There are national guidelines for the treatment of severe mental health disorders in prison (24).

United Kingdom and Northern Ireland: Appendix 1 shows that screening for severe mental health disorders is carried out in all prisons with diversion to mental health treatment following screening. Access to mental health support is available in all prisons and there are national guidelines for the treatment of severe mental health disorders in prison (24).

4.1.1. Recommendations for the provision of mental healthcare

All prisoners should be **screened** on entry to prison for a range of mental health and related problems, particularly where there is a risk of suicide (22). However, in England and Wales the screening process undertaken during reception into prison contains questions about suicide and self harm which are optional and data was not entered in relation to risk of suicide in 68% of the screening records and 59% in relation to the risk of self harm (23). Subsequent opportunities to identify mental health needs should therefore also be provided as vulnerable prisoners may develop depression and anxiety and increase the risk of self harm or suicide (7).

NICE guidance published in 2017 establishes evidence based principles for assessment and management, coordinated care planning, and service organisation within the criminal justice system (27). First stage health assessments combining physical and mental health on intake are recommended (see Appendix 2). These also addresses self-harm and suicide risk where it is

recommended that people at risk of suicide or self-harm are referred for an urgent mental health assessment to the mental health in-reach team and an Assessment, Care in Custody and Teamwork (ACCT) plan opened where necessary.

The ACCT plan requires that certain actions are undertaken to reduce the risk of suicide such as talking to the prisoner and completing and Immediate Action Plan within one hour of the ACCT to ensure the individuals safety. Within 24 hours further actions such as trained assessor's interview and a multidisciplinary case review meeting should also be held. The ACCT policy and process were reviewed in 2015 and recommendations for improvements were made to improve compliance and care and support of prisoners (28).

NICE (27) also recommend second stage health assessments using the Correctional Mental Health Screen for Men (CMHS-M) or women (CMHS-W) as a validated tool to assess current and lifetime indications of serious mental disorder (29).

Prisons should commit to improving the mental health and well-being of prisoners through **appropriate assessment, treatment, and transfer of care (27)**. This may be particularly relevant for those prisoners with protected characteristics. The evaluation of prisoners requires the deployment of staff within the institution with the training and skills to perform this (25).

While all staff working in prisons should have an appropriate level of **mental health awareness training** (22), and indeed prison officers have a responsibility to identify prisoners with mental health needs (23), It is often the case that the basic training provided to prison officers in detecting and managing poor mental health in prisoners is not adequate and rarely updated (23). In a review of inspection reports for a 42 prisons in England and Wales Glorney et al. (30) reported that there was a recognised need for further staff training in the ACCT process and that failure to apply this process consistently may have contributed to incidents of self harm.

NICE guidance includes the recommendation for all staff working in the criminal justice system who provide care or supervision to have a comprehensive induction covering protocols for dealing with mental health problems along with education covering issues such as the stigma associated with mental health problems (27).

Training, as part of continuing professional development, should be provided covering the prevalence of mental health problems, the main features of commonly occurring conditions and how to recognise and respond to mental health problems in the criminal justice system. Support and supervision should also be given to staff so they can manage and de-escalate incidents, recognise, assess, and manage behaviours as well as understand how best to protect their own mental wellbeing (27).

Access to a psychiatric unit either within the prison or in the community may be necessary for prisoners with severe or acute needs (22). Ambulatory mental health care should be provided by a **multidisciplinary team** of psychiatrists, mental health nurses, psychologists and psychotherapists with special programmes to reduce self-harm and anti-social behaviour (7). Prisons should have primary care physicians with the skills to detect mental disorders who are supported by psychiatrists and other mental health professionals as well as having access for prisoners to psychosocial support and psychotropic medication (7)

Continuity of care, the continuation of treatment received prior to incarceration and the handover of care to a community based provider on release, is essential (22). Adults in the criminal justice system who experience mental health problems should have a care plan in place which is shared across all relevant services both inside the criminal justice system, for example when transferring to another prison or outside of the criminal justice system. This will ensure they continue to receive the treatment and support they require (27, 31). This care plan should identify the individual's needs and a means to progress towards them and identify the roles and responsibilities of practitioners involved with them. A risk management plan and crisis plan should be included if necessary (27).

When transferring within the criminal justice system any risk management plan should take an individualised approach to changes in risk level and set out interventions to reduce it. This risk management plan should take into account all legal and statutory responsibilities and be implemented in line with protocols to safeguard the individual particularly if they are at risk of self harm. It should be shared with the person and all other relevant parties and be reviewed by the receiving service (27, 31).

Where possible, prison medical services should collaborate with community mental health services to identify individuals already receiving psychotropic medication prior to imprisonment, patients on maintenance therapy for substance abuse and persons out of contact with community mental health services but known to have mental health problems. Any psychotropic medications available in the community and required by a prisoner should be available without cost to the prisoner (7).

Peer mentors are a useful addition to the health care model and can provide support for prisoners to reconnect with health services and improve their quality of life and social functioning both inside the prison and on release (22).

More broadly, in order for mental health services to adequately address the needs of prisoners the ministries and departments responsible for overseeing and delivering healthcare should ensure they **fully understand the needs of prisoners** and the scale of the challenge. This could be ascertained from a combination of screening, referrals and linkages to primary care health records (23). There should also be data sharing agreements in place and joint care planning between community and prison health services for smooth transitions and unnecessary assessments (27).

4.2. Addiction

Achieving abstinence from the drug (or drugs) on which prisoners are dependent is the goal of a drug treatment plan in prison. This can reduce both drug use and rates of re-offending. Drug dependence is long term and characterised by attempts at stabilisation followed by relapse and requiring ongoing care and support including diagnosis and treatment planning. Drug services in prison typically incorporate assessment, prevention, counselling, abstinence oriented and medication-assisted treatment, self-help groups and peer-driven interventions, harm-reduction measures and pre-release and aftercare programmes. While capacity to respond to the health needs of drug users is often lacking in prison, time in prison provides an opportunity to intervene with drug users (22).

The Lisbon Agenda for Prisons (32) states that successful in-prison treatment 'helps inmates to continue treatment after release, reduce relapse rates and related health risks, and also reduce delinquency recidivism'. There is recognition that a commitment to reducing the impact of addiction and resultant harms is needed (33) and as such, drug related interventions and harm reduction programmes are available in prisons across Europe with a particular focus on the prevention of infection from injection. However, the implementation of guidance on blood borne infection is behind that in the community and level of coverage is low (13).

Examples of current practice:

Finland: Drug treatment services in prisons are guided by service guidelines which emphasise equivalence with community services**.** Substance use rehabilitation is provided by trained personnel (34). Appendix 1 shows that drug free units are available in all prisons and screening for illicit drug use is mandatory in prisons for certain subgroups of prisoner. Both sentenced and prisoners on pre-trial detention are able to access and maintain opioid substitution therapy. Detoxification treatment with or without opioid agonist is available along with other psychosocial treatments. Mutual support and self help treatment are not available and there are no national guidelines on the prevention of post release drug related death (24).

France: Treatment of drug dependency in prison is based on a three tier system**:** (i) prison-based hospital healthcare units which monitor the physical health of prisoners; (ii) regional medico-psychological hospital services which manage the mental health aspects of drug use and (iii) care support and prevention centres located in 162 prisons which offer support relating to drug dependency to over half the prison population (34). Appendix 1 shows that drug free units are not available and screening for illicit drug use is not mandatory in prisons. Both sentenced and prisoners on pre-trial detention are able to access and maintain opioid substitution therapy. Detoxification treatment with opioid agonist is available along with mutual support and self-help treatment though other psychosocial treatments are not available. There are national guidelines on the prevention of post release drug related death (24).

Examples of current practice continued:

Netherlands: Prisoners are screened for dependency issues and are referred to treatment services. Prison staff receive training relating to substances and dependencies with a named contact within every prison for drug dependency. Prisons have improved relationships with regular addiction care and the use of community services is promoted (34). Appendix 1 shows that drug free units are not available and screening for illicit drug use is not mandatory. Both sentenced and prisoners on pre-trial detention are able to access and maintain opioid substitution therapy. Detoxification treatment with opioid agonist is available. Mutual support and self help and other psycho social treatments are not available. There are national guidelines on the prevention of post release drug related death (24).

Norway: External providers are responsible for the provision of drug treatment services within the prison system and more than half of the healthcare staff working in prisons have been trained on drug and alcohol related problems with 13 units also established within the prison system for addressing these (34). Appendix 1 shows that both sentenced and prisoners on pre-trial detention are able to access and maintain opioid substitution therapy. Detoxification treatment with or without opioid agonist is available, along with other psychosocial treatments. Mutual support and self help treatment are not available. There are national guidelines on the prevention of post release drug related death (24).

Portugal: There are open centres for young drug addicts with a number of psychiatrists, psychologists, and general practitioners (25) and two types of interventions are available within prisons: abstinence programmes and medication-assisted treatment programmes (34) Appendix 1 shows that drug free units are available in less than half of prisons and screening for illicit drug use is not mandatory in prisons. Both sentenced and prisoners on pre-trial detention are able to access and maintain opioid substitution therapy. Detoxification treatment with or without opioid agonist is available, along with mutual support and self help treatment and other psychosocial treatments. There are national guidelines on the prevention of post release drug related death (24).

United Kingdom and Northern Ireland: Treatment and recovery of prisoners with substance abuse problems are managed by the three separate administrations and in England there was a pilot project for a 'drug recovery prison' launched in 2017 and drug recovery units have been piloted in England, Wales and Northern Ireland (34). The Integrated Drug Treatment System in England provides generalised access to substitution treatment, particularly the provision of opioid substitution treatment, and the bringing together of two treatment services: psychosocial (counselling, assessment, referral, advice and through care) and clinical misuse management (detoxification services). Wide scale training of staff providing the necessary skills and knowledge around the integrated treatment system was also undertaken (22).

Examples of current practice continued:

United Kingdom and Northern Ireland: Appendix 1 shows that drug free units are available in less than half of prisons and screening for illicit drug use is not mandatory in prisons. Both sentenced and prisoners on pre-trial detention are able to access and maintain opioid substitution therapy. Detoxification treatment with or without opioid agonist are available, along with mutual support and self-help treatment and other psychosocial treatments. There are national guidelines on the prevention of post release drug related death (24).

4.2.1. Recommendations for the provision of addiction services

Enggist et al. (22) provide recommendations for the provision of addition services in prison. These state that intervention and treatment strategies in prison should be in line with a national drug strategy with **equivalence between services inside and outside prison**.

Pharmacological and psychosocial as well as other supportive "wraparound" interventions with a comprehensive range of services which meet the needs of drug-dependent prisoners are critical for effective services. Abstinence or at least a reduction in harmful drug use through self-help should be encouraged through:

- Counselling on drug-related issues by prison staff or specialized personnel
- Housing for drug-using prisoners in specialized units with a treatment approach and multidisciplinary staff
- Provision of printed and audiovisual material in different languages, with the involvement of prisoners and external counselling agencies in its production.

In order to have the greatest chance of effectiveness, the therapy should take into account the wishes and views of the prisoner, provide intensive psychosocial support, be provided at the right time and dose and be available continuously throughout imprisonment and on release(22).

The **structured therapeutic community approach** aims to teach new behaviour, attitudes and values, reinforced through peer and therapeutic community support. It is available for adult prisoners with a medium or high risk of reconviction and level of dependence on drugs (22). A systematic review comparing drug treatment programmes (therapeutic communities, counselling, narcotic maintenance programmes and boot camps) conducted by Mitchell et al. (35) found that therapeutic community programmes were the only programme to show a modest reduction in recidivism and drug relapse

Abstinence-oriented treatment provided in therapeutic communities for prisoners with a history of severe drug dependence and related offending who have a minimum of 12–15 months of their sentence left to serve is recommended. The drug-free environment and intensive treatment approach requires 24-hour residential care and comprehensive rehabilitation services. Residents are expected to take from 3 to 12 months to complete the programme (22). However, Werb et al. (36)

caution that any abstinence based programmes should not be compulsory as this gives rise to the risk of human rights abuses, rather, a voluntary programme should be implemented.

Drug-free units or wings or contract treatment units aim to allow prisoners to keep a distance from the prison drug scene and to provide a space to work on dependence related problems though they do not necessarily include a treatment element (22).

Peer support or peer education can facilitate reduction in risk via the 12-step approach based on social learning. New group members are given instruction on ways to lead a drug-free life by more established prisoners. The programmes are high intensity for highly dependent prisoners, regardless of the specific drug and may last for 15 to 18 weeks (22). In a systematic review of peer-delivered recovery support services in the United States Bassuk et al. (37) reported that peer support had a positive effect on substance use outcomes, though the quality of the evidence included in the review was limited with few studies reporting results against either a comparison group or against the outcomes of no treatment.

Opioid substitution therapy is effective for opioid dependence and the prevention of HIV and hepatitis C infection. In a 'review of reviews' Sumnall et al. (38) found moderate quality evidence that opioid substitution therapy was effective at reducing heroin use in prison and after release and that there is a dose response relationship. Opioid agonist treatment is considered the gold standard treatment but is often overlooked in favour of an abstinence only approach (39). In a systematic review of opioid-related treatments and interventions, Malta et al. (39) found that prisoners treated with an opioid agonist had higher adherence to the treatment, lower rates of relapse and were less likely to be re-incarcerated. They were also less likely to experience a post-release overdose fatality.

Where it is acknowledged that prisoners may not be able to abstain from drug use then the potential for harm to both the individual and wider society should be lowered through the provision of **harm reduction programmes**. These include the provision of disinfectants to reduce the risk of transmission of blood borne viruses and needle and syringe exchanges alongside support for the individual to stabilise their condition and move towards becoming drug free (22). There is some low quality evidence that the distribution of injecting equipment in prisons can reduce blood-borne virus incidence (38). In an overview of harm reduction services in seven European countries Sander et al. (40) report that the provision of harm reduction programmes in prison is not equivalent to those provided in the community. In prisons, these services tend to be of a narrower range at not of the same quality as in those in the community. Where harm reduction programmes have been available in prison settings for some time better health outcomes have been observed.

4.3. Communicable diseases

Communicable diseases, including blood-borne viruses (BBVs), tuberculosis, influenza, measles, mumps and rubella, viral hepatitis, tetanus, diphtheria, and sexually transmitted infections (STIs) are all more common among people in prison than in the general population (18). They present an important problem within prisons as overcrowding, high risk behaviours or delays in diagnosis can result in higher prevalence within the prison population (22). If a prison system improves detection and management of infectious diseases it may help with the response to outbreaks both within the prison itself and in the wider community.

Examples of current practice:

Finland: Appendix 1 shows that HIV testing is available though not mandatory and screening for STIs is available in all prisons. Testing for hepatitis B and C is routinely offered though not mandatory and a full vaccination course against hepatitis B is offered to those prisoners who are eligible. Condoms are available in all prisons and are free of charge. Disinfectants for syringes, razors and tattoo equipment are available in more than half of prisons and are free of charge though needle or syringe exchanges are not available. Non supervised family or partner visits are available in all prisons (24).

France: Prisoners with HIV/AIDS get psychological support; psychotherapy and other forms of help. The Public Health Code provides for systematic screening for pulmonary tuberculosis on committal to prison. The Penal Code of Procedure specifies that the responsibility for screening lies with the regional councils. Whenever infectious tuberculosis is suspected the patient must be isolated and, if necessary hospitalised (25). Appendix 1 shows that HIV testing is available though not mandatory and screening for STIs is available in fewer than half of prisons. Testing for hepatitis B and C is routinely offered though not mandatory and a full vaccination course against hepatitis B is offered to those prisoners who are eligible. Condoms are available in more than half of prisons and are free of charge. Lubricants are available in less than half of prisons and are free of charge. Disinfectants for syringes, razors and tattoo equipment are available in more than half of prisons and are free of charge though needle or syringe exchanges are not available. Non supervised family or partner visits are available in fewer than half of prisons (24).

Netherlands: Information on the prevention of AIDS and other sexually transmitted diseases is available to prisoners and translated into several languages (25). Appendix 1 shows that HIV testing is available though not mandatory. Testing for hepatitis B and C is available though not mandatory and a full vaccination course against hepatitis B is offered to men who have sex with men. Needle or syringe exchanges are not available. Non supervised family or partner visits are available in less than half of prisons (24).

Examples of current practice continued:

Norway: Appendix 1 shows that HIV testing is available though not mandatory. Testing for hepatitis B and C is available though not mandatory and a full vaccination course against hepatitis B is offered to those prisoners who are at risk. Condoms are available in all prisons and are free of charge. Disinfectants for syringes, razors and tattoo equipment are available in more than half of prisons and are free of charge though needle or syringe exchanges are not available. Non supervised family or partner visits are available in more than half of prisons (24).

Portugal: Information about HIV infection risk behaviour and prevention is provided to all prisoners. Condoms are made available regularly (25).Appendix 1 shows that HIV testing is routinely available though not mandatory and screening for STIs is available in all prisons. Testing for hepatitis B and C is routinely offered though not mandatory and a full vaccination course against hepatitis B is offered to those prisoners who are eligible. Condoms are available in all prisons and are free of charge. Lubricants are not available in prisons. Disinfectants for syringes, razors and tattoo equipment are available in all prisons though needle or syringe exchanges are not. Non supervised family or partner visits are available in more than half of prisons (24).

United Kingdom and Northern Ireland: In England all prison staff have basic information about HIV/AIDS infection, risk behaviour, prevention, testing and treatment (25). Appendix 1 shows that HIV testing is routinely available though not mandatory and screening for STIs is available in all prisons. Testing for hepatitis B and C is routinely offered though not mandatory and a full vaccination course against hepatitis B is offered to those prisoners who are eligible. Condoms are available in all prisons and are free of charge. Lubricants are available in all prisons and are free of charge. Disinfectants for syringes, razors and tattoo equipment are available in all prisons though needle or syringe exchanges are not. Non supervised family or partner visits are not available in prisons (24).

4.3.1. Recommendations for the provision of communicable disease services

A first stage **health assessment** should be carried out by a trained health professional for every individual at first reception into prison. This should identify any issues that may have an immediate effect in the individual's health and safety along with priority health needs to be addressed (41). Appendix 2 contains an example of the tool used for this joint mental and physical health assessment. A second stage health assessment should be carried out within seven days of completion of the first stage assessment and include a comprehensive review of the individuals history with advice and discuss appropriate testing and care planning as appropriate (41, 42).

To address **HIV and hepatitis** guidelines and standard operating procedures should be developed by prisons in line with national and international guidelines on blood borne viral diseases as all preventative, curative and supportive interventions that are available in the community are feasible in the prison environment (22). All prisoners should be offered testing for hepatitis B, C and HIV on entry to prison and a hepatitis B vaccination made available. An evaluation of a nurse-led model of

care in the Australian prison system found that high numbers of prisoners could be assessed and treated safely for hepatitis C (43).

Annual HIV testing should be offered to men who have sex with men, people at risk of other sexually transmitted infections should be identified from their history and discussions with a trained practitioner arranged (41).

Prompt detection of **tuberculosis** should be ensured through screening within 48 hours of intake (41) and airborne infection control, including protective measures for prison staff, should be supplied. All suspected and confirmed cases should be reported to the local multidisciplinary TB team within one working day (41).Programmes to raise awareness of tuberculosis for both staff and prisoners should be provided (22).

A comprehensive vaccination programme should be put in place for measles, mumps, rubella, tetanus, diphtheria, and for **influenza**. Where this is not possible in the event of an influenza outbreak, quarantine and tracing of close contacts should be undertaken. There should also be direct links made with national crisis centres (22).

The European Centre for Disease Prevention and Control and the European Monitoring Centre for Drugs and Drug Addiction (34) suggest that **active case finding** is a key measure for the prevention and control of communicable diseases. In hepatitis B and C and HIV it is recommended for the institution to initiate testing o prevent transmission within the prison and between the prison population and the community at large though there was no evidence of effectiveness for any particular intervention aimed at increasing uptake. For sexually transmitted infections, testing initiated by the institution may have a higher uptake than voluntary testing though there is no clear evidence for which approach (risk based, age based or universal testing) promotes the greatest uptake. For tuberculosis active case finding is advisable through institution instigated universal testing at prison intake.

Implementation of a **prison health surveillance system** to monitor infectious diseases is recommended. This should be interrogated regularly depending on need and resources. This system should account for the demographics and size of the prison population as well as the physical environment within the prison (44).

The different staff teams which manage a prisoner’s care, including prison staff should communicate and share information, including medical records, in order to coordinate care particularly during periods of transit between settings. Those with complex health and social care needs should have a lead care coordinator responsible for overall management of their care (41).

For those entering prison with previously undiagnosed infections the medical examination on admission may present an opportunity for diagnosis and treatment. As part of the structured life within prison the opportunity for **health education and health promotion** should be taken up particularly in relation to disease prevention and harm reduction (7), and peer support and mentoring may be particularly useful (41).

4.4. Other emerging trends

As discussed, there are high levels of poor physical, mental and social health in the prison population compared with the general population (44) with health needs further impacted by factors within the prison environment such as the amount of time spent out of the cell engaging in purposeful activity, overcrowding or security concerns resulting in a lower priority for health concerns (16). The literature suggests that emerging trends in prison health care include:

- Prisoners with special needs: including appropriate assessment as part of the admissions procedure, and staff training to ensure they are able to respond effectively to those prisoners with special needs in an individualised way. Many older and overcrowded institutions may not be able to meet the needs of some prisoners who require specialist facilities (45).

- Older prisoners: The ageing prison population presents a challenge to service planners which will shift demand for health care for non communicable diseases (cardiovascular disease, cancer, chronic respiratory disease and diabetes) as well as physical disabilities (22, 44, 46). The improvement of outcomes for older people and those with serious illness are an area of increasing focus for policy makers so as to avoid the costly escalation of unplanned or emergency care (16) along with an increased demand for end of life care (44).

- Self harm and suicide: the rate of suicide in the prison population is higher than that in the general population and there is an increasing need for early prevention (18).

- Drug –related problems: the prevalence of drug use among those in prison is higher than people living in the community. Drug treatment and harm reduction is an area of increasing need (22) particularly in relation to the spread of new psychoactive substances inside prison (13).

- Intellectual disabilities: estimates suggest that the population of the criminal justice system may contain a higher prevalence of intellectual disabilities than the general population, many of which will lack a formal diagnosis The prison environment may create additional barriers for an individual with intellectual disabilities to access healthcare and there is significant risk that their health needs will not be met. Prisons should undertake a full screening for intellectual disabilities at reception using a recognised tool such as the Learning Disability Screening Questionnaire or the Hayes Ability Screening Index (63). Establishing whether an individual has capacity to make decisions must also be a first step, with every effort made to involve them in decision making even if a lack of capacity is established (63). Guidance highlights that while these disabilities should not be 'medicalised' in prison, the healthcare team should liaise with the Disability Liaison Officer or Equalities and Diversity Officer to identify support needs at each stage of the prison journey (64). Prison healthcare providers should also work with local community services through joint working practices to ensure access to expertise and high quality case management (65). A register of people with intellectual disabilities should be put in place to help manage communication between healthcare and prison staff (65) and a personalised Health Action Plan in an easy to understand format should be put in place. Reasonable adjustments to the

prison environment should also be implemented, particularly in relation to some or all forms of communication, and the 'Gold Standard' checklist used to ensure the provision high quality support within the healthcare service and across the whole prison (63).

4.5 Summary

This section has presented recent trends and approaches to the delivery of healthcare in relation to three main areas: mental health, addiction and communicable diseases. Practice was found to be varied across the jurisdictions reviewed and no single model of healthcare delivery was identified. For each area a range of evidence-based recommendations were reported. Other emerging areas were also described though evidence in relation to the COVID-19 pandemic was not included in this review.

5. Prisoners' healthcare rights

This section reviews prisoners' rights to healthcare in other jurisdictions focusing on the continuity of service delivery between prison and the community and between prisons themselves.

5.1. Context

International bodies such as the United Nations (UN) Human Rights Committee and the European Court of Human Rights have consistently provided assurances about the rights of people in prison, including the right to personal security and the right to be free of torture and ill treatment. Jurisdictions also have a mandate to provide access to adequate health services, including preventive services. International standards such as the UN's Mandela Rules and Bangkok Rules affirm the responsibility of the state to ensure that people who are incarcerated are provided health care that is, at a minimum, equivalent to that available in the community (known as the principle of equivalence) (11):

> *"The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status."* (47)

5.2. Rights to healthcare

KEY POINTS
Prison health care should be equivalent to that provided in the wider community.
Continuity of care after release is a critical factor in the health and wellbeing of prisoners.

The right of the imprisoned persons to health care is one of the basic principles of the Recommendation of the Committee of Ministers of the Council of Europe (7). Healthcare policy and healthcare integration between prison and the wider community should be compatible. According to WHO, health policy in custody should be integrated into, and compatible with, national health policy. To enable this, a prison health care service should be able to provide medical, psychiatric and dental treatment and to implement programmes of hygiene and preventive medicine in conditions comparable to those in the wider community. The prison therefore should have staffing consistent in technical and professional expertise to which exist in the outside environment. Moreover, facilities and equipment should be of the same, if not identical standard (9). The practical application of these principles have been elaborated in various international documents and through the process of reforms in structure, organisation and governance of prison health care services in several European jurisdictions (7).

Equivalence is a right-based framework. It recognises prisons as a microcosm of society with links to the general community as the logical consequence of the high throughput of prisoners from and back to the community (48). Though government policy for prison health is saturated with references to equivalence, this does not reflect the complexity and reality of delivering services in

the setting (46). Critics have deconstructed the notion of equivalence in prison health services and have argued that an equivalent health service is an *"insufficient public health response"* (49, p.276). These commentators argue that the inputs needed to generate equivalence of health outcomes in prisoners must be greater than those expected at a community level as research demonstrates that prisoners have poorer health than the general community (48, 50). Supporting this, Niveau (51) suggests that prison health services *cannot* be taken in a manner equivalent to those in the general population. He suggests that they must be directed in a more intense and precise approach and never fall short of community standards. Indeed, Lines (49) proposes that prison health services should move beyond the notion of equivalence and endorse standards that achieve equivalent objectives instead.

In some cases, however, the interpretation of 'equivalent' has been interpreted loosely and these standards have not been met. Even within countries, opinions are divided on the notion of equivalence with research suggesting that policymakers would require refreshed guidance (48). Some research suggests it is a matter of 'luck' as to whether healthcare equivalence is achieved, even in relatively wealthy European countries (52). Currently, there is no guidance on resource allocation and indeed out how equivalent care should be defined, measured or compared within the secure setting to that in the wider community (53). Within the literature, the lack of availability of dental care seems to be a prime example in some prisons where equivalence is not reached (7, 54) and also free choice in relation to who you treated by, e.g. doctor or physician (52). In Ireland, it is difficult to adopt the notion of equivalence of care as there are currently no Irish national standards for equipment in general practice surgeries. Evidence suggests that the type of medical equipment provided within the IPS appears to be below that normally available in the community and that the infrastructure in the older establishments within the IPS dates from Victorian or pre-Victorian times and is inadequate for the provision of good quality modern medical care (6).

5.2.1. Example of current practice

England

The notion of equivalence in prison healthcare seems to be well-developed in policy and practice. This is perhaps because the concept of equivalence was first introduced in 1999 in the Joint Prison Service and National Health Service Executive working group report on the future organisation of prison health care (55). The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population. The NHS provides a service to all and has a wider social duty to promote equality through the services it provides (53). However, research has shown how constrained and difficult access to equivalence is – rising prison numbers; shrinking resource allocation; health complications of the prison population; and the need to maintain security all jeopardises equivalent prison healthcare services (48). Other research has echoed challenges with equivalence in a range of European countries (45, 52).

5.3. Continuity of care

Caring for and advocating the health and well-being of prisoners, including making arrangements for continuity of care after release features in all relevant international rules on prison healthcare (9). It is arguably the most critical time in the offender healthcare journey as evidence shows that this transition can be challenging (56). Studies indicate that the transition from the prison back to the community is difficult and disordered, and in the USA has been described as 'deeply flawed' (57). Further, it has deleterious effects on health and well-being. For example, Binswanger et al. (58) demonstrated that during the first two weeks after release, the risk of death among former US prisoners was 12.7 times higher than community residents of the same age, sex, and race. Starker still, Farrell and Marsden's (59) research in England and Wales showed that male prisoners were 29 times more likely to die during the week following release compared to the general population. The cause of death soon after release from prison is often linked to drug overdoses and furthermore, on release from prison many men engage in other risky health-behaviours (e.g. hazardous alcohol consumption, unprotected sex) which potentially jeopardise their and others' health (60). These findings overall support the notion that the transition from the prison to the community is a health depleting episode (61).

The movement of people between prison facilities and communities and the overrepresentation of underserved populations in prisons make prison health a critical component of public health. This has been highlighted repeatedly by international standards. Promoting continuity between prison and community health care services is an essential part of providing adequate services and ensuring continuity of care. This is important for managing health conditions such as HIV or diabetes as well as for ongoing access to resources (11). However, challenges in continuity can be caused by a poor sharing of information between services (62).

6. Conclusions

This report sought to examine three salient research objectives for the delivery of healthcare services for prisoners. These were:

1. Review models of the provision of healthcare in other jurisdictions, focusing particularly on countries which have implemented recent changes in healthcare delivery.
2. Review recent trends and approaches in the delivery of prison healthcare, focusing particularly on mental health treatment; addiction; and communicable disease.
3. Review prisoners' rights to healthcare in other jurisdictions and focusing on the continuity of service delivery between prison and the community and between prisons themselves.

This report has outlined some of the key evidence in relation to these objectives, demonstrating variance in healthcare delivery across a range of jurisdictions. The report informs broader investigation and exploration of the needs of the IPS in relation to prison healthcare.

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8. Appendix 1

Summary table of the Health in Prison European Database (WHO, 2019).

	Ireland	Finland	France	Netherlands	Norway	Portugal	United Kingdom and Northern Ireland
Prison population – 2016:							
Occupancy level	89%	97%	114%	75%	Not applicable	114%	96%
Incarceration rate/100 000 population	77	55	100	53	Not applicable	139	143
<18yrs	0.3%	0.4%	1.1%	Not applicable	0.2%	0.3%	0.80%
>55yrs	6.8%	6.8%	No national data	Missing	2.0%	18.1%	Missing
BAME	10%	No national data	No national data	42.8%	No national data	No national data	23.9%
Sentenced	86.3%	81%	76.3%	No national data	70.9%	84.4%	85.7%
Male	96.4%	93.4%	96.5%	94.6%	93.8%	94.1%	95.5%
Prison health system - healthcare governance:							
Authority of prison healthcare system	Ministry of Justice	Ministry of Health / Public Health authorities	Ministry of Health / Public Health authorities	Ministry of Justice	Ministry of Health / Public Health authorities	Ministry of Justice	Ministry of Health / Public Health authorities
Administrative authority for healthcare budget	Healthcare department of prison system	Ministry of Health / Public Health authorities	Ministry of Health / Public Health authorities	Ministry of Justice	Ministry of Health / Public Health authorities	Ministry of Justice	Ministry of Health / Public Health authorities
Health services funding source	Ministry of Justice	State budget: Ministry of Health / Public Health authorities	State budget: Ministry of Health / Public Health authorities	Ministry of Justice	State budget	Ministry of Justice	State budget: Ministry of Health / Public Health authorities

	Ireland	Finland	France	Netherlands	Norway	Portugal	United Kingdom and Northern Ireland
National healthcare complaints service	Exists and available	Exists and available	Exists and available	Exists and available	Exists and available	Exists and available	Exists and available
Ministry of health or other with direct or indirect responsibility for:							
Authorisation of prison health services	No	Yes	Yes	No	Yes	Yes	Yes
Assessment of prison health services	No	Yes	Yes	No	Yes	Yes	Yes
Prevention of infectious diseases	No	Yes	Yes	No	Yes	No	Yes
Inspection of medical documentation	No	Yes	Yes	Yes	Yes	No	Yes
Inspection of prison hygiene, nutrition, living conditions	No	Yes	Yes	Yes	Yes	Yes	Yes
Prison healthcare workforce:							
Healthcare staff per 1,000 prisoners	42	61	49.9	No national data	36.3	8.6	Not applicable
Physicians per 1,000 prisoners	3.2	6.7	3.4	Not applicable	3.8	1	Not applicable
Pharmacists	<half of prisons	<half of prisons	>half of prisons	Not working in prisons	Not working in prisons	All prisons	All prisons
Dental hygienists / oral health promoters	Not working in prisons	All prisons	All prisons	All prisons	No national data	<half of prisons	>half of prisons
Prison environment and risk factors:							
Smoke free cells	All prisons	All prisons	All prisons	No	No national data	All prisons	All prisons

	Ireland	Finland	France	Netherlands	Norway	Portugal	United Kingdom and Northern Ireland
Drug free units available	No	All prisons	No	No	No national data	<half of prisons	>half of prisons
Meals produced in centralised kitchen	All prisons	>half of prisons	All prisons	All prisons	>half of prisons	All prisons	All prisons
Screening of illicit drug use	For subgroups	Mandatory for subgroups	Not mandatory	Not mandatory	No national data	Not mandatory	Not mandatory
Screening for harmful alcohol use	All prisons	All prisons	>half of prisons	All prisons	No national data	No	All prisons
Screening for severe mental health disorders	All prisons	All prisons	<half of prisons	All prisons	All prisons	No	All prisons
Disease screening on or close to reception:							
HIV testing	Available not mandatory	Not mandatory - routinely offered	Not mandatory - routinely offered	Available not mandatory	Available not mandatory	Not mandatory - routinely offered	Not mandatory - routinely offered
STI screening	All prisons	All prisons	<half of prisons	All prisons	No national data	All prisons	All prisons
Hepatitis B testing	Available not mandatory	Not mandatory - routinely offered	Not mandatory - routinely offered	Available not mandatory	Available not mandatory	Not mandatory - routinely offered	Not mandatory - routinely offered
Hepatitis C testing	Available not mandatory	Not mandatory - routinely offered	Not mandatory - routinely offered	Available not mandatory	Available not mandatory	Not mandatory - routinely offered	Not mandatory - routinely offered
Screening for oral health problem	Yes	No	<half of prisons	No	>half of prisons	All prisons	>half of prisons
Prevention of infection:							
Condoms available / free	No / N/A	All prisons / Yes	>half of prisons / Yes	All prisons / Yes	All prisons / Yes	All prisons / Yes	All prisons / Yes
Lubricants available / free	No / N/A	No national data	<half of prisons / Yes	No national data	No national data	No / NA	All prisons / Yes

	Ireland	Finland	France	Netherlands	Norway	Portugal	United Kingdom and Northern Ireland
Disinfectants for syringes, razors, tattoo equip / free	No / N/A	All prisons / Yes	>half of prisons / Yes	No national data	>half of prisons / Yes	All prisons / Yes	All prisons / Yes
Needle/syringe exchange	No / N/A	No	No	No	No	No	No
Non supervised family / partner visits	No / N/A	All prisons	<half of prisons	<half of prisons	>half of prisons	>half of prisons	No
Full vaccination course against hepatitis B	Offered to all those eligible	Offered to all those eligible	Offered to all those eligible	Other	Offered to at risk groups	Offered to all those eligible	Offered to all those eligible
Links between prison health system and community health system:	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Treatment for mental health and drug dependency:							
Access to mental health support	All prisons	All prisons	All prisons	All prisons	All prisons	>half of prisons	All prisons
Diversion to MH treatment following screening	All prisons	No	Yes	All prisons	No	NA	All prisons
National guidelines on treatment of severe MH disorders in prison	No	No	Yes	Yes	Yes	Yes	Yes
Prisoners for whom OST is available	Sentenced and pre-trial detention	Sentenced and pre-trial detention	Sentenced and pre-trial detention	Sentenced and pre-trial detention	Sentenced and pre-trial detention	Sentenced and pre-trial detention	Sentenced and pre-trial detention
OST maintenance available	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Detox with opioid agonist	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Detox without opioid agonist	Yes	Yes	No	No	Yes	Yes	Yes
Mutual support / self help	Yes	No	Yes	No	No	Yes	Yes
Other psychosocial treatment	No	Yes	No	No	Yes	Yes	Yes

	Ireland	Finland	France	Netherlands	Norway	Portugal	United Kingdom and Northern Ireland
National guidelines on prevention of post release drug related death:	Yes	No	Yes	Yes	Yes	Yes	Yes

Appendix 2:

NICE (2017) questions for first stage health assessment on reception into prison.

Topic questions	Yes/No	Actions
Prison sentence		
1. Has the person committed murder, manslaughter or another offence with a long sentence?	Yes	Refer the person for mental health assessment by the prison mental health in-reach team if necessary.
	No	Record no action needed.
Prescribed medicines		
2. Is the person taking any prescribed medicines (for example, insulin) or over-the-counter medicines (such as creams or drops)? If so: • what are they • what are they for • how do they take them?	Yes	Document any current medicines being taken and generate a medicine chart. Refer the person to the prescriber for appropriate medicines to be prescribed, to ensure continuity of medicines. If medicines are being taken, ensure that the next dose has been provided (see recommendations 1.7.10 and 1.7.11). Let the person know that medicines reconciliation will take place before the second-stage health assessment.
	No	Record no action needed.
Physical injuries		
3. Has the person received any physical injuries over the past few days, and if so: • what were they • how were they treated?	Yes	Assess severity of injury, any treatment received and record any significant head, abdominal injuries or fractures. Document any bruises or lacerations observed on a body map. In very severe cases, or after GP assessment, the person may need to be transferred to an external hospital. Liaise with prison staff to transfer the person to the hospital emergency department by ambulance. If the person has made any allegations of assault, record negative observations as well (for example, 'no physical evidence of injury').

	No	Record no action needed.
Other health conditions		
4. Does the person have any of the following: • allergies, asthma, diabetes, epilepsy or history of seizures • chest pain, heart disease • chronic obstructive pulmonary disease • tuberculosis, sickle cell disease • hepatitis B or C virus, HIV, other sexually transmitted infections • learning disabilities • neurodevelopmental disorders • physical disabilities?	**Ask about each condition listed.**	
	Yes	Make short notes on any details of the person's condition or management. For example, 'Asthma – on Ventolin 1 puff daily'. Make appointments with relevant clinics or specialist nurses if specific needs have been identified.
	No	Record no action needed.
5. Are there any other health problems the person is aware of that have not been reported?	Yes	Record the details and check with the person that no other physical health complaint has been overlooked.
	No	Record no action needed.
6. Are there any other concerns about the person's health?	Yes	Make a note of any other concerns about physical health. This should include any health-related observations about the person's physical appearance (for example, weight, pallor, jaundice, gait or frailty). Refer the person to the GP or relevant clinic.
	No	Note 'Nil'.
Additional questions for women		

<table>
<tr><td rowspan="2">7. Does the woman have reason to think she is pregnant, or would she like a pregnancy test?</td><td>Yes</td><td>If the woman is pregnant, refer to the GP and midwife.
If there is reason to think the woman is pregnant, or would like a pregnancy test: provide a pregnancy test. Record the outcome. If positive, make an appointment for the woman to see the GP and midwife.</td></tr>
<tr><td>No</td><td>Record response.</td></tr>
<tr><td colspan="3">Living arrangements, mobility and diet</td></tr>
<tr><td rowspan="2">8. Does the person need help to live independently?</td><td>Yes</td><td>Note any needs. Liaise with the prison disability lead in reception about:
• the location of the person’s cell
• further disability assessments the prison may need to carry out.</td></tr>
<tr><td>No</td><td>Record response.</td></tr>
<tr><td rowspan="2">9. Do they use any equipment or aids

(for example, walking stick, hearing aid, glasses, dentures, continence aids or stoma)?</td><td>Yes</td><td>Remind prison staff that all special equipment and aids the person uses should follow them from reception to their cell.</td></tr>
<tr><td>No</td><td>Record response.</td></tr>
<tr><td rowspan="2">10. Do they need a special medical diet?</td><td>Yes</td><td>Confirm the need for a special medical diet. Note the medical diet the person needs and send a request to catering. Refer to appropriate clinic for ongoing monitoring.</td></tr>
<tr><td>No</td><td>Record response.</td></tr>
<tr><td colspan="3">Past or future medical appointments</td></tr>
<tr><td rowspan="2">11. Has the person seen a doctor or other healthcare professional in the past few months?

If so, what was this for?</td><td>Yes</td><td>Note details of any recent medical contact. Arrange a contact letter to get further information from the person’s doctor or specialist clinic. Note any ongoing treatment the person needs and make appointments with relevant clinics, specialist nurses, GP or other healthcare staff.</td></tr>
<tr><td>No</td><td>Record no action needed.</td></tr>
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<tr><td rowspan="2">12. Does the person have any outstanding medical appointments?

If so, who are they with, and when?</td><td>Yes</td><td>Note future appointment dates. Ask healthcare administrative staff to manage these appointments or arrange for new dates and referral letters to be sent if the person’s current hospital is out of the local area.</td></tr>
<tr><td>No</td><td>Record no action needed.</td></tr>
<tr><td colspan="3">Alcohol and substance misuse</td></tr>
<tr><td rowspan="2">13. Does the person drink alcohol, and if so:
• how much do they normally drink?
• how much did they drink in the week before coming into custody?</td><td>Yes</td><td>Urgently refer the person to the GP or an alternative suitable healthcare professional if:
• they drink more than 15 units of alcohol daily or
• they are showing signs of withdrawal or
• they have been given medication for withdrawal in police or court cells.</td></tr>
<tr><td>No</td><td>Record response.</td></tr>
<tr><td rowspan="2">14. Has the person used street drugs in the last month? If so, how frequently?
When did they last use:
• heroin
• methadone
• benzodiazepines
• amphetamine
• cocaine or crack
• novel psychoactive substances
• cannabis
• anabolic steroids
• performance and image enhancing drugs?</td><td>Yes</td><td>Refer the person to substance misuse services if there are concerns about their immediate clinical management and they need immediate support.
Take into account whether:
• they have taken drugs intravenously
• they have a positive urine test for drugs
• their answers suggest that they use drugs more than once a week
• they have been given medication for withdrawal in police or court cells.
If the person has used intravenous drugs, check them for injection sites. Refer them to substance misuse services if there are concerns about their immediate clinical management and they need immediate support.</td></tr>
<tr><td>No</td><td>Record response.</td></tr>
<tr><td colspan="3">Problematic use of prescription medicines</td></tr>
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<table>
<tr><td rowspan="2">15. Has the person used prescription or over-the-counter medicines in the past month:
• that were not prescribed or recommended for them or
• for purposes or at doses that were not prescribed?
If so, what was the medicine and how did they use it (frequency and dose)?</td><td>Yes</td><td>Refer the person to substance misuse services if there are concerns about their immediate clinical management and they need immediate support.</td></tr>
<tr><td>No</td><td>Record response.</td></tr>
<tr><td colspan="3">Mental health</td></tr>
<tr><td rowspan="2">16. Has the person ever seen a healthcare professional or service about a mental health problem (including a psychiatrist, GP, psychologist, counsellor, community mental health services, alcohol or substance misuse services or learning disability services)?
If so, who did they see and what was the nature of the problem?</td><td>Yes</td><td>Refer the person for a mental health assessment if they have previously seen a mental health professional in any service setting.</td></tr>
<tr><td>No</td><td>Record response.</td></tr>
<tr><td rowspan="2">17. Has the person ever been admitted to a psychiatric hospital, and if so:
• when was their most recent discharge
• what is the name of the hospital
• what is the name of their consultant?</td><td>Yes</td><td>Yes: refer the person for a mental health assessment.</td></tr>
<tr><td>No</td><td>Record response.</td></tr>
<tr><td rowspan="2">18. Has the person ever been prescribed medicine for any mental health problems? If so:
• what was the medicine
• when did they receive it
• when did they take the last dose</td><td>Yes</td><td>Refer the person for a mental health assessment if they have taken medicine for mental health problems.</td></tr>
<tr><td>No</td><td>Record response</td></tr>
<tr><td>• what is the current dose (if they are still taking it)
• when did they stop taking it?</td><td></td><td></td></tr>
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<tr><th colspan="3">Self-harm and suicide risk</th></tr>
<tr><td rowspan="2">19. Is the person:
feeling hopeless or
currently thinking about or planning to harm themselves or attempt suicide?</td><td>Yes</td><td>Refer the person for an urgent mental health assessment. Open an Assessment, Care in Custody and Teamwork (ACCT) plan if:
there are serious concerns raised in response to questions about self-harm, including thoughts, intentions or plans, or observations (for example, the patient is very withdrawn or agitated) or
the person has a history of previous suicide attempts.
Be aware and record details of the impact of the sentence on the person, changes in legal status and first imprisonment, and the nature of the offence (for example, murder, manslaughter, offence against the person and sexual offences).</td></tr>
<tr><td>No</td><td>Record response.</td></tr>
<tr><td rowspan="2">20. Has the person ever tried to harm themselves, and if so:
do they have a history of suicide attempts
was this inside or outside prison
when was the most recent incident
what was the most serious incident?</td><td>Yes</td><td>Refer the person for a mental health assessment if they have ever tried to harm themselves.</td></tr>
<tr><td>No</td><td>Record response.</td></tr>
</table>