Focal Point Ireland: national report for 2016 - Prison

Health Research Board. Irish Focal Point to the European Monitoring Centre for Drugs and Drug Addiction

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Please use the following citation:
Health Research Board. Irish National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction (2017) ***Focal Point Ireland: national report for 2016 – prison***. Dublin: Health Research Board.

Other reports in this National report series can be found at
http://www.drugsandalcohol.ie/php/annual_report.php

(2017) *Focal Point Ireland: national report for 2016 – drug policy*.
(2017) *Focal Point* Ireland: national report for 2016 – treatment.
(2017) *Focal Point* Ireland: national report for 2016 – drug markets and crime.
(2017) *Focal Point Ireland: national report for 2016 – prevention*.
(2017) *Focal Point Ireland: national report for 2016 – legal framework*.
(2017) *Focal Point Ireland: national report for 2016 – harms and harms reduction.*
(2017) *Focal Point Ireland: national report for 2016 – drugs.*

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0. Summary

0.1 National profile

There are 14 institutions in the Irish prison system comprising 11 traditional 'closed' institutions, two open centres, which operate with minimal internal and perimeter security, and one 'semi-open' facility with traditional perimeter security but minimal internal security (the Training Unit). The majority of female prisoners are accommodated in the purpose-built Dóchas Centre adjacent to Mountjoy prison in Dublin and the remainder are located in a separate part of Limerick prison.

Political responsibility for the prison system in Ireland is vested in the Minister for Justice, Equality and Defence. The Irish Prison Service (IPS) operates as an executive agency within the Department of Justice, Equality and Defence. It is headed by a Director General supported by seven directors. The Office of the Inspector of Prisons is a statutory, independent office established to carry out regular inspections of the 14 prisons and to report to the Minister for Justice, Equality and Defence. Four policy documents have a particular bearing on the provision of drug-related healthcare in the Irish prison system – the IPS policy and strategy document, Keeping drugs out of prisons, and the National Drugs Strategy (interim) 2009–2016, the IPS three-year strategic plan 2012–2015, and the joint IPS–Probation Service strategic plan 2015–2017.

One of the key benchmark criteria relevant to the treatment of prisoners is equivalence of care. This, according to the Inspector of Prisons, is the minimum legal standard required in prison healthcare and entitles prisoners to the same care as that available in the community. Since the launch of the Irish Prison Service (IPS) drugs policy and strategy document, Keeping drugs out of prisons, the provision of drug services in Irish prisons has improved. The contracting-out of treatment services to addiction services based in the community and to private consultants including pharmacists has also been beneficial and has enhanced links between prison and community-based services. The IPS and the Probation Service have a multi-agency approach to offender and rehabilitation from pre- and post-imprisonment in order to reduce offending and improve prisoner outcomes. The availability of drugs within prisons is a cause of concern and prison visiting committees have described the situation as extremely worrying. It impedes the work of providing support and counselling in prisons.

0.2 New developments

Although there has been an improvement in drug-related health policies and services in Irish prisons in recent years, the effective delivery of these services and the attainment of the goal of equivalence of care have been has been hampered because of overcrowding. In such a context the therapeutic benefit of drug treatment can become a secondary concern to the control and security priorities of the prison environment. Equally, a lack of clarity of responsibility and coherence of delivery hinders the provision of a seamless care service pre and post release and exposes vulnerable people to preventable drug-related deaths. A number of initiatives have recently been introduced by the IPS in collaboration with the Probation Service which are helping, or have the potential to help, address these issues.

1. National profile

1.1 Organization

1.1.1 Overview of prison services

Political responsibility for the prison system in Ireland is vested in the Minister for Justice and Equality. The Irish Prison Service operates as an executive agency within the Department of Justice and Equality. It is headed by a Director General supported by 5 Directors.

The Irish Prison Service deals with male offenders who are 17 years of age or over and female offenders who are 18 years of age or over.

The annual budget for the Irish Prison Service for 2015 was € 332.182 million. At end 2015 there were 3,308 staff in the Irish Prison Service including civilian grades and headquarters staff.

The overall daily average number of prisoners in custody in 2015 was 3,722 compared to 3,915 in 2014. The average number of female offenders in custody was 131, a 12.7% decrease on the 2014 average of 150. There were 13,987 committed to prison under sentence in 2015 an 8.8% increase (1,134) in the numbers committed in 2014 (12,853).

There are 14 institutions in the Irish prison system comprising 11 traditional 'closed' institutions, two open centres, which operate with minimal internal and perimeter security, and one 'semi-open' facility with traditional perimeter security but minimal internal security (the Training Unit). The majority of female prisoners are accommodated in the purpose-built Dóchas Centre adjacent to Mountjoy Prison in Dublin and the remainder are located in a separate part of Limerick prison.

Table 1.1.1. Irish prison population, 2015

Prison name	Description	Operational capacity	Population (average 2015)
Mountjoy Prison	Closed, medium-security prison for males aged 18 years and over. It is the main committal prison for Dublin city	554	537
Dóchas Centre	Closed, medium-security prison for females aged 18 years and over. It is the committal prison for females committed on remand or sentenced from all courts outside the Munster area	105	123
Training Unit, Mountjoy	A semi-open, low-security prison for males aged 18 years and over, with a strong emphasis on work and training	96	92
Arbour Hill Prison	A closed, medium-security prison for males aged 18 years and over.	142	138
Castlerea Prison	Closed, medium-security prison for males aged 18 years and over. It is the committal prison for remand and sentenced prisoners in the west of Ireland.	340	308
Cork Prison	Closed, medium-security prison for males aged 18 years and over. It is the committal prison for the south west of Ireland	210	218
Limerick Prison	Closed, medium-security prison for males and females aged 18 years and over. It is the committal prison for the mid-west of Ireland	220 (m) 28 (f)	224 (m) 24 (f)
Loughan House	Open, low-security prison for males aged 18 years and over.	140	116
Shelton Abbey	Open, low-security prison for males aged 19 years and over.	115	101
Portlaoise Prison	A closed, high-security prison for males aged 18 years and over. It is the committal prison for those sent from the Special	291	246

Prison name	Description	Operational capacity	Population (average 2015)
	Criminal Court		
Midlands Prison	Closed, medium-security prison for males aged 18 years and over. It is the committal prison for the Irish midlands	870	823

Source: IPS website 2016

1.2 Drug use and related problems among prisoners

1.2.1 Drug use prior to imprisonment and inside prison

In 2010 the National Advisory Committee on Drugs (NACD) commissioned a study to:

- describe the nature, extent and pattern of consumption for different drugs among the prisoner population;
- describe methods of drug use, including intravenous drug use, among the prisoner population;
- estimate the prevalence of blood-borne viruses among the prisoner population and identify associated risk behaviours; and
- measure the uptake of individual drug treatment and harm reduction interventions (including hepatitis B vaccination) in prison.

The NACDA published this study in 2014 ((Drummond*, et al.* 2014)) and a summary was included in the 2014 National Report (Section 4.3.2).

1.2.2 - Drug related problems, risk behaviour and health consequences

Much of the information available relating to drug use in Irish prisons and responses is obtained through answers to parliamentary questions (PQs) put to the Minister for Justice and Equality in Ireland's national assembly, Dáil Éireann. (Fitzgerald F 2016 31 May)**.**

In response to a PQ on 31 May 2016, Minister Frances Fitzgerald said, from reports to her from the Irish Prison Service, Any prisoner who enters the custody of the Irish Prison Services has access to specialist addiction services, and is actively encouraged to engage with those services. Treatments available are similar to those available in the community setting, including harm reduction, detoxification, stabilisation, and opiate replacement therapies. These interventions are based on a multi-professional approach to ensure that the prisoner's motivation, commitment and likelihood of success are always at the centre of planned care.

The healthcare team which delivers these treatments include GP Specialist Addiction services, Consultant Addiction psychiatrist, specialist addiction nurses, addiction counsellors, addiction links workers, pharmacists, primary care GP's, and prison nurses.

The Irish Prison Service also works very closely with the Probation Service, community, voluntary, and statutory agencies to maintain a pathway of care ensuring supports remain in place for prisoners on their release from custody.

All prisoners have access to group and individual counselling services where they can address their own personal requirements and specific support arrangements can be put in place and implemented during the prisoners' period in custody. The person in custody can also benefit from peer support groups, music therapy, and a 9 week psycho-social based programme similar to community residential treatment services, which assists the person in remaining drug free.

The Irish Prison Service and the Probation Service are considering the recommendations of an independent evaluation of the addiction and drugs services in prisons, and are developing an Action Plan for those services based on the evaluation undertaken. The Action Plan will be informed by the recommendations of best practice from the National Drugs Rehabilitation Implementation Committee, and the National Drugs Strategy which is under review at present.

Regarding the number of persons currently serving custodial or suspended sentences for drug possession Minister Fitzgerald, in response to a PQ on 31 May 2016, said she had been informed by the Irish Prison Service (IPS) 30 April 2016 there were 3,756 prisoners in custody across the prison system. Of this 381 or 10% were serving sentences for drugs related offences. It is not possible to provide the number of person on suspended sentences for drugs offences.

A full breakdown of the offences, taken from the most recent snapshot of the prison population conducted on 30th April 2016, is set out in the following table. The figures include the length of the sentence in each case.

Table 1.2.2.1 Number of people serving sentences for drugs related offences by length of sentence

Data from 30th April 2016	<3 Mths	3 to <6 Mths	6 to <12 Mths	1 to <2 Yrs	2 to <3 Yrs	3 to <5 Yrs	5 to <10 Yrs	10+ Yrs	Total
Cultivation of Cannabis Plants and Opium Poppy	0	0	1	1	3	7	3	0	15
Possession for sale or supply drugs valued €13,000.00 or more	0	0	0	2	5	20	38	26	91
Possession of drugs for the purpose of sale or supply	0	6	15	26	26	44	66	32	215
Unlawful possession of Drug(s)	2	3	0	4	11	15	13	6	54
Unlawful supply/offer to supply controlled drug	0	0	0	0	0	1	0	0	1
Unlawfully importing or exporting controlled drugs	0	0	0	2	0	2	1	0	5
Total	2	9	16	35	45	89	121	64	381

Source (Fitzgerald F 2016 31 May)

Prison visiting committees reports

A visiting committee is appointed to each prison under the Prisons (Visiting Committees) Act 1925 and the Prisons (Visiting Committees) Order 1925. Members of the 14 visiting committees are appointed by the Minister for Justice, Equality and Defence for a term not exceeding three years. The function of prison visiting committees is to visit at frequent intervals the prison to which they are appointed and hear any complaints which may be made to them by any prisoner. They report to the Minister any abuses observed or found by them in the prison and any repairs which they think are urgently needed. Visiting committee members have free access either collectively or individually to every part of the prison to which their Committee is appointed.

The 2015 Annual Report of the visiting committee for Mountjoy Prison (Prison visiting committees 2016) reported that 'the pervasiveness of a drug culture within the prison can be unsettling to prisoners, prison management and staff' (p.10). The committee welcomed the plan for more treatment places for prisoners in Mountjoy prison and noted recent findings regarding the upward trend in patterns of drug use in European prisons.

The report of the Wheatfield Prison visiting committee noted that extra netting had been installed to prevent prisoners accessing drugs which had been thrown over the prison wall from outside the prison.

1.3 Drug-related health responses in prisons

1.3.1 Drug-related prison health policy

Four policy documents are shaping the provision of drug-related healthcare in the Irish prison system.

1. **IPS three-year strategic plan 2016–2018**

The 3-year strategic plan committed the IPS to providing prisoners with access to the same quality and range of healthcare services as that available to those entitled to General Medical Scheme (GMS) health services in the community. (Irish Prison Service 2016) The recruitment of Assistant Psychologists, who under the supervision of qualified Psychologists will increase the number of those in prison accessing therapies for mental health difficulties. The IPS will Department of Justice endorsement of the recommendation that prison healthcare services be brought under the responsibility of the Department of Health and operated by the Health Service Executive (HSE). The plan promises to implement a prison wide system of random drug testing which can support positive prisoner choices, and assist in making prisons a safer environment and to develop appropriate interventions for offenders presenting with co-morbidities.

(Details from the three policy documents listed below were included in the 2015 workbook)

2. **Keeping drugs out of prisons**

In May 2006 the Minister for Justice launched Keeping drugs out of prisons: drug policy and strategy (Irish Prison Service 2006). This set out the steps required to tackle the supply of drugs into prisons, to provide adequate treatment services to those addicted to drugs, and to ensure that developments in the prisons were linked to those in the community.

3. **National drugs strategy (interim) 2009–2016**

The following actions in the NDS relate to treatment in prisons (Department of Community Rural and Gaeltacht Affairs 2009):

- Treatment and rehabilitation (Action 43) – continue the expansion of treatment, rehabilitation and other health and social services in prisons and develop an agreed protocol for the seamless provision of treatment services as a person moves between prison (including prisoners on remand) and the community; and
- Research/information (Action 55) – research prevalence patterns of problem substance use among prisoners.

4. **Joint Irish Prison Service and Probation Service strategic plan 2015–2017**

The strategy sets out the multi-agency approach offender management and rehabilitation from pre- to post-imprisonment that the IPS and Probation Service will pursue in order to reduce re-offending and improve prisoner outcomes. (Irish Prison Service and Probation Service 2015).

1.3.2 Structure of drug-related prison health responses

Primary care is the model of care through which healthcare is provided in the prison system. A number of contracted private services assist the Irish Prison Service (IPS) and Health Service Executive (HSE) in the provision of drug treatment services. The service is delivered by a mix of part-time and full-time doctors and nursing staff. Nurses first began working in the IPS in 1999 (Nursing and Midwifery Planning and Development Unit & Irish Prison Service 2009).

The Probation Service and the Irish Prison Service (IPS) are responsible for managing offenders in the community and in prison, respectively. Both the IPS and the Probation Service are represented on The National Drugs Rehabilitation Implementation Committee (NDRIC) which was set was set up to oversee and monitor implementation of recommendations from the Report of the Working Group on Drugs Rehabilitation (2007).

A range of drug rehabilitation programmes within the prison system are delivered in partnership with Community Based Organisations (CBOs) with a value of €1.14m per annum. The Probation Service engages with offenders who have addiction problems, to ensure the offender has access to required supports. Addiction services are delivered in partnership with 18 CBOs with a value of €1.59m per annum.

Annual funding of approximately €0.22m is provided by the Department of Health through its drug initiative fund to a number of Local Drug and Alcohol Task Forces (LDATFs) to employ community prison links workers.

All of the organisations funded by the Probation Service and the IPS have Service Level Agreements (SLAs). SLAs between the Probation Service and CBOs operate for a year. The SLA between the IPS and MQI operates for three years.

Table 1.3.2. Irish Prison Service expenditure on health and addiction Services

	2011	2012	2014
Total health spend	c.9,600,00	c. 9,200,00	c.8,800,00
Of which:			
Drug treatment pharmacy services	743,678	781,709	512,325
Addiction counselling services	1,178,520	1,225,039	1,142,384
Methadone	67,012	78,076	80,169
Total addiction spend	1,989,210	2,084,824	1,734,878
Addiction spend as a % of total health spend	17%	18%	16%

Source: (Clarke and Eustace 2016)

Developing inside: transforming prison for young adults

On 31 May 2016, the Jesuit Centre for Faith and Justice published a report that examined the needs, circumstances and conditions experienced by young adults (18–24 years) within the Irish prison system.

Young adults in prison: why are they unique?

Drawing on theory and research from the fields of criminology, sociology and psychology, the report argued that young adults aged 18 to 24 form a unique but distinct group, and in consequence should be treated differently to older prisoners.

Characteristics of this cohort include:

- During the transition, biological and psychological developments can continue for some until their mid-twenties.

- They experience changes in key areas of life, such as education, occupation, finances, living arrangements and romantic relationships.
- Most grow out of crime and will have stopped altogether by the time they are 30.
- They are more malleable and susceptible to peer influence
- They are more likely to behave in a manner that will bring them into contact with the justice system.
- There is a higher level of risk taking; impulse control does not fully develop until mid-twenties.
- Their lack of maturity diminishes their ability to understand and participate in justice proceedings.
- They are not as equipped to plan ahead, reason, think abstractly or anticipate consequences.

Notably, some behaviours and levels of maturity displayed by this cohort may resemble adolescence and may result in an assumption that this phase is an extension of adolescence. However, Jeffrey Arnett, who coined the term 'emerging adulthood' to represent this phase of development, defines it as a period that is 'much different from adolescence, much freer from parental control, much more a period of independent exploration' (p. 4).4 Proponents of the adolescent/emerging adulthood distinction argue that it is harmful to treat young adults as adults, particularly within the criminal justice system.

Young adults in prison in Ireland: historical review
The report provides an overview of the treatment of young adults within the Irish justice system since the 19th century. An important point to note is that historically there has been fluidity in the age classification of young offenders, with an acknowledgement that children on reaching the age of 18 do not become adults overnight.

Young adult prisoner: Irish context
A major finding of the report is that young adults are overrepresented in Irish prisons. Centred on data from the Irish Census of Population 2011, young adults represent approximately 11.94% of the adult population nationally. However, within prison populations young adults represent 24% of individuals committed, 20% of those sentenced to prison and 26% of prisoners on remand. Notably, the overrepresentation is more apparent in young adults aged 21 to 24, who represent 14.7% of the prison population but only 5% of the general population.
International responses

Despite the existence of international standards and guidelines, countries vary in their responses to the detention of young adults.5,6,7 In comparison to other European countries (e.g. Germany, Northern Ireland, Scotland, Switzerland, Sweden and Turkey), Ireland does not fare well in its treatment of offenders aged 18 to 24. The Committee of Ministers of the Council of Europe issued the European Rules for Juvenile Offenders Subject to Sanctions or Measures (ERJOSSM) to European states in 2009.8 This document provides guidance on regimes that are best suited to young adult offenders where detention is used as a last resort.

Recommendations
It is recommended that Ireland should avail of an alternative approach based on principles of education, rehabilitation and reintegration, where continuity of care of young adult offenders is guaranteed. A number of recommendations for reform have been put forward:

- There should be recognition that young adults (aged 18 to 24) are a distinct group who should be under the remit of the Irish Youth Justice Service.
- Ireland should aim to reduce the number of young adults in prison.
- Young adults should be accommodated in detention centres that are humane and designed specifically for them and their age group.

- Young adults that are detained and prison officers should be in settings where they both feel safe.
- There should be greater accessibility to specialised services within prison and upon release in the community.
- A new regime for young adults in prison should be provided.
- Extended lock-up and 'basic' regime standards should be eradicated. On committal to a prison, young adults should be placed in the 'enhanced' accommodation standard (p. 67).
- Young adult offenders should be included in operational decision-making of the detention centre and prison.
- There should be a reduction of remand. However, when necessary, all detention centres should have dedicated remand facilities.
- Motivation and support to abstain from drugs in the prison setting should be provided, while also providing harm reduction measures.
- Training of prison staff should be enhanced and avail of an evidence-based approach that is based on best international policy and practice.

A new report from the Irish Penal Reform Trust *Improving prison conditions by strengthening the monitoring of HIV, HCV, TB and harm reduction: mapping report – Ireland* (MacNamara*, et al.* 2016) was published on 23 June 2016. The report forms part of the EU co-funded project, Improving Prison Conditions by Strengthening Infectious Disease Monitoring, which was implemented under the lead of Harm Reduction International. The project aims to reduce the ill-treatment of persons in detention and improve prison conditions through improved and standardised monitoring and inspection mechanisms on HIV, HCV and TB. This broader research informed the development of a user-friendly tool3 to help generate better informed, more consistent, and sustained monitoring of these diseases and harm reduction in prisons by national, regional and international human rights-based prison monitoring mechanisms.

The Irish report presented the findings of a national mapping exercise carried out to investigate available standards relating to human rights, infectious diseases and prison monitoring. It described the evolution in Ireland of the healthcare and prison systems; illicit drug use and the related legislative and policy context; and, human rights, particularly in the context of judicial care. It then explored the situation in relation to infectious diseases among prisoners. Information was collected through a literature review, analysis of public documents, Freedom of Information requests, and consultation with experts in the prison service.

Among the key findings was that the Irish Prison Service's (IPS) provision for HIV and hepatitis C prevention measures did not meet the standards of best practice models found elsewhere in Europe and North America. Furthermore, the IPS did not fulfil its stated objective of providing primary healthcare (prevention, treatment and health rehabilitation) to offenders of at least an equivalent standard to that available to the general population. The authors argued that the IPS's response to the HIV and hepatitis C crisis fell 'far short' of this.

In terms of surveillance, they noted that while the Health Protection Surveillance Centre collected and collated data on notifiable diseases nationally, it was not possible for the authors to distinguish between those identified in the prison setting and the general population. They maintained that while some progress had been made in the adoption of monitoring mechanisms for infectious diseases in Irish prisons, it was less than sufficient or consistent in meeting the standards of human rights-based prison monitoring.

The report identified a number of monitoring mechanisms for Irish prisons. These include the Inspector of Prisons, prison visiting committees, and the European Committee for the Prevention of Torture. All of these had been critical of conditions in Irish prisons. The authors also concluded that

Ireland's ongoing failure to have ratified the Optional Protocol to the Convention Against Torture presented a threat to the protection of the human rights of prisoners in Ireland.
The 2015 Prison workbook included a summary of *Culture and organisation in the Irish prison service: a road map for the future*, a new report completed by the Inspector of Prisons, Judge Michael Reilly, and Professor Andrew Coyle, Emeritus Professor of Prison Studies at the University of London that examines all aspects of the administration and governance of the Irish prison system and identifies a number of deficiencies in administration, treatment of prisoners and delivery of services by prison staff (Reilly 2015).

Several issues relating to management of prisoners and their rehabilitation were beyond the scope of this review. The authors recommended that a separate review should deal comprehensively deal with these and should include the following in its terms of reference:

- health care including mental health, and
- drug and other substance abuse.

1.3.3 Types of drug-related health responses available in prisons

The Probation Service currently commissions 18 community-based organisations to provide range of services including residential treatment programmes harm reduction counselling and support, recovery and aftercare programmes, community education, therapeutic advice and family support. The Irish Prison Service fund six community-based organisations in the prison system.

The main treatment modalities provided in the prison system are counselling, substitution treatment and detox. In addition, Mountjoy offers an eight week programme, the Drug Treatment Programme (DTP), delivered by the addiction health team and external CBOs (which are funded by the Probation Service).

Addiction counselling services have been provided to the IPS by Merchants Quay Ireland (MQI) since 2007. A voluntary organisation providing services to vulnerable people including drug users, the service operates in 13 prisons throughout the country and provides structured assessments, 1–1 counselling, therapeutic group work and multi-disciplinary care and release planning interventions with clearly defined treatment plans and goals. Services offered by MQI include:

- brief interventions,
- motivational interviewing and motivational enhancement therapy,
- 12-step facilitation programme,
- relapse prevention,
- harm reduction approaches, and
- individual care planning and release planning.

Treated problem drug use in prisons from TDI data

As reported in TDI, between 2009 and 2015, 5,450 cases received treatment in prison (Table 1.3.3.1). The treatment, mainly counselling, was provided by in-reach voluntary services or the prison medical service. Between 2009 and 2015, 9.2% of all cases reported to TID treated received treatment in prison. Of those cases treated in prison, 42.8% were new to treatment.

Table 1.3.3.1 Treated problem drug use in prison, NDTRS 2009 to 2015

	2009	2010	2011	2012	2013	2014	2015
Total	793	916	753	636	743	835	774
New treatment entrants	461	471	337	264	270	285	244
Previously treated	307	406	393	324	446	505	517
Treatment status unknown	25	39	23	48	27	45	13

All treatment entrants in prison

For the period, the main problem drug reported by all treatment entrants was opiates (mainly heroin) (57.7%) (Figure 1.3.3.1). Cocaine was the second most common drug reported (15.6%), followed by cannabis (13.9%). Between 2009 and 2014, just over a third of cases (34.6%) reported ever injecting. In 2015, 33.6% of all cases treated in prison reported ever injecting.

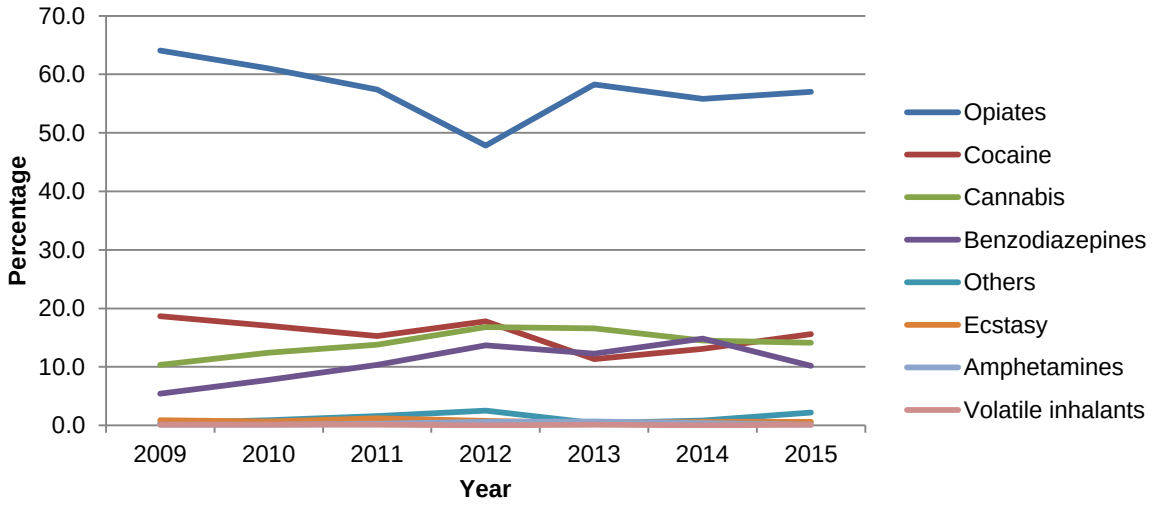

Figure 1.3.3.1 Main problem drug (excluding alcohol), all treatment entrants in prison, by year, NDTRS 2009 to 2015

In 2015, 85.9% of cases were male. There was a higher proportion of females (13.8%) recorded in 2015, which is due to one of the two women's prisons commencing participation in TDI in that year. In 2015, the mean age was 30 years (male 30 years; female 32 years).

New treatment entrants in prison

For the period, the main problem drug reported by all cases was opiates (mainly heroin) (46.1%) (Figure 1.3.3.1). In 2015 cocaine was the second most common drug reported (20.8%), followed by cannabis (17.9%). Almost all new entrants to treatment were male (98.0%) and the mean age was 29 years. Among this group, 23.0% reported ever injecting in 2015.

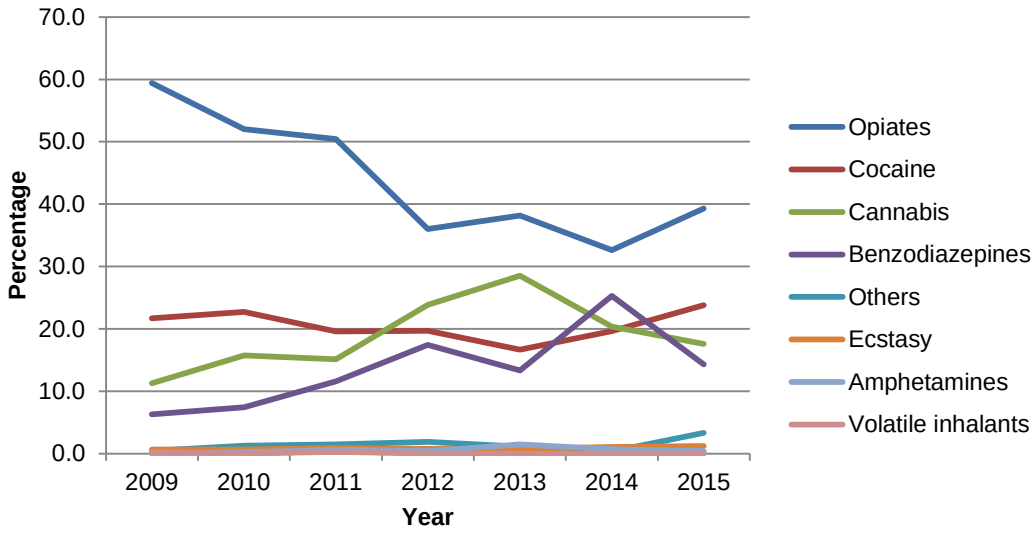

Figure 1.3.3.1 Main problem drug (excluding alcohol), new treatment entrants in prison, by year, NDTRS 2009 to 2015

MQI, in partnership with Ana Liffey Drug Project, Ballymun Youth Action Project and Coolmine Therapeutic Community, deliver a structured multi-agency 8-week drug treatment programme (DTP) in the Mountjoy Medical Unit. The programme helps prisoners to detox from methadone and benzodiazepines (Merchants Quay Ireland 2014).

There were 2,725 prisoners who used the MQI addiction services during 2015. During 2015 there were 11,657 counselling sessions delivered to prisoners by the MQI Addiction Counselling service.

The dispensing of methadone by drug treatment pharmacists in Mountjoy Prison is described in Section 5.2.2.2 of the 2014 National Report.

2. New developments

2.1 New or topical developments

Review of Drug and Alcohol Treatment Services for Adult Offenders in Prison and in the Community

In March 2016 published an independent review of alcohol and drug treatment services for adult offenders in the community and in prison (Clarke and Eustace 2016). The review explores current provision and sets out a model of effective practice for the treatment of adult offenders that can facilitated a continuum of care from prison to the community. The authors argue that the prison environment provides a unique opportunity to support individuals to address addiction and it is appropriate that a range of treatment and intervention options is provided in the prison estate.

Excluding direct staff and GP costs, the IPS and Probation Service have combined expenditure of €3.33m on the provision of addiction services for adult offenders. Spending has declined in recent years (see Table 1.3.2.) in line with the decline in prisoner numbers. This includes those with a dual diagnosis of addiction and mental health issues. The reduction in overall health spending mirrors a fall in the number of prisoners held in the prison estate as more initiatives such as community return have been introduced. However, the authors of the review point out those who are within the prison system now tend to be the more challenging, high risk and chaotic whose criminality and addictions are more entrenched.

During the review, concern was expressed about the lack of investment in health in the prison systems and the absence of a Clinical Director or Health Director at senior management. Reduced expenditure on addiction counselling has resulted in a reduction in the number of addiction counsellors provided by MQI and changes in the types of services they provide. Some prisons only have part-time access and waiting times for addiction counsellors has increased.

Consultations with service providers, the Probation Service, the IPS and the HSE all highlighted a number of recent changes that were impacting capacity to treat offenders with addictions:

- A decline in opiate based addiction and an increase in benzodiazepine, novel psychoactive substances, opiate-based analgesics and other narcotics usage as well as poly-substance abuse;
- Increasing numbers of offenders presenting with co-morbidities, most notably mental illness combined with drug and/or alcohol addiction;
- The ready availability of drugs within the prison system;
- Younger people with complex needs, e.g. drug addiction combined with chaotic personal lifestyles, homelessness, mental health issues, poor literacy and communication skills deficits;
- A cohort of offenders moving in and out of the criminal system repeatedly posing significant challenges to effective treatment. Female offenders are more likely to be chaotic substance

users than their male counter parts. This results in particular challenges when treating their addictions.

Model of Effective Practice
The review sets out a model effective practice aligned with the principles set out in National Drugs Rehabilitation Implementation Committee (NDRIC) framework and refined following consultations with community-based organisations, prison-based health teams and addiction counsellors and a review of international literature.

The model recognises that recovery takes time and often requires several episodes of treatment and that the person in recovery should have a broad range of options available to facilitate the process. Good communication both within the prison system and between the prison environment and the community are necessary to ensure clear treatment pathways and that the opportunity provided by time in prison to address addiction is taken. The core components of the model are pre-work and preparation, referral, assessment, care planning, case management, treatment and recovery management.

Outcomes
Apart from initial outcomes monitored by MQI in Mountjoy, there is currently no robust systematic tracking of outcomes for prisoners treated in the prison estate. The review acknowledges that, while work needs to be done regarding the identification and measurement of outcomes, good progress has been made by community-based organisations in developing outcome models. Most of these are abstinence based but there is recognition that other outcomes, such as completing treatment, increased social skills and behavioural change are also valid outcomes in recovery programme.

A number of CBOs have conducted research into outcomes for clients and provide data on outcomes named in their SLAs with the Probation Service. These outcomes included treatment completion, attending aftercare and returning to training or education.

Recommendations
The authors recommend that the Irish Prison Service adopts this model and provides the required resources and funding to support its implementation. Some of the gaps in provision identified in the review include availability of drug-free environments within the prison setting for prisoners who have completed detoxification and treatment programmes, development of non-opiate based detoxification services, alcohol treatment services and access to treatment for difficult cohorts such as sex offenders. Coordination of services for prisoners between the prison and outside agencies is very important in insuring prisoners receive the services they need. Continuum of care depends on reliable referral pathways to HSE treatment services and CBOs and this process needs to be refined through clearer protocols and mechanisms to support greater inter-agency information sharing. A related issue is co-ordination of services with a more defined role for prison addiction nurses in care planning and case management required.

The authors of the review recognise the considerable progress that has been made in recent years in the management of release planning from prisons, for instance the involvement of Integrated Sentencing Managers (ISM) but prisoners with an addiction still face considerable problems on release from prison, especially if they are homeless. The review makes a number of recommendations which should help the coordination of pre-release planning and communication with probation and other external services. These recommendations include the involvement of relevant prison health staff and a specialised resettlement support service. As coordination and communication between services is such an important part of addiction services, the review pays particular attention to role of service level agreements in the overall governance of external providers and community-based organisations.

3. Sources and methodology

3.1 Sources

Notable sources include the Annual Reports of the Irish Prison Service, reports of the Inspector of Prisons and responses to Parliamentary Questions. Also, publications and the website of the Irish Penal Reform Trust are of use.

3.2 Methodology

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European Monitoring Centre for Drugs and Drug Addiction

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is a decentralised EU agency based in Lisbon. The EMCDDA provides the EU and its Member States with information on the nature, extent, consequences and responses to illicit drug use. It supplies the evidence base to support policy formation on drugs and addiction in both the European Union and Member States.

There are 30 National Focal Points that act as monitoring centres for the EMCDDA. These focal points gather and analyse country data according to common data-collection standards and tools and supply these data to the EMCDDA. The results of this national monitoring process are supplied to the Centre for analysis, from which it produces the annual *European drug report* and other outputs.

The Irish Focal Point to the EMCDDA is based in the Health Research Board. The focal point writes and submits a series of textual reports, data on the five epidemiological indicators and supply indicators in the form of standard tables and structured questionnaires on response-related issues such as prevention and social reintegration. The focal point is also responsible for implementing Council Decision 2005/387/JHA on the information exchange, risk assessment and control of new psychoactive substances.

Acknowledgements
Completion of the national focal point's reports to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) depends on the support and cooperation of a number of government departments and statutory bodies. Among those to whom we would like to express our thanks are the staff of the following:

Customs Drugs Law Enforcement, Revenue
Department of Children and Youth Affairs
Department of Education and Skills
Drugs and Organised Crime Unit, An Garda Síochána
Drugs Policy Division, Department of Justice and Equality
Drugs Policy Unit, Department of Health
Forensic Science Ireland
Health Protection Surveillance Centre, Health Service Executive
Hospital In-Patient Enquiry Scheme, Health Service Executive
Irish Prison Service
National Advisory Committee on Drugs and Alcohol, Department of Health
National Social Inclusion Office, Primary Care Division, Health Service Executive

We also wish to acknowledge the assistance of the coordinators and staff of local and regional Drug and Alcohol Task Forces, voluntary, community-based and other non-governmental organisations.

We wish to thank our HRB colleagues in the Evidence Centre, National Drug Treatment Reporting System, the National Drug-related Deaths Index and the HRB National Drugs Library, all of whom make significant contributions to the preparation of the national report.