Editorial

The future of forensic mental health services in Ireland

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The publication in this issue of the Journal of two further reports[1,2] from the survey of psychiatric morbidity in the Irish prison population, along with the pending publication of morbidity results for those seen on committal to prison, makes the prison population the best described in Ireland for psychiatric morbidity as well as general health.[3,4] We now know that Ireland commits over 300 people to prison each year who have a six month prevalence of severe and enduring mental illness.[5] The prevalence of such illness among the remand population is twice the rate in other countries.[6,7] There is a need for 200 secure beds to accommodate all those currently inappropriately detained in prison. It should therefore be possible to plan a rational needs-led service for mentally disordered offenders and those like them.

Unfortunately, the recently published discussion paper from the Mental Health Commission[8] ignores research, makes too few recommendations about resources and appears to have misunderstood the organisation of forensic mental health services for other similar populations.

Model building

Ireland currently does not have a maximum security hospital of the sort familiar in the UK, and with a population of 4.1 million, will never need one. The three special hospitals for England and Wales, each serving populations of 15 to 20 million, have several times been recommended for closure[9] and have survived only at the behest of securocrats.[10] The Mental Health Commission however recommends the UK model. The UK model of high, medium and low security institutions each on separate sites, each under separate management is an historical artefact unique to that jurisdiction. It has long been acknowledged that most of the patients in UK maximum security hospitals do not need maximum security.[9] Patients ought to be able to move freely between levels of security according to need. Artificial institutional and organisational barriers are counter-therapeutic, lead to excessive delays in rehabilitation and wastage of resources in the UK.

Most states with populations of similar size to Ireland eg. in Australia (Victoria, New South Wales etc.), German states or Scandinavian provinces and countries have a single service for populations of three to five million, providing predominantly medium secure care with some high security and low security also, all on one site. This is the current model in Ireland. Elsewhere however, these central units are supported by local low secure units (acute psychiatric intensive care units and longer-term low secure units). These local units serve populations of 350,000 or so, similar to recommendations in the recent report of the Expert Group.[12] Local low secure units operate with the single central unit as a 'flat' hub and spoke network. There is good evidence that providing adequate local low secure resources prevents excessive reliance on medium and high security,[13] probably by enabling early intervention for challenging and disruptive people with severe and enduring mental illness. The 'flat' hub and spoke network operates better than the hierarchical, tiered three-level network of the UK since it provides more resources nearer to patients' homes and shortens lines of communication between the centre and local services.

Ireland already has at the Central Mental Hospital, the continental and antipodean model of high, medium and low therapeutic security on one central site, a model admired by UK colleagues. Ireland has just enough of a population to support one such service. Overwhelming evidence from other jurisdictions[14,15,16] and in Ireland,[17,18] shows that most patients needing medium or high security come from large cities where population density and deprivation occur together.[19]

A central forensic unit should not grow larger than about 200 secure beds, since larger units cannot preserve continuity of through-care, which is essential for patient-centred care planning, therapeutic relationships and responsible, timely decision-making when risks are taken for the sake of rehabilitation. However units smaller than about 100 beds cannot support the full range of specialist therapies and services needed for this selected group of patients. Acute and long-term low secure units work best at 15 to 30 beds each, side by side and adjacent to admission and rehabilitation units. Local services with advanced crisis or home treatment and assertive community treatment teams manage with fewer admission and rehabilitation beds, but do not reduce the number of compulsory admissions.[20] About 3% of admissions will become 'new long stay', so a constant supply of new high support community places is required to avoid silting up.

Politics and transparency

Given the heightened and at times irrational resistance to population-based services in Ireland, from the 1969 Fitzgerald report to Hanley, it is unfortunate that the Mental Health Commission's report appears to have succumbed to the same sort of parish-pump special pleading for unwarranted 'regional' medium secure units in low-morbidity areas. Mental health services should not be treated as a form of rural

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employment scheme. Any report or discussion document (including this article), no matter how authoritative the source, is a matter of opinion. Government reports and discussion documents normally list the authors, committee members and those consulted. The Mental Health Commission's recent discussion document however has adopted a worryingly authoritarian voice, free of identified authorship. Can we be sure that the masked authors are not mere vested interests?

A commitment to rehabilitation in forensic mental health services requires the willingness to take therapeutic risks. Managers and politicians need to support such recovery-orientated risk taking. Yet it is always safer for politicians, journalists and inspectorates to criticise than to support, to use hindsight rather than foresight.

Recent progress

For now, the National Forensic Mental Health Service has a particularly high success rate in achieving remission of treatment resistant psychoses, high standards in multidisciplinary therapeutic work and progressive practices concerning the involvement of service users and their carers in policy development and the improvement of services. The service has a growing reputation for multi-disciplinary research, teaching and training on consent and capacity, prevention and management of violence and aggression, risk management and therapeutic uses of security.

Forensic services are routinely the subject of higher than normal levels of scrutiny and supervision. This is as it should be. Services that detain almost all of their patients must be able to demonstrate high standards of respect for patients' rights, choices and quality of life. This requires a system of governance in which staying within budget and within manpower allocations are not the only criteria for management success. The substantial under-spends and staff shortages of recent years ought to be regarded as a sign of corporate mismanagement. Where change succeeds it is usually progressive rather than revolutionary. There is for example a progression from an exclusively medical and nursing service, to multi-disciplinary work, then on to involving service users and their carers in policy and in practice. The more a service improves, the more the service itself recognises how much more remains to be done. Ideally, service leaders will communicate this and inspectorates will acknowledge it.

Next steps

The future shape of forensic mental health services in Ireland should develop from pathways through care that are designed to match patient needs and patient preferences rather than historical and legal artifacts. Legal processes should be drafted to match naturalistic care pathways, not legal tradition, though there is little evidence of this in new legislation.[21] There will always be some tension between the unique needs of each patient and the need to provide services for groups. This is why relational and procedural aspects of therapeutic security, which are easier to individualise, will always be the most important elements of patient care in any mental health service.[22] It is also why local and central forensic mental health services should be as closely integrated into general adult services as possible.[23] General adult mental health services will have to be flexible and responsive to change, challenge stigma, prioritise those with severe and enduring mental illness, recognise and treat co-morbidity and provide a range of services in the community and in hospital including a regular supply of long-term support for those who require it.

Ideally, a sequence of developments across the country would see local low secure units (all of which should be both approved under the Mental Health Act 2001 and designated under the Criminal Law (Insanity) Act 2006) linking to local prison in-reach clinics and court diversion schemes,[24] while all community mental health teams would provide liaison services to Garda stations for assessments and early diversion from the criminal justice system. We might then see the withering away of specialist forensic mental health services, in the way that an earlier generation of idealists expected to see the withering away of the dictatorship of the proletariat. Until then, pragmatism and political will is required to end the scandal of Irish prisons being used as psychiatric waiting rooms, the equivalent of A & E trolleys. Forensic mental health services in Ireland should be managed by a single agency, part of the HSE, which integrates all prison in-reach services (arguably all prison healthcare including primary care), secure hospital services and community aftercare for selected, stabilised high-risk service users.

Declaration of Interest: None

References

1. Duffy DM, Linehan SA, Kennedy HG. Psychiatric morbidity in the male sentenced Irish Prison's population. Ir J Psychological Medicine 2006; 23(2):
2. Wright B, Duffy D, Curtin K, Linehan S, Monks S, Kennedy HG. Psychiatric morbidity among women prisoners newly committed and amongst remanded and sentenced women in the Irish prison system. Ir J Psychological Medicine 2006; 23(2):
3. Hannon F, Kelleher C, Friel S. 2000. General Healthcare Study of the Irish Prisoner Population. Dublin: The Stationary Office.
4. Long J, Allwright S, Barry J, Reaper Reynolds S, Thornton L, Bradley F, Parry JV. (2001). Prevalence of antibodies to hepatitis B, hepatitis C, and HIV and risk factors in entrants to Irish prison: a national cross sectional survey. BMJ 2001; 323: 1-6.; Allwright S, Bradley F, Long J, Barry J, Thornton L, Parry JV. Prevalence of antibodies to hepatitis B, hepatitis C, and HIV and risk factors in Irish prisoners: results of a national cross sectional survey. British Medical Journal 2000; 321: 78-82.
5. HG Kennedy, S Monks, K Curtin, B Wright, S Linehan, D Duffy, C Teljeur, A Kelly. Psychiatric Morbidity in the Irish Prisoner Population 2002-2004. Publication pending, 2005.
6. Psychiatric morbidity in a cross-sectional sample of male remanded prisoners. SA Lenihan, DM Duffy, B Wright, K Curtin, S Monks, HG Kennedy. Ir J Psychological Med 2005; 22(4): 128-132.
7. Fazel S, Danesh J. Serious mental disorder in 23,000 prisoners: a systematic review of 62 surveys. Lancet 2002; 359: 545-550.
8. Anon. Forensic Mental Health Services for Adults in Ireland: Discussion Paper. Dublin: Mental Health Commission, 2006.
9. Bluglass R. 1992. The Special Hospitals. British Medical Journal 1992; 305: 323-324. Murphy E, Coid J, Boa W. 1997. Mental health. Security cheques. Health Serv J 1997; 107(5535): 28-29.
10. Tilt R. Report of the Review of Security at the High Security Hospitals. London: Department of Health, 2000.
11. Reed J. 'Review of Health and Social Services for Mentally Disordered Offenders and others Requiring Similar Services', Department of Health and Home Office, HMSO, 1992.
12. J O'Connor (chair). A Vision For Change: Report of the Expert Group on Mental Health Policy. Dublin, The Stationery Office 2006.
13. O'Grady J. The complimentary role of regional and local secure provision for psychiatric patients. Health Trends 1990; 22: 14-16.
14. Coid J. Socio-economic deprivation and admission rates to secure forensic psychiatric services. Psychiatric Bulletin 1998; 22: 294-297.
15. Kennedy HG, Iveson RCY, Hill O. Violence, homicide and suicide: Strong correlation and wide variation across districts. Br J Psychiatry 1999; 175: 462-466.
16. Coid J, Kahtan N, Cook A, Gault S, Jarman B. Predicting admission rates to secure forensic psychiatry services. Psychological Medicine 2001; 31(3): 531-539.
17. Bacik I, Kelly A, O'Connell M, Sinclair H. Crime and Poverty in Dublin: an analysis of the association between community deprivation, District Court appearance and sentence severity. Dublin: Round Hall Press, 2000.
18. C O'Neill, H Sinclair, A Kelly, HG Kennedy. Interaction of forensic and general psychiatric services in Ireland: learning the lessons or repeating the mistakes? Ir J Psychological Med 2002; 19(2): 48-54.
19. C O'Neill, A Kelly, H Sinclair, H Kennedy. Deprivation: Different implications for forensic psychiatric need in urban and rural areas. Social Psychiatry and Psychiatric Epidemiology 2005; 40: 551-556.
20. Johnson S, Nolan F, Pilling S, Sandor A, Hoult J, McKenzie N, White IR, Thompson M, Bebbington P. Randomised controlled trial of acute mental health care by a crisis resolution team. BMJ 2005; 331: 599.
21. Criminal Law (Insanity) Act, 2006.
22. HG Kennedy. Therapeutic Uses of Security: mapping forensic mental health services by stratifying risk. Advances in Psychiatric Treatment 2002; 8: 433-443.
23. Pierzchniak P, Purchase N, Kennedy HG. Liaison between court, prison and psychiatric services. Health Trends 1997; 29: 26-29.
24. Shaw J, Creed F, Price J, Huxley P, Tomenson B. Prevalence and detection of serious psychiatric disorder in defendants attending court. Lancet1999; 353: 1053-1056.

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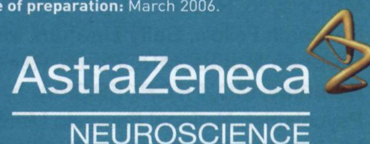

(References)
1. Tandon R & Jibson MD. Psychoneuroendocrinology. 2003; 28:9-26
2. Small JG et al. Arch of Gen Psych. 1997; 54: 549-557
3. Arvanitis LA et al. Biol Psych. 1997; 42:233-246
4. Vieta E et al. Current Medical Research and Opinion. 2005; 21:P1-P12

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