Assessing need and advancing psychiatric care in Irish prisons

Gautam Gulati
MBBS FRCPsych PGDipLATHE (Oxon) FHEA

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Graduate Entry Medical School,
Faculty of Education and Health Sciences, University of Limerick

Supervisors: Professor Colum P. Dunne and Professor David Meagher

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Declaration of originality

I declare that this thesis, which I submit to the University of Limerick for examination in consideration for the award of MD, is my own personal effort, and was completed with the counsel of my supervisors Professor Colum P. Dunne and Professor David Meagher. Where any of the content presented is the result of collaborative research this is duly acknowledged. I have not already obtained a degree in University of Limerick or elsewhere on the basis of this work. Furthermore, I took reasonable care to ensure that the work is original, and, to the best of my knowledge, does not breach copyright law, and has not been taken from other sources except where such work has been cited and acknowledged within the text.

Signed:

Student number: 16210492

Date: 09.03.2018
Thesis abstract

The mental healthcare of prisoners is seen as a public health challenge internationally. Emerging research has highlighted higher rates of mental illness and intellectual disabilities in prisons as compared to general population prevalence across multiple jurisdictions. This is reflected in higher rates of adverse outcomes such as suicide rates amongst prisoners. Psychiatrists visiting prisons play a key role in providing clinical guidance and expertise in managing those with mental illness in prison, identifying those that need diversion from the criminal justice system and highlighting those that may need additional support so as to reduce suicide risk. This is done whilst operating in an environment with specific clinical, legal and ethical challenges. As presented in this thesis, Irish prisons have higher rates of multiple vulnerabilities including mental illness, substance misuse, homelessness and intellectual disabilities as compared to the general population. Advances in screening practices and service development are needed to facilitate diversion. This thesis describes the development of care pathways to manage the care of prisoners with intellectual disabilities and prisoners on hunger strike. These aim to advance care in prisons within Ireland and internationally.
Acknowledgements

I would like to sincerely thank my supervisors, Professor Colum P. Dunne and Professor David Meagher for their guidance and patience in supporting my research.

I would like to extend my appreciation to my colleagues at Limerick Prison, The National Forensic Mental Health Service, Trinity College Dublin, NUI Galway, University College Cork and the University of Cambridge for collaboration.

To my family. This thesis is dedicated to you.
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Abbreviations

A

AAMR: American Association for Mental Retardation

AC: Approved Centre

ADMCA: Assisted Decision Making (Capacity) Act, 2016

C

CLIA: Criminal Law (Insanity) Act, 2006

CMH: Central mental Hospital

D

DSM-5: Diagnostic and Statistical Manual, 5th Edition


H

HASI: Hayes Ability Screening Index

I

ICU: Intensive Care Unit

ICRU: Intensive Care Regional Unit

ID: Intellectual Disability

ICD-10: International Classification of Diseases, 10th Edition

IQ: Intelligence Quotient

IPRT: Irish Prison Reform Trust
IPS: Irish Prison Service

K

KBIT: Kauffman Brief Intelligence Test

L

LDSQ: Learning Disability Screening Questionnaire

M

MHA: Mental Health Act, 2001

N

NAPS: National Adult Prisoner Survey

U

US: United States (of America)

UK: United Kingdom

V

VABS: Vineland Adaptive Behaviour Scale

W

WAIS: Wechsler Adult Intelligence Scale

WHO: World Health Organisation

WMA: World Medical Association

WRAT: Wide Range Achievement Test
Summary Introduction

There are 10.35 million people held in penal establishments worldwide, and 3,674 people of these are in Ireland. There is an emerging body of research internationally, highlighting the vulnerabilities of prisoners.

This thesis provides insights into the prevalence of multiple vulnerabilities amongst Irish prisoners, as well as patterns of diversion from one regional prison. The prevalence of psychotic illness, substance misuse disorder and homelessness in Irish prisons is higher compared to the general population and largely in keeping with international prison estimates. The prevalence of intellectual disabilities is likely to be higher than comparative estimates but evidence is limited by the quality of studies available. An analysis of needs from one regional prison identified the requirement for improved screening practices as well as a necessity to develop low secure units to facilitate diversion for those with mental illness away from the criminal justice system.

The evolution of this thesis moved from measuring need and making service focussed recommendations relevant nationally to developing care pathways for two specific complex scenarios: the management of prisoners with an intellectual disability and that of prisoners on hunger strikes. Both these areas were lacking prior guidance. Through expert elicitation using qualitative methodology and the collaboration of colleagues from multiple agencies and universities, care pathways were developed to inform psychiatric care in these scenarios.

The chapters of this thesis are laid out as follows. Chapter 1 (published) is a systematic review
and meta-analysis of major mental illness, substance misuse and homelessness prevalence in Irish prisoners. Chapter 2 (accepted for publication) is a descriptive study of mental healthcare interfaces in a regional Irish prison. Chapter 3 (accepted for publication) is a systematic review of the prevalence of Intellectual Disabilities in Irish prisons. Chapter 4 (accepted for publication) proposes a care pathway, developed through expert elicitation to guide management considerations for prisoners with an intellectual disability. Chapter 5 (published) is a narrative systematic review of ethical issues for physicians when managing prisoners on hunger strike. Chapter 6 (published) summarises legal issues relevant to Irish psychiatrists when managing prisoners on hunger strikes. Chapter 7 (submitted for publication) formulates an algorithm for the psychiatric management of prisoners on hunger strike developed through expert elicitation.

The findings from this thesis could be used to inform service and policy development addressing the needs of those with mental illness in Irish prisons. They can be used as a benchmark for international comparison. They provide a baseline to which future studies may usefully refer to, when evaluating the outcomes from service and policy development. The care pathway developed for prisoners with intellectual disabilities has overarching considerations that are generalisable internationally and may impact care in this area where relatively little guidance exists. The care pathway informing the psychiatric management of prisoners on hunger strike is the first such algorithm that has been developed in consultation with experts in law and ethics, and may help inform care in this particularly complex clinical scenario where little guidance existed beforehand. Whilst developed in Ireland, it has considerations that may be generalised to other jurisdictions based on consistency with internationally agreed ethical principles.
In summary, the studies in this thesis aim to impact care in prison settings through the assessment of need and development of care pathways. Whilst the anticipated impact includes driving service change, stimulating further research interest and improving standards of clinical care, the primary outcome hoped for is humanitarian and at the level of the individual who is receiving care.
CHAPTER 1

The prevalence of major mental illness, substance misuse and homelessness in Irish prisoners; systematic review and meta-analyses

The prevalence of major mental illness, substance misuse and homelessness in Irish prisoners; systematic review and meta-analyses

Gautam Gulati FRCPsych, Adjunct Senior Lecturer in Psychiatry, Graduate Entry Medical School, University of Limerick, Ireland. Email: gautam.gulati@hse.ie Tel: 063 98 668 (Corresponding Author)

Noreen Keating MRCPsych, Senior Registrar, Department of Psychiatry, University Hospital Limerick, Limerick, Ireland.

Aoife O’Neill, Department of Mathematics and Statistics, University of Limerick, Limerick, Ireland.

Isabelle Delaunois, Head Librarian, University Hospital Limerick, Dooradoyle, Limerick, Ireland.

David Meagher PhD, Foundation Professor of Psychiatry, Department of Psychiatry, University of Limerick Graduate Entry Medical School, Limerick, Ireland.

Colum P. Dunne PhD, Director of Research, University of Limerick Graduate Entry Medical School, Limerick, Ireland.

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Abstract

Objectives

To systematically review studies from Irish prisons that estimate the prevalence of major mental illness, alcohol and substance misuse and homelessness at the time of committal.

Methods

Healthcare databases were searched for studies quantifying the point prevalence for each outcome of interest. Searches were augmented by scanning of bibliographies and searches of governmental and non-governmental websites. Proportional meta-analyses were completed for each outcome.

Results

We found 8, 6 and 5 studies quantifying the point prevalence of major mental illness, substance misuse and homelessness, respectively. Considerable heterogeneity was found for each subgroup (except psychosis where substantial heterogeneity was observed) and random effects models were used to calculate pooled percentages. The pooled percentage for psychotic disorder was 3.6% (95% CI 3.0% - 4.2%), for affective disorder 4.3% (95% CI 2.1% - 7.1%), for alcohol use disorder 28.3% (95% CI 19.9% - 37.4%), for substance use disorder 50.9% (95% CI 37.6% - 64.2%) and for those who were homeless on committal 17.4% (95% confidence interval 8.7% - 28.4%).
Conclusions

Estimates for the prevalence of psychotic illness and substance abuse amongst Irish prisoners are in keeping with international estimates of morbidity in prisons, whilst those for affective disorders are lower. The prevalence of homelessness on committal to Irish prisons is higher than some international estimates. Rates for psychoses, alcohol and substance misuse as well as homelessness in Irish prisons are significantly higher than the general population prevalence of these vulnerabilities. A need for service development is discussed.
Introduction

There are 10.35 million people held in penal establishments worldwide (Walmsley, 2016). Recent large scale systematic reviews have established that prisoners suffer multiple vulnerabilities including mental disorder, substance misuse and homelessness. Fazel & Seewald (2012), in a systematic review of international literature, found that mental illness is overrepresented in prisoners. They identified a pooled six-month prevalence of psychosis of 3.6% in male prisoners and 3.9% in female prisoners. The pooled prevalence of major depression was 10.2% in male prisoners and 14.1% in female prisoners. No significant differences in rates of psychosis and depression between remand and sentenced prisoners were identified. The authors further found high levels of heterogeneity in the review, partly explained by higher rates of psychosis in low-middle income countries. Fazel and Danesh (2002), in an earlier review of six-month prevalence data from 12 countries, found that 3.7% of men (95% CI 3.3–4.1) had psychotic illnesses and 10% major depression. Rates in women were 4% with psychotic illnesses and 12% major depression. Older prisoners, in addition, may have significantly higher rates of affective disorder, with one study reporting a prevalence of 30% for Depressive Disorder (Fazel et al, 2001). These prison estimates are significantly higher than international population point prevalence estimates for psychotic illness, which have been reported as 4.6/1000 (Saha et al., 2005) and major depressive disorder reported as 4.7% (Ferrari et al., 2013).

Suicides are also over-represented in the prison population. A study (Fazel et al, 2011) reviewing data from 12 countries found that in men, crude relative rates of suicide were at least three times higher than the general population. Western European countries had similar
rates of prisoner suicide, which were mostly higher than those in Australia, Canada, and New Zealand. In women, inmate suicide rates varied widely and were raised compared with rates in the general population.

Substance and alcohol misuse are associated with significant economic burden (Rehm et al., 2006) and are risk factors for offending (Grann & Fazel, 2004). Their prevalence in marginalised communities such as homeless populations and in prisons is of international concern. A systematic review evaluating substance abuse and dependence (Fazel et al, 2006) across 13 prison-based studies, found that estimates of prevalence for alcohol abuse and dependence in male prisoners ranged from 18 to 30% and 10 to 24% in female prisoners. The prevalence estimates of drug abuse and dependence varied from 10 to 48% in male prisoners and 30 to 60% in female prisoners. This review excluded studies citing only lifetime prevalence rates. Compared with US general population estimates (Kessler et al., 1994), this review noted that male prisoners have a slight excess of alcohol dependence and a two- to 10-fold excess of drug dependence whilst estimates for female prisoners noted a two to fourfold excess of alcohol dependence and thirteen-fold increase in drug dependence.

Incarceration is associated with homelessness, and homelessness can be a cause or consequence of incarceration (McCann, 2003). Homelessness is in itself associated with higher levels of mental illness and substance misuse (Fazel et al., 2008) with both these vulnerabilities affected by trends towards the closure of long stay psychiatric hospitals or “asylums” (Paulson, 2012). Dale et al. (2005) found that 16% of those incarcerated in the San Francisco penal system were homeless. Greenberg et al (2008), in a national study of US inmates, found that 12.4% had been homeless in the previous year, although not at the time
of incarceration; and 2.9% were homeless at the time of incarceration. A United States Bureau of Justice Statistics study (Hughes, Wilson, & Beck, 2001) representing a nationwide survey of state prisoners expecting to be released in 1999, found that 12 percent reported being homeless at the time of their arrest. Estimates in the UK for homelessness at the time of committal are 15% (Williams, Poyser & Hopkins, 2012).

The Irish Prison Reform Trust (2016) reported that there were 3,674 people in prison custody in Ireland as of December 2016, with a rate of imprisonment of 79 per 100,000 of population. The Irish prison population increased by 400% from 1970 to 2011. The 14 institutions in the Irish prison system consists of 11 traditional “closed” institutions, two open centres and one “semi-open” facility. Female prisoners are accommodated in two prisons nationally. The Irish Prison service (2015) reported of those sent to prison, 79.4% were male and 20.6% were female. Approximately one sixth of the total prison population comprised remand prisoners.

Mental disorder, substance misuse (Council of Europe, 2015) and homelessness (Irish Prison Reform Trust, 2003) have been highlighted as key areas of need amongst Irish prisoners. Whilst the prevalence of these vulnerabilities are studied by health services, governmental and non-governmental organisations, they have not been systematically reviewed.

Whilst reviews of international literature often report lifetime prevalence of these vulnerabilities, an analysis of need informing resource management requires estimates of point prevalence – What proportion of prisoners actively suffer with a psychotic, major affective disorder or substance misuse disorder at the time of assessment? What proportion
are homeless at the time of committal to prison? This is in contrast to those that have a history of these vulnerabilities, which although relevant to their long term needs, may be less pertinent when estimating immediate care needs. In this study, we systematically review published studies which estimate the reported point prevalence of major mental illness, alcohol and substance misuse at the time of assessment, and that of homelessness on committal in Irish prisoners.
Objectives

To systematically analyse published data pertaining to three questions:

a) What is the reported point prevalence of psychotic illness and major affective disorder in Irish prisoners?

b) What is the reported point prevalence of alcohol or substance misuse disorder in Irish prisoners?

c) What was the reported point prevalence of homelessness on committal in Irish prisoners?
Methods

PRISMA Guidelines (Moher et al, 2009) were followed in the conduct of this review. A research librarian (ID) conducted searches of PsycINFO, MEDLINE, PubMed, EMBASE & Google Scholar (1 January 1966 – 31 December 2016) for publications citing Irish data (Republic of Ireland) on point prevalence of Major Mental Illness, Substance misuse/dependence and Homelessness amongst prisoners using the search terms “mental*, psych*, prevalence, disorder, prison*, substance*, alcohol, drug*, misuse, dependen*, abuse, home*, nfa, no fixed abode, prison*, inmate, jail, sentenced, remand, detainee” and also combinations of those.

We additionally searched websites of the Irish Prison Reform Trust, Mental Health Commission, Irish Prison Service and the Council of Europe. We augmented searches by reviewing research repositories including Lenus (a repository specific to the Irish health service), Scopus and reviewing governmental reports.

As overarching general inclusion criteria, studies were required to 1) be drawn from the general prison population, 2) relate to adult (> 18 years) males and/or females in an Irish prison and 3) cite quantitative data with a clear numerator and denominator.

Additional specific inclusion/exclusion criteria included:

1) For the purpose of this study, “Major mental Illness” included Psychosis (Schizophrenia, Schizoaffective disorder, Delusional Disorder, Psychotic Depression,
Mania with Psychosis, Drug induced psychosis) and Affective Disorder (Major Depressive Disorder, Bipolar Affective Disorder). Inclusion required the use of a standardised diagnostic classification and/or psychiatric assessment. Studies based solely on self-reported symptoms were excluded, as were those drawn from select prison subpopulations (Giblin, Kelly et al. 2012) and hospitalisation samples (O’Connor and O’Neill 1990; Linehan, Duffy et al. 2002). Data on point prevalence were extracted, as opposed to lifetime prevalence. Therefore, samples reporting historical diagnoses based on retrospective chart review (Davoren et al., 2014) were excluded.

2) Studies on Substance Misuse and Alcohol Misuse were included where diagnoses were made using a standardised diagnostic classification and/or psychiatric assessment. For the purpose of this study, “misuse” was defined as harmful use or dependence. Studies based solely on self-reported symptoms or drug testing (Long, 2008) were excluded, as were those drawn from prison subpopulations such as hospitalisation samples or screened sub samples where the screening tool used did not target substance misuse (O’Neill et al., 2016; McInerney et al., 2013). Data on point prevalence were extracted, as opposed to lifetime prevalence (O’Mahony, 1997). Therefore, samples reporting historical diagnoses based on retrospective chart review (Davoren et al, 2014) were excluded.

3) For the purpose of this study, homelessness was defined as included those living “homeless and roofless” and in “unsettled accommodation”. Data on homelessness at the time of incarceration were extracted, as opposed to a lifetime history of homelessness. Studies drawn from prison subpopulations such as screened samples
where the screening tool used did not assess homelessness (O’Neill et al., 2016; McInerney et al., 2013) and hospitalisation samples were excluded.

Data were independently extracted by two researchers (GG, a Consultant Psychiatrist and NK, a Senior Registrar in Psychiatry) for each included publication. There was no disagreement in data extracted by the two researchers.

Statistical Analysis

For each outcome (psychosis, affective disorder, alcohol use, substance use, homelessness upon committal) a proportion meta-analysis was conducted to calculate the pooled percentage of prisoners who were suffering from each outcome. Inconsistency was measured across studies using the $I^2$ statistic, which reflects the percentage of variability in effect estimates due to heterogeneity, rather than sampling error; 30% to 60% is considered moderate levels of heterogeneity, 50% to 90% substantial heterogeneity and 75% to 100% considerable heterogeneity (Higgins et al., 2011). Heterogeneity in meta-analysis refers to when the true effects being evaluated differ between studies. If the variation between the studies’ results is above that expected by chance there is evidence of heterogeneity. The Cochrane Q test was used to test heterogeneity, where random effects models were used where there was evidence of significant heterogeneity and fixed effects models where there was no evidence of significant heterogeneity. Meta-analysis calculations were performed and graphical plots were created using StatsDirect software.
**Study quality**

For each included study, the quality of the study was assessed using the adapted Newcastle-Ottawa scale (Wells et al, 2011). This is a commonly used quality assessment tool for non-randomised studies including case control and cohort designs. It has previously been adapted to use in cross sectional studies (Herzog et al., 2013). However, due to the lack of validation for cross sectional studies, we have used this as a descriptive indicator of study quality and not in statistical weighting.
Results

We reviewed 408 abstracts of which inclusion criteria were met for 8, 6 and 5 studies reporting the prevalence of major mental illness, substance misuse and homelessness on committal, respectively (Figure 1). Study quality is reported, using the adapted Newcastle-Ottawa scale in Table 1. Based on the evidence of significant heterogeneity in our review, random effects models were used for proportion meta-analyses.

Psychotic disorder

Eight studies, with a total sample size of 28012 prisoners, reported suffering from a psychotic disorder (Table 2). The pooled percentage suffering from a psychotic disorder, from a random effects model, was 3.6% (95% confidence interval = 3.0%, 4.2%) (Figure 2). There was substantial heterogeneity in the percentage of prisoners diagnosed with a psychotic disorder across studies ($I^2 = 54.8\%$; Cochran’s $Q$ $p=0.03$).

The prevalence in male samples was 3.8% (n=1060/27781). Only two studies (Mohan et al., 1997; Wright et al., 2006) evaluated prevalence in a purely female sample and estimates for females were 3.9% (n=9/231). Estimates of prevalence in purely remand samples could be extracted from four studies (Linehan et al., 2005; Curtin et al., 2009; McInerney et al., 2013; O’Neill et al., 2016) and were 3.9% (n=1043/26806).
Major Affective Disorder

Seven studies, with a total sample size of 7928 prisoners, reported an affective disorder (Table 3). The pooled percentage suffering from an affective disorder, from a random effects model, was 4.3% (95% confidence interval = 2.1%, 7.1%) (Figure 3). There was considerable heterogeneity in the percentage diagnosed with an affective disorder across studies ($I^2 = 91.9%$; Cochran’s Q $p<0.001$).

Prevalence from male samples was 2.33% (n=180/7697). Only two studies (Mohan et al., 1997; Wright et al., 2006) evaluated prevalence in a purely female sample and estimates for females were 9.1% (n=21/231). Estimates of prevalence in purely remand samples could be extracted from two studies (Linehan et al., 2005; O’Neill et al., 2016) and were 2.1% (n=134/6409).

Alcohol and Substance use disorders

Six studies, with a total sample size of 1659 prisoners, reported alcohol or substance use disorders (Table 4). The pooled percentage suffering from alcohol disorder across the six studies, from a random effects model, was 28.3% (95% confidence interval = 19.9%, 37.4%) (Figure 4). There was considerable heterogeneity in the percentage suffering from alcohol use disorder across studies ($I^2 = 92.9%$; Cochran’s Q $p<0.0001$). The pooled percentage for prisoners reporting a substance use disorder across the studies, from a random effects model, was 50.9% (95% confidence interval = 37.6%, 64.2%) (Figure 5). There was considerable heterogeneity in the percentage suffering from substance use disorder across studies ($I^2 =$...
Prevalence in male only samples was 37.1% (n=564/1520) for alcohol use disorder and 51% (n=775/1520) for substance use disorder. Two studies (Mohan et al., 1997; Wright et al., 2006) evaluated prevalence in a purely female sample and estimates for females were 17.2% (n=24/139) for alcohol use disorder and 62.6% (n=87/139) for substance use disorder. Estimates of prevalence in purely remand samples could be extracted from only one study (Linehan et al., 2005) and were 34.5% (n=80/232) for alcohol use disorder and 53% (n=123/232) for substance use disorder.

Homelessness on committal

Five studies, with a total sample size of 1523 prisoners reported homelessness at time of committal (Table 5). The pooled percentage of homelessness from a random effects model was 17.4% (95% confidence interval = 8.7%, 28.4%) (Figure 6). There was considerable heterogeneity in the percentage of homelessness on committal across studies ($I^2 = 96.2%$; Cochran’s Q p<0.001).

Prevalence in purely male samples was 8.2% (n=55/670). Only one study (Wright et al., 2006) evaluated prevalence in a purely female sample and estimates for females were 18.8% (n=35/186). Estimates of prevalence in purely remand samples could be extracted from two studies (Linehan et al., 2005; Davoren et al., 2014) and were 23.2% (n=153/658).
Conclusions and Discussion

Prisoners can experience a range of barriers to successful re-entry into society (Sarma, 2014). Homelessness, mental illness and substance misuse are three such barriers, which our study show as being prevalent in Irish prisons. To our knowledge, this is the first systematic review estimating the current prevalence of these vulnerabilities amongst Irish prisoners.

Implications

A number of implications arise from these findings. This study confirms that a significant proportion of Irish prisoners present with a current psychotic or major affective disorder, which are potentially treatable mental illnesses. From a clinical view point, effective treatment of mental illness may reduce morbidity as well as potentially reduce mortality through suicide (Kapur, 2008), and potentially impact recidivism rates (Lovell et al., 2002). This finding strengthens the argument for development of diversion services which, to date, are geographically variable and still evolving in Ireland (Gulati & Kelly, 2018). Ireland has the lowest per capita secure psychiatric bed availability in developed countries (Kennedy, 2016). Diversion services need an expansion of bed capacity within Irish mental health services (Kennedy, 2006; Gulati & Kelly, 2018) and changes in attitudes towards mentally disordered offenders (Duffy et al., 2013). Rates for psychotic disorders are in keeping with international estimates of prison morbidity (Fazel & Seewald, 2012), which are significantly higher than general population estimates (Saha et al., 2005).

Rates for affective disorders in our study were higher, as would be expected in purely female
samples, but low for remand samples in Ireland. The overall rates were lower than international comparisons and this may be due to the skewing of results based on one study where no prisoner was found to be suffering with a major affective disorder (Smith et al., 1996) or the use of point prevalence estimates in our study as opposed to period prevalence estimates in international comparisons. However, this would not explain why the rates in remand samples were low and may inform the need to review whether current screening processes for affective disorder in remand prisons (Grubin et al., 2002) are adequate.

The burden of harmful use or dependence on alcohol and substances in Irish prisons is substantial. One in three prisoners had a current alcohol misuse or dependence and one in two a problem with current substance misuse or dependence. This is in keeping with international prison estimates (Fazel et al., 2006) and substantially higher than Irish general population estimates (Irish Medical Organisation, 2015). Substance and alcohol misuse are seen as key risk factors for recidivism. Prison and probation services have invested in treatment programmes but availability remains variable geographically. In the Irish context, treatment programmes for women, those specific to alcohol misuse as well as those focussed on novel drugs of misuse are seen as gaps in provision (Clarke and Eustace, 2016). The co-occurrence of a severe mental illness and a substance use or abuse disorder are common (Bluckley, 2006) with causes including self-medication, genetic vulnerability or lifestyle. The consequences include self-neglect, poor physical health, poor medication adherence, increased suicide risk and increased recidivism. There may be value in integrated treatment plans for that address both the addiction disorder and the mental illness (Minkoff, 1989).

Our study found that over one in six Irish prisoners is homeless at the point of committal. This is higher than prison estimates in the US (Greenberg et al, 2008; Hughes, Wilson & Beck, 2001)
but only slightly higher than a comparative UK prison estimate (Williams, Poyser & Hopkins, 2012). However, it is significantly higher than the prevalence of homelessness in the general Irish population (Central Statistics Office, 2016). McCann (2003) concluded that homelessness was both a cause and consequence of imprisonment. Hickey (2002) qualitatively studied the experience of ex-offenders. Nearly half of those participating in Hickey’s study highlighted homelessness as one of the key contributory factors leading them to re-offend on release.

Recidivism rates in Ireland are often used as a proxy for the success of rehabilitation programmes (Martynowicz & Quigley, 2010). Analysing data relating to over 19,000 prisoners in Ireland, O’Donnell et al (2008) found that 49.2% of prisoners were re-imprisoned within four years with 27.4% within the first year. Addressing homelessness would potentially impact recidivism and imprisonment rates over and above the obvious humanitarian impact.

The coexistence of severe mental illness, substance misuse and homelessness has been studied in international literature (Drake, Osher & Wallach, 1991) and these often go hand in hand, interacting in ways that amplify the vulnerability of an individual. Homeless individuals with mental illness are unlikely to seek help and treatment, and those that also have an active substance misuse often excluded from temporary accommodation, with consequent further social decline and increased risk of imprisonment. It would follow that efforts to find suitable accommodation through resettlement services should be undertaken in conjunction with treatment of mental illness and/or substance misuse in prisoners.

In summary, the extent of psychiatric and psychosocial morbidity in worldwide prisons is of international concern as they are significantly higher than general population prevalence. Our review found that psychiatric and psychosocial morbidity in Irish prisons are largely in keeping with worldwide prison estimates, and recommends improved screening for affective
disorders, the development of diversion services and the consideration of integrated treatment plans addressing psychiatric and psychosocial need.

Strengths and Limitations

The strengths of this review include the search criteria which led to the identification of multiple samples for each outcome of interest within a relatively small jurisdiction.

The key limitation of this study is the high level of heterogeneity. While pooled prevalences are reported, and random-effects model used to account for heterogeneity, we recommend interpreting these results with caution. Such a high level of heterogeneity would be expected in such a study in view of differences in study designs, study periods, sampling, diagnostic criteria (ICD vs DSM), category of prisoners (remand vs sentenced vs mixed) and gender differences, as has been seen in previous meta-analyses (Fazel & Seewald, 2012). Furthermore, two included studies (McInerney et al., 2013; O’Neill et al., 2016) used case ascertainment through screening. In McInerney’s study (2013), screening consisted of selecting all committals who on reception disclosed a history of previous psychiatric contact or prescription of psychiatric medication, a history of deliberate self-harm, who exhibited unusual or disturbed behaviour, those charged with homicide and individuals with a known history of treatment by prison psychiatric services. In O’Neill’s study (2016), this was undertaken using the Grubin screening tool questions (Grubin et al., 2002) which has a reported sensitivity and specificity of 97% and 84% respectively in a UK sample. The use of screening for case ascertainment has the potential to bias prevalence estimates.
Future research may usefully be aimed at re-evaluating point prevalence of these vulnerabilities through an up to date nationwide cross-sectional study with a robust study design and standardised outcome measures to limit heterogeneity.
### Table 1: Study Quality assessment (adapted Newcastle-Ottawa Scale)

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Psychosis</th>
<th>Affective Disorder</th>
<th>Substance Misuse</th>
<th>Homelessness On Committal</th>
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**Legend for rating:** Representativeness of sample (0-1) + Sample size (0-1) + Non-respondents (0-1) + Use of validated tool (0-2) + Assessment of outcome (0-2) + Statistical methods (0-1), Maximum score = 8
### Table 2: Prevalence of Psychotic Disorder

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Location</th>
<th>Diagnostic Criteria</th>
<th>% Male</th>
<th>Remand/Sentenced/Mixed</th>
<th>n (psychosis)</th>
<th>N (total)</th>
<th>Prevalence (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith et al</td>
<td>1996</td>
<td>Mountjoy</td>
<td>DSM III R</td>
<td>100</td>
<td>Mixed</td>
<td>9</td>
<td>235</td>
<td>3.8% (1.8%, 7.1%)</td>
</tr>
<tr>
<td>Mohan et al</td>
<td>1997</td>
<td>Dochas</td>
<td>DSM IV</td>
<td>0</td>
<td>Mixed</td>
<td>1</td>
<td>45</td>
<td>2.2% (0.1%, 11.8%)</td>
</tr>
<tr>
<td>Linehan et al</td>
<td>2005</td>
<td>Cloverhill, other remand centres</td>
<td>ICD 10/DSM III R</td>
<td>100</td>
<td>Remand</td>
<td>10</td>
<td>232</td>
<td>4.3% (2.1%, 7.8%)</td>
</tr>
<tr>
<td>Duffy et al</td>
<td>2006</td>
<td>Multiple prisons</td>
<td>DSM IV/ICD 10</td>
<td>100</td>
<td>Sentenced</td>
<td>7</td>
<td>438</td>
<td>1.6% (0.6%, 3.3%)</td>
</tr>
<tr>
<td>Wright et al</td>
<td>2006</td>
<td>Dochas, Limerick</td>
<td>ICD 10</td>
<td>0</td>
<td>Mixed</td>
<td>8</td>
<td>186</td>
<td>4.3% (1.9%, 8.3%)</td>
</tr>
<tr>
<td>Curtin et al</td>
<td>2009</td>
<td>Mountjoy, Cloverhill</td>
<td>ICD 10</td>
<td>100</td>
<td>Mixed</td>
<td>13</td>
<td>615</td>
<td>2.1% (1.1%, 3.6%)</td>
</tr>
<tr>
<td>McInerney et al</td>
<td>2013</td>
<td>Cloverhill</td>
<td>ICD 10</td>
<td>100</td>
<td>Remand</td>
<td>766</td>
<td>20084</td>
<td>3.8% (3.6%, 4.1%)</td>
</tr>
<tr>
<td>O’Neill et al</td>
<td>2016</td>
<td>Cloverhill</td>
<td>ICD 10</td>
<td>100</td>
<td>Remand</td>
<td>255</td>
<td>6177</td>
<td>4.1% (3.6%, 4.7%)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1069</td>
<td>28012</td>
<td>3.6% (3.0%, 4.2%)</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Location</td>
<td>Diagnostic Criteria</td>
<td>%Male</td>
<td>Remand/ Sentenced/ Mixed</td>
<td>n (affec.)</td>
<td>N (total)</td>
<td>Prevalence (95% CI)</td>
</tr>
<tr>
<td>---------------</td>
<td>------</td>
<td>----------------------------------------</td>
<td>---------------------</td>
<td>-------</td>
<td>-------------------------</td>
<td>------------</td>
<td>-----------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Smith et al</td>
<td>1996</td>
<td>Mountjoy</td>
<td>DSM III R</td>
<td>100</td>
<td>Mixed</td>
<td>0</td>
<td>235</td>
<td>0% (0%, 1.6%)</td>
</tr>
<tr>
<td>Mohan et al</td>
<td>1997</td>
<td>Dochas</td>
<td>DSM IV</td>
<td>0</td>
<td>Mixed</td>
<td>6</td>
<td>45</td>
<td>13.3% (5.1%, 26.8%)</td>
</tr>
<tr>
<td>Linehan et al</td>
<td>2005</td>
<td>Cloverhill, other remand centres</td>
<td>ICD 10/ DSM III R</td>
<td>100</td>
<td>Remand</td>
<td>17</td>
<td>232</td>
<td>7.3% (4.3%, 11.5%)</td>
</tr>
<tr>
<td>Duffy et al</td>
<td>2006</td>
<td>Multiple prisons</td>
<td>DSM IV/ ICD 10</td>
<td>100</td>
<td>Sentenced</td>
<td>14</td>
<td>438</td>
<td>3.2% (1.8%, 5.3%)</td>
</tr>
<tr>
<td>Wright et al</td>
<td>2006</td>
<td>Dochas, Limerick</td>
<td>ICD 10</td>
<td>0</td>
<td>Mixed</td>
<td>15</td>
<td>186</td>
<td>8.1% (4.6%, 13.0%)</td>
</tr>
<tr>
<td>Curtin et al</td>
<td>2009</td>
<td>Mountjoy, Cloverhill</td>
<td>ICD 10</td>
<td>100</td>
<td>Mixed</td>
<td>32</td>
<td>615</td>
<td>5.2% (3.6%, 7.3%)</td>
</tr>
<tr>
<td>O’Neill et al</td>
<td>2016</td>
<td>Cloverhill</td>
<td>ICD 10</td>
<td>100</td>
<td>Remand</td>
<td>117</td>
<td>6177</td>
<td>1.9% (1.6%, 2.3%)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>201</td>
<td>7928</td>
<td>4.3% (2.1%, 7.1%)</td>
</tr>
</tbody>
</table>
## Table 4: Prevalence of Alcohol and Substance Use Disorders

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Location</th>
<th>Diagnostic Criteria</th>
<th>% Male</th>
<th>Remand/Sentenced / Mixed</th>
<th>n (alc.)</th>
<th>n (subs.)</th>
<th>N (sample)</th>
<th>Prevalence (95% CI) for alcohol</th>
<th>Prevalence (95% CI) for substance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith et al</td>
<td>1996</td>
<td>Mountjoy Prison</td>
<td>DSM III R</td>
<td>100</td>
<td>Mixed</td>
<td>63</td>
<td>46</td>
<td>235</td>
<td>26.8% (21.3%, 33.0%)</td>
<td>19.6% (14.7%, 25.2%)</td>
</tr>
<tr>
<td>Mohan et al</td>
<td>1997</td>
<td>Mountjoy Women’s Prison</td>
<td>DSM IV</td>
<td>0</td>
<td>Mixed</td>
<td>1</td>
<td>26</td>
<td>45</td>
<td>2.2% (0.1%, 11.8%)</td>
<td>57.8% (42.2%, 72.3%)</td>
</tr>
<tr>
<td>Linehan et al</td>
<td>2005</td>
<td>Cloverhill, other remand centres</td>
<td>ICD 10/DSM IV</td>
<td>100</td>
<td>Remand</td>
<td>80</td>
<td>123</td>
<td>232</td>
<td>34.5% (28.4%, 41.0%)</td>
<td>53.0% (46.4%, 59.6%)</td>
</tr>
<tr>
<td>Duffy et al</td>
<td>2006</td>
<td>Multiple prisons</td>
<td>DSM IV/ICD 10</td>
<td>100</td>
<td>Sentenced</td>
<td>200</td>
<td>235</td>
<td>438</td>
<td>45.7% (40.9%, 50.5%)</td>
<td>53.7% (48.9%, 58.4%)</td>
</tr>
<tr>
<td>Wright et al</td>
<td>2006</td>
<td>Dochas, Limerick</td>
<td>ICD 10</td>
<td>0</td>
<td>Mixed</td>
<td>23</td>
<td>61</td>
<td>94</td>
<td>24.5% (16.2%, 34.4%)</td>
<td>64.9% (54.4%, 74.5%)</td>
</tr>
<tr>
<td>Curtin et al</td>
<td>2009</td>
<td>Mountjoy, Cloverhill</td>
<td>ICD 10</td>
<td>100</td>
<td>Mixed</td>
<td>221</td>
<td>371</td>
<td>615</td>
<td>35.9% (32.1%, 39.9%)</td>
<td>60.3% (56.3%, 64.2%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>588</td>
<td>862</td>
<td>1659</td>
<td>28.3% (19.9%, 37.4%)</td>
<td>50.9% (37.6%, 64.2%)</td>
</tr>
</tbody>
</table>
### Table 5: Prevalence of Homelessness on Committal

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Location</th>
<th>Diagnostic Criteria</th>
<th>%Male</th>
<th>Remand/Sentenced/Mixed</th>
<th>n (Homeless)</th>
<th>N (total)</th>
<th>Prevalence (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seymour and Costello</td>
<td>2005</td>
<td>Multiple Dublin prisons</td>
<td>Survey</td>
<td>95</td>
<td>Mixed</td>
<td>60</td>
<td>241</td>
<td>24.9% (19.6%, 30.9%)</td>
</tr>
<tr>
<td>Linehan et al</td>
<td>2005</td>
<td>Cloverhill and other remand centres</td>
<td>Semi structured interview</td>
<td>100</td>
<td>Remand</td>
<td>30</td>
<td>232</td>
<td>12.9% (8.9%, 17.9%)</td>
</tr>
<tr>
<td>Duffy et al</td>
<td>2006</td>
<td>Multiple prisons</td>
<td>Semi structured interview</td>
<td>100</td>
<td>Sentenced</td>
<td>25</td>
<td>438</td>
<td>5.7% (3.7%, 8.3%)</td>
</tr>
<tr>
<td>Wright et al</td>
<td>2006</td>
<td>Dochas, Limerick</td>
<td>Semi structured interview</td>
<td>0</td>
<td>Mixed</td>
<td>35</td>
<td>186</td>
<td>18.8% (13.5%, 25.2%)</td>
</tr>
<tr>
<td>Davoren et al</td>
<td>2014</td>
<td>Cloverhill Dochas</td>
<td>Retrospective record review</td>
<td>74</td>
<td>Remand</td>
<td>123</td>
<td>426</td>
<td>28.9% (24.6%, 33.4%)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>273</td>
<td>1523</td>
<td>17.4% (8.7%, 28.4%)</td>
</tr>
</tbody>
</table>
Figure 1: Study inclusion flowchart

Records identified (n = 408)

Records after duplicates removed (n = 380)

Records screened (n = 380)

Records excluded (n = 353)

Records after duplicates removed (n = 380)

Records screened (n = 380)

Full-text articles assessed for eligibility (n = 27)

Full-text articles excluded; not drawn from general prison population, non-quantitative, not current prevalence, based on self-report (n = 16)

Studies included in in quantitative synthesis (meta-analysis) (n = 11*)

For mental illness, (n=8)
For substance misuse, (n=6)
For homelessness, (n=5)
(* Included studies with one or more outcome of interest)
Figure 2: Forest plot of studies with prisoners diagnosed with a Psychotic Disorder
Figure 3: Forest plot of studies with prisoners diagnosed with an Affective Disorder
Figure 4: Forest plot of studies with prisoners diagnosed with an Alcohol Use Disorder

Proportion meta-analysis plot [random effects]

<table>
<thead>
<tr>
<th>Study</th>
<th>Proportion (95% confidence interval)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith06</td>
<td>0.27 (0.21, 0.33)</td>
</tr>
<tr>
<td>Mohan07</td>
<td>0.02 (0.01, 0.12)</td>
</tr>
<tr>
<td>Linehan05</td>
<td>0.34 (0.26, 0.41)</td>
</tr>
<tr>
<td>Duffy06</td>
<td>0.46 (0.41, 0.50)</td>
</tr>
<tr>
<td>Wright06</td>
<td>0.24 (0.16, 0.34)</td>
</tr>
<tr>
<td>Curtin09</td>
<td>0.36 (0.32, 0.40)</td>
</tr>
<tr>
<td>Combined</td>
<td>0.28 (0.20, 0.37)</td>
</tr>
</tbody>
</table>
Figure 5: Forest plot of studies with prisoners diagnosed with a Substance Use Disorder

Proportion meta-analysis plot [random effects]

- Smith96: 0.20 (0.15, 0.25)
- Mohan97: 0.58 (0.42, 0.72)
- Linehan05: 0.53 (0.46, 0.60)
- Duffy06: 0.54 (0.49, 0.58)
- Wright06: 0.65 (0.54, 0.74)
- Curtin09: 0.60 (0.56, 0.64)
- Combined: 0.51 (0.30, 0.64)
Figure 6: Forest plot of studies with prisoners Homeless on Committal

Proportion meta-analysis plot [random effects]

- Seymour05: 0.25 (0.20, 0.31)
- Linehan05: 0.13 (0.09, 0.18)
- Duffy06: 0.06 (0.04, 0.08)
- Wright06: 0.19 (0.13, 0.25)
- Davoren14: 0.29 (0.25, 0.33)

Combined: 0.17 (0.09, 0.28)
References


Council of Europe: Committee for the Prevention of Torture (2015), “Report to the government of Ireland on the visit to Ireland carried out by the European committee for the prevention of torture and inhuman or degrading treatment or punishment (CPT) from 16 to 26 September 2014 (No. CPT/Inf (2015) 38)”, Strasbourg: Council of Europe: Committee for the Prevention of Torture. Available at:


consecutive male remands”, *International Journal of Mental Health Systems*, 7(1), pp. 18, DOI:10.1186/1752-4458-7-18


**Seymour, M., & Costello, L.** (2005), *A study of the number, profile and progression routes of homeless persons before the court and in custody*. Dublin: Department of Justice, Equality and Law Reform. Available at:


Wells, G., Shea, B., O'Connell, J., Robertson, J., et al. (2013), The Newcastle-Ottawa Scale (NOS) for assessing the quality of nonrandomised studies in meta-analysis. [Website].


Williams, K., Poyser, J., & Hopkins, K. (2012), *Accommodation, homelessness and reoffending of prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) survey*. London:
Ministry of Justice. Available at:

CHAPTER 2

Mental healthcare interfaces in a regional Irish prison

Mental healthcare interfaces in a regional Irish prison

Gautam Gulati FRCPsych, Consultant Psychiatrist, Department of Psychiatry, University Hospital Limerick, Limerick, Ireland & Adjunct Senior Lecturer in Psychiatry, Graduate Entry Medical School, University of Limerick, Ireland. Email: gautam.gulati@hse.ie Tel: 063 98 668 (Corresponding Author)

Kizito Otuokpaikhian MRCPsych, Senior Registrar, Department of Psychiatry, Ennis General Hospital, Co Clare, Ireland.

Maeve Crowley MRCPsych, Senior Registrar, Department of Psychiatry, University Hospital Limerick, Limerick, Ireland.

David Meagher PhD, Foundation Professor of Psychiatry, Department of Psychiatry, University of Limerick Graduate Entry Medical School, Limerick, Ireland.

Colum P. Dunne PhD, Director of Research, University of Limerick Graduate Entry Medical School, Limerick, Ireland.

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Abstract

Objectives

We sought to study the demographic, clinical characteristics and outcomes for those prisoners referred to secondary mental healthcare in a regional Irish prison and the proportion of individuals diverted subsequently from prison to psychiatric settings.

Methods

We conducted a retrospective review of 130 successive psychiatric assessment case records at a regional mixed gender prison serving six southern Irish counties. We analysed demographics, clinical characteristics and outcomes. Where diversion out of prison was undertaken, DUNDRUM scores were retrospectively completed to assess security need.

Results

8.6% of all committals from liberty were referred by a general practitioner and 8.1% subsequently assessed by the visiting psychiatrist. Predominantly, these were young males charged with a violent offence. 42.2% of those assessed by secondary care were diagnosed with a substance misuse disorder and 21.1% with a personality disorder. 20.3% suffered with a psychotic disorder and 10.6% with an affective disorder. Of those seen by psychiatric services, 51.2% required psychotropic medication, 29.2% required psychological input and 59.3% required addiction counselling. 10.6% of those assessed were diverted from prison, the
majority to approved centres. Mean DUNDRUM 1 scores suggested that those referred to High and Medium secure hospitals were appropriately placed whereas those diverted to open wards would have benefited from a Low secure/Intensive Care setting.

Conclusions

The multifaceted need set of those referred strengthens the argument for provision of multidisciplinary mental healthcare into prisons. The analysis of security needs for those diverted from prisons supports the need for Intensive Care Regional Units in Ireland.
Introduction

Mental illness is over represented in Irish prisons compared to the general population (Kennedy et al., 2004; O’Neill et al., 2016) in keeping with data from the United Kingdom (Senior et al., 2013) and prisons worldwide (Fazel & Seewald, 2012; Fazel & Danesh, 2002). In a country-wide Irish cross sectional study, Kennedy et al. (2004) estimated that 7.5% of men on remand, 2.6% of sentenced men and 5.4% of female prisoners should be diverted to psychiatric services. Rates of psychosis were 7.6% amongst men on remand, 2.6% amongst sentenced men and 5.4% amongst women prisoners. Depressive disorder was present in 10% of male prisoners and 20% of female prisoners. In comparison, Senior et al (2013) screened 3492 prisoners from six English prisons and found that 23% suffered with a serious mental illness. They reported that prison mental health in reach teams assessed only 25% of these unwell prisoners, subsequently accepting 13% onto their caseloads. Fazel & Danesh (2002) reviewed 62 surveys from 10 countries including 23000 prisoners and found that 3.7% of men and 4% of women had a psychotic illness whilst 10% of men and 12% of women suffered major depression.

Remand prisoners have different needs, and different prevalence rates of mental illness (Kennedy et al., 2004) and in many countries have higher suicide rates as opposed to sentenced prisoners (Fazel et al., 2008). Similarly, female prisoners (Kennedy et al., 2004; Fazel and Danesh., 2002) are known to have higher rates of mental illness compared to their male counterparts.
From an Irish perspective, the national policy document for mental health services ‘A Vision for Change’ (Department of Health and Children, 2006) highlights the needs of mentally ill prisoners and encourages the development of diversion services. Although established in Dublin based prisons, these are still in the development stage for much of the country. Services have been developed at Cloverhill prison, a male remand prison in Dublin, to screen and divert mentally ill offenders (McInerney et al., 2013; O’Neill et al., 2016) in collaboration with the courts.

In comparison, the UK piloted diversion services in the 1980’s and by the early 21st Century, there were over 150 such services focusing on diversion through the justice pathway such as the point of arrest, policy custody, in court and within prisons. However, there is significant geographical disparity in coverage with no diversion arrangements in some areas. and it was previously estimated that only one-fifth of the potential national caseload was receiving care (Sainsbury Centre for Mental Health, 2009).

Limerick prison houses approximately 248 remand and sentenced prisoners (male n=220; female n=28) from the southern Irish province of Munster (Irish Prison Service, 2017). This corresponds to approximately 7% of the national prison capacity of 3700. On initial reception, all prisoners at Limerick Prison are screened for mental health problems by primary care general nurses. This is done using a computer based questionnaire and completed using prisoner self-report. Minor mental illness is assessed and treated by the General Practitioner in primary care, who provides a 7 day/week service. If a mental illness of a severity requiring secondary care input is suspected, the prison General Practitioner makes a referral for assessment to the visiting psychiatrist (secondary care). The visiting psychiatrist assesses and
advises on further management in prison and may, in some cases, divert the prisoner to a hospital setting (tertiary care) through liaison with community mental health services and the courts. Prisoners may also be transferred to the Central Mental Hospital, which is the only Medium and High secure forensic secure hospital in Ireland.

The need for regional Low secure services (referred to as ICRU’s or Intensive Care Regional Units) to facilitate diversion from hospital has been highlighted (Department of Health and Children, 2006; Mental Health Commission, 2011) but these remain at a planning stage (O’Regan, 2015).

There is little existing data in terms of demographics, diagnoses and outcomes for patients referred to, and assessed by, secondary health services in Irish prisons outside of Dublin. In particular, there is little published data about diversion from such prisons which do not have access to ICRU’s for Low secure psychiatric care and must largely rely on non-secure units, such as general psychiatric wards (referred to as ‘approved centres’ in Ireland) to facilitate local diversion.
Objectives

We sought to comment on mental healthcare interfaces in Limerick prison based on a retrospective analysis of 130 prison mental healthcare case records.

The study questions included:

a) What are the demographic and clinical characteristics of those referred by primary to secondary mental healthcare in the prison?

b) What are the outcomes on assessment for those assessed by secondary mental health services?

c) What is the proportion of individuals diverted from prison to psychiatric settings?

d) Is diversion made to an appropriate level of security?
Methods

Ethical approval was obtained from the Research Ethics Committee of University of Limerick Hospitals.

All 130 assessments by the visiting psychiatrist from January 2015 to May 2016 were within scope.

A spreadsheet was designed to capture demographic (sex, age, remand or sentenced status, educational level, history of alcohol misuse, history of drug misuse, history of self-harm, nature of index offence), eventual diagnoses and outcomes (e.g. prescription of psychotropic medication, referral to psychology, diversion). Two researchers (MC and KO) extracted data from prison electronic healthcare records for 130 consecutive assessments to populate the datasheet.

Where patients were diverted from the criminal justice system, one researcher (GG) completed retrospective analyses using DUNDRUM (Dangerousness, Understanding, Recovery and Urgency Manual) scales (Kennedy et al., 2010). The DUNDRUM-1 scale guides the assessment of the appropriate level of therapeutic security for those requiring mental health interventions using an 11 item scale. Each item is rated using a five-point scale from 0 (no security needed, or no mental disorder), 1 (could be managed in an open psychiatric ward), 2 (could be managed in a local psychiatric intensive care ward/Low secure unit), 3 (could be managed in a Medium secure unit) and 4 (High security required). The ratings for each item have operational definitions. The DUNDRUM-2 triage urgency scale is intended to
be used only for those who have been accepted onto a waiting list for hospital. The DUNDRUM-2 triage urgency instrument consists of six operationally defined items including issues concerning the current location, mental health, suicide prevention, human rights considerations, systemic issues and legal urgency. These tools have been validated in Irish prison populations (Flynn et al., 2011a; Flynn et al., 2011b).
Results

_Demographic and clinical characteristics_

During the study period (1<sup>st</sup> January 2015- 31<sup>st</sup> May 2016), there were 837 male receptions and 681 female receptions ‘from liberty’, 1518 in total. One hundred and thirty (n=130, 8.6%) of these were referred by primary care for psychiatric assessment. There were 7 non-attendances (all male, n=7, 5.4%) and 123 (94.6% of those referred) were assessed by secondary care mental health services. It follows that 8.6% of all committals were referred by a general practitioner and 8.1% subsequently assessed by the visiting psychiatrist (males 108/837=12.9% and females 15/681=2.2%). The majority (n=97, 74.6%) of those referred to secondary care were sentenced prisoners whilst the remainder were on remand (n=33, 25.4%).

See **Table 1** for the demographics of those referred to secondary care. These were predominantly young adults aged 18-30 years (51.5%). There was a wide geographical spread in relation to the county from which patients originated (**Figure 1**), and whilst the majority of referrals were from Limerick (43%), there were patients from 7 different counties and 6.9% (9/130) of those referred were of no fixed abode.

Most of those referred reported that they could read (n=121, 93%) and write (n= 117, 90%), and a significant majority (n=109, 83.8%) completed post-primary schooling. A majority (n=92, 70.8%) had been charged or convicted of a violent offence.
On initial screening, 17 (13%) reported use of alcohol and 68 (52.3%) the use of illicit drugs. Sixty-two (47.7%) gave a history of previous self-harm. Eight individuals (6.2%) reported hopelessness or suicidality at initial screening. Fifty individuals (38.4%) described having a comorbid medical illness.

Assessment outcomes

Following psychiatric consultation (n=123), 42.2% were diagnosed with a substance misuse disorder and 21.1% a personality disorder (emotionally unstable or dissocial). 20.3% suffered with a psychotic disorder (Schizophreniform, delusional or other psychotic disorder) and 10.6% an affective disorder (Depression or Bipolar Disorder). See Table 2 for a detailed breakdown of diagnoses.

Of those seen by psychiatric services, over half (51.2%, n=63) were prescribed psychotropic medication, 29.2% (n=36) were referred for psychological input and 59.3% (n=73) referred for addiction counselling. Diversion to hospital from prison and/or court was undertaken in 13 cases (10.6%) to a hospital or community setting (0.86% of all committals).

Diversions

We recorded 13 diversions from the criminal justice pathway to a mental healthcare setting (11 male, 2 female). Three diversions were made using the Criminal Law Insanity Act, 2006 and eight under provisions of the Mental Health Act, 2001. The diagnoses of those diverted were Bipolar Affective Disorder (n=3), Schizoaffective Disorder (n=2), Delusional Disorder
Diversions (Table 3) were made to High/Medium security (n=3), Low Secure/Psychiatric Intensive Care (n=1), Approved Centres (n=7) and community settings (n=2). The mean age of those diverted was 40 years (Range 21-66 years for Males and 38-64 years for Females). Two patients were admitted to hospitals in County Limerick, two to County Kilkenny, one each to County Cork and County Kerry, two to County Clare and three to County Dublin.

The mean DUNDRUM-1 scores in our dataset were higher for each category of hospital (open ward, PICU, Medium/High Security) than comparative datasets (Flynn et al, 2011a) although our numbers were smaller. In particular, a mean score of 19.28 for those transferred to approved centres (open wards) in our study would indicate that such transfers occurred to a lower level of therapeutic security than would be appropriate. The mean score of 29.66 for those transferred to the Central Mental Hospital (Medium/High Secure) would indicate that these diversions were appropriate to risk and need.

The mean DUNDRUM-2 scores in our study were greater for those requiring transfer to the Central Mental Hospital (Medium/High Security) than those requiring lesser security (PICU and open wards). This would indicate that those requiring a Medium/High secure forensic setting also required a more urgent transfer out of prison.
Conclusions and Discussion

We use a descriptive dataset to outline the demographics, clinical characteristics and outcomes of those referred to secondary mental health services in a regional Irish prison, and a subset reflecting those diverted to tertiary care. Our study found that 8.6% of those arriving in prison from liberty were referred by primary to secondary care, and of this proportion, 10.6% were diverted from prison to tertiary care. This compares to 15% and 5.3% respectively when compared to a recent large scale study in Ireland’s largest remand prison (O’Neill et al., 2016).

Whilst this may give some indication of need, there are three main limitations. Firstly, caution should be exercised when extrapolating to hypothesise prevalence figures for mental illness in the prison, as a number of those with mental illness would be managed by primary healthcare in prison and, therefore, not referred to secondary mental healthcare or reflected in this dataset. This would be more likely the case since the psychiatric service to the prison is sessional (part-time) rather than dedicated (5 days a week in larger remand prisons); only those with active symptoms of severe mental illness or overt behavioral disturbance are referred on for assessment by secondary care. Therefore, a like for like comparison cannot be made with existing large scale studies (O’Neill et al., 2016; McInerney et al., 2013) where a positive screen for any severity of mental illness would lead to an automatic referral to secondary care.

Secondly, whilst our dataset uses recorded clinical outcomes, diagnoses were based on clinical interview guided by the International Classification of Diseases, 10th Edition (World
Health Organization, 1992) rather than validated research based assessments. Therefore, referral rates and diagnoses on assessment in secondary care could potentially be affected by the training and experience level of the assessors and operational issues such as staff turnover which may impact these due to levels of familiarity with a particular prisoner or their history.

Lastly, the prison population is dynamic. A prison with a capacity of 248 would usually have a large throughput. To accurately estimate prevalence a more robust methodology (as in Kennedy et al., 2004) using validated research based interviews to cross-sectionally interview a representative prison population would be more meaningful. The last such Irish dataset would appear to be from 2004, and it may be prudent to repeat such a study given the possibility of transinstitutionalisation (Fakhoury & Priebe, 2007) following closure of large psychiatric hospitals in Ireland over the last decade.

Notwithstanding the above limitations our data set found that the majority of mental healthcare likely takes place in primary care. This would be in keeping with the primary/secondary care interface in community psychiatric settings (Agius & Butler, 2000).

Those referred to secondary mental health care in our study were largely young, charged with a violent offence, with a post primary education and able to read and write. Comorbid medical problems (38.4%) and homelessness (6.9%) were significant. In keeping with previously published studies (O’Neill et al, 2016; Kennedy etal, 2004; Fazel and Danesh, 2002), a high proportion of those assessed by secondary care had a comorbid substance use or alcohol use disorder (42.2%). A significant proportion of psychotic illness was encountered (20.3%) amongst those referred. There was substantial need for the prescription of psychotropics
but this was surpassed by the need for addiction counselling (59.3%). A significant number warranted referral for specialist psychological input (29.2%). The above findings would support the recommendations set out in ‘A Vision for Change’ (Department of Health and Children, 2006) which detail a plan for multidisciplinary care in prisons and international calls for equivalence of care between prisons and the community. The visiting psychiatric service to the prison at present, consists of a sessional psychiatrist and sessional nurse employed by the state health service. Psychological services are provided by the Irish Prison Service and addiction counseling by the voluntary sector. There could be benefits for those in receipt of care to receive this from a single multidisciplinary mental health team; an individual who has mental illness and may also suffer substance misuse issues and have housing problems would then have a single point of initial assessment with an integrated care plan thereafter, which would be keeping with mental health services in the community.

Our results suggest that improved screening such as through the inclusion of additional screening questions (Grubin et al., 2002) could potentially contribute to a higher level of referrals, subsequent identification of need and onward diversion. Whilst 12.9% of male committals were referred to mental health services, only 2.2% of female committals were referred. Likewise, only 25.6% of those referred were remand prisoners. Given that remand prisoners and female prisoners (Fazel and Seewald, 2012, Kennedy et al., 2004, Fazel and Danesh, 2002) are known to have higher levels of morbidity, improved screening may need to be focused on the needs of female prisoners and those on remand.

Our analysis of DUNDRUM-1 scores for those diverted would suggest that those in need of Medium or High therapeutic security were afforded such care by the national facility at the
Central Mental Hospital. However, those admitted to approved centres (open psychiatric wards) have a higher need for therapeutic security than what is being afforded, in keeping with calls for Intensive Care Regional Units nationwide (Department of Health and Children, 2006). Put simply, some patients may not be getting the care they need in an appropriate setting, due to the lack of ICRU’s in Ireland. This may have a bearing on tensions in the interface between forensic and general psychiatry services (Khosla et al., 2004) wherein there may be a reticence to accept prison transfers into approved centres wherein the accepting unit does not have sufficient security as well as indirectly impact upon efforts to provide care in settings of least restrictiveness for those who do not require secure hospital care.

In summary, our study contributes to existing national (Kennedy et al., 2004) and international (Fazel and Seewald, 2012) datasets in relation to prison mental health services that indicate psychiatric need alongside psychosocial need. It strengthens the argument for providing multidisciplinary mental healthcare in prison as well as the need to develop Intensive Care Regional Units to facilitate diversion.
Table 1: Demographics of patients referred to secondary care

<table>
<thead>
<tr>
<th>Age (yrs)</th>
<th>Total</th>
<th>n male</th>
<th>n female</th>
<th>n read</th>
<th>n write</th>
<th>n violent</th>
<th>n remand</th>
<th>n DSH</th>
<th>n hopeless/suicidal</th>
<th>n alcohol</th>
<th>n drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-30</td>
<td>67</td>
<td>61</td>
<td>6</td>
<td>62</td>
<td>58</td>
<td>46</td>
<td>15</td>
<td>34</td>
<td>4</td>
<td>7</td>
<td>40</td>
</tr>
<tr>
<td>31-40</td>
<td>37</td>
<td>31</td>
<td>6</td>
<td>36</td>
<td>36</td>
<td>29</td>
<td>9</td>
<td>20</td>
<td>0</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>41-50</td>
<td>14</td>
<td>12</td>
<td>2</td>
<td>12</td>
<td>12</td>
<td>4</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>51-60</td>
<td>7</td>
<td>7</td>
<td>0</td>
<td>7</td>
<td>7</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>&gt;60</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Total (%)</td>
<td>130</td>
<td>115</td>
<td>15</td>
<td>121</td>
<td>117</td>
<td>92</td>
<td>33</td>
<td>62</td>
<td>8</td>
<td>17</td>
<td>68</td>
</tr>
<tr>
<td></td>
<td>(100)</td>
<td>(88.5)</td>
<td>(11.5)</td>
<td>(93)</td>
<td>(90)</td>
<td>(70.8)</td>
<td>(25.4)</td>
<td>(47.7)</td>
<td>(6.2)</td>
<td>(13)</td>
<td>(52.3)</td>
</tr>
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</table>
Table 2: Diagnosis on psychiatric consultation

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Total n* (%) / 123</th>
<th>n (male)* /108</th>
<th>n (female)* /15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Disorder</td>
<td>7 (5.7)</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Adjustment disorder</td>
<td>13 (10.6)</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Bipolar Affective disorder</td>
<td>7 (5.7)</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Depressive disorder</td>
<td>6 (4.9)</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Delusional disorder</td>
<td>2 (1.6)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Schizoaffective disorder or Schizophrenia</td>
<td>11 (8.9)</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Other Psychotic disorders</td>
<td>12 (9.8)</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>26 (21.1)</td>
<td>22</td>
<td>4</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>52 (42.2)</td>
<td>45</td>
<td>7</td>
</tr>
<tr>
<td>Hyperkinetic Disorder</td>
<td>2 (1.6)</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Intellectual Disability</td>
<td>1 (0.7)</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

*More than one diagnosis may be present per individual
### Table 3: Diversions

<table>
<thead>
<tr>
<th>Diverted to</th>
<th>DUNDRUM 1 Mean Scores</th>
<th>DUNDRUM 2 Mean Scores</th>
<th>n (violent offence)</th>
<th>n (male)</th>
<th>n (female)</th>
<th>Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Settings (n=2)</td>
<td>3.5</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>Bipolar Affective Disorder (2)</td>
</tr>
<tr>
<td>Approved centres (n=7) (open psychiatric wards)</td>
<td>19.28</td>
<td>9.42</td>
<td>5</td>
<td>6</td>
<td>1</td>
<td>Paranoid Schizophrenia (3), Schizoaffective disorder (2), Bipolar Affective Disorder (1), Delusional Disorder (1)</td>
</tr>
<tr>
<td>PICU (n=1)</td>
<td>18</td>
<td>9</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>Paranoid Schizophrenia (1)</td>
</tr>
<tr>
<td>High/Medium security (n=3)</td>
<td>29.66</td>
<td>16.33</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>Paranoid Schizophrenia (3)</td>
</tr>
</tbody>
</table>
Figure 1: County of Origin

County of Origin for Individuals referred for Assessment

n= 56 (43%)

n= 16 (12.3%)

n= 6 (5%)

No fixed abode=9 (6.9%)

n=4 (3%)

n=24 (18.5%)

n=1 (0.1%)

n=14 (10.8%)
References


World Health Organisation (1993), “The ICD-10 Classification of Mental and Behavioural
CHAPTER 3

Intellectual disability in Irish prisoners: systematic review of prevalence


Presented at the *Spring Conference of the College of Psychiatrists*, Kilkenny, 6th April 2017.
Intellectual disability in Irish prisoners: systematic review of prevalence

Gautam Gulati FRCPsych, Adjunct Senior Lecturer in Psychiatry, Graduate Entry Medical School, University of Limerick, Ireland. Email: gautam.gulati@hse.ie Tel: 00 353 63 98 668

Valerie Murphy PhD, Clinical Senior Lecturer, University College Cork, Ireland.

Ana Maria Clarke MRCPsych, Senior Registrar, HSE Mid-West.

Kristin Delcellier, Graduate Entry Medical School, University of Limerick, Ireland.

David Meagher PhD, Department of Psychiatry, University of Limerick Graduate Entry Medical School, Limerick, Ireland.

Harry Kennedy MD, Clinical Professor of Forensic Psychiatry, Trinity College Dublin, Ireland.

Elizabeth Fistein PhD, Ethics & Law Curriculum Co-ordinator, University of Cambridge School of Clinical Medicine, Cambridge CB2 0SR, United Kingdom.

John Bogue DClinPsy, School of Psychology, NUI Galway.

Colum P. Dunne PhD, Director of Research, University of Limerick Graduate Entry Medical School, Limerick, Ireland.
Abstract

Objectives

While individuals with an intellectual disability form a significant minority in the worldwide prison population, their healthcare needs require specialist attention. In Ireland, services for prisoners with intellectual disabilities need development. However, there is little substantive data estimating prevalence of intellectual disabilities within the Irish prison system.

Methods

We systematically review published data relating to the prevalence of intellectual disabilities in prisons in the Republic of Ireland. We searched four databases, governmental websites and corresponded with experts.

Results

Little published data were elicited from searches except for one nationwide cross sectional survey which reflected a higher prevalence than reported in international studies. Studies from forensic mental health populations are narrated to contextualize findings.
Conclusions

This study found that there is little data to accurately estimate the prevalence of intellectual disabilities in the Irish prison system and the limited data available suggests that this is likely to be higher than international estimates. We highlight the need for further research to accurately estimate prevalence in this jurisdiction, alongside the need to develop screening and care pathways for prisoners with an intellectual disability.
Introduction

The prevalence of Intellectual disabilities in Ireland is 6.13 per 1,000 population. This is based on National Intellectual Disability Database (NIDD) data from 2015 and population census data from 2011. The prevalence rate for mild intellectual disability is 1.99 per 1,000 while the rate for moderate, severe or profound intellectual disability is 3.59 per 1,000 (Doyle & Crew, 2016). Considerable confusion exists worldwide over the appropriate use of terms such as mental handicap, learning disability, mental retardation and intellectual disability. These are terms derived variously from current or superceded legislation in various jurisdictions and nosological terms from various international classifications. The term ‘developmental disorder’ also has medical currency. The term is often used to describe autistic spectrum disorder and excludes those with acquired brain injuries. For this study, we use the terms mental handicap, learning disability, mental retardation, intellectual disability interchangeably but specified as necessary where defined based on a diagnostic classification or when used in a study. A diagnosis of intellectual disability is typically made if an individual meets three criteria: firstly, a score below 2 standard deviations from the mean on a validated test of intelligence, secondly, evidence of significant impairments in adaptive functioning relative to same-age peers and finally, a developmental history suggesting onset of difficulties before the age of 18 years. The two major diagnostic systems currently in use are the International Classification of Diseases, 10th Edition (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). The ICD-10 Diagnostic Criteria (World Health Organization, 1992) state that “degrees of mental retardation are conventionally estimated by standardized intelligence tests. These can be supplemented by scales assessing social adaptation in a given environment.”
The DSM-5 (American Psychiatric Association, 2013) emphasises the need to use both clinical assessment and standardized testing of intelligence when diagnosing intellectual disability, with the severity of impairment based on adaptive functioning rather than IQ test scores alone. By removing IQ test scores from the diagnostic criteria but still including them in the text description of intellectual disability, DSM-5 aimed to remove overemphasis on IQ as the defining factor of a person’s overall ability without considering functioning levels. The assessment of intelligence across three domains including the conceptual, social and practical domains is highlighted in this classification.

Individuals with intellectual disability form a significant minority in prisons worldwide. Tort et al (2016) found that in a sample of 398 Spanish prisoners, 3.77% of those assessed measured an IQ below 70 (an IQ below 70 is considered part of the criteria for diagnosis of an intellectual disability by international classification systems). Søndenaa et al (2008) in a random sample of 143 Norwegian prisoners found that the prevalence of intellectual disability (IQ <70) was 10.8%. Hassiotis et al (2011) interviewed 3142 prisoners across 131 prisons in England and Wales, reporting a prevalence of Intellectual Disability (IQ <65) as 4%.

Whilst Tort et al (2016) used the Test of Non-Verbal Intelligence (TONI-2), Søndenaa et al (2008) used the Hayes Ability Screening Index (HASI) validated with the Wechsler Abbreviated Scale of Intelligence (WASI) and Hassiotis et al (2011) used the Quick Test. This exemplifies one of the key limitations in interpreting cross-national comparisons of estimates; that is, the differences in methodology used to measure intellectual disability and the differences in cut offs for IQ taken as indicating the presence of an intellectual disability.
A systematic review evaluating 10 surveys from 4 countries dating between 1966-2004 (Fazel, Xenitidis & Powell, 2008) showed that typically 0.5-1.5% (range 0-2.8%) of prisoners were diagnosed with an intellectual disability. Estimates were likely to be conservative given the limited numbers of studies and substantial heterogeneity and, indeed, a more recent systematic review (Hellenbach et al, 2017) reporting four studies published from 2004-2014 noted a higher prevalence estimate of 7-10% worldwide. Hellenbach et al (2017) reported that none of the studies discussed in their paper applied a full clinical assessment of intellectual disability considering both intellectual and adaptive functioning in contrast to the 2008 review by Fazel et al., where included studies used the International Classification of Diseases (ICD) or American Association of Mental Retardation (AAMR) criteria.

Whether intellectually disabled individuals are at higher risk of offending is controversial. Simpson & Hogg (2001) concluded their systematic review of the evidence regarding the association between intellectual disability and offending by commenting that there is ‘no clear evidence that the prevalence of offending among people with a learning disability is higher than for the wider population’. However, there are social theories indicating that although this may be the case, individuals with intellectual disabilities are more likely to be unsuccessful in criminal activities. They are less likely to evade detection or arrest and therefore more likely to be prosecuted. They are also likely to be vulnerable in terms of their rights on arrest such as potentially being unable to understand ‘the right to remain silent’ (Irish College of Psychiatrists, 2005).

Those who have mild intellectual disabilities, but do not have dysmorphic features or physical disabilities, may be less likely to be recognized as having a disability during their criminal
justice journey through the courts or on reception into prisons than those who have physical features or disabilities associated with specific syndromes such as Down Syndrome or Foetal Alcohol Syndrome (Smith et al, 2008). Such “hidden” disabilities could potentially impact prevalence rates disproportionately. Those with comorbid autistic spectrum disorders (ASD) may present as “more able” than would be expected given their IQ. This can be due to the discrepancy between performance and verbal IQ which is a frequent finding for those with ASD.

The Irish College of Psychiatrists (2005), in their publication “People with a Learning Disability who offend: Forgiven but not Forgotten” note the challenges faced by those with intellectual disabilities in contact with the Irish criminal justice system. They note from a nationwide pilot survey, despite a modest response rate, that there were over 400 such individuals in contact with community services and around a quarter of these thought to need urgent forensic psychiatric evaluation. The estimate of prevalence was 9 per 100,000 population and variance from 0.5 to 22.5 per 100,000. Males (4:1) in the age group of 25-54 years (31%) charged with assault (36%) or indecent exposure (14%), were overrepresented in the surveyed population. This survey also noted that 5 individuals then at the Central Mental Hospital had a diagnosis of intellectual disability (about 4%).

A national survey of offending behavior amongst intellectually disabled mental health service users in Ireland (Leonard, Morrison, Delaney-Warner & Calvert, 2015) noted an over representation of young males. In terms of severity 45% had severe, 41.3% moderate and 13.7% mild intellectual disability. This study found that the most common offence type was assault and the second most common was indecent exposure. Of the 82 most serious
offenders, the vast majority were managed by Intellectual Disability Services or General Adult Psychiatry Services.

Secure beds in the Irish Republic are limited to the Central Mental Hospital, Dundrum, offering high and medium secure beds for a national catchment area. Only the Central Mental Hospital is designated under the Criminal Law Insanity Act, 2006, which forms the legal basis for transfer of prisoners. There are no separate specialist secure facilities for intellectually disabled patients in Ireland, although there is recognition of the need for at least two 30 bedded specialist units (Leonard, Morrison, Delaney-Warner & Calvert, 2015). The provision of secure beds is therefore both geographically disparate and substantially lower than other Western European countries.

In this paper, we systematically review published data from prisons in the Irish Republic looking at estimates of prevalence of intellectual disability. This is with a view to establishing need and strengthening the argument for service development and/or policy review.
Methods

Studies of the prevalence of intellectual disabilities in Irish prison populations reported between January 1966 and September 2016 were sought by searches of electronic bibliographic databases (MEDLINE, EMBASE, PsycINFO & CINAHL) using combinations of keywords relating to intellectual disabilities (e.g., intellectual disabilities, mentally retarded, learning disabilities, mental retardation) and to prisoners (e.g., inmate, sentenced, remand, detainee, prison*).

“Learning disability” is the term commonly used in the United Kingdom, whereas this term is more used to describe those with specific learning difficulties in the United States. “Mental Handicap”, a terminology used in the late 20th Century has now been phased out due to pejorative connotations but has been included in the study strategy to avoid publication bias. “Mental Retardation” is a term used in The International Classification of Diseases, 10th Edition (World Health Organization, 1992) and “Intellectual Disability” as used in Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (American Psychiatric Association, 2013). Preferred terminology in contemporary literature would support the use of “Intellectual Disabilities” (Fazel et al, 2008; Hellenbach et al, 2017).

The search strategy was similar to that used for a systematic review and meta-analysis by Fazel, Xenitidis & Powell, 2008. This was supplemented with a review of published article reference lists and computerised searching of governmental and non-governmental sources (e.g., from the Mental Health Commission & the Irish Prison Reform Trust) as well as contact with experts in intellectual disabilities.
Studies were included if all the following were met: (a) presented data on the prevalence of intellectual disabilities; (b) sampled from detainees or sentenced prisoners; (c) used validated instruments for measuring intelligence and/or clinical examination of individual subjects; and (d) presented quantitative findings.

For each eligible study, the following were extracted: year of interview; number of prisoners interviewed; diagnostic instrument(s) criteria and number diagnosed with intellectual disabilities. We provide a narrative review based on the lack of published data we found.
Results

No individual published study identified from database searches met the inclusion criteria. One governmental report with data meeting the inclusion criteria was identified from the website of the Irish Prison Reform Trust. Three studies from database search and one study identified through correspondence with experts detailed diagnoses of intellectual disability in forensic mental health subpopulations. Table 1 summarises the study included and those excluded but narrated for contextual purposes.

We found no single published study evaluating a nationwide cross sectional survey of prevalence through a search of databases. The only country wide cross sectional survey was not elicited by database search, but rather through a search of the website of the Irish Prison Reform Trust. Commissioned by the Department of Justice, Equality and Law Reform of the Irish Government in 1999, Murphy et al (2000) completed psychological assessment on 264 prisoners (255 male, 9 female) which represented 10% of the contemporaneous Irish prisoner population identified through a random selection across 14 Irish prisons. Assessments included the Kaufman Brief Intelligence Test (KBIT), the Wide Range Achievement Test, the Vocabulary sub test from the Weschler Adult Intelligence Scale- Revised, and the National Adult Prisoner Survey. These tests were administered by psychologists and measured intelligence and academic ability. Results showed that 28.8% of the sample population scored below 70 on the KBIT, which was suggestive of a “significant degree of intellectual disability/mental handicap”. Results from other tests were consistent with those of the KBIT.
Four of the published studies included only individuals who were in contact with forensic mental health services and so did not record prevalence estimates in the general prison population. The findings of these were notable for contextual purposes.

O’Connor & O’Neill (1990) studied male prison transfers to the Central Mental Hospital between 1983-1988. The recorded number of admissions was 627. “Mental Handicap” was recorded in 24 patients (4%). The mean length of stay for those with a ‘Mental Handicap’ was noted to be 6 weeks and 38% of these were remand prisoners who had been transferred to hospital. 41% (10/24) were charged with either Murder or an offence against the person. The authors noted that “a large number had other categories of psychiatric disorder and their low intelligence was the least important.” They found that 58% of their sample had an affective or psychotic illness. This publication does not specify the criteria used for diagnosis of ‘Mental Handicap’. The study did not meet inclusion criteria as it did not relate to the general prison population.

Linehan et al (2002) studying the needs of Irish travellers, analysed a computerised case register of all admissions to the Central Mental Hospital for the three years 1997-1999. During that time, all transfers from the prison to hospital were made to the Central Mental Hospital in the first instance. There were 476 admissions of 352 individuals and the travelling community was overrepresented in these admissions. The table presenting the diagnostic clusters makes reference to 484 admissions, out of which 21 (4.34 %) had a diagnosis of an intellectual disability. The authors also noted that 21.4% of travelers admitted to the Central Mental Hospital were diagnosed with an intellectual disability as compared to 3.4% of those with White European ethnicity. There was no individual with an intellectual disability
identified from the Black and Minority ethnic group. Diagnoses were based on the International Classification of Diseases, 10th Edition. This study did not meet inclusion criteria as it did not relate to the general prison population.

Giblin et al (2012) demonstrated reduction in the use of seclusion within a large Irish prison following the setting up of a 10 bedded ‘High Support Unit’ at Mountjoy prison, a prison for sentenced offenders with a capacity of 630. The purpose of the unit was to enhance care for prisoners identified as having substantial mental health needs or those at risk of self-harm. They noted that through the duration of their study 96 patients were admitted to the High Support Unit (HSU). They noted that 29% of these admissions were diagnosed with a major mental illness, 7% with a personality disorder and 4% of patients who required admission to the HSU had an intellectual disability. Diagnoses were made through clinical interview based on the International Classification of Diseases, 10th Edition (ICD-10). This study did not meet inclusion criteria as it did not relate to the general prison population.

Correspondence with experts identified one additional paper (O’Neill et al, 2016) looking at data from 3 years of assessments (6177 remands, 917 individuals assessed, all male) by the PICLS (Prison Inreach and Court Liaison Service) at Cloverhill Prison, the largest remand prison in Ireland. They noted a discharge diagnosis of ‘Mental Retardation’ (F70-79, International Classification of Diseases, 10th Edition) in 1.3% of those who received a full psychiatric assessment by the PICLS team (n=14/1109). ICD-10 diagnoses were recorded following assessment based on clinical interviews and review of past medical and psychiatric case records from prison and community sources. There is little information identifiable on the specific outcomes for those diagnosed with ‘Mental Retardation’. Another way of looking at
the results of this study would be that 0.2 % (14/6177) of those committed to this prison over the study period were eventually diagnosed with Mental Retardation. As the initial screening by general nurses at the prison does not include specific screening for intellectual disability, this would need to be contextualized with caution.
Conclusions and Discussion

We describe a systematic review evaluating the prevalence of intellectual disabilities in prisons within the Irish republic. The significant limitation of our review is that only one study met the inclusion criteria; we therefore narrate four additional studies that indirectly relate to the question but were not eligible for inclusion.

Our review found that there was only one cross sectional survey (Murphy et al., 2000) that estimated nationwide prevalence in a prison setting. This survey showed a substantially higher prevalence (28%) of “significant intellectual disability” in Irish prisons when compared with international estimates of 1.5% (Fazel et al., 2008) and 7-10% (Hellenbach et al, 2017). The strength of the study was cross-sectional sampling from fourteen national prisons. However, the major limitation of the Murphy et al (2000) study was the lack of standardized tests of functional performance. They use KBIT (Kaufman & Kaufman, 2004) as the primary assessment tool; this is a brief, individually administered measure of verbal and non-verbal intelligence. They correlated results with the WRAT (Jastak & Wilkinson, 1984) and the vocabulary subtest of the WAIS-R (Wechsler, 1981) and the NAPS (National Adult Prisoner Survey). The National Adult Prison Survey (NAPS) was an individually administered questionnaire developed specifically for their study, to elicit social functioning indicators from respondents regarding their demographic status, educational history, work skills, employment record and leisure activities. This was, therefore, not a standardized or research validated tool measuring adaptive functioning. As such, it is difficult to know what proportion of those identified would meet the diagnostic threshold for Mental Retardation or Intellectual Disability as defined in an accepted clinical diagnostic manual such as the ICD-10 or DSM-5.
and may point to a potential overestimation in the reported prevalence of 28%, which is higher than international studies. Best practice in the diagnosis of intellectual disabilities places an emphasis on the need to use both clinical assessment and standardized testing of intelligence when diagnosing intellectual disability, with the severity of impairment based on adaptive functioning across conceptual, social and practical domains (British Psychological Society, 2015).

Interestingly, all the studies that looked at forensic mental health subpopulations arrived at approximately the same prevalence of intellectual disability (4%) within the respective subpopulation. It is perhaps not surprising that the prevalence of intellectual disability in this ‘high need’ group is greater than the 0.5-1.5% prevalence of intellectual disability in general prison populations found in the Fazel et al review (2008).

O’Neill et al. (2016) looked at people already identified as having potential health needs (and consequently referred to an inreach and court liaison service), and identified an estimate of 1.3% of those assessed by the psychiatric team or 0.2% of all committals. However, no specific screening for intellectual disability was included for each committal and, as a result, the latter figure is likely to be an underestimate.

It is accepted that reliable studies of intellectual disabilities in prison populations are rare (Duffy et al, 2003) and our review illustrates this finding.

Our study indicates the need for a nationwide cross sectional survey using validated diagnostic systems to define contemporaneous need, so that services can be developed and
national policy can be better informed. There would be additional value in such a study specifying prevalence rates of specific diagnoses such as foetal alcohol syndrome and Down syndrome. It would also be valuable to identify prevalence of “hidden disabilities”, where the individual’s disability only became clear over time or through testing. Such individuals are at a considerable disadvantage as their disability is not immediately identifiable; they often underperform in tasks they are asked to complete and struggle with social interaction, both of which may result in the individual being judged more harshly than they would have been if their disability were more obvious.

If a more contemporaneous systematic prevalence study replicates the findings of the survey in 2000 (Murphy et al., 2000), it may be indicative of a need for effective screening within prisons, as well as a need to reflect on policing and/or prosecution to allow for early identification of significant intellectual disabilities prior to incarceration.

Current screening mechanisms on reception to prison focus on detection of mental illness and have evolved to develop value through minimization of false positives based on high prevalence rates of mental illness in prison (Martin et al, 2016). Recent studies report the feasibility of screening for intellectual disabilities (Board et al., 2015).

A potential starting point for effective screening in a prison setting could be literacy-based. Irish studies have found poor literacy rates in the prison population: Wright et al (2006) found that 12% of a cross sectional sample of female Irish prisoners attended special school or remedial classes in mainstream school. Duffy et al (2006) found that amongst male sentenced Irish prisoners, 47 out of 436 (10.8%) reported having no literacy skills whilst 82 out of 438
(18.7%) reported having attended a special school (including schools for those with behavioural problems) or had remedial classes within a mainstream school. However, using literacy as a sole measure to screen for intellectual disabilities would be confounded by specific learning difficulties as well as demographics such as social deprivation.

Several screening tools have been cited in relation to the screening of intellectual disabilities in prison populations (Hayes, 2002; Paxton & McKenzie, 2006). These have included the The Kaufman Brief Intelligence Test (KBIT), the Vineland Adaptive Behaviour Scales (VABS), the Hayes Ability Screening Index (HASI) and the Learning Disability Screening Questionnaire (LDSQ).

The LDSQ has been validated in a UK sample (McKenzie et al., 2015). It is a 7-item scale and does not require the assessor to have qualifications or training. It has sensitivity of 91% and specificity of 87%, based on a community sample (Paxton et al., 2008); it has a lower sensitivity and higher specificity in forensic populations but has demonstrated discriminative validity (McKenzie et al, 2012). No tool, however, has been validated specifically in an Irish setting, and this may be a further research consideration.

As with any screen, the burden of a false positive and false negative need to be considered. A false positive to a screening test for intellectual disabilities would lead to a comprehensive assessment but also potential stigmatisation. A false negative, however, would potentially leave the individual without access to a care pathway.
Screening would only be meaningful if, firstly, there were resources to conduct a comprehensive follow on assessment and, secondly, if there was a care pathway in place to assist prisoners with intellectual disabilities. For remand prisoners, this would mean access to a timely comprehensive assessment and court diversion service but also access to specialist hospital beds and residential spaces. For sentenced prisoners, this would mean access to specialist treatment, such as adapted sexual offender treatment programmes or violence reduction programmes and specialised rehabilitation (UNODC, 2009). However, even without such pathways, identification of those with intellectual disabilities would be advantageous as offenders with an intellectual disability are associated with elevated suicide rates in prison (Fazel, Xenitidis, & Powell, 2008) and are at risk of victimisation (Talbot, 2008), often requiring housing on vulnerable prisoner wings.

In summary, our findings indicate a need for further research to ensure that those with intellectual disabilities in Irish prisons have, as per prior recommendations, their rights respected (Irish College of Psychiatrists, 2005).
### Table 1. Studies Described (only the first study met inclusion criteria)

<table>
<thead>
<tr>
<th>First Author</th>
<th>Date</th>
<th>Criteria for Diagnosis</th>
<th>Sample size</th>
<th>%Male</th>
<th>Sentenced / Remand</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Murphy, M</td>
<td>2000</td>
<td>KBIT, WRAT, Vocabulary subtest from WAIS-R, NAPS</td>
<td>264</td>
<td>96</td>
<td>Mixed</td>
<td>28.80% in a sample of prisoners</td>
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<tr>
<td>Linehan, S</td>
<td>2002</td>
<td>ICD 10</td>
<td>352</td>
<td>43</td>
<td>Sentenced</td>
<td>4.34% of those admitted to the Central Mental Hospital</td>
</tr>
<tr>
<td>O'Conner, A</td>
<td>1990</td>
<td>Not specified</td>
<td>627</td>
<td>100</td>
<td>Mixed</td>
<td>4% of those admitted to the Central Mental Hospital</td>
</tr>
<tr>
<td>Giblin, Y</td>
<td>2012</td>
<td>ICD 10</td>
<td>96</td>
<td>100</td>
<td>Sentenced</td>
<td>4% of those in a high support prison unit</td>
</tr>
<tr>
<td>O'Neill, C</td>
<td>2016</td>
<td>ICD 10</td>
<td>917 individuals / 1109 remand episodes</td>
<td>100</td>
<td>Remand</td>
<td>1.3 % of those offered a full psychiatric assessment in a remand prison</td>
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</tbody>
</table>
References


http://www.irishpsychiatry.ie/Libraries/External_Affairs/People_with_a_Learning_Disability_who_Offend_Forgiven_but_Forgotten.sflb.ashx


O’Neill, C., Smith, D., Cadow, M., Duffy, F., Hickey, P., Fitzpatrick, M., Cadow, F., Cronin,


CHAPTER 4

A novel care pathway for prisoners with intellectual disability designed through a Delphi process

A novel care pathway for prisoners with intellectual disability designed through a Delphi process

Gautam Gulati FRCPsych, Adjunct Senior Lecturer in Psychiatry, Graduate Entry Medical School, University of Limerick, Ireland. Email: gautam.gulati@hse.ie Tel: 00 353 63 98 668 (Corresponding author)

Stephen Quigley, Stephen Quigley, Psychologist in Clinical Training, Department of Psychology, University of Limerick, Ireland.

Valerie E. Murphy PhD, Clinical Senior Lecturer, University College Cork, Ireland.

Evan Yacoub MRCPsych, Consultant Psychiatrist in Intellectual Disabilities, Brothers of Charity, Galway, Ireland.

John Bogue DClinPsy, Senior Lecturer, School of Psychology, Room 1041, Arts Millennium Building, NUI Galway.

Anthony Kearns FRCPsych, Consultant Forensic Psychiatrist in Intellectual Disabilities, Central Mental Hospital, Dublin, Ireland.

Conor O’Neill MRCPsych, Consultant Forensic Psychiatrist, Central Mental Hospital, Dublin, Ireland.
Mary Kelly FRCPsych, Consultant Psychiatrist in Intellectual Disabilities, Brothers of Charity and Daughters of Charity, Limerick, Ireland.

Aideen Morrison MRCPsych, Consultant Psychiatrist in Intellectual Disabilities, Donegal, Ireland.

Gerard Griffin, Probation Officer, Limerick Prison, Mulgrave Street, Limerick, Ireland.

Mary Blewitt, Chief Nursing Officer, Limerick Prison, Mulgrave Street, Ireland.

Elizabeth Fistein PhD, Ethics & Law Curriculum Co-ordinator, University of Cambridge School of Clinical Medicine, Cambridge CB2 0SR, United Kingdom.

David Meagher PhD, Department of Psychiatry, University of Limerick Graduate Entry Medical School, Limerick, Ireland.

Colum P. Dunne PhD, Director of Research, University of Limerick Graduate Entry Medical School, Limerick, Ireland.
Abstract

Objectives

Individuals with an intellectual disability form a significant minority in the Irish prison population and worldwide prison populations. There is growing recognition that specialist services for such individuals are in need of development. In this paper, we propose a care pathway for the management of individuals with an intellectual disability who present in prison, based on expert elicitation and consensus.

Methods

A convenience sample of professionals with a special interest in forensic intellectual disabilities were invited to participate in a Delphi exercise. Twelve agreed to participation and 10 subsequently completed the study (83.3%). Expert views were elicited using a semi-structured questionnaire. Content analysis was completed using NVivo 11 software. A care pathway was subsequently proposed, based on the outcomes of the analysis, and circulated to participants for debate and consensus. A consensus was reached on management considerations.

Results

Ten experts across a range of disciplines with a combined experience of 187 years participated in the study. Current provision of care was seen as limited and geographically variable. The
vulnerability of prisoners with intellectual disability was highlighted. The need for equivalence of care with the community through multidisciplinary input and development of specialist secure and residential placements to facilitate diversion was identified. Consensus was achieved on a proposed care pathway.

Conclusions

This study proposes a care pathway for the assessment and management of prisoners with an intellectual disability and is, therefore, potentially relevant to those interested in this topic internationally who may similarly struggle with the current lack of decision-making tools for this setting. Although written from an Irish perspective, it outlines key considerations for psychiatrists in keeping with international guidance and, therefore, may be generalisable to other jurisdictions.
Introduction

A diagnosis of intellectual disability is typically made if an individual meets three criteria: firstly, a score below 2 standard deviations from the mean on a validated test of intelligence; secondly, evidence of significant impairments in adaptive functioning relative to same-age peers; and, finally, a developmental history suggesting onset of difficulties before the age of 18 years. The two major diagnostic systems currently in use are the International Classification of Diseases, 10th Edition (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). The prevalence of intellectual disabilities in Ireland is 6.13 per 1,000 population based on National Intellectual Disability Database (NIDD) data from 2015 and using 2011 population census data. The prevalence rate for mild intellectual disability is 1.99 per 1,000, and the rate for moderate, severe or profound intellectual disability is 3.59 per 1,000 (Doyle & Carew, 2016).

The association between intellectual disability (ID) and offending is controversial. Simpson & Hogg (2001) concluded their systematic review of the evidence regarding the association between learning disability and offending by commenting that there is “no clear evidence that the prevalence of offending among people with a learning disability is higher than for the wider population” and that offending amongst those with an IQ less than 50 was rare. There are little contemporary data in relation to the prevalence of intellectual disability in Irish prisoners (Gulati et al., 2017) and existing data would suggest a higher prevalence than international estimates. A survey of 264 Irish prisoners (Murphy, Harold, Carey & Mulrooney, 2000) showed a point prevalence of 28.8% for “significant intellectual disabilities” based on a battery of assessments including the Kaufman Brief Intelligence Test, the Wide Range
Achievement Test, the Vocabulary sub test from the Weschler Adult Intelligence Scale-Revised and the National Adult Prisoner Survey. However, methodological limitations would suggest potential overestimation based on the lack of standardized tests of functional performance (Gulati et al., 2017; British Psychological Society, 2015). For international comparison, a systematic review evaluating 10 surveys from 4 countries dating between 1966-2004 (Fazel, Xenitidis & Powell, 2008) showed that typically 0.5-1.5% (range 0-2.8%) of prisoners were diagnosed with an intellectual disability. Estimates were likely to be conservative given the limited numbers of studies and substantial heterogeneity and, indeed, a more recent systematic review (Hellenbach et al, 2017) reporting four studies published between 2004-2014 noted a higher prevalence estimate of 7-10% worldwide. Hellenbach et al (2017) stated that none of the studies discussed in their paper applied a full clinical assessment of intellectual disability considering both intellectual and adaptive functioning, in contrast to the 2008 review by Fazel et al., where included studies used the International Classification of Diseases (ICD) or American Association of Mental Retardation (AAMR) criteria.

Irish prisons house approximately 3700 inmates across 14 prisons (Irish Prison Reform Trust, 2016). They have access to primary care seven days a week. The prison General Practitioner, in conjunction with primary care nursing staff, plays a key role in the initial assessment of physical and mental health, and in the initiation of psychiatric referral and/or general hospital referral in the case of a physically unwell individual or when mental illness is suspected. The majority of Irish prisons have sessional input from a Consultant Forensic Psychiatrist. Service provisions vary from one to three sessions a week in regional prisons to a full time PICLS (Prison In reach and Court Liaison Service) team based at the national remand prison.
Similarly, the availability of emergency psychiatric input to a prison is variable geographically. Such geographical variability in access to prison mental healthcare has been described in other developed jurisdictions such as the US (Wilper et al., 2009) and the UK (Offender Health Research Network, 2009). Current screening processes for mental disorder in Irish prisons are variable and where present rely on screening questions for mental illness (Grubin et al., 2002) but not intellectual disabilities. Often, the first time an individual with intellectual disability comes to the attention of prison primary care would be when officers raise concerns regarding vulnerability.

Secure beds in Ireland are limited to the Central Mental Hospital, Dundrum offering High and Medium secure beds for a national catchment area and two Psychiatric Intensive Care Units (Cork and Dublin) offering a lesser secure setting. Only the Central Mental Hospital is designated under the Criminal Law Insanity Act, which limits transfer of remand prisoners through legal provisions. There are no separate specialist secure facilities for learning disabled patients in Ireland save for 10 beds at the Central Mental Hospital in Dublin. The provision of secure beds is therefore both geographically disparate and substantially lower than other Western European countries (Kennedy, 2016). High court orders have been used to access specialist care in the United Kingdom. An expert working group of the Irish College of Psychiatrists postulated a need for at least two 30 bedded specialist units (Leonard et al., 2015). The Irish expert group based this estimate on previously published research that cited the need for 30 specialist beds /500,000 population (Day, 1993) and an analysis of the needs of “existing out of state placements” (i.e., patients who have travelled outside of the Irish jurisdiction in order to receive care due to the lack of appropriate resources within the state). The expert group (Leonard et al., 2015) stated that a “30-bedded unit has the advantage of
critical mass, and value for money... It would provide a tertiary service and specialist in-patient assessment and treatment unit for this population”.

Patients with an Intellectual Disability needing acute psychiatric care are therefore managed within Acute Psychiatric Units, despite recognition that specialist services are likely to be beneficial (Department of Health and Children, 2006). A national survey of offending behavior amongst intellectually disordered mental health service users in Ireland (Leonard et al., 2015) noted an over-representation of young males, and reducing percentages in terms of severe (45%), moderate (41.3%) and mild (13.7%) degrees of intellectual disability. This study found that the most common offence types were assault followed by indecent exposure, and that amongst the 82 most serious offenders, the vast majority were managed by Intellectual Disability Services or General Adult Psychiatry Services. Care of individuals in the community are either managed by voluntary sector bodies or the Health Service Executive, and this can lead to inconsistencies in provision and issues along interfaces. Advances are being made however through efforts of the Forensic Learning Disability Working Group (Irish College of Psychiatrists, 2005) and the horizon is more positive with the recent appointment of a specialist in Forensic Learning Disabilities at the National Forensic Service and a plan to open ten specialist secure beds in a purpose-built secure facility in Dublin (Mudiwa, 2014).

There is growing international recognition (World Health Organization, 2008) of the need for specialist care provision for those in prison so as to mirror care in the community. In the case of those with disabilities, the principle of non-discrimination is enshrined in the principles contained in the United Nations Convention on the Rights of Persons with Disabilities, which
apply to all persons with disabilities, including those facing criminal prosecution and prisoners.

There is limited published guidance specifically advising on care considerations for those with ID in prison. Consequently, there is variation in standards and provision of such care. In this paper, we propose a care pathway to inform such care and outline basic steps that should be considered where an individual in prison is suspected or known to suffer with an intellectual disability. Whilst written from an Irish perspective, these considerations may be generalisable to similar jurisdictions.
Methods

Ethical approval was obtained from the Research Ethics Committee of the University Hospital Limerick.

A Delphi process (Hasson et al., 2000) was used to elicit expert opinion. This method has advantages over traditional methods in eliciting expert views such as brainstorming sessions and round-table discussion groups to reduce bias from factors such as the presence of a dominant personality, a 'bandwagon effect', polarization of views, and the unwillingness to change an opinion which had been publicly expressed. This technique replaces direct debate by a carefully designed program of sequential interrogations conducted by questionnaires interspersed with opinion feedback derived by computed consensus from the earlier parts of the program (Brown, 1968).

An email inviting voluntary participation in the study was sent to multidisciplinary professionals including members of an Irish special interest group in forensic intellectual disabilities. Eleven experts (n=11) from Ireland consented to participate. An independent academic psychiatrist (n=1) with expertise in intellectual disabilities from an external jurisdiction (United Kingdom) was separately asked to participate and consented to do so (total n=12).

In round 1, an initial questionnaire (Table 1) was agreed by 4 researchers (GG, DM, SQ & CD) and sent electronically to the 12 experts to elicit views with a 6-week response window, and reminder after week 4. Responders were blind to the views of others. Ten responses (83.3%)
were received, and all ten respondents completed subsequent rounds of the study (hereafter ‘participants’). Participants included a prison psychiatrist, a forensic learning disability psychiatrist, a consultant in mental health and intellectual disabilities, two consultant psychiatrists in community intellectual disability, a prison chief nursing officer, a forensic psychologist, a probation officer and the external academic psychiatrist with expertise in intellectual disabilities. Participants were based in 6 different Irish counties and had a cumulative experience of 187 years (mean 18.7 years, SD 7.76, range 8-30 years). Six (60%) had completed specialist training in intellectual disabilities.

One researcher (SQ) completed Content Analysis using NVivo 11 software extracting themes and content into a codebook. Content was collated into a proposed algorithm by one researcher (GG) which was circulated to participants for agreement and debate (round 2). Consensus was reached on the algorithm.
Results

Content Analysis

The following key themes and associated content emerged from content analysis of 10 questionnaires received (n=10/12, response rate 83.3%). These were amalgamated into a proposed algorithm as presented in Figure 1, and agreed by participants.

Assessment

Participants in our study reported that individuals with ID may be identified by prison staff or the judge/legal team in Court when issues arise in relation to fitness to stand trial. However, those with mild ID / borderline ID may not be identified as frequently.

The Chief Officer (the most senior prison officer) would have a key role in identifying vulnerable prisoners and requesting assessments to be conducted. The prison chaplain can often help identify vulnerable individuals in prisons. Subsequent assessment would be directed by whether there is an existing diagnosis of ID, and collateral from community services and family would assist in this. A formal case conference with local disability services would inform assessment and management where someone is already known to have ID.

A psychiatric history and mental state examination should be appended with questions around vulnerabilities such as bullying, financial exploitation, sexual exploitation, homelessness, harmful behaviour such as sharing needles where injection drug misuse is
comorbid and risks to others such as violence (e.g. to elderly parents) and inappropriate
sexual behavior, based on the nature of the offences. Medical history was highlighted as
important, as higher rates of seizure disorders which of themselves may require special
observation/placement in vulnerable prisoners wing. Formal IQ testing will often, but not
always, have been done in the community. This may need to be completed by the
psychologist based at the prison, alongside assessment of adaptive functioning using
standardised assessments. Participants reported that neuropsychological evaluations are
more difficult to access and the court may be asked to order this from the independent sector
(professionals working in independent organisations on a case by case basis). Behavioural
analysis where required may also involve specialist assistance. Assessments may include
fitness to stand trial, determination of ability to cope in the prison environment alongside
rehabilitation needs and identification of any comorbidities, such as mental illness and
neurodevelopmental disorder.

Care provision

Participants identified that the current care available to those with ID in the prison setting
was variable in multidisciplinary membership, usually only comprising a doctor and nurse.
Participants highlighted the need for multidisciplinary care availability for individuals with ID
involving Psychiatrists, Psychologists, Social Workers, Occupational Therapy, Speech and
Language Therapy, a General Practitioner and educational staff mirroring the hospital-based
service in Dublin. In particular, the lack of availability of adapted courses such as 'stress
management' and 'effective communication' was identified as a need, as well as the lack of a
‘Prison Welfare Officer’ who historically performed a valuable role with vulnerable prisoners.
On the other hand, it was felt “difficult to identify supports appropriate to someone who presented a with potentially highly criminalised lifestyle and low intellectual functioning”.

Diversion to hospital

Participants identified that transfer to hospital may be needed in a number of different circumstances:

a) When the person with ID is, as a consequence of their ID, vulnerable to harm in the prison setting.

b) In relation to issues arising from unfitness to stand trial.

c) When the person with ID has a mental illness which cannot be safely or effectively treated in prison.

d) When the person with ID cannot, as a result of the ID, engage effectively with a rehabilitation and education programme that would be necessary to reduce the risk of re-offending, transfer to a specialist in-patient unit can provide adapted offender treatment programmes.

Although the Criminal Law (Insanity) Act, 2006 has provisions for the transfer of prisoners to a hospital setting, lack of specialist inpatient hospital beds was seen as a barrier to effective provision of diversion, as was perceived reticence from community services to accept a prisoner based on stigma conferred by this status. This was more often the case for people with mild or borderline ID, specialist services for whom are still in early development in Ireland despite the fact that these were recommended a decade ago (Department of Health & Children, 2006).
**Recommendations**

Participants raised the potential value of screening to identify people with ID registered on the National Intellectual Disability Database on reception to prison, in order to mobilise additional monitoring and/or support to reduce the “risk of harm, exploitation or even radicalization”.

Awareness training for prison staff on induction as well as for members of the judiciary and probation services were seen as potentially impacting the care pathway for those with ID. The need for advocacy, often through close liaison with the individual’s solicitor, was outlined as a measure to ensure equitable rights for people with ID.

Simple interventions such as a “communication passport” may help improve quality of life and help navigate the legal system. There is a need for multidisciplinary input with general practitioners, psychologists, psychiatrists, nursing staff, specially trained welfare officers, chaplains and educational staff. The latter may assist with adapted courses such as those addressing “effective communication” and “stress control”.

Advice from local disability teams (i.e. from person's home area) and their attendance at case conference was seen as important in helping inform care in prison and in pre-release planning. The development of care pathways through expansion in the provision of specialist hospital beds and funding for specialist community placements was identified.
Vulnerability

Participants identified vulnerability as a major concern for those with ID in prisons. Bullying may relate to attempts to acquire their medication, persuade them to use illicit drugs, and could extend to emotional, financial and sexual exploitation. Particular challenges were highlighted in the management of persons with autistic-spectrum disorders, who not infrequently present following violent offences but are more likely to be victims of violence in prison settings. Placement on vulnerable prisoner wings were seen as an important measure to help manage some of these difficulties.
Conclusions & Discussion

This study proposes a care pathway for the assessment and management of prisoners with an intellectual disability based on expert elicitation and consensus. This is a subject where there is relatively little structured guidance to date. Although written from an Irish perspective, it outlines key considerations in keeping with international principles (UNODC, 2009; World Health Organisation, 2008) and, therefore, may be generalisable to similar jurisdictions. Care considerations proposed in Australia (State of Victoria, 2008) specific to legal, probation and governmental provisions in the State of Victoria highlight parallel overarching considerations as proposed in our algorithm.

A particular strength of our study is the involvement of representatives from multiple disciplines and an expert external to the jurisdiction. Use of the Delphi method lends to external validity by coalescing the views of multiple experts (Hasson et al, 2000). Our response rate for each round exceeded the suggested response rate of 70% for this method (Sumsion, 1998). A limitation of our study is that the overall number of experts involved is small, as would be expected in a relatively small jurisdiction. Additionally, to pursue non-respondents, the identity of the participants was known to the primary researcher and therefore the process was 'quasi-anonymous' (McKenna, 1994).

Participants in this study stressed the need for equivalence of care for those with ID such that it mirrors provision in the community. This is in keeping with European and international principles for the provision of prison healthcare (United Nations General Assembly, 1990; World Health Organisation, 2008; Council of Europe, 1998; CPT, 2002).
However, responses to our initial survey showed that current care is limited and geographically disparate within Irish prisons. This is similar to the situation in other jurisdictions such as the US (Wilper et al., 2009) and the UK (Offender Health Research Network, 2009). A lack of standardised care for those with ID was highlighted in the UK by the prison inspectorate (Wilson & Hardwick, 2015) who found “extremely poor systems for identifying prisoners with learning disabilities...Even where a learning disability was identified, it was not always sufficiently taken into account in prison processes ...As a result, prisoners with learning disabilities are at risk of having a much more difficult time in prison than those who do not”. Without the appropriate resourcing of prison care services, this proposed care pathway is likely to have a limited impact in practice, and especially so in prisons where the current multidisciplinary complement is limited to a doctor and a nurse; in such prisons, the assessment of those with suspected ID poses a significant challenge. In the absence of appropriate identification, there will be a lack of access to vital services and a potential lack of safeguarding.

Whilst screening for mental illness is developing, systematic screening for intellectual disabilities does not occur currently in Irish prisons. It seems reasonable to state that this may be a focus of significant future research as such screening has been shown to be feasible in other jurisdictions (Board, Ali & Bartlett, 2015). In particular, several screening tools have been cited in relation to the screening of intellectual disabilities in prison populations (Hayes, 2002; Paxton & McKenzie, 2006). These have included the Kaufman Brief Intelligence Test (KBIT), the Vineland Adaptive Behaviour Scales (VABS), the Hayes Ability Screening Index (HASI) and the Learning Disability Screening Questionnaire (LDSQ). The LDSQ has been validated in a UK sample; arguably the most closely-related to an Irish cohort (McKenzie,
Sharples & Murray, 2015). The test is a 7-item scale, does not require the assessor to have particular qualifications or training, with demonstrated discriminative validity in forensic populations (Paxton et al., 2008; McKenzie at al, 2012). It is notable, however, that none of these tools have been validated specifically in an Irish setting, and the impact of cultural and socioeconomic diversity may represent further research avenues.

Physical health comorbidity is common in people with intellectual disability (Bradshaw et al., 2017; Lhatoo & Sander, 2001). There is, in particular, an elevated risk of seizure disorder which may be associated with higher mortality (Robertson et al., 2015) and needs specialist care planning (Murphy et al., 2017; NIHCE, 2016). Participants in our study identified that the assessment of such comorbidity is important and may necessitate specialist placement in itself. Little is known about how such physical health comorbidity is currently managed within the prison setting. In keeping with the principle of equivalence of prison healthcare, a further consideration would be an audit of physical healthcare provision for those with ID in prisons using accepted standards from the community (NIHCE, 2016).

The lack of access to specialist hospital beds for those with ID so as to facilitate diversion was further highlighted as a barrier to delivering effective care. Ireland has the lowest complement of secure beds in Western Europe (Kennedy, 2016) and to develop these would need both political will and specialist expertise.

Participants in our study highlighted the vulnerability of those with ID in the prison setting. This is in keeping with international literature (Hellenbach et al., 2017) in relation to those with ID and parallels the elevated risk of sexual and violent victimisation in the community
(Fogden et al., 2016). Vulnerability may be magnified when there are comorbidities such as Autism Spectrum Disorder, which can lead to challenges arising from social naivety and sensory difficulties and “meltdowns” being perceived as challenging behavior (Murphy, 2010; Dein & Woodbury-Smith, 2009).

Placement on vulnerable prisoner wings may mitigate such risks, but exposes those placed in such settings to limited social contact, a restricted prison regime and potential stigmatization. Arguably, the answer lies in prevention, i.e. effective diversion prior to imprisonment. From an Irish perspective, the interim report of the Interdepartmental Group to examine issues relating to people with mental illness who come in contact with the criminal justice system in Ireland (Department of Justice, 2016) and A Vision for Change (Department of Health and Children, 2006) raise the importance of inter-agency working and potential diversion of those with mental illness and/or ID at the point of arrest and/or custody through the involvement of An Garda Síochána (literally ‘Guardians of the Peace’; the Irish police force). However, diversion services at the arrest and police custody stage of the criminal pathway are yet to be developed in Ireland.

Within existing services, despite geographical variability, one recommendation that is achievable is the use of case conferences to facilitate care planning in prison and post-release planning (Bradshaw et al., 2017) in conjunction with local disability teams. This may be the first step in ensuring that specialist expertise is made available to a person who needs it, and that interfaces such as release associated transfer of care are not times of undue stress for people with ID. This would need strengthening of links between the state health service,
voluntary sector and prison service and a coordinated approach that breaks down practical barriers at these interfaces.

The care pathway proposed in this study is not exhaustive, and is not designed to be such. It is an expert consensus view from one jurisdiction, but it raises many pertinent issues central to the care of those with ID in prisons that are generalisable. If adopted in practice, it may represent an opportunity for people with an intellectual disability in prison to have their basic rights respected (Irish College of Psychiatrists, 2005). Having said that, the value of any proposed pathway lies in effective implementation; future research may usefully be aimed at process mapping the journeys of individuals with ID who find themselves in contact with the Criminal Justice System to learn lessons about the degree to which this pathway is being implemented at the level of the individual and wider systems.
### Table 1: Initial questionnaire

<table>
<thead>
<tr>
<th>Question</th>
</tr>
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<tbody>
<tr>
<td>1. What has been your experience of managing a referral for someone with an intellectual disability (ID) in a prison setting? Was this, for example, a smooth experience, a challenging experience etc?</td>
</tr>
<tr>
<td>2. What do you understand the current stages to be, in the assessment of an individual with an ID in an Irish prison setting?</td>
</tr>
<tr>
<td>3. In your experience which professionals typically undertake these assessments?</td>
</tr>
<tr>
<td>4. To your knowledge, what care is currently available to individuals with an ID in the prison system? Do you feel this is sufficient/appropriate?</td>
</tr>
<tr>
<td>5. Which professionals typically deliver such care?</td>
</tr>
<tr>
<td>6. What additional roles could be taken on by healthcare professionals in the assessment and care of these individuals? Who may be involved? What would this add?</td>
</tr>
<tr>
<td>7. In what circumstances, if any, would you consider treatment in a hospital setting of someone with an ID, currently resident in a prison setting? Have you done this to date? What was the outcome? What problems, if any, did you encounter?</td>
</tr>
<tr>
<td>8. Which pieces of legislation do you believe are relevant to the psychiatric management of someone with an intellectual disability in a prison setting?</td>
</tr>
<tr>
<td>9. What resources have you found helpful when providing assessment and care for individuals with an ID in a prison setting? (Examples may include guidance, advice from a colleague but also specific issues such as legal advice)</td>
</tr>
<tr>
<td>10. What barriers have you encountered to assessing or providing care to an individual with an ID in a prison setting? What was the impact? Did you attempt to overcome them? What did you do? Did it work?</td>
</tr>
<tr>
<td>11. What changes, in your opinion, could be made to improve the assessment and care of individuals with ID in the Irish prison system?</td>
</tr>
</tbody>
</table>
Figure 1: A proposed care pathway for a person with ID presenting to Prison

Trigger:
Individual received to custody & Possibility of ID raised through Chief Officer, Chaplain, GP or Reception nursing staff

Decision point A: Individual with known ID
Actions:
- Recommend placement in Vulnerable Prisoner Wing
- Assessment by GP and Psychiatrist:
  - Assess for comorbid mental and physical illness especially Seizure disorder
- Formulate multidisciplinary Plan addressing Physical, Psychological, Communication, Psychiatric, Educational needs.
- Assess and manage risks arising from vulnerability in conjunction with local services.
- Advise court in relation to presence of ID, comorbidities and potential vulnerability
- Regular review of care plan.
- Arrange pre-release care conference with local disability team

Decision point B: Suspected ID
Actions:
- Recommend placement in vulnerable prisoner wing
- Referral to psychologist for assessment of IQ and adaptive functioning

Outcome: ID Present
Action: Progress as from decision point A.

Outcome: ID not diagnosed
Actions:
- Primary care team to seek collateral to establish if known ID by contacting community GP and Family

Decision point:
Consider diversion to hospital for management of vulnerability, adapted offender treatment programmes or to treat comorbid mental illness
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CHAPTER 5

Hunger Strikes in Prisons– A narrative systematic review of ethical considerations from a physician’s perspective

Hunger Strikes in Prisons—A narrative systematic review of ethical considerations from a physician’s perspective

Gautam Gulati FRCPsych, Consultant Psychiatrist, Department of Psychiatry, University Hospital Limerick, Limerick, Ireland & Adjunct Senior Lecturer in Psychiatry, Graduate Entry Medical School, University of Limerick, Ireland. Email: gautam.gulati@hse.ie Tel: 063 98 668 (Corresponding Author)

Brendan D. Kelly PhD, Professor of Psychiatry, Department of Psychiatry, Trinity College, Dublin, Ireland.

David Meagher PhD, Foundation Professor of Psychiatry, Department of Psychiatry, University of Limerick Graduate Entry Medical School, Limerick, Ireland.

Harry Kennedy MD, Executive Clinical Director, Central Mental Hospital, Dublin & Clinical Professor of Forensic Psychiatry, Trinity College Dublin, Ireland.

Colum P. Dunne PhD, Director of Research, University of Limerick Graduate Entry Medical School, Limerick, Ireland.
Abstract

Objectives

We sought to identify and review published studies that discuss the ethical considerations, from a physician’s perspective, of managing a hunger strike in a prison setting.

Methods

A database search was conducted to identify relevant publications. We included case studies, case series, guidelines and review articles published over a 20-year period. Non-English language publications were translated.

Results

The review found 23 papers from 12 jurisdictions published in 5 languages suitable for inclusion.

Conclusions

Key themes from included publications are identified and summarised in the context of accepted guidelines from the World Medical Association. Whilst there seems to be an overall consensus favouring autonomy over beneficence, tensions along this fine balance are magnified in jurisdictions where legislation leads to a dual loyalty conflict for the physician.
Introduction

A ‘hunger strike’ is by definition food refusal as a form of protest or demand (Crosby, Apovian & Grodin, 2007). This is distinct from food refusal as a consequence of mental illness such as in situations where someone may be severely depressed or harbouring a fixed false belief that their food is poisoned.

Hunger strikes in prison have occurred in several countries including Turkey, South Africa, Ireland and the US Naval base at Guantanamo Bay, Cuba (Crosby, Apovian & Grodin, 2007). In Ireland, these came to the forefront of international attention in 1981, after the death of 10 individuals protesting against the withdrawal of special category status for paramilitary prisoners by the then British Government (Beresford, 1997).

General practitioners, physicians and psychiatrists are commonly involved in the assessment and treatment of those refusing food in prison, and in such a role may be faced with legal and ethical complexities as well as media and governmental pressures. The general practitioner is commonly asked to assess capacity, monitor physical health and may be called upon to provide emergency treatment for the acutely unwell prisoner on hunger strike (Getaz et al, 2012). The general practitioner may refer to a psychiatrist to exclude mental illness and assist in capacity assessment (Brockman, 1999). The general practitioner may seek a medical hospital consultant’s advice when there is substantial deterioration of physical health including in medical emergencies arising from prolonged fasting or if there is a need for supervised re-feeding (Caenazzo, Tozzo & Rodriguez, 2016).
The most widely accepted basis for contemporary decision making remains the Declaration of Malta adopted by the World Medical Association (2006). This cites the need for ethical decision making, respect for autonomy, balancing beneficence (whilst stating that this does not necessarily involve prolonging life at all costs) and non-maleficence (which would include not forcing treatment on competent people). It states unambiguously that forced feeding contrary to an informed and voluntary refusal is unjustifiable. It states that in the case of dual loyalties (to the patient and the state), the first duty remains to the patient and highlights the need for clinical independence, developing trust and maintaining confidentiality.

Increasing international experience and ethical debate has been published over the last two decades. To date, much of this literature has been published in jurisdiction-specific contexts, although the key themes appear to converge. Here, we systematically review literature relating to ethical issues for physicians (a term used interchangeably with ‘medical doctor’ in this paper and includes general practitioners, psychiatrists and hospital medicine consultants) to identify these themes and inform discussion.
Methods

A MEDLINE & CINAHL (1996-2016) search was conducted with the search terms ‘Hunger Strike’ and ‘Ethic*’. We included case studies, case series, guidelines and review articles provided there was a discussion of ethical issues. Publications that did not cite ethical issues (15) were excluded as were publications discussing issues exclusively to do with children/adolescents aged <18 years (1). The timeframe of the database search included 10 years before and 10 years after the landmark consensus position adopted by the World Medical Association in 2006. Grey literature and book chapters were not included in this review.
Results

We reviewed 39 publications of which 23 were included in our review. Studies were mainly in the English language, with others translated from Norwegian (1), French (3), Spanish (1) and Dutch (1) using Google translate software. The publications included papers from twelve separate jurisdictions.

Publications cited ethical arguments along one or more recognised axes in medical ethics: the principles of justice, autonomy, beneficence and non-maleficence (Beauchamp & Childress, 2001). Justice requires that procedures uphold the spirit of existing laws and are fair to all involved. Autonomy requires that the patient have independence of thought, intention, and action when making decisions regarding health care procedures and that a decision-making process must be free of coercion. Beneficence requires that the procedure be provided with the intent of doing good for the patient involved. Non-maleficence requires that a procedure does not harm the patient involved or others in society.

We present our findings in a narrative format, identifying the jurisdiction that the publication relates to, where possible, to aid contextualisation.

Australia

Kenny, Silove and Steel (2004) writing from an Australian perspective and looking at hunger strikes in detained asylum-seekers, noted that there may be pressures on the treating physician based on legal directives from an employing authority that may contradict ethical
positions adopted worldwide. They report that such hunger strikes have occurred in Australia since the introduction of the policy of mandatory detention for asylum seekers, and that these came to the forefront of public attention when 200 detainees embarked on a hunger strike at the Woomera Immigration Reception and Processing Centre in 2002. They further report that an Australian Government regulation empowering the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) to authorise non-consensual medical treatment for a person in immigration detention if they are at risk of physical harm, could inherently conflict with World Medical Association guidelines that prohibit force-feeding (World Medical Association, 2006). However, they also state that authorisation by DIMIA does not compel medical practitioners to enforce treatment if such action is contrary to their “ethical, moral or religious convictions”.

**Austria**

Roggla (2005) raised an issue similar to the Australian context with a then recent Austrian legislation “which demands and legalises medically enforced feeding of detained asylum seekers on hunger strike”. He noted that the doctor’s involvement in the process, which included positioning of nasogastric tubes would be contrary to international medical standards and cited the importance for prison medical doctors to act independently of “governmental interests”. He noted that the doctor’s duties in handling a prisoner on hunger strike were well defined: acquiring a detailed medical history; carrying out a thorough examination; advising the prisoner of clinical consequences; and regular reevaluation and ascertainment of wishes. He argued that any treatment administered to the patient must be with the patient’s approval.
France

Fayeulle et al (2010) surveyed doctors in France about the management of hunger strikes. Ninety-five responses were received from 174 penal institutions across the country. They concluded that the majority of doctors opted for “a neutral attitude” (63%), noting that hunger strikes were mostly brief (less than a week in 85% of cases). They went on to state that it was refusal of care that made the medical approach potentially challenging. They further detailed how “faced with such a situation, 45% of the doctors (surveyed) privileged their duty of care” and 28% “respected the patient's wishes”. 5.5% of the doctors surveyed provided written information concerning the risks incurred during a fast and 23% of those surveyed had witnessed complications due to fasting. The utility of treatment using vitamins was rarely recognized (32.7%).

Italy

Caenazzo, Tozzo & Rodriguez (2016) writing from an Italian perspective regarding prisoners hospitalised at Padua hospital, report instances of court ordered treatment including force-feeding. The authors suggest the use of independent ‘ethics consultants’ becoming involved in the case of hospitalized hunger strikers to assist the building of trust, information giving and to facilitate informed decision making. Garasic and Foster (2012) raise potential inconsistencies in the application of law so as to favour the weight given to either autonomy or beneficence based on the demographics of an individual case. They describe the case of a Tunisian Muslim prisoner charged with rape and held in an Italian prison. He went on a hunger
strike, protesting his innocence and subsequently died with prison authorities reporting that force-feeding was withheld to respect autonomy.

Norway

Dahlberg and Dahl (2015) describe a Norwegian case wherein an asylum seeker in his fifties was on hunger strike for seven weeks and thereafter brought to an emergency room with impaired consciousness, but deemed to have capacity following assessment by a psychiatrist. They note that the two opposing issues are one of patient autonomy and an ethical duty to provide immediate medical assistance. The latter, in the Norwegian legal context specifically excludes situations relating to hunger strikes, blood products and life-prolonging treatment. However, the authors opine that legislation did not appear to reflect any consistent balance between the considerations of autonomy and the medical professional’s duty to provide immediate medical care. They note that exemptions for providing emergency medical care for hunger strikers were unconditionally accepted without weighing the gravity of risk to the person’s life. They hypothesise that if their patient instead had expressed their political dissent by igniting himself, the relationship would not have been exempt from the obligation to help, as this is not listed among the exceptions in Norwegian legislation.

Serbia

Alempijevic et al (2011) discuss the ethical issues arising in a 48-year-old sentenced male Serbian prisoner who died 15 days after commencing a hunger strike. Throughout the fasting period, he refused medical examinations and was found to be mentally competent while
doing so. Autopsy results did not suggest starvation and the cause of death was one of heroin intoxication. The authors opine that despite potential conflicting opinions, one of the attending doctor’s duties is to recognise the right to refuse treatment, with complexity arising when a competent hunger striker becomes incompetent. They note that the conflict between the need for treatment and respecting refusal is pressured given that the hunger striker will die or sustain permanent damage without food. The authors report that the Law on Enforcement of Penal Sanctions in The Republic of Serbia determines that prisoners must not be medically treated without having their explicit consent and that forced feeding of prisoners is prohibited. However, if refusal of medical treatment or voluntary deprivation of food seriously impairs the prisoner’s health and endangers his or her life, medical treatment shall be carried out as determined by a medical doctor who must subsequently examine the patient daily. The ethical standard set by the Serbian Medical Chamber advises that no medical examination or treatment should be initiated without the patient’s consent. The Serbian Act on Health Protection also permits a medical doctor “conscious objection” except in providing emergency medical care.

Spain

Garcia-Guerrero (2013) summarises that the ethical issues to consider are those of autonomy, beneficence and non-maleficence. He goes on to say that autonomous actions have three fundamental components: knowledge, intention and the absence of external pressures that may influence the act. Respect for personal autonomy is twofold: adequate information to inform sound decision-making by those who take them, and the absence of control. Beneficence comes into play if help is voluntarily asked for. The author suggests that force-
feeding of a prisoner on hunger strike is against the principle of autonomy of the people, and could not be considered beneficence but could be considered ethically maleficent. He reports that the legal position in Spain is complex with interplays of penitentiary regulations and constitutional doctrines. García-Guerrero et al (2015) in a descriptive analysis of episodes of “voluntary total fasting” amongst Spanish prison inmates over a 14-month period reviewed biochemistry and weight changes. They found that only one third of those who go on hunger strike in prison actually fast. They conclude that episodes of voluntary total fasting were common in Spanish prisons, but “rarely were they carried out rigorously and entail a risk for those who fast”.

Switzerland

Getaz et al (2012) from a Swiss perspective, propose guidelines for managing hunger strikes. In the ethical discussion, they highlight the role of autonomy stating that “As any citizen, detainees have the right to refuse food and fluid, as well as any medical treatment.... The physician should not override voluntary, informed and competent decisions of the patient.” They highlight the need for a competency assessment and encourage the use of advance directives. They outline that the conventional dual physician-patient relationship shifts to a triadic physician-patient-authority relationship in case of a hunger strike and that additional partners claim a role and may try to pressure the physician, such as family, public, media or politics. By refusing to force-feed a detainee, doctors may be exposed to judicial pressure or sanctions and to negative opinions from media. They assert that the physician should be impartial, empathic and should not become involved in the conflict between the hunger striker and partners as it is critical that the physician obtains the confidence of the hunger
striker but also the respect of the authority which the patient conflicts with. They indicate that the physician is also expected to play a role as neutral mediator in the conflict between the person who fasts and the partner he pressures. They narrate, in relation to conscientious refusal that “If, for conscience reasons, a physician is unable to abide by a hunger striker’s refusal of treatment or artificial feeding, the physician should make this clear at the outset and refer the hunger striker to another physician who is willing to abide by the hunger striker’s refusal”. Their opinion is that the duty of care is to the patient alone and recommend that the stewardship of health care in custody should be passed from Ministry of Justice to the Ministry of Health to minimise the dual loyalty conflict for the doctor involved.

Martin (2010), also writing with the Swiss context highlights the tensions between beneficence in the medical profession and the individual’s right to autonomy. He cites the case of a cannabis farmer, who carried out a hunger strike against his sentence. An ethical conflict existed for the state, whereby it must on one hand keep those in custody safe and, on the other, be seen to treat everyone equally under the law. This could be undermined if the state was seen to be ‘blackmailed’ to alter a sentence through food refusal.

*The Netherlands*

Gevers (2000) noted that the Dutch legal position was less problematic than some other European jurisdictions and more in keeping with ethical positions adopted internationally that supported the principle of autonomy and a presumption of capacity. He noted the importance of neutrality of the doctor and raised the issue of a professional independent of the institution. The difficulty in establishing autonomy in the presence of peer pressure in a
group hunger strike was recognised. Gevers noted that the Council of Europe recommendation on health care in prisons in 1998 included rules on medical examination of hunger strikers. His opinion is that the Council of Europe, however, defers to national legislation of member states in the case of intervention in hunger strikes.

**Turkey**

Arda (2002) commenting on the role of physicians in Turkish hunger strikes argues the need to maintain autonomy and respect consent, whilst noting that “the boundary and validity of autonomy and its position in suppressed groups is a controversial and questionable issue”. Oguz and Miles (2005) cite their reflections from Turkey’s experience with hunger strikes in 1996 and 2000-2003, where over a hundred lives were lost. Tensions between the positions that were taken by government authorities and the Turkish Medical Association are described. Their belief is that the neutrality of the treating physician is key and that the duties of the physician extend to assessing competence, checking the person’s freedom to go on a hunger strike (the absence of coercion), providing information on the risks of fasting and supervise refeeding in hospital if there is informed consent for this.

**United States of America**

Dougherty et al (2013), when evaluating the ethical complexities involved in the force-feeding of detainees at the US detention centre at Guantanamo Bay, Cuba stated that such force-feeding violates medical ethics and constitutes medical complicity in torture. They note that this practice was contrary to the Declaration of Malta (2006) and that personal morals,
national security imperatives or “the norm of military detention” were not in themselves sufficient to justify departure from the general principles of medical ethics and that issues arose from “dual loyalty” of healthcare professionals. They noted that the Guantanamo force feeding policy was a departure in two ways; favouring beneficence over autonomy and reducing informed consent to a procedural issue. They further note that the Declaration of Malta is unambiguous in stating that autonomy trumps beneficence in cases of hunger strike and go on to emphasise that beneficence does not necessarily involve prolonging life at all costs irrespective of other values. The issue of “dual loyalties” in hunger strike cases was also raised by a Military Medical Ethics workshop (2008) in the US; such that there were two issues related to ethical decision making including the individual circumstances of each case (including cultural issues), and organizational resources to help physicians manage ethical quandaries without resorting to ‘heroic tactics’. An anonymous case report in the American Journal of Bioethics (2014) describes a case wherein a prisoner refusing food, deemed to have capacity, is returned to prison from a hospital setting with a decision that there was “no case to treat in the absence of consent”. An application to have a guardian was not accepted given the presence of capacity. Therefore, in the United States, there would appear to be different approaches taken towards detainees in military and civil settings.

United Kingdom

Brockman (1999) summarises the ethical consideration for the psychiatrist: autonomy, competence and mental disorder. He states that psychiatrists visiting prisons may be faced with a variety of other practical and ethical dilemmas, including conflicting obligations, personal distress, countertransference and institutional illness (wherein imprisonment is
causing the illness). The author states that both “society and the law acknowledge that a competent prisoner may choose to commit suicide by starvation”. He notes that the United Kingdom’s policy in relation to force feeding altered in 1974 when the home secretary advised that a prison medical officer would not be neglecting his duty if he did not force-feed a prisoner against his will. Safeguards included a second opinion from a psychiatrist in relation to capacity, and with confirmation from the same, advice to the prisoner that whilst he would receive supervision in a hospital wing and be offered food, the authorities do not require doctors to force-feed and that medical intervention would not occur unless the prisoner himself requests this.

Non-Jurisdiction specific publications

Fessler (2003) reviewing literature on psychological changes following starvation comments that decision making capacity can be impaired through psychological changes following a period of starvation, and the need to work with advance directives in such cases. He notes that whilst clouding of consciousness and psychotic breakdown can affect competence, increases in “aggressivity and anger” as the fast continues do not in themselves preclude competent decision making.

Sakelliadis, Spiliopoulou & Papadodima (2009) reviewed European and international guidelines relating to healthcare in prisons. Their recommendations on managing hunger strikes focus on the principle of informed consent and are consistent with the Declaration of Malta (2006) in that autonomy is favoured in the competent hunger striker and advance
directives respected unless they are thought to be made under duress. They recommend daily re-evaluations by a physician.

Reider et al (2010) summarise historical considerations across various jurisdictions reporting that legal and ethical conflicts arise when the self-determination and intrinsic rights of the striker are ignored by authorities and cite examples of adverse outcomes where force feeding was undertaken. They note that the European Court of Human Rights ruled in 2007 that "forced and repeated nutrition without medical indication, with the aim of compelling the detainee to cease his protesting attitude and applied in a way that the latter causes unnecessary pain and humiliation of the detainee, is considered an act of torture ". The authors assert that medical care in these situations should impartial and independent from the judicial and penal system to avoid conflicts of interest.

Irmar (2015) outlines the potential conflict between the obligations of beneficence and autonomy. He states that International medical guidelines require physicians to accede to unpressured advance directives and in the absence of such, to make a decision on the basis of the patient's values, previously expressed wishes, and best interests. He argues that in the absence of an advance directive and if competence is already lost, the physician has a responsibility to resuscitate and review when decision-making capacity is regained. Thereafter, the physician has a “moral obligation” to respect any decisions and follow advance directives, even if this were to mean continued fasting.

Druml et al (2016) published guidelines on artificial nutrition and hydration using a consensus based methodology (Delphi). Their guidelines include a discussion of ethics. In the case of
Hunger strikes, the guidelines report a strong consensus for the statement that “providing nutrition against the will of the patient who is able to give his/her consent or make judgments (enforced feeding) is generally prohibited”. They indicate that although the legal situation might differ in some countries, the World Medical Association has established clear guidelines for physicians involved in managing people on hunger strike. The forced feeding of hunger strikers who are mentally competent is not allowed.
Conclusions and Discussion

We summarise key ethical issues relating to hunger strikes in prisons as highlighted by authors from twelve jurisdictions worldwide. Our review suggests that there are several key themes emerging which remain consistent with the widely accepted consensus position of the World Medical Association (2006):

a) There seems to be agreement from a medical view point that the right to autonomous self-determination should be respected in an individual who is competent and acting without duress.

b) That treatment proceeds only when voluntary consent to treatment is obtained, or in an emergency when treatment is provided to an incompetent individual in the absence of a valid unpressured advance refusal.

c) That the balance between the principles of autonomy and beneficence could be at odds in a person who is on a hunger strike, but that beneficence does not necessarily mean prolonging life at all costs.

d) That force feeding a competent individual against his will is an act against the principle of non-maleficence.

e) That in the case where there is conflict between loyalty to the patient and the state, the first duty of the medical professional is to his patient.

This to our knowledge, is the largest review of this topic to date. One significant limitation of this study is the lack of publications from the Middle East, China, Russia and Korea, which may bias the findings, given differing human rights perspectives across the world. Human rights
intrinsically affect the weightage given to the fine balance between autonomy and beneficence considerations, especially in relation to detained individuals. The source of this bias may be linguistic, a Tower of Babel bias (Gregoire et al, 1995) wherein linguistic exclusions to review studies lead to exclusions, however, non-English language studies were included in this review and there were no exclusions based on articles published in dialects from the said countries. There may be a potential bias arising from a lack of studies from these regions being indexed in the electronic databases used in this review. Future research would benefit from a review of grey literature and a more comprehensive world view of the debate extending to a review including searches of legal and human rights databases. Similar ethical issues exist in jurisdictions such as Israel, where concerns have been expressed around legislation that permits force-feeding of Palestinian hunger strikers (Bob, 2016) and China, where hunger strikes in relation to political prisoners are sometimes reported in local media as monitored by human rights organizations (Fung, 2016).

Capacity assessment is a key consideration for practitioners attending a prisoner on hunger strike. Capacity may be affected by mental illness or as a result of physiological changes arising from prolonged fasting, although, as Fessler (2003) points out, this evaluation is complex. The clinical boundaries of mental incapacity may be critically tested in hunger strikes. For example, in some jurisdictions, the elements of mental capacity to give or withhold consent may be defined in statutes that do not fully accord with international rights, conventions or clinical science. In jurisdictions with legal provisions for making advance directives, such may be used to respect autonomy for those who subsequently lose decision-making capacity (Getaz, 2012; Irmak, 2015).
Ethical conflicts for physicians may be highlighted by jurisdictional law. In relation to the position in Australia (Kenny, Silove & Steel, 2004), a useful distinction could be made from a position taken by a Government Department which ‘authorises’ non-consensual medical treatment. The key argument arising would be that ‘authorising’ is not the same as ‘ordering’. In comparison, legislation which ‘demands’ (Roggla, 2005) in the Austrian context is more strongly worded and likely to be a more potent source of ethical conflict for attending physicians.

Our review highlights several potential conflicts of interest for physicians working in prisons. The majority of publications included highlight the fact that that despite these conflicts of interest, the “duty of care” is primarily to the patient. Roggla (2005) cites the importance of acting independently from “governmental pressures” and Getaz (2011) surmises that physicians could be subject to judicial pressure or sanction as well as adverse media coverage in the course of their work in these circumstances. The primary conflict of interest comes from “dual loyalty” (Military Medical Ethics, 2008) in that the physician has a “loyalty” to the patient as also a loyalty to the employing organisation. As the latter are likely to be governmental organisations, the latter “loyalty” extends to that of the state. There are areas of clinical practice in prisons where there is clear guidance wherein to breach patient confidentiality such as when disclosure is made of information that could potentially affect the security of the institution or the immediate wellbeing of another (Blightman, Griffiths & Danbury, 2013). This would be one example of when duty to the state overrides the duty of confidentiality to the patient.

The state has penal interest in those found to have criminal culpability following principles
of justice, whether restorative or retributive. Ethical conflicts exist for the state in the case of prisoners on hunger strike where the state must on one hand keep those in custody safe, and on the other be seen to treat everyone equally under the law (Martin, 2010). Such ethical conflicts may cause the state to pressure a physician to share more information about a prisoner than he usually would or indeed coerce the prisoner to end the hunger strike. The latter would arguably, fundamentally conflict the principle of autonomy. A number of publications reviewed (Oguz & Miles, 2005; Getaz et al, 2012; Caenazzo, Tozzo & Rodriguez, 2016) cited the importance of the “neutrality” of physicians involved as key to their involvement. Caenazzo, Toozo & Rodriguez (2016) argue that such conflicts of interest may be avoided by the use of independent “ethics consultants”. Dougherty et al (2013) argued that personal morals, national security imperatives or military detention were not in themselves sufficient to justify departure from the general principles of medical ethics despite the “dual loyalty conflict”. No publication in this review suggested a departure from this position, which is in keeping with the Declaration of Malta (World Medical Association, 2006) which notes that “Physicians with dual loyalties are bound by the same ethical principles as other physicians, that is to say that their primary obligation is to the individual patient…Physicians must remain objective in their assessments and not allow third parties to influence their medical judgement. They must not allow themselves to be pressured to breach ethical principles, such as intervening medically for non-clinical reasons.” Brockman (1999) writing from a psychiatrist’s perspective notes that the prisoner may see the doctor as an “agent of the state” which in itself is not conducive to a therapeutic relationship and that the doctor, who may already be subject to conflicting obligations in having to weigh up the duty to the patient versus a duty to the institution, may experience personal distress precipitating feelings of therapeutic impotence or anger.
Establishing autonomy and the absence of coercion within a prison setting can be challenging. The goal of prison officers is to maintain order while operating within the limits of the law. Privacy and confidentiality of medical consultation may be threatened where prison officers escort a patient for review. Staff suspicion and animosity toward prisoners have the potential to colour a medical encounter (McKinney, 2008). Such potential infringements on autonomy need to be factored into medical assessment.

Dougherty et al (2013), in keeping with the position of the World Medical Association (2006), note that force feeding competent hunger strikers may be complicit to torture. It may be worth considering the ethical complexities which may arise for a physician called to conduct the feeding procedure itself. Boyd (2015) says that any form of force feeding of the competent hunger striker whether it be through nasogastric tube or intravenous total parenteral nutrition would be “wrong” and a violation of basic human rights. The physician bound by the accepted worldwide position may refuse to be involved (Tait, 2015). In such circumstances, non-medical personnel might potentially be employed such as in the case of state ordered executions in the United States (Boehnlein, 2013) which albeit a separate, more complex ethical issue, raises some shared ethical conflicts for the physician involved. The issue is that whilst a procedure may be incompatible with medical ethics, the consequences of lack of medical expertise may have significant adverse effects on patient wellbeing through procedural complications, improper pain control and such considerations may themselves violate human rights through increased suffering.

It is evident from our review and considerations discussed that the care of prisoners on a hunger strike will remain an ethically complex issue for medical practitioners who are asked...
to advise in this circumstance or if their patient is subjected to a medical procedure by non-
medical staff. Ethical issues arise for psychiatrists who play a key role in assessing for the
presence or absence of mental disorder, motives for hunger strike and, most importantly,
help assess capacity. The central premise remains the need to act in the interests of the
patient in the face of institutional and societal pressures.
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CHAPTER 6

Hunger strikes in prison: a legal perspective for psychiatrists


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Hunger strikes in prison: a legal perspective for psychiatrists

Gautam Gulati FRCPsych, Adjunct Senior Clinical Lecturer in Psychiatry, Graduate Entry Medical School, University of Limerick, Ireland. Email: gautam.gulati@hse.ie Tel: 063 98 668
(Corresponding author)

Darius Whelan PhD, Senior Lecturer, School of Law, University College Cork, Cork, Ireland.

Eimear Spain PhD, Senior Lecturer in Health Law, Faculty of Education and Health Sciences and the School of Law, University of Limerick, Limerick, Ireland.

David Meagher PhD, Foundation Professor of Psychiatry, Department of Psychiatry, University of Limerick Graduate Entry Medical School, Limerick, Ireland.

Colum P. Dunne PhD, Director of Research, University of Limerick Graduate Entry Medical School, Limerick, Ireland.
Abstract

Hunger strikes in a custodial setting are complex to manage clinically, with associated legal and ethical complexities. Hunger strikes in Irish prisons have received, and are likely to continue to be the focus of, considerable media attention. Whilst there is an internationally accepted consensus ethical position, there is limited legal guidance available for psychiatrists to draw upon in such cases. In this paper, we review recent case-law and discuss the legal considerations in the management of prisoners on hunger strike.
Introduction

“He has chosen death: Refusing to eat or drink, that he may bring disgrace upon me; for there is a custom, an old and foolish custom, that if a man be wronged, or think that he is wronged, and starve upon another’s threshold till he die, the Common People, for all time to come, will raise a heavy cry against that threshold” (Yeats, 1904, The King’s Threshold)

A “hunger strike” is by definition food refusal as a form of protest or demand (Crosby, Apovian & Grodin, 2007). Hunger strikes in prison have been reported in several countries including Turkey, South Africa, Ireland and the US Naval base at Guantanamo Bay, Cuba (Crosby, Apovian & Grodin, 2007). In Ireland, these came to the forefront of national attention in 1981, after the death of 10 individuals protesting against the withdrawal of special category status for paramilitary prisoners by the British Government of the day (Beresford, 1997). Food refusal has been noted as a ‘particularly Irish form of protest’ (Governor of X Prison v McD. 2015). Hunger strikes are relatively uncommon but nonetheless challenging. Recent hunger strikes reported by the Irish media have included protests against water charges (Lally, 2015) and prison conditions (Governor of X Prison v McD. 2015). Most hunger strikes are motivated by political concerns and are self-resolving, and where short term or feigned food refusals occur, they are less clinically problematic than sustained refusal of food and fluid.

A psychiatrist is usually called to assess individuals who are refusing food and/or fluid. Their role extends to excluding an underlying mental illness and may include assistance in the assessment of capacity. Mental illness, whilst overrepresented in Irish prisons (Kennedy et al., 2004) and prisons worldwide (Fazel & Seewald, 2012) is rarely the cause for food refusal
(Brockman, 1999; Larkin, 1991). Having said that, the psychiatric examination needs to exclude causes (Sullivan and Romily, 2009; Brockman, 1999) including, but not limited to severe depression wherein an individual is refusing food in order to end their life, psychosis wherein an individual may falsely believe their food is poisoned, eating disorders wherein there may be a morbid fear of fatness or autism spectrum disorder with associated sensory difficulties.

The role of the medical professional in this context is fraught with legal and ethical complexities. Guidelines for medical professionals have been drafted (World Medical Association, 2006) and suggest a position to adopt ethically. They favour autonomy over beneficence and stress the importance of neutrality of involved physicians, who otherwise would be subject to a dual loyalty conflict. They unambiguously state that force feeding of an individual with capacity who refuses the same is not acceptable. Key principles relating to the role of medical professionals in relation to prisoners on hunger strike as outlined in international literature (Gulati et al, 2017; Getaz et al, 2012; Sakelliadis, Spiliopoulou & Papadodima, 2009; Brockman, 1999) in keeping with the Declaration of Malta (World Medical Association, 2006) agree that the issue of capacity and consent is central to guiding management.

Clinicians involved in assessing and treating prisoners on hunger strike should ideally have an understanding of capacity related legislation, mental health legislation and a knowledge of recent case-law. We aim to summarise these considerations in relation to the jurisdiction of the Irish republic.
Case-law

Until recently, there was no Irish case-law on the issue of food refusal in prison while precedents from other common law jurisdictions were inconsistent. This inconsistency is evident in a series of cases in the US which reached differing conclusions on whether prison authorities should be permitted to force feed prisoners against their wishes and contrary to their right to self-determination (In re Caulk, 1984; Thor v Superior Court, 1993). More recently, there was some US case-law which sanctioned force-feeding of prisoners in Guantanamo Bay (Al-Adahi v Obama, 2009; Easton, 2013). In England, the courts had originally stated that prison governors had a duty preserve the health of prisoners, a duty which extended to force feeding. Thus, they were permitted to force-feed hunger striking suffragettes at a time when suicide was illegal (Leigh v Gladstone, 1909). The crime of suicide was abolished by the Suicide Act 1961 but the offence of aiding and abetting suicide was retained. Prison medical staff may have been concerned about possible criminal liability for aiding and abetting suicide. In 1995, it was held that it was lawful for the prison authorities not to intervene if a prisoner with capacity was on hunger strike (Secretary of State for Home Department v Robb, 1995). Drawing on an earlier case relating to the withdrawal of life sustaining treatment from a young man injured in the Hillsborough disaster (Airedale NHS Trust v Bland, 1993), the court declared that death following food and fluid refusal by a patient with capacity, is an exercise of self-determination and does not constitute an act of suicide. Therefore medical staff who fail to administer treatment in accordance with the patient’s wishes do not aid and abet a suicide. The court did not have to decide if it would have been lawful for the authorities to force-feed the prisoner (Kennedy, 1995). However, if a hunger striking prisoner was also detained under the Mental Health Act and lacked capacity,
they could be force-fed (*R. v Collins ex parte Brady*, 2001). The European Court of Human Rights has also explored this issue and held that force-feeding a prisoner on hunger strike was not a breach of the Convention, provided there was a “medical necessity” and the method used was humane (*Nevmerzhitsky v Ukraine*, 2006).

The legal principles to be applied in Ireland have recently been discussed in the significant cases of *Governor of X Prison v McD.* (2015), *Nash v Chief Executive of the Irish Prison Service* (2015) and *A.B. v C.D.* (2016).

Similarly in *Governor of X Prison v McD.* (2015), the prison was not seeking to force feed Mr McD., instead it was seeking guidance from the court as to whether it was lawful to withhold medical and nutritional assistance from Mr McD. The prisoner had been assessed by a psychiatrist to have full capacity, with no mental illness but with borderline personality disorder. Baker J. (High Court Judge) issued a declaration that the prison could withhold assistance. She followed the principles in *Fitzpatrick v F.K.* (2008) in assessing Mr McD’s capacity. These principles include the following: “(1) There is a presumption that an adult patient has the capacity, that is to say, the cognitive ability, to make a decision to refuse medical treatment. (2) In determining whether a patient is deprived of capacity to make a decision to refuse medical treatment the test is whether the patient's cognitive ability has been impaired to the extent that he or she does not sufficiently understand the nature, purpose and effect of the proffered treatment and the consequences of accepting or rejecting it in the context of the choices available (including any alternative treatment) at the time the decision is made...” (*Fitzpatrick v F.K.*, 2008).
Having concluded that Mr McD. had full capacity, Baker J. noted that the European Court of Human Rights case-law did not mean that failing to forcibly administer food or medicine is a breach of human rights (Governor of X Prison v McD., para. 104). Baker J. went on to approve of the reasoning of Thorpe J. (High Court Judge, England) in Secretary of State for Home Department v Robb (1995), including his emphasis on the competent individual’s right to self-determination. It was held that it was well established that an adult person with full cognitive capacity is entitled to refuse medical treatment, even if that refusal is likely to inevitably lead to that person’s death. While it could not be said that a person has a right to die by suicide, the person has a right to freely elect to refuse food, provided his/her choice is full, free and informed and he/she does not require assistance to achieve that end (para. 105). She distinguished this case from Fleming v Ireland (2013), where it was held that a competent person does not have an entitlement to the benefit of assistance to end her life. Baker J. also stated that the prison should respect Mr McD’s advance directive regarding his future care (para. 126), for the first time providing a binding ruling on the legal status of advance healthcare directives (Mulligan, 2015).

The reasoning in Governor of X Prison v McD. was quoted with approval in Nash v Chief Executive of the Irish Prison Service (2015). In that case, the applicant was reported to have been suicidal and had not been eating for a number of weeks. Kearns P. (President of the High Court) noted: “there is no suggestion that the applicant lacks mental capacity to make his own decision as to whether or not he wishes to end his life by starvation.” While the outcome of the case turned on other issues which are not directly relevant to this article, including possible threats to the applicant from other prisoners, the court approved of the reasoning in Governor of X Prison v McD and the Supreme Court decision in Creighton v
Ireland & Ors (2012) to the effect that prisoners may continue to exercise a variety of constitutional rights which do not depend on liberty, including the right to bodily integrity. The court also clarified that threats of suicide may not be used by prisoners to achieve their own objectives: “Any suggestion that prisoners can or should be detained in the prison of their own choosing, or avail of hunger strike or suicide threats to secure their own objectives, would create chaos in prisons and fatally compromise the proper administration of our prison system.”

However, a very different approach was taken by Humphreys J. (High Court Judge) in a more recent High Court decision, A.B. v C.D. (2016), which concerned a prisoner, Mr D., who was admitted to hospital due to a self-inflicted injury to his neck. Mr D. was refusing life-saving treatment, was reported to have “likely schizophreniform psychosis” and was assessed as lacking capacity to refuse treatment. The hospital sought court authorisation for all necessary medical and surgical treatment to protect Mr D’s life and bodily integrity. Humphreys J. did not make an explicit finding as to whether Mr D. lacked capacity on the basis that he did not have sufficient information to decide on capacity and the case did not hinge on Mr D’s capacity in any event. Rather, he preferred to decide the case on the question of whether prisoners may refuse medical treatment where such refusal would put his/her life at risk and thereby, fail to complete the sentence handed down by the court. The court disagreed with Baker J’s approach to prisoner autonomy in Governor of X Prison v McD. for various reasons. Humphreys J. analysed US case-law and concluded that the vast majority of US cases find no legal violation in forced medical treatment, feeding or nutrition of mentally competent adult prisoners. He also disagreed with Baker J.’s reasoning in McD. as it involved reliance on the English case of Secretary of State for the Home Department v Robb (1995) which in turn had
heavily relied on the unrepresentative Californian case of *Thor v Superior Court* (1993). Ultimately, Humphreys J. made an order compelling treatment as “a prisoner in custody under a court order... is not simply entitled to refuse treatments where this would either directly or ultimately put his life at risk and thereby frustrate the verdict and order of the court” (para. 52), that is, to ensure that a prisoner completes the prison sentence imposed by a court of law.

Despite this, Humphreys J. did not disagree with the outcome in *McD.* as the court had granted a declaration that the Prison Governor was entitled to give effect to the prisoner’s wishes not to be fed or treated. Humphreys J. stated: “If a prisoner wants to starve to death or die by medical neglect, it is a matter for executive discretion as to whether to allow them to do so in all the circumstances: it might be too prescriptive in the modern era to declare a positive duty to force-feed a person of full age and capacity in particular, at least in all cases” (para. 50). Humphreys J. was also adamant that a prisoner “simply does not have any legal entitlement to cheat justice, and the court should not co-operate in him or her attempting to do so.” The approach of the court in *A.B. v C.D.* is significantly out of line with current thinking on autonomy of prisoners in Ireland and is likely to be challenged in later cases.

This case also highlights a matter of complexity wherein courts make decisions based on “prisoner” status of an individual (even if the individual is in hospital) as opposed to health professionals who view the individual as a “patient”. In their determination, the court must be cognizant of the status of the individual as prisoner. Under Irish law the “normal constitutional rights [of prisoners] are abrogated or suspended during the period of imprisonment...” (State (*McDonagh* v *Frawley*, 1978; *Murray v Ireland*, 1991; *Breathnach* v
As such, cases involving prisoners must be approached differently than those involving non-prisoners. When considering cases involving prisoners, the court must consider whether the rights in question, including the right to self-determination or bodily integrity, have been abrogated, suspended or limited for the period of imprisonment. In his recent decision in A.B v C.D (2016) Humphreys J. held that while “a prisoner retains the right to bodily integrity in prison in the sense that he or she cannot be harmed or neglected by the State... it by no means follows from a prohibition on harming prisoners that the prisoner’s full rights of autonomy have to be recognised.” A.B. v C.D. (2016).
Mental Health Legislation

Mental illness although overrepresented in Irish prisons (Kennedy et al, 2004), is rarely the underlying cause for food refusal (Brockman, 1999). If a prisoner has a mental disorder, he/she may be transferred from a prison setting to a Designated Centre, currently the Central Mental Hospital under s.15 of the Criminal Law (Insanity) Act 2006. Section 3 of this Act defines a Designated Centre. Mental disorder as defined in the Criminal Law (Insanity) Act, 2006 includes “mental illness, mental disability, dementia or any disease of the mind but does not include intoxication” (Irish Statute Book, 2001). This is broader than the definition for the same concept in the Mental Health Act, 2001, Section 3 of which defines mental disorder as “mental illness, severe dementia or significant intellectual disability...”. Once in the designated centre, issues of treatment are governed by Part 4 of the Mental Health Act 2001 (Whelan, 2009). If the person has capacity, he or she can refuse treatment. If he/she lacks capacity, treatment may be administered under the terms of sections 56-60 of the 2001 Act, as amended by the Mental Health (Amendment) Act 2015. Section 57 of this Act states “The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.”

There is no reported (the word “reported” being used in a legal context) Irish case-law on the question of whether force-feeding constitutes treatment of a mental disorder. However, recent cases have been noted in media wherein the High Court has authorized tube feeding
and ancillary measures for individuals with eating disorders (Carolan, 2015) or severe psychotic depression (Carolan, 2014). European and English cases mentioned earlier may be of some assistance to any future Irish court faced with this question (See also B. v Croydon Health Authority, 1995).

Arguably the case for treatment under Mental Health legislation would not arise in the case of a true hunger strike as defined earlier (Crosby, Apovian & Grodin, 2007). However, should there be refusal of food as a direct consequence of mental disorder such as a paranoid delusion that food is being poisoned as in the case of someone with a paranoid schizophrenic illness, or a refusal of food as a suicidal act in the case of someone who is severely depressed, or indeed the refusal of food arising from a “morbid fear of fatness” in the case of someone with an eating disorder, treatment of the underlying psychiatric condition would be in accordance with the principles of consent or provisions of Section 56-60 of the Mental Health Act, 2001 as amended by the Mental Health (Amendment) Act 2015. Hence the need to differentiate, by a thorough psychiatric evaluation, the concept of food refusal in the latter cases from a true “hunger strike” motivated by a demand or protest.
The Assisted Decision-Making (Capacity) Act 2015 has been enacted into law by presidential assent on 30 December 2015 but most sections have yet to be commenced (some sections from Part 1 and Part 9 were commenced in October 2016). The assessment of capacity would be based on the functional test set out in the legislation, rather than the principles from *Fitzpatrick v F.K.* (2009) as outlined earlier.

The assessment of capacity would be a matter for the attending general practitioner/physician who may request psychiatric expertise. In practice, a joint consultation may be indicated wherein the physician provides information as to the potential risks of prolonged fasting, risks and benefits of treatment and the psychiatrist assists the general practitioner/physician in reaching a decision about the capacity. This is not an isolated event and good practice would involve gathering collateral information from multiple sources such as the prion officers, the prisoner’s family doctor and family members prior to the assessment to ascertain the presence or otherwise of mental or physical disorder. The test for capacity encompasses evaluating the individual’s ability to understand the information presented to him, retain this long enough to make a decision, weigh up the pros and cons of alternative courses of action and communicate their decision. The individual should have been advised of the likely consequences of their intended action, including the possibility of death and keeping in mind, any existing physical illness which may potentially hasten the latter. This test for capacity is specific to the matter being assessed and whilst the primary assessment would be of the capacity to refuse food and/or fluids, further assessments may be necessary in relation to the need for physical health monitoring such as the need for blood tests. The test
for capacity is also time-specific, and repeated examinations of capacity may be necessary and indeed advisable, given the progression of both psychological and physiological changes as hunger strikes persist (Fessler, 2003).

The 2015 Act defines Capacity as “decision-making capacity” and it is the ability to understand, at the time that a decision is to be made, the nature and consequences of the decision to be made by him or her in the context of the available choices at that time. Despite the fact that this is the first legislative adoption of the functional approach, this approach to the assessment of capacity has been used in practice in Ireland already (Health Service Executive, 2013; Medical Council, 2016). The 2015 Act also proposes three types of decision-making support options to respond to the range of support needs that people may have in relation to decision-making capacity. With each of the three decision-making support options (assisted decision making, co-decision making or a decision-making representative) decisions can be made on personal welfare, property and finance or a combination of both (Department of Justice and Equality, 2015).

Following the decision in Governor of X Prison v McD. or once this law is enacted, under the Assisted Decision Making (Capacity) Act, an individual with capacity could make an advance refusal of treatment in case of deterioration in health following food refusal. Treatment, in the presence of a valid directive would then be illegal. However, in the case of a prisoner, this is less clear given the decision in A.B. v C.D. (2016). Based on the reasoning in that case, while the state is not mandated to force-feed prisoners, it is entitled to authorise force feeding against the wishes of a prisoner with capacity or a prisoner with a valid advance healthcare
directive in order to fulfil the court order, that is, to ensure he/she completes the prison sentence.
Conclusions & Discussion

Psychiatrists in the prison setting may find themselves in a clinically, ethically and legally complex situation when faced with someone on hunger strike. The role of the psychiatrist in assessing prisoners on hunger strike is not limited to the diagnosis and treatment of mental illness but extends to assisting the assessment of capacity to refuse food as well as the motivation behind the hunger strike (Getaz et al, 2012; Brockman, 1999). From a clinical perspective, an interagency and multidisciplinary approach with regular case conferences may be helpful to guide decision making.

Whilst there is a consensus governing the ethical position (Gulati et al, 2017; World Medical Association, 2006), we discuss, in this paper, the relevant case-law and legislation, including the Criminal Law (Insanity) Act, Mental Health Act and the new Assisted Decision Making (Capacity) Act that the Irish prison Mental Health Practitioner can draw upon in practice. With changing capacity legislation, there will likely be additional case-law to refer to in the coming years.

In practice however, most prison hunger strikes are short lived (Garcia-Guerrero & Vera-Remartinez, 2015) and, where they persist, and in particular, in complex circumstances wherein there is no mental illness but issues around capacity, the prison mental health practitioner may wish to seek legal advice from solicitors for the health service and their own medical indemnity organisation given the limited and complex national case-law existent at this time.
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CHAPTER 7

The psychiatric management of prisoners on hunger strike: developing a management algorithm using the Delphi technique

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The psychiatric management of prisoners on hunger strike: developing a management algorithm using the Delphi technique

Gautam Gulati FRCPsych, Graduate Entry Medical School, University of Limerick, Ireland. Email: gautam.gulati@hse.ie Tel: 00 353 63 98 668 (corresponding author)

Brendan D. Kelly PhD, Department of Psychiatry, Trinity College, Dublin, Ireland.

Conor O’Neill MRCPsych, Central Mental Hospital, Dundrum, Dublin, Ireland.

Paul O’Connell MRCPsych, Central Mental Hospital, Dundrum, Dublin, Ireland.

Sally Linehan MRCPsych, Central Mental Hospital, Dundrum, Dublin, Ireland.

Eimear Spain PhD, Faculty of Education and Health Sciences and the School of Law, University of Limerick, Limerick, Ireland.

David Meagher PhD, Department of Psychiatry, University of Limerick Graduate Entry Medical School, Limerick, Ireland.

Colum P. Dunne PhD, Director of Research, University of Limerick Graduate Entry Medical School, Limerick, Ireland.
Abstract

Objectives

The assessment and management of prisoners on hunger strikes in a custodial setting is complex. There is limited clinical guidance available for psychiatrists to draw upon in such cases. This study aimed to develop a management algorithm through expert elicitation to inform the psychiatric care of prisoners on a hunger strike.

Methods

A Delphi method was used to elicit views from Irish prison psychiatrists, a legal expert and an expert in ethics using a structured questionnaire. Themes were extracted from the results of the questionnaire to propose a management algorithm. A consensus was reached on management considerations.

Results

Five consultant forensic psychiatrists, a legal expert and an expert on psychiatric ethics (n=7) consented to participation, with a subsequent response rate of 71.4%. Consensus was achieved on a proposed management algorithm. Assessment for mental disorder, capacity to refuse food and motivation for food refusal are seen as key psychiatric tasks. The need to work closely with the prison General Practitioner and the value of multidisciplinary working,
additional clinical opinions and legal advice is described. Relevant aspects of law included mental health, criminal law (insanity) and capacity legislation.

Conclusions

This study outlines a management algorithm for the psychiatric assessment and management of prisoners on a hunger strike, a subject where there is limited guidance to date. Although written from an Irish perspective, it outlines key considerations for psychiatrists in keeping with international guidance and therefore may be generalisable to other jurisdictions.
Introduction

A ‘hunger strike’ is by definition food refusal as a form of protest or demand (Crosby, Apovian & Grodin, 2007). Whilst the time-based consideration in defining a hunger strike is debated, US prison and immigration service definitions use a cut-off of 72 hours of food refusal in defining a hunger strike (Wei & Brendel, 2010).

Hunger strikes in prison have been reported in several countries including Turkey, South Africa, Ireland and the US Naval base at Guantanamo Bay, Cuba (Crosby, Apovian & Grodin, 2007). In Ireland, these came to the forefront of national attention in 1981, after the deaths of 10 individuals protesting against the withdrawal of special category status for paramilitary prisoners by the then British Government (Beresford, 1997). Food refusal has been noted as a ‘particularly Irish form of protest’ (High Court of Ireland, 2015).

A referral to assess a prisoner on hunger strike in contemporary prison psychiatry is relatively uncommon but nonetheless challenging. There is limited specific guidance as to how to proceed (Wei & Brendel, 2010) with such a referral. The role of the medical professional is fraught with legal and ethical complexities (Sullivan & Romily, 2009) and any guidance would need to be consistent with relevant statutes, case law, human rights and constitutional provisions. General considerations in psychiatric management have previously been proposed by Brockman (1999). In the intervening years, there has been further ethical debate (e.g. Gulati et al., 2017) and guidance (World Medical Association, 2006).
Irish prisons house approximately 3700 inmates across 14 prisons (Irish Prison Reform Trust, 2016). Irish prisons have access to primary care seven days a week. The prison General Practitioner, in conjunction with primary care nursing staff, plays a key role in the initial assessment of physical and mental health, and in the initiation of psychiatric referral and/or general hospital referral in the case of a physically unwell individual. Individuals on hunger strike are seen frequently (at least daily) by the prison general practitioner to evaluate for physical deterioration. The majority of Irish prisons have sessional input from a Consultant Forensic Psychiatrist. Service provisions vary from one to three sessions a week in regional prisons (Cork, Limerick, Castlerea) to a full time PICLS (Prison In reach and Court Liaison Service) team based at Cloverhill prison. Similarly, the availability of emergency psychiatric input to a prison is variable geographically. Such geographical variability in access to prison mental healthcare has been described in other developed jurisdictions such as the US (Wilper et al., 2009) and the UK (Offender Health Research Network, 2009).

The Irish Prison Service Healthcare standards provide guidelines on management "where a prisoner informs the prison authorities that s/he intends to refuse food or does so". This guidance is aimed largely at physical healthcare and recommends procedures specific to primary healthcare such as urgent and regular review by a general practitioner and advises a referral to a psychiatrist. However, there is little agreement and guidance on psychiatric considerations in management thereafter. Guidance drafted in other jurisdictions including the UK Prison Service (Department of Health & HM Prison Service, 2002), the US Office of Detention and Removals (Hayes, 2008) and by the World Health Organisation (2014) similarly focusses on primary healthcare and general management with little specific guidance for psychiatrists.
We sought to develop a management algorithm through expert elicitation to provide guidance to prison psychiatrists when managing a prisoner on hunger strike.
Methods

Ethical approval was obtained from the Research Ethics Committee of the University Hospital Limerick. A Delphi process (Hasson et al., 2000) was used to elicit expert opinion. This method has advantages over traditional methods in eliciting expert views such as brainstorming sessions and round-table discussion groups to reduce bias from factors such as the presence of a dominant personality, a ‘bandwagon effect’, polarization of views, and the unwillingness to change an opinion which had been publicly expressed. This technique replaces direct debate by a carefully designed program of sequential interrogations conducted by questionnaires interspersed with opinion feedback derived by computed consensus from the earlier parts of the program (Brown, 1968).

In keeping with the three key aspects of management consideration (Clinical, Legal and Ethical), an email inviting voluntary participation in formulating the consensus was sent to 12 experts: all Consultant Forensic Psychiatrists in Ireland (n= 10), an expert on mental health law (n=1) and an expert on psychiatric ethics (n=1). Seven individuals including 5 psychiatrists, 1 lawyer, 1 expert on ethics consented involvement in the study (58.3%).

In round 1, an initial questionnaire (Table 1) was agreed by 3 researchers (GG, DM & CD) and sent electronically to the 7 participants to elicit views with a 6-week response window, and reminder after week 4. Responders were blind to the views of others. Five responses (71.4%) were received, and these five respondents completed subsequent rounds of the study (hereafter ‘participants’). Participants included three prison psychiatrists, one legal expert and one expert on psychiatric ethics.
One researcher (GG) analysed content and amalgamated these into an algorithm which was circulated to participants for agreement and debate (round 2). Consensus was reached on the algorithm.
Results

Responses to the initial questionnaire

Themes arising in response to the initial questionnaire are listed in Table 2.

Participants identified three key roles for the Psychiatrist: assessment for the presence of mental illness, assessment of capacity to understand the consequences of food refusal and ascertainment of the reason for food refusal.

Measures identified as helpful included a multidisciplinary approach in keeping contemporary models of mental healthcare and access to additional psychiatric opinion and legal advice. There was a stated need to work closely with prison staff to obtain collateral information and with the prison general practitioner to facilitate repeated physical and laboratory examination for sequelae of starvation. The need to develop and safeguard the therapeutic relationship through offering an interview in private, and out of earshot of correctional staff was highlighted. Participants suggested frequent review in psychiatric clinic, especially in the case of someone who is mentally unwell. Hospital diversion was identified as potentially necessary to a general hospital in the case of physical deterioration or to a psychiatric setting in the case of mental disorder. Participants suggested recourse to the courts for decision making in ‘life or death circumstances’, or in cases where there was either uncertainty or differing opinions in relation to decision making capacity. A wide range of legislation including Criminal Law (Insanity) legislation, Capacity legislation, Mental Health Legislation and Common Law were seen as relevant to management.
Participants identified the prison environment as a potential barrier to care, in particular, the possible proximity of prison staff when conducting a psychiatric assessment. This would potentially affect the ability of the prisoner to speak freely about his motivation for refusing food. Participants also reported that a pressure to treat a hunger strike as a ‘mental health issue’ in the absence of a mental illness was also a barrier to providing care.

*Management considerations for psychiatrists – the algorithm*

A practical algorithm for consideration by psychiatrists as elicited from this study and agreed by participants is portrayed in Figure 1.

*First steps – assessment by a general practitioner*

A ‘hunger strike’ is by definition food refusal as a form of protest or demand (Crosby, Apovian & Grodin, 2007). The definition encompasses a prisoner with capacity who is refusing food whilst either making a specific demand or as a protest. This needs to be differentiated from ‘food refusal’ as a whole (Sullivan & Romily, 2009) which may have a number of causes including those driven by severe mental illness, particularly severe depression or acute psychosis or indeed physical illness such as a neurological cause or acute confusional state. This differentiation is all-important and therefore all cases of food fluid refusal in prison should as a minimum be seen by a general practitioner to evaluate their physical health prior to review by a psychiatrist to evaluate their mental health. The general practitioner, based on clinical and laboratory testing would aim to assist monitoring the severity of sequelae of starvation, as well as assess for urgency of need for physical health interventions. The role of
the general practitioner and primary care is outlined in existing international guidance (Sakellidou, Spiliopoulou & Papadodima, 2009) which recommends daily re-evaluations.

Assessment of motivation behind the hunger strike

The first role for a psychiatrist is an assessment of the motivation behind the refusal of food. This includes an exploration of possible causes including physical illness, mental disorder, protest and pressure from a group within or outside of prison. This assessment is best carried out in a private setting out of earshot of prison officers as gaining the trust of the patient is important. The patient may see the doctor as acting ‘for the state’ and/or as an employee or representative of the correctional facility and this would hamper the building of trust. Reassurance may therefore need to be provided in relation to the duty of care and limits of confidentiality.

Assessment for mental disorder

The psychiatrist, in conjunction with the above, should undertake a complete psychiatric assessment including a history, mental state examination and collateral history with a view to identifying any mental illness, and if it is linked to the food refusal. Mental illness, whilst overrepresented in Irish prisons (Kennedy et al., 2004) and prisons worldwide (Fazel & Seewald, 2012; Fazel & Danesh, 2002) is rarely the cause for food refusal (Brockman, 1999). Having said that, the psychiatric examination needs to exclude causes (Sullivan and Romily, 2009; Brockman, 1999) including, but not limited to severe depression wherein an individual is refusing food in order to end their life, psychosis wherein an individual may falsely believe
their food is poisoned, eating disorders wherein there may be a morbid irrational fear of fatness or autism spectrum disorder with sensory difficulties. Given the high prevalence of mental illness in prison populations (Fazel & Seewald, 2012), it may be possible that mental illness is present, but unrelated to the hunger strike. In these circumstances, the two may need to be managed as separate entities. In either case, mental health and criminal law (insanity) legislation may be used to facilitate treatment. The key question however is whether the prisoner has the capacity for autonomous decision making.

The assessment of capacity

The evaluation of the capacity of the prisoner to make the decision to refuse food and fluids is a principal consideration which informs subsequent care. The test for capacity encompasses evaluating the individual’s ability to understand the information presented to him, retain this long enough to make a decision, weigh up the pros and cons of alternative courses of action and communicate their decision. The individual should have been advised of the likely consequences of their intended action, including the possibility of death and keeping in mind, any existing physical illness which may potentially hasten the latter. The provision of adequate and accurate information is an important part of the process and may require the psychiatrist to ask to see the patient alongside a general practitioner or physician to ensure this. The test for capacity is also time-specific, and repeated examinations of capacity may be necessary and indeed advisable, given the progression of both psychological and physiological changes as hunger strikes persist (Fessler, 2003).

Considerations following the assessment of capacity
Individuals who lack capacity may need treatment such as nutrition and rehydration using assisted decision making (capacity) legislation in a general hospital setting, taking into considerations, any advance directives that may exist. Such directives are on a legal footing in some jurisdictions such as the UK (McLean, 2009) and will be on a legal footing in Ireland when the Assisted Decision Making (Capacity) Act 2015 is enacted.

The situation becomes much more complex in the ‘true hunger striker’ who does not have a mental illness and who does not lack the capacity to make the decision. Ethical guidelines in such cases would support the principle of autonomous decision making and respecting the individual’s wishes (World Medical Association, 2006) even though doing so may lead to organisational or societal pressure. In clinical practice, the issue of capacity may be less than clear cut and a second opinion and legal advice may be advisable, given the potentially serious consequences of continued hunger strike. In the face of differing opinions from stakeholders, such as family or prison authorities, consideration should be given to approaching the Courts for decision-making. There is precedent for approaching the court in such circumstances across multiple jurisdictions (High Court of Ireland, 2015; Wei & Brendel, 2010; Sullivan & Romily, 2009).

*Ethical considerations*

The overarching ethical position in the management of prison hunger strikes is the declaration of Malta (World Medical Association, 2006) and a recent systematic review of literature from 12 jurisdictions (Gulati et al., 2017) indicates that there is an overall convergence in keeping with the principles outlined in the declaration. The principles include: the right to
autonomous self-determination in an individual who is competent and acting without duress; that treatment proceeds only when voluntary consent to treatment is obtained; or in an emergency when treatment is provided to an incompetent individual in the absence of a valid unpressured advance refusal; and that the balance between the principles of autonomy and beneficence could be at odds in a person who is on a hunger strike, but that beneficence does not necessarily mean prolonging life at all costs.

The psychiatrist’s role as a practitioner includes advocacy. It extends to ensuring that the individual’s autonomy is balanced with beneficence (do good) and non-maleficence (do no harm). Frequent and ongoing dialogue with the prisoner, the prisoner’s legal representative, prison authorities, the prison General Practitioner and any hospital consultants involved is likely to be central to respecting the patient’s rights and wellbeing.
Conclusions and Discussion

Psychiatrists are invariably asked by the prison General Practitioner to assess prisoners on a hunger strike. In this paper, we sought to develop a psychiatric management algorithm for hunger striking prisoners through expert elicitation. This is a complex area with little previously published guidance for psychiatrists and whilst no single algorithm can capture every potential scenario, we looked to agree on key guiding principles in management. To our knowledge, this is the first such proposed algorithm on psychiatric management of prisoners on a hunger strike in the international literature. Whilst formulated within Ireland, the key principles outlined in the algorithm are in keeping with international literature (Getaz et al, 2012; Sakelliadis, Spiliopoulou & Papadodima, 2009; Brockman, 1999), guidance from the World Health Organisation (2014) and consistent with internationally accepted ethical guidance as agreed in the Declaration of Malta (World Medical Association, 2006). An algorithm for the medical management of detainees on hunger strike has reportedly been proposed in a US Military setting (Joint Medical Group, 2013) at Guantanamo Bay, Cuba; this does not outline guidance for psychiatric involvement.

The key strength of our study is the involvement of three disciplines: forensic (prison) psychiatrists, a legal expert and an expert on psychiatric ethics. The use of the Delphi method lends to external validity by bringing together the views of a number of experts which has strengths over a single opinion (Hasson et al, 2000). Our response rate for each round exceeded the suggested response rate of 70% for this method (Sumsion, 1998). A limitation of our study is that the overall number of experts involved is small, as would be expected in a relatively small jurisdiction. Additionally, to pursue non-respondents, the identity of the
participants was known to the primary researcher and therefore the process was 'quasi-anonymous'; respondents were known to the researcher and even to one another, but their judgements and opinions remained anonymous (McKenna, 1994).

Our study found that participants found that the role of the psychiatrist in assessing prisoners on hunger strike is not limited to the diagnosis and treatment of mental disorder. The assessment of capacity to refuse food, and the assessment of the motivation behind the hunger strike were seen as additional key tasks in keeping with published international viewpoints from jurisdictions such as Switzerland and the UK (Getaz et al, 2012; Brockman, 1999). Caenazzo, Tozzo & Rodriguez (2016) from an Italian viewpoint additionally suggest the use of independent “ethics consultants” to carry out some of these tasks such as the assessment of capacity based on the premise of the neutrality of the assessor.

Ethical conflicts exist for the state in the case of prisoners on hunger strike where the state must on one hand keep those in custody safe, and on the other be seen to treat everyone equally under the law (Martin, 2010). Such ethical conflicts may cause organisations such as prisons to pressure psychiatrists to share more information about a prisoner than he usually would or indeed coerce the prisoner to end the hunger strike. In such scenarios, the maintenance of neutrality by treating psychiatrists is important to foster trust (Gulati et al., 2017). Participants in this study stressed the need for a ‘private interview’ i.e. out of earshot of prison staff where possible. This is important as someone who may be protesting against prison conditions in the state and may therefore not trust a professional in direct employment by a prison service. In the Irish republic, prison psychiatrists are employed by the health service rather than the prison service. This independence is central to maintaining
independence in clinical decision making as has been highlighted in certain other jurisdictions such as Turkey (Arda, 2002) and Austria (Roggla, 2005), direct employment by custodial authorities has the potential to lead to a ‘dual loyalty conflict’ for doctors involved.

In the decision tree outlined by our paper, the situation arising from hunger strike as a protest with no mental illness can be particularly challenging. In effect those clinicians engaged with a hunger striker who reaches this point could find themselves juggling capacity versus forced treatment. This could go on with episodic restoration of capacity followed by resumption of hunger strike followed by loss of capacity potentially until death. Clinicians whose role it is to preserve life are therein arguably placed in a situation where they are themselves forced to confront an irreconcilable affront to the dignity of life. In order to offset what can be anticipated to cause psychological injury to the clinican(s) involved, a process of shared decision making, changing treating team composition, post incident debriefing, and construction of a specialist skill set may be of benefit. Algorithms, such as the one proposed in this study, have value in guiding objective decision making.

The assessment of a prisoner on hunger strike is perhaps one of the most complex clinical situations faced by a prison psychiatrist, who needs to bear clinical ethical, and legal aspects of management in a fine balance to ensure that the duty of care remains to the patient, to allay whose suffering remains the central premise of involvement.
1. What do you see as the role(s) of a psychiatrist when referred someone refusing food in a prison setting?

2. In what circumstances, if any, would you consider treatment in a hospital setting of someone referred due to refusing food in a prison setting?

3. Which pieces of legislation do you believe are relevant to the psychiatric management of food refusal in an Irish prison setting?

4. In your experience, what measures have you found helpful when faced with such a referral? Examples may include guidance, advice from a colleague but also specific issues such as legal advice, or practical measures such as seeing someone out of earshot from prison officers.

5. In your experience, what measures or issues have been unhelpful, or a barrier to providing care, when faced with such a referral? Examples may include pressure from authorities to elicit a psychiatric underlying cause.

6. IPS Policy states that there should be daily review by a general practitioner. Should there be food refusal in a prison setting, how often would you see someone, from a psychiatric point of view? For example, Every week? More often?

7. With respect to treatment of a person refusing food in a prison setting, in what circumstances would you be likely to involve the courts in decision making?
Table 2: Themes arising from responses to Initial Questionnaire

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>Themes arising</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of Psychiatrist</td>
<td>• Assessment for the presence of mental illness</td>
</tr>
<tr>
<td></td>
<td>• Assessment of capacity to understand the consequences of food refusal</td>
</tr>
<tr>
<td></td>
<td>• Ascertainment for the reason for food refusal</td>
</tr>
<tr>
<td>Circumstances for hospital treatment</td>
<td>• To psychiatric hospital if mental disorder present, especially where this</td>
</tr>
<tr>
<td></td>
<td>directly impacts food refusal based on symptoms</td>
</tr>
<tr>
<td></td>
<td>• To general hospital if significant deterioration in physical status</td>
</tr>
<tr>
<td>Relevant legislation</td>
<td>• Criminal Law Insanity Act, 2006</td>
</tr>
<tr>
<td></td>
<td>• “Capacity Legislation”</td>
</tr>
<tr>
<td></td>
<td>• Assisted Decision Making Capacity Act, 2015</td>
</tr>
<tr>
<td></td>
<td>• Mental Health Act, 2001</td>
</tr>
<tr>
<td></td>
<td>• Common Law</td>
</tr>
<tr>
<td>Helpful measures</td>
<td>• Multidisciplinary Approach</td>
</tr>
<tr>
<td></td>
<td>• Second opinion from a consultant colleague</td>
</tr>
<tr>
<td></td>
<td>• Repeated physical examination, particularly for dehydration, weight</td>
</tr>
<tr>
<td></td>
<td>measurement and blood tests</td>
</tr>
<tr>
<td></td>
<td>• Collateral from prison staff regarding food intake</td>
</tr>
<tr>
<td></td>
<td>• Private interview with patient without prison staff present to elicit practical motivations for food refusal</td>
</tr>
<tr>
<td></td>
<td>• Legal advice</td>
</tr>
<tr>
<td></td>
<td>• Early clarification of autonomous decision making capacity</td>
</tr>
<tr>
<td></td>
<td>• Liaison with prison staff and prisoner’s solicitor</td>
</tr>
<tr>
<td>Barriers to care</td>
<td>• Assessment with prison staff in close proximity</td>
</tr>
<tr>
<td></td>
<td>• Pressures to treat as a mental health issue in the absence of mental illness</td>
</tr>
<tr>
<td>Frequency of review</td>
<td>• Every psychiatric clinic (1-3 times weekly)</td>
</tr>
<tr>
<td></td>
<td>• Daily review if mentally unwell, until hospital admission and less frequent</td>
</tr>
<tr>
<td></td>
<td>if no mental illness</td>
</tr>
<tr>
<td>Circumstances when courts should be</td>
<td>• In the event of significant deterioration in physical health where there is</td>
</tr>
<tr>
<td>involved</td>
<td>uncertainty around capacity</td>
</tr>
<tr>
<td></td>
<td>• In the absence of severe mental illness or in the case of personality</td>
</tr>
<tr>
<td></td>
<td>disorder, where there is capacitous food refusal and there is a difference</td>
</tr>
<tr>
<td></td>
<td>of opinion from family or criminal justice staff</td>
</tr>
<tr>
<td></td>
<td>• If there is a need for forced feeding</td>
</tr>
<tr>
<td></td>
<td>• ‘Life or death’</td>
</tr>
</tbody>
</table>
Figure 1. Algorithm for psychiatric management of a prisoner on hunger strike

Trigger:
Referral received from Prison General Practitioner

Action:
Ensure GP/Physical assessment has occurred. May need General Hospital referral by GP if physically very unwell

Decision Point:
What is the motivation behind Food refusal

Outcome:
As a protest - Hunger Strike

Action:
Recommend special observations and a shared cell if suicidality evident

Outcome:
Mental illness present

Decision Point:
Assess for mental illness and capacity to refuse food in light of this

Outcome:
Lacks Capacity to refuse food

Action:
Low threshold for diversion to psychiatric hospital

Action:

Action:
If capacity lost, may need treatment in General Hospital using Assisted Decision Making legislation - However consider Advance Directive if present

Action:
Assess and Treat mental illness and food refusal issues as separate entities

Outcome:
No Mental Illness present

Decision Point:
Assess Capacity to refuse food

Outcome:
Has Capacity to refuse food

Action:
Respect autonomy Review capacity regularly Consider second opinion/legal advice

Action:

Outcome:
Lacks Capacity to refuse food

Action:
Consider High Court referral for advice if 'life and death' issue

Outcome:
Mental illness comorbid but unrelated to subject of protest, and not affecting capacity

Outcome:
To end life i.e. as a suicidal act or based on a false belief eg that food is being poisoned
References


High Court of Ireland (2015) Governor of X Prison v McD: IEHC 259.


McLean, S.A.M. (2009), “Are advance directives legally binding or simply the starting point for


**World Health Organisation (2014)**, “Prisons and Health”, WHO Regional Office for Europe, Denmark, pp 13-14, available at:


CHAPTER 8

Final discussion
Final discussion

This thesis aims to bring together three different strands related to Irish prison psychiatry: the estimation of psychiatric and psychosocial need, alongside the development of care pathways for two discrete clinical issues – hunger strikes and prisoners with an intellectual disability.

Internationally, prison psychiatric morbidity has been studied increasingly over the last 2-3 decades with recent large scale systematic reviews summarising the position that, essentially, prisons are places where mental illness and substance misuse are over represented. This finding has led to the development of mental health services in prisons and diversion services. Separately, prisons have been the focus of human rights considerations and in Europe. The treatment of mentally ill prisoners remains the subject of consideration during unannounced inspections by the Council of Europe’s Committee for the Prevention of Inhuman and Degrading Treatment. There has been governmental interest in the development of services for prisoners with mental illness but policy development in Ireland is informed chiefly by citing studies arising from a landmark prison morbidity study from 2004. There was little up to date consolidated data estimating morbidity since that date. Chapter 1 of this thesis provides an up to date estimate, through meta-analysis of prison morbidity in Ireland. It goes further by analysing rates not just for major mental illness but looking at psychosocial issues such as the prevalence of alcohol and substance misuse and homelessness on committal. The study in this thesis found that prisoners in Ireland have higher rates of psychosis, homelessness and substance misuse issues than the general population and, in the case of homelessness, higher than international prison estimates. This study, therefore, represents the most up to date dataset that can help inform research and policy initiatives going forward. Addressing the areas of need highlighted by the study will likely have humanitarian impact in terms of mitigation of suffering but also positive societal impact through a reduction in recidivism, as seen in other jurisdictions. This study can be used as a benchmark for international comparison and as a baseline to evaluate progress made within Ireland through service and policy development.
Within Ireland, prison research has largely been conducted in Dublin-based prisons. Little was
known about mental healthcare in regional prisons. Chapter 2 of this thesis describes a
retrospective record-based study conducted in a non-Dublin regional prison. It showed that
there was a wide geographical catchment area for those assessed by psychiatric services to
the prison and a significant need for psychological services and addiction services, in addition
to a psychiatrist. It identified the need to improve screening for remand and female prisoners
as these were underrepresented in those referred, but are known to have higher morbidity
rates. Finally, it found that those needing medium and high secure psychiatric care were
afforded the same by the National Forensic Mental Health Service but that those diverted to
local psychiatric wards would have been afforded more appropriate care in Intensive Care
Regional Units (ICRUs), which are yet to be developed for much of Ireland. The findings of this
study strengthen the argument for a national system of systematic screening for prisoners
and multi-disciplinary input into peripheral Irish prisons, many of which have only sessional
input from a doctor and a nurse. They also strengthen calls for the development of ICRUs to
facilitate effective diversion for those with mental illness in prison requiring hospital care. The
results of this study can be used as a baseline to measure service improvements through
defined interventions, as well as a benchmark for comparison of morbidity in other prisons in
Ireland and other jurisdictions.

Prisoners with Intellectual Disability (ID) form a significant minority in the prison population
worldwide and have specialist needs. They are vulnerable, and have higher needs in terms of
mental and physical health comorbidities. Little, however is known about the prevalence of
ID in Irish prisons and these prisoners often “fall between the cracks” given artificial systemic
boundaries between prison medical services, community mental health services and disability
services. Little guidance existed relating to the management of those with ID in prisons. Non-
recognition of need and lack of services for those with ID has significant humanitarian
implications in terms of suffering. Chapter 3 of this thesis systematically reviewed published
data estimating the prevalence of ID in Irish prisons. It found that very little data exist in
relation to prevalence, and those which exist, suggest that the estimates in Ireland are above
international comparisons. The anticipated impact of this study is to re-invigorate research
into this area and the study recommends incorporating screening into existing mechanisms,
as well as repeating a nation-wide cross sectional study to acquire an estimate. It highlighted that even if there was recognition of ID, little guidance exists in terms of provision of care.

The study described in Chapter 4 of this thesis brought together a group of professionals across a range of disciplines with nearly 200 years of combined experience to propose a care pathway for those with ID in Irish prisons. It identified a range of needs – protection against exploitation, treatment of mental health comorbidity, care around physical health comorbidity (particularly seizure disorder) and the need to work with local disability services to agree diversion from prison in specific circumstances. This is the first such agreed care pathway in Ireland, and has considerations that can be generalised to other jurisdictions where little guidance exists in relation to this area of specialist care. The publication of this pathway underlines the need for minimum standards of care for people with ID in prisons internationally and could form the basis for service-based audits of care.

Hunger strikes in Irish prisons are not rare and food refusal as a means of protest has historical origins dating back to Brehon law. The role of the psychiatrist is fraught with clinical, legal and ethical complexities. Little guidance existed in relation to these issues in Irish prison healthcare settings predating the studies in this thesis. Chapter 5 of this thesis studies the ethical complexities from a physician’s perspective through a systematic review reflecting studies from twelve jurisdictions. The ethical position worldwide largely converges onto a consensus position agreed in 2006 called the “Declaration of Malta”. This study found that challenges exist in jurisdictions where doctors were employed directly by prison authorities. In Ireland, prison psychiatrists are employed by a separate service, the Health Service Executive and, therefore, the “dual loyalty” conflict can be mitigated. This is the largest such review to date and has international relevance given its multi-jurisdictional context. Services in any jurisdiction developing policies and/or care pathways to inform management of care may find this a useful reference document to ensure consistency with internationally accepted principles.

The study described in Chapter 6 of this thesis brought together lawyers and psychiatrists to elicit specific legal considerations for prison psychiatrists in Ireland when assessing someone refusing food. It found that whilst Mental Health and Criminal Law (Insanity) legislation may
help in some circumstances, the case law in this area is complex and divergent and recommends that prison psychiatrists seek legal advice. This is the first published study of its kind, and is likely to be of practical help as a reference document to prison practitioners in this jurisdiction and other jurisdictions with similar legal frameworks.

The study described in Chapter 7 brought together senior prison psychiatrists from around Ireland as well as experts in law and ethics, to propose a care pathway which psychiatrists can refer to when managing prisoners on hunger strike. It emphasises the need for neutrality, close working with other disciplines, the value of “second opinions” and the central aspect of clinical decision making based on an assessment of capacity. This study helps develop a body of knowledge and expertise in a challenging area where little guidance existed beforehand. Such expertise may improve objective clinical decision making and reduce clinician burnout. This is the first such care pathway that has been considered from a legal and ethical viewpoint and, although developed in Ireland, is based on principles which may be generalised to other jurisdictions.

In conclusion, the studies in this thesis aim to impact care in Irish and international prison settings. Whilst the anticipated impact includes driving service change, stimulating further research interest and improving standards of clinical care, the primary outcome hoped for is humanitarian and at the level of the individual who is receiving care.
Appendices

**Appendix I:** Copies of scales used in this thesis

**Appendix II:** Copies of letters of approval from Ethics Committee(s)

**Appendix III:** Copies of publications arising from this thesis

**Appendix IV:** Copies of letters of acceptance for publications and oral presentations
Newcastle-Ottawa Scale adapted for cross-sectional studies

Selection: (Maximum 5 stars)

1) Representativeness of the sample:
   a) Truly representative of the average in the target population. * (all subjects or random sampling)
   b) Somewhat representative of the average in the target population. * (non-random sampling)
   c) Selected group of users.
   d) No description of the sampling strategy.

2) Sample size:
   a) Justified and satisfactory. *
   b) Not justified.

3) Non-respondents:
   a) Comparability between respondents and non-respondents characteristics is established, and the response rate is satisfactory. *
   b) The response rate is unsatisfactory, or the comparability between respondents and non-respondents is unsatisfactory.
   c) No description of the response rate or the characteristics of the responders and the non-responders.

4) Ascertainment of the exposure (risk factor):
   a) Validated measurement tool. **
   b) Non-validated measurement tool, but the tool is available or described.*
   c) No description of the measurement tool.

Comparability: (Maximum 2 stars)

1) The subjects in different outcome groups are comparable, based on the study design or analysis. Confounding factors are controlled.
   a) The study controls for the most important factor (select one). *
   b) The study control for any additional factor. *

Outcome: (Maximum 3 stars)

1) Assessment of the outcome:
   a) Independent blind assessment. **
   b) Record linkage. **
   c) Self report. *
   d) No description.

2) Statistical test:
   a) The statistical test used to analyze the data is clearly described and appropriate, and the measurement of the association is presented, including confidence intervals and the probability level (p value). *
   b) The statistical test is not appropriate, not described or incomplete.
## DUNDRUM RATING SCALES

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<td><strong>S1</strong> Seriousness of violence</td>
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<tr>
<td><strong>S2</strong> Seriousness of self-harm</td>
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<tr>
<td><strong>S3</strong> Immediacy of risk of violence</td>
<td></td>
</tr>
<tr>
<td><strong>S4</strong> Immediacy of risk of suicide/ self harm</td>
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</tr>
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<td><strong>S5</strong> Specialist forensic need</td>
<td></td>
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<tr>
<td><strong>S6</strong> Absconding / eloping</td>
<td></td>
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<tr>
<td><strong>S7</strong> Preventing access</td>
<td></td>
</tr>
<tr>
<td><strong>S8</strong> Victim sensitivity/public confidence issues</td>
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<tr>
<td><strong>S9</strong> Complex Risk of Violence</td>
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<td><strong>S10</strong> Institutional behaviour</td>
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<td><strong>S11</strong> Legal process</td>
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<th>DUNDRUM-2: TRIAGE URGENCY ITEMS</th>
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<td><strong>U1</strong> Current Location</td>
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<td><strong>U2</strong> Mental Health</td>
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<td><strong>U5</strong> Systemic</td>
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<td><strong>U6</strong> Legal Urgency</td>
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<td><strong>Subtotal</strong></td>
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</table>

| TOTAL SCORE                     |      |   |   |   |   |
20th May, 2016.

Dr. Gautam Gulati,
Consultant Psychiatrist,
Kilmallock Day Hospital,
Railway Rd.,
Kilmallock,
Co. Limerick.

Re/ Protocol Title
Analysis of Referrals to a Secondary Mental Healthcare Team in a Regional Irish Prison.

Dear Dr. Gulati,

The Research Ethics Committee at the University Hospital Limerick has received a submission for ethical approval for the above study.

The following documents were reviewed and approved by the Research Ethics Committee:

Application to the Research Ethics Committee
Approved

From an insurance perspective, please note that cover does not extend to those parties not employed by the Health Service Executive (HSE), or non-HSE Institutions unless working under a Principal Investigator who is a HSE employee in a site covered under the Clinical Indemnity Scheme.

Yours sincerely,

[Signature]

Brian McKeon,
Planning, Performance & Business Information Manager.
(For and on behalf of the Research Ethics Committee & the QPS Department).
9th May, 2017.

Dr. Gautam Gulati,
Consultant Physician,
Kilmallock Day Hospital,
Railway Rd.,
Kilmallock,
Co. Limerick.

Re:  Protocol Title:
Analysis of Referrals to a Secondary Mental Healthcare Team in a Regional Irish Prison.
REC Ref: 049/16.

Dear Dr. Gulati,

The Research Ethics Committee at the University Hospital Limerick has received a submission for ethical approval for an amendment to the above study dated 8th May, 2017.

I can now confirm approval to this amendment.

Yours sincerely,

Pat Dillon,
Consultant Anaesthetist,
Chairperson, Research Ethics Committee.
29th September, 2016.

Dr. Gautam Gulati,
Consultant General/Forensic Psychiatrist,
HSE Mid-West,
Kilmallock Day Hospital,
Railway Rd.,
Kilmallock,
Co. Limerick.

Re/ Protocol Title
"Pathways to care for adults with an Intellectual Disability in an Irish Prison Setting."

Dear Dr. Gulati,

The Research Ethics Committee at the University Hospital Limerick has received a submission for ethical approval for the above study.

The following documents were reviewed and approved by the Research Ethics Committee:

Application to the Research Ethics Committee                     Approved

From an insurance perspective, please note that cover does not extend to those parties not employed by the Health Service Executive (HSE), or non-HSE Institutions unless working under a Principal Investigator who is a HSE employee in a site covered under the Clinical Indemnity Scheme.

Yours sincerely,

Brian McKeon,
Director of Informatics, Planning & Performance.
(For and on behalf of the Research Ethics Committee & the Quality & Safety Department).
9th September, 2016.

Dr. Gautam Gulati,
Consultant General/Forensic Psychiatrist,
HSE Mid-West,
Kilmallock Day Hospital,
Railway Rd.,
Kilmallock,
Co. Limerick.

Re: Protocol Title
“Pathways to care for adults with an Intellectual Disability in an Irish Prison setting”
REC Ref: 086/16

Dear Dr. Gulati,

I am in receipt of your proposal as above submitted for review by our Research Ethics Committee. I have reviewed the contents of same.

I wish to advise that I have given your study Chairperson ethical approval.

You should note that your study cannot commence until you also receive AON approval which will issue from the Quality and Patient Safety Department shortly. You are obliged to inform us as soon as your study is completed or if it terminates early for any reason.

I wish you every success with your study.

Yours sincerely,

Pat Dillon,
Consultant Anaesthetist,
Chairperson, Research Ethics Committee.
19th October, 2016.

Dr. Gautam Gulati,
Consultant General/Forensic Psychiatrist,
Kilmallock Day Hospital,
Railway Rd.,
Kilmallock,
Co. Limerick.

Re/ Protocol Title
Developing a consensus through expert elicitation to inform a psychiatric care pathway for patients on a hunger strike in a prison setting.
REC Ref: 84/16.

Dear Dr. Gulati,

Thank you for submitting the documentation as requested by the Research Ethics Committee.

I wish to advise that the Committee has now approved your study.

You should note that your study cannot commence until you also receive AON approval which will issue from the Quality and Patient Safety Department shortly.

You are obliged to inform us as soon as your study is completed or if it terminates early for any reason.

I wish you every success with your study.

Yours sincerely,

Pat Dillon,
Consultant Anaesthetist,
Chairperson, Research Ethics Committee
22nd September, 2016.

Dr. Gautam Gulati,
Consultant General/Forensic Psychiatrist,
Kilmalloch Day Hospital,
Railway Rd.,
Kilmalloch,
Co. Limerick.

Re/ Protocol Title
Developing a consensus through expert elicitation to inform a psychiatric care pathway for patients on a hunger strike in a prison setting.
REC Ref: 84/16.

Dear Dr. Gulati,

Thank you for attending the Research Ethics Committee meeting on the 21st September, 2016 in connection with your study.

I wish to advise that the Committee has approved your study subject to you submitting a Participant Information Leaflet and questionnaire for review. You should also amend the application form at point E2.8 (a) to reflect that the data collected will be retained for a period of 7 years. Please submit the requested documentation to Ms. Joanne O'Conner at joanne.oconnor@hse.ie

You should note that your study cannot commence until you also receive AON approval which will issue from the Quality and Patient Safety Department shortly.

You are obliged to inform us as soon as your study is completed or if it terminates early for any reason.

I wish you every success with your study.

Yours sincerely,

[Signature]

Karl Dillon,
Consultant Anaesthetist,
Chairperson, Research Ethics Committee.
19th October, 2016.

Dr. Gautam Gulati,
Consultant Genera/Forensic Psychiatrist,
Kilmallock Day Hospital,
Railway Rd.,
Kilmallock,
Co. Limerick.

Re/ Protocol Title
Developing a consensus through expert elicitation to inform a psychiatric care pathway for patients on a hunger strike in a prison setting.

Dear Dr. Gulati,

The Research Ethics Committee at the University Hospital Limerick has received a submission for ethical approval for the above study.

The following documents were reviewed and approved by the Research Ethics Committee:

Application to the Research Ethics Committee  Approved
Letter of Invitation                   Approved
Questionnaire                        Approved

From an insurance perspective, please note that cover does not extend to those parties not employed by the Health Service Executive (HSE), or non-HSE Institutions unless working under a Principal Investigator who is a HSE employee in a site covered under the Clinical Indemnity Scheme.

Yours sincerely,

Brian McKeon,
Director of Informatics, Planning & Performance.
(For and on behalf of the Research Ethics Committee & the QPS Department).
Hunger strikes in prisons: a narrative systematic review of ethical considerations from a physician’s perspective

G. Gulati1,2, B. D. Kelly3, D. Meagher4, H. Kennedy4,5 and C. P. Dunne6

1 Department of Psychiatry, University Hospital Limerick, Limerick, Ireland
2 Department of Psychiatry, Graduate Entry Medical School, University of Limerick, Limerick, Ireland
3 Department of Psychiatry, Trinity College Dublin, Dublin, Ireland
4 Central Mental Hospital, Dublin, Ireland
5 Graduate Entry Medical School, University of Limerick, Limerick, Ireland

Objectives. We sought to identify and review published studies that discuss the ethical considerations, from a physician’s perspective, of managing a hunger strike in a prison setting.

Methods. A database search was conducted to identify relevant publications. We included case studies, case series, guidelines and review articles published over a 20-year period. Non-English language publications were translated.

Results. The review found 23 papers from 12 jurisdictions published in five languages suitable for inclusion.

Conclusions. Key themes from included publications are identified and summarised in the context of accepted guidelines from the World Medical Association. Whilst there seems to be an overall consensus favouring autonomy over beneficence, tensions along this fine balance are magnified in jurisdictions where legislation leads to a dual loyalty conflict for the physician.

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Key words: Asylum seeker, ethics, food refusal, hunger strike, prison.

Introduction

A ‘hunger strike’ is by definition food refusal as a form of protest or demand (Crosby et al. 2007). This is distinct from food refusal as a consequence of mental illness such as in situations where someone may be severely depressed or harbouring a fixed false belief that their food is poisoned.

Hunger strikes in prison have occurred in several countries including Turkey, South Africa, Ireland and the US Naval base at Guantanamo Bay, Cuba (Crosby et al. 2007). In Ireland, these came to the forefront of international attention in 1981, after the death of 10 individuals protesting against the withdrawal of special category status for paramilitary prisoners by the then British Government (Berenstain, 1997).

General practitioners, physicians and psychiatrists are commonly involved in the assessment and treatment of those refusing food in prison, and in such a role may be faced with legal and ethical complexities as well as media and governmental pressures. The general practitioner is commonly asked to assess capacity, monitor physical health and may be called upon to provide emergency treatment for the acutely unwell prisoner on hunger strike (Getaz et al. 2012). The general practitioner may refer to a psychiatrist to exclude mental illness and assist in capacity assessment (Brockman, 1999). The general practitioner may seek a medical hospital consultant’s advice when there is substantial deterioration of physical health including in medical emergencies arising from prolonged fasting or if there is a need for supervised feeding (Casnazzu et al. 2016).

The most widely accepted basis for contemporary decision making remains the Declaration of Malta adopted by the World Medical Association (2006). This cites the need for ethical decision making, respect for autonomy, balancing beneficence (whilst stating that this does not necessarily involve prolonging life at all costs) and non-maleficence (which would include not forcing treatment on competent people). It states unambiguously that force-feeding contrary to an informed and voluntary refusal is unjustifiable. It states that in the case of dual loyalties (to the patient and the state), the first duty remains to the patient and highlights the need for clinical independence, developing trust and maintaining confidentiality.

Increasing international experience and ethical debate has been published over the last two decades. To date, much of this literature has been published in
jurisdiction-specific contexts, although the key themes appear to converge. Here, we systematically review literature relating to ethical issues for physicians (a term used interchangeably with 'medical doctor' in this paper and includes general practitioners, psychiatrists and hospital medicine consultants) to identify these themes and inform discussion.

Methods
A MEDLINE and CINAHL (1996-2016) search was conducted with the search terms ‘Hunger Strike’ and ‘Ethics’. We included case studies, case series, guidelines and review articles provided there was a discussion of ethical issues. Publications that did not cite ethical issues (13) were excluded as were publications discussing issues exclusively to do with children/adolescents aged <18 years (1). The timeframe of the database search included 10 years before and 10 years after the landmark consensus position adopted by the World Medical Association in 2006. Grey literature and book chapters were not included in this review.

Results
We reviewed 39 publications of which 23 were included in our review. Studies were mainly in the English language, with others translated from Norwegian (1), French (3), Spanish (1) and Dutch (1) using Google translate software. The publications included papers from 12 separate jurisdictions.

Publications cited ethical arguments along one or more recognised axes in medical ethics: the principles of justice, autonomy, beneficence and non-maleficence (Beauchamp & Childress, 2001). Justice requires that procedures uphold the spirit of existing laws and are fair to all involved. Autonomy requires that the patient have independence of thought, intention, and action when making decisions regarding health care procedures and that a decision-making process must be free of coercion. Beneficence requires that the procedure be provided with the intent of doing good for the patient involved. Non-maleficence requires that a procedure does not harm the patient involved or others in society.

We present our findings in a narrative format, identifying the jurisdiction that the publication relates to, where possible, to aid contextualisation.

Australia
Kenny et al. (2004) writing from an Australian perspective and looking at hunger strikes in detained asylum seekers, noted that there may be pressures on the treating physician based on legal directives from an employing authority that may contradict ethical positions adopted worldwide. They report that such hunger strikes have occurred in Australia since the introduction of the policy of mandatory detention for asylum seekers, and that these came to the forefront of public attention when 200 detainees embarked on a hunger strike at the Woomera Immigration Reception and Processing Centre in 2002. They further report that an Australian Government regulation empowering the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) to authorise non-consensual medical treatment for a person in immigration detention if they are at risk of physical harm, could inherently conflict with World Medical Association (2006) guidelines that prohibit force-feeding. However, they also state that authorisation by DIMIA does not compel medical practitioners to enforce treatment if such action is contrary to their ‘ethical, moral or religious convictions’.

Austria
Röggl (2005) raised an issue similar to the Australian context with a then recent Austrian legislation ‘which demands and legalises medically enforced feeding of detained asylum seekers on hunger strike’. He noted that the doctor’s involvement in the process, which included positioning of nasogastric tubes would be contrary to international medical standards and cited the importance for prison medical doctors to act independently of ‘governmental interests’. He noted that the doctor’s duties in handling a prisoner on hunger strike were well defined: acquiring a detailed medical history; carrying out a thorough examination; advising the prisoner of clinical consequences; and regular reevaluation and ascertainment of wishes. He argued that any treatment administered to the patient must be with the patient’s approval.

France
Fayeuille et al. (2010) surveyed doctors in France about the management of hunger strikes. In all, 95 responses were received from 174 penal institutions across the country. They concluded that the majority of doctors opted for ‘a neutral attitude’ (63%), noting that hunger strikes were mostly brief (less than a week in 85% of cases). They went on to state that it was refusal of care that made the medical approach potentially challenging. They further detailed how ‘faced with such a situation, 45% of the doctors (surveyed) privileged their duty of care’ and 28% ‘respected the patient’s wishes’. In total, 5.5% of the doctors surveyed provided written information concerning the risks incurred during a fast and 23% of those surveyed had witnessed complications due to fasting. The utility of treatment using vitamins was rarely recognised (32.7%).
Italy

Caenazzo et al. (2016) writing from an Italian perspective regarding prisoners hospitalised at Padua hospital, report instances of court ordered treatment including force-feeding. The authors suggest the use of independent 'ethics consultants' becoming involved in the case of hospitalised hunger strikers to assist the building of trust, information giving and to facilitate informed decision making. Garasc & Foster (2012) raise potential inconsistencies in the application of law so as to favour the weight given to either autonomy or beneficence based on the demographics of an individual case. They describe the case of a Tunisian Muslim prisoner charged with rape and held in an Italian prison. He went on a hunger strike, protesting his innocence and subsequently died with prison authorities reporting that force-feeding was withheld to respect autonomy.

Norway

Dahlberg & Dahl (2015) describe a Norwegian case wherein an asylum seeker in his fifties was on hunger strike for 7 weeks and thereafter brought to an emergency room with impaired consciousness, but deemed to have capacity following assessment by a psychiatrist. They note that the two opposing issues are one of patient autonomy and an ethical duty to provide immediate medical assistance. The latter, in the Norwegian legal context specifically excludes situations relating to hunger strikes, blood products and life-prolonging treatment. However, the authors opine that legislation did not appear to reflect any consistent balance between the considerations of autonomy and the medical professional’s duty to provide immediate medical care. They note that exemptions for providing emergency medical care for hunger strikes were unconditionally accepted without weighing the gravity of risk to the person’s life. They hypothesise that if their patient instead had expressed their political dissent by ignoring himself, the relationship would not have been exempt from the obligation to help, as this is not listed among the exceptions in Norwegian legislation.

Spain

Garcia-Guerrero (2013) summarises that the ethical issues to consider are those of autonomy, beneficence and non-maleficence. He goes on to say that autonomous actions have three fundamental components: knowledge, intention and the absence of external pressures that may influence the act. Respect for personal autonomy is twofold: adequate information to inform sound decision making by those who take it, and the absence of control. Beneficence comes into play if help is voluntarily asked for. The author suggests that force-feeding of a prisoner on hunger strike is against the principle of autonomy of the people, and could not be considered beneficence but could be considered ethically maleficent. He reports that the legal position in Spain is complex with interplays of penitentiary regulations and constitutional doctrines.

Garcia-Guerrero & Vera-Romartinez (2015) in a descriptive analysis of episodes of ‘voluntary total fasting’ amongst Spanish prison inmates over a 14-month period reviewed biochemistry and weight changes. They found that only one-third of those who go on hunger strike in prison actually fast. They conclude that episodes of voluntary total fasting were common in Spanish prisons, but “rarely were they carried out rigorously and entail a risk for those who fast”.

Switzerland

Getaz et al. (2012) from a Swiss perspective, propose guidelines for managing hunger strikes. In the ethical discussion, they highlight the role of autonomy stating that ‘As any citizen, detainees have the right to refuse food and fluid, as well as any medical treatment considered unnecessary for the maintenance of bodily integrity’.
treatment .... The physician should not override voluntary, informed and competent decisions of the patient. They highlight the need for a competency assessment and encourage the use of advance directives. They outline that the conventional dual physician-patient relationship shifts to a triadic physician-patient-authority relationship in case of a hunger strike and that additional partners claim a role and may try to pressure the physician, such as family, public, media or politics. By refusing to force-feed a detainee, doctors may be exposed to judicial pressure or sanctions and to negative opinions from media. They assert that the physician should be impartial, empathic and should not become involved in the conflict between the hunger striker and partners as it is critical that the physician obtains the confidence of the hunger striker but also the respect of the authority which the patient conflicts with. They indicate that the physician is also expected to play a role as neutral mediator in the conflict between the person who fasts and the partner he pressures. They illustrate, in relation to conscientious refusal that ‘If, for conscience reasons, a physician is unable to abide by a hunger striker’s refusal of treatment or artificial feeding, the physician should make this clear at the outset and refer the hunger striker to another physician who is willing to abide by the hunger striker’s refusal’. Their opinion is that the duty of care is to the patient alone and recommend that the stewardship of health care in custody should be passed from Ministry of Justice to the Ministry of Health to minimise the dual loyalty conflict for the doctor involved.

Martin (2010), also writing with the Swiss context in mind, highlights the tensions between beneficence in the medical profession and the individual's right to autonomy. He cites the case of a cannabis farmer, who carried out a hunger strike against his sentence. An ethical conflict existed for the state, whereby it must on one hand keep these in custody safe and, on the other, be seen to treat everyone equally under the law. This could be undermined if the state were seen to be ‘blackmailed’ to alter a sentence through food refusal.

The Netherlands

Govers (2000) noted that the Dutch legal position was less problematic than some other European jurisdictions, and more in keeping with ethical positions adopted internationally that supported the principle of autonomy and a presumption of capacity. He noted the importance of neutrality of the doctor and raised the issue of a professional independent of the institution. The difficulty in establishing autonomy in the presence of peer pressure in a group hunger strike was recognised. Govers noted that the Council of Europe recommendation on health care in prisons in 1998 included rules on medical examination of hunger strikers. His opinion is that the Council of Europe, however, defers to national legislation of member states in the case of intervention in hunger strikes.

Turkey

Arda (2002) commenting on the role of physicians in Turkish hunger strikes argues the need to maintain autonomy and respect consent, whilst noting that ‘the boundary and validity of autonomy and its position in suppressed groups is a controversial and questionable issue’. Oguz & Miles (2005) cite their reflections from Turkey’s experience with hunger strikes in 1996 and 2000–2003, where over a hundred lives were lost. Tensions between the positions that were taken by government authorities and the Turkish Medical Association are described. Their belief is that the neutrality of the treating physician is key and that the duties of the physician extend to assessing competence, checking the person’s freedom to go on a hunger strike (the absence of coercion), providing information on the risks of fasting and supervise refeeding in hospital if there is informed consent for this.

United States of America

Dougherty et al. (2013), when evaluating the ethical complexities involved in the force-feeding of detainees at the US detention centre at Guantanamo Bay, Cuba stated that such force-feeding violates medical ethics and constitutes medical complicity in torture. They note that this practice was contrary to the Declaration of Malta (2006) and that personal morals, national security imperatives or ‘the norm of military detention’ were not in themselves sufficient to justify departure from the general principles of medical ethics and that issues arose from ‘dual loyalty’ of health care professionals. They noted that the Guantanamo force-feeding policy was a departure in two ways; favouring beneficence over autonomy and reducing informed consent to a procedural issue. They further note that the Declaration of Malta is unambiguous in stating that autonomy trumps beneficence in cases of hunger strike and go on to emphasise that beneficence does not necessarily involve prolonging life at all costs irrespective of other values. The issue of ‘dual loyalties’ in hunger strike cases was also raised by a Military Medical Ethics workshop (Weisfield et al. 2009) in the United States; such that there were two issues related to ethical decision making including the individual circumstances of each case (including cultural issues), and organisational resources to help physicians manage ethical quandaries without resorting to ‘heroic tactics’. An Anonymous (2014) case report in the American Journal of Bioethics describes a case wherein a prisoner refusing food, deemed to have capacity, is returned to prison from a
hospital setting with a decision that there was ‘no case to treat in the absence of consent’. An application to have a guardian was not accepted given the presence of capacity. Therefore, in the United States, there would appear to be different approaches taken towards detainees in military and civil settings.

**United Kingdom**

Brooke (1999) summarises the ethical consideration for the psychiatrist: autonomy, competence and mental disorder. He states that psychiatrists visiting prisoners may be faced with a variety of ethical dilemmas, including conflicting obligations, personal distress, countertransference and institutional illness (whom prison hospitalisation is causing the illness). The author states that both ‘society and the law acknowledge that a competent prisoner may choose to commit suicide by starvation’. He notes that the United Kingdom’s policy in relation to force-feeding altered in 1974 when the home secretary advised that a prison medical officer would not be neglecting his duty if he did not force-feed a prisoner against his will. Safeguards included a second opinion from a psychiatrist in relation to capacity, and with confirmation from the same, advice to the prisoner that whilst he would receive supervision in a hospital wing and be offered food, the authorities do not require doctors to force-feed and that medical intervention would not occur unless the prisoner himself requests this.

**Non-Jurisdiction-specific publications**

Fesser (2003) reviewing literature on psychological changes following starvation comments that decision-making capacity can be impaired through psychological changes following a period of starvation, and the need to work with advance directives in such cases. He notes that whilst clouding of consciousness and psychotic breakdown can affect competence, increases in ‘aggressivity and anger’ as the fast continues do not in themselves preclude competent decision-making.

Sakelladis et al. (2009) reviewed European and international guidelines relating to health care in prisons. Their recommendations on managing hunger strikes focus on the principle of informed consent and are consistent with the Declaration of Malta (World Medical Association, 2006) in that autonomy is favoured in the competent hunger striker and advance directives respected unless they are thought to be made under duress. They recommend daily re-evaluations by a physician.

Rieder et al. (2010) summarise historical considerations across various jurisdictions reporting that legal and ethical conflicts arise when the self-determination and intrinsic rights of the striker are ignored by authorities and cite examples of adverse outcomes where force-feeding was undertaken. They note that the European Court of Human Rights ruled in 2007 that ‘forced and repeated nutrition without medical indication, with the aim of compelling the detainee to cease his protesting attitude and applied in a way that the latter causes unnecessary pain and humiliation of the detainee, is considered an act of torture’. The authors assert that medical care in these situations should impartial and independent from the judicial and penal system to avoid conflicts of interest.

Irmsch (2015) outlines the potential conflict between the obligations of beneficence and autonomy. He states that international medical guidelines require physicians to accede to unpressured advance directives and in the absence of such, to make a decision on the basis of the patient’s values, previously expressed wishes, and best interests. He argues that in the absence of an advance directive and if competence is already lost, the physician has a responsibility to resuscitate and review when decision-making capacity is regained. Thereafter, the physician has a ‘moral obligation’ to respect any decisions and follow advance directives, even if this were to mean continued fasting.

Druml et al. (2016) published guidelines on artificial nutrition and hydration using a consensus-based methodology (Delphi). Their guidelines include a discussion of ethics. In the case of Hunger strikes, the guidelines report a strong consensus for the statement that ‘providing nutrition against the will of the patient who is able to give his/her consent or make judgments (enforced feeding) is generally prohibited’. They indicate that although the legal situation might differ in some countries, the World Medical Association has established clear guidelines for physicians involved in managing people on hunger strike. The force-feeding of hunger strikers who are mentally competent is not allowed.

**Summary and discussion**

We summarise key ethical issues relating to hunger strikes in prisons as highlighted by authors from 12 jurisdictions worldwide. Our review suggests that there are several key themes emerging which remain consistent with the widely accepted consensus position of the World Medical Association (2006):

- There seems to be agreement from a medical viewpoint that the right to autonomous self-determination should be respected in an individual who is competent and acting without duress.
- That treatment proceeds only when voluntary consent to treatment is obtained, or in an emergency when treatment is provided to an incompetent individual in the absence of a valid unpressured advance refusal.
- That the balance between the principles of autonomy and beneficence could be at odds in a person who is on a hunger strike, but that beneficence does not necessarily mean prolonging life at all costs.
d. That force-feeding a competent individual against his will is an act against the principle of non-maleficence.

e. That in the case where there is conflict between loyalty to the patient and the state, the first duty of the medical professional is to his patient.

This to our knowledge, is the largest review of this topic to date. One significant limitation of this study is the lack of publications from the Middle East, China, Russia and Korea, which may bias the findings, given differing human rights perspectives across the world. Human rights intrinsically affect the weightage given to the fine balance between autonomy and beneficence considerations, especially in relation to detained individuals. The source of this bias may be linguistic, a Tower of Babel bias (Gégoire et al. 1995) wherein linguistic exclusions to review studies lead to exclusions, however, non-English language studies were included in this review and there were no exclusions based on articles published in dialects from the said countries. There may be a potential bias arising from a lack of studies from these regions being indexed in the electronic databases used in this review. Future research would benefit from a review of grey literature and a more comprehensive world view of the debate extending to a review including searches of legal and human rights databases. Similar ethical issues exist in jurisdictions such as Israel, where concerns have been expressed around legislation that permits force-feeding of Palestinian hunger strikers (Bob, 2016) and China, where hunger strikes in relation to political prisoners are sometimes reported in local media as monitored by human rights organisations (Fung, 2016).

Capacity assessment is a key consideration for practitioners attending a prisoner on hunger strike. Capacity may be affected by mental illness or as a result of physiological changes arising from prolonged fasting, although, as Fessler (2003) points out, this evaluation is complex. The clinical boundaries of mental incapacity may be critically tested in hunger strikes. For example, in non-jurisdictions, the elements of mental capacity to give or withhold consent may be defined in statutes that do not fully accord with international rights, conventions or clinical science. In jurisdictions with legal provisions for making advance directives, such may be used to respect autonomy for those who subsequently lose decision-making capacity (Getaz et al. 2012; Irnak, 2015).

Ethical conflicts for physicians may be highlighted by jurisdictional law. In relation to the position in Australia (Kenny et al. 2004), a useful distinction could be made from a position taken by a Government Department which ‘authorises’ non-consensual medical treatment. The key argument arising would be that ‘authorising’ is not the same as ‘ordering’. In comparison, legislation which ‘demands’ (Röggl, 2005) in the Austrian context is more strongly worded and likely to be a more potent source of ethical conflict for attending physicians.

Our review highlights several potential conflicts of interest for physicians working in prisons. The majority of publications included highlight the fact that despite these conflicts of interest the ‘duty of care’ is primarily to the patient. Röggl (2005) cites the importance of acting independently from ‘governmental pressures’ and Getaz et al. (2012) surmises that physicians could be subject to judicial pressure or sanction as well as adverse media coverage in the course of their work in these circumstances. The primary conflict of interest comes from ‘dual loyalty’ (Weissfield et al. 2009) in that the physician has a ‘loyalty’ to the patient as also a loyalty to the employing organisation. As the latter are likely to be governmental organisations, the latter ‘loyalty’ extends to that of the state. There are areas of clinical practice in prisons where there is clear guidance whereby to breach patient confidentiality such as when disclosure is made of information that could potentially affect the security of the institution or the immediate well-being of another (Blightman et al. 2013); this would be one example of when duty to the state overrides the duty of confidentiality to the patient.

The state has penal interest in those found to have criminal culpability following principles of justice, whether restorative or retributive. Ethical conflicts exist for the state in the case of prisoners on hunger strike where the state must, on one hand, keep those in custody safe, and, on the other, be seen to treat everyone equally under the law (Martin, 2010). Such ethical conflicts may cause the state to pressure a physician to share more information about a prisoner than he usually would or indeed coerce the prisoner to end the hunger strike. The latter would arguably, fundamentally conflict the principle of autonomy.

A number of publications reviewed (Ozug & Miles, 2005; Getaz et al. 2012; Caenazzo et al. 2016) cited the importance of the ‘neutralities’ of physicians involved as key to their involvement. Caenazzo et al. (2016) argue that such conflicts of interest may be avoided by the use of independent ‘ethics consultants’. Dougherty et al. (2013) argued that personal morals, national security imperatives or military detention were not in themselves sufficient to justify departure from the general principles of medical ethics despite the ‘dual loyalty conflict’. No publication in this review suggested a departure from this position, which is in keeping with the Declaration of Malta (World Medical Association, 2006), which notes that ‘Physicians with dual loyalties are bound by the same ethical principles as other physicians, that is to say that their primary obligation is
to the individual patient ... Physicians must remain objective in their assessments and not allow third parties to influence their medical judgement. They must not allow themselves to be pressured to breach ethical principles, such as intervening medically for non-clinical reasons'. Brockman (1996) writing from a psychiatrist's perspective notes that the prisoner may see the doctor as an 'agent of the state' which in itself is not conducive to a therapeutic relationship and that the doctor, who may already be subject to conflicting obligations in having to weigh up the duty to the patient versus a duty to the institution, may experience personal distress precipitating feelings of therapeutic impotence or anger.

Establishing autonomy and the absence of coercion within a prison setting can be challenging. The goal of prison officers is to maintain order while operating within the limits of the law. Privacy and confidentiality of medical consultation may be threatened where prison officers escort a patient for review. Staff suspicion and animosity towards prisoners have the potential to colour a medical encounter (McKinney, 2008). Such potential infringements on autonomy need to be factored into medical assessment.

Dougherty et al. (2013), in keeping with the position of the World Medical Association (2006), note that force-feeding competent hunger strikers may be complicit to torture. It may be worth considering the ethical complexities which may arise for a physician called to conduct the feeding procedure itself. Boyd (2015) says that any form of force-feeding of the competent hunger striker whether it be through nasogastric tube or intravenous total parenteral nutrition would be 'wrong' and a violation of basic human rights. The physician bound by the accepted worldwide position may refuse to be involved (Tait, 2015). In such circumstances, non-medical personnel might potentially be employed such as in the case of state ordered executions in the United States (Boehnlein, 2013) which albeit a separate, more complex ethical issue, raises some shared ethical conflicts for the physician involved. The issue is that whilst a procedure may be incompatible with medical ethics, the consequences of lack of medical expertise may have significant adverse effects on patient well-being through procedural complications, improper pain control and such considerations may themselves violate human rights through increased suffering.

It is evident from our review and considerations discussed that the care of prisoners on a hunger strike will remain an ethically complex issue for medical practitioners who are asked to advise in this circumstance or if their patient is subjected to a medical procedure by non-medical staff. Ethical issues arise for psychiatrists who play a key role in assessing for the presence or absence of mental disorder, motives for hunger strike and, most importantly, help assess capacity. The central premise remains the need to act in the interests of the patient in the face of institutional and societal pressures.

Conflicts of Interest
None.

Ethical Standards
The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008. The authors assert that ethical approval for publication of this review was not required by their local Ethics Committee.

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References
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Hunger strikes in prison: a legal perspective for psychiatrists

G. Gulati¹, D. Whelan², E. Spain³, D. Meagher⁴ and C. P. Dunne¹

¹ Graduate Entry Medical School, University of Limerick, Limerick, Ireland
² School of Law, University College Cork, Cork, Ireland
³ Faculty of Education and Health Sciences and the School of Law, University of Limerick, Limerick, Ireland
⁴ Department of Psychiatry, Graduate Entry Medical School, University of Limerick, Limerick, Ireland

Hunger strikes in a custodial setting are complex to manage clinically, with associated legal and ethical complexities. Hunger strikes in Irish prisons have received, and are likely to continue to be the focus of, considerable media attention. Whilst there is an internationally accepted consensus ethical position, there is limited legal guidance available for psychiatrists to draw upon in such cases. In this paper, we review recent case-law and discuss the legal considerations in the management of prisoners on hunger strike.

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Key words: Detainee, hunger strike, law, prison.

Introduction

He has chosen death: Refusing to eat or drink, that he may bring disgrace upon me; for there is a custom, an old and foolish custom, that if a man be wronged, or think that he is wronged, and starve upon another’s threshold till he die, the Common People, for all time to come, will raise a heavy cry against that threshold (Yeats, 1904, The King’s Threshold).

A ‘hunger strike’ is by definition food refusal as a form of protest or demand (Crosby et al. 2007). Hunger strikes in prison have been reported in several countries including Turkey, South Africa, Ireland and the US Naval base at Guantanamo Bay, Cuba (Crosby et al., 2007). In Ireland, these came to the forefront of national attention in 1981, after the death of 10 individuals protesting against the withdrawal of special category status for paramilitary prisoners by the British Government of the day (Bereford, 1997). Food refusal has been noted as a ‘particularly Irish form of protest’ (Governor of X Prison v McD., 2015). Hunger strikes are relatively uncommon but nonetheless challenging. Recent hunger strikes reported by the Irish media have included protests against water charges (Lally, 2015) and prison conditions (Governor of X Prison v McD., 2015). Most hunger strikes are motivated by political concerns and are self-resolving, and where short term or feigned food refusals occur, they are less clinically problematic than sustained refusal of food and fluid.

A psychiatrist is usually called to assess individuals who are refusing food and/or fluid. Their role extends to excluding an underlying mental illness and may include assistance in the assessment of capacity. Mental illness, whilst overrepresented in Irish prisons (Kennedy et al. 2004) and prisons worldwide (Fazel & Seewri, 2012) is rarely the cause for food refusal (Larkin, 1991; Brockman, 1999). Having said that, the psychiatric examination needs to exclude causes (Brockman, 1999; Sullivan & Romily, 2009) including, but not limited to severe depression wherein an individual is refusing food in order to end their life, psychosis wherein an individual may falsely believe their food is poisoned, eating disorders wherein there may be a morbid fear of fatness or autism spectrum disorder with associated sensory difficulties.

The role of the medical professional in this context is fraught with legal and ethical complexities. Guidelines for medical professionals have been drafted (World Medical Association, 2006) and suggest a position to adopt ethically. They favour autonomy over beneficence and stress the importance of neutrality of involved physicians, who otherwise would be subject to a dual loyalty conflict. They unambiguously state that force feeding of an individual with capacity who refuses the same is not acceptable. Key principles relating to the role of medical professionals in relation to prisoners on hunger strike as outlined in international literature (Brockman, 1999; Sakelladias et al. 2009; Getz et al. 2012; Gulati et al. 2017) in keeping with the Declaration of Malta (World Medical Association, 2006)
agree that the issue of capacity and consent is central to
guiding management.

Clinicians involved in assessing and treating
prisoners on hunger strike should ideally have an
understanding of capacity related legislation, mental
health legislation and a knowledge of recent case-law.
We aim to summarise these considerations in relation to
the jurisdiction of the Irish republic.

Case-law

Until recently, there was no Irish case-law on the issue
of food refusal in prison while precedents from other
common law jurisdictions were inconsistent. This
inconsistency is evident in a series of cases in the US
which reached differing conclusions on whether prison
authorities should be permitted to force feed prisoners
against their wishes and contrary to their right to self-determination (In re Caud, 1984; Thor v Superior
Court, 1993). More recently, there was some US
case-law which sanctioned force-feeding of prisoners in
Guantanamo Bay (Al-Adahi v Chapman, 2009; Easton,
2013). In England, the courts had originally stated that
prison governors had a duty to preserve the health of
prisoners, a duty which extended to force feeding.
Thus, they were permitted to force-feed hunger-striking
suffragettes at a time when suicide was illegal (Leigh v
Glidestone, 1909). The crime of suicide was abolished by
the Suicide Act 1961 but the offence of aiding and
abetting suicide was retained. Prison medical staff may
have been concerned about possible criminal liability
for aiding and abetting suicide. In 1995, it was held that
it was lawful for the prison authorities not to intervene
if a prisoner with capacity was on hunger strike
(Secretary of State for Home Department v Robb, 1995).
Drawing on an earlier case relating to the withdrawal of
life sustaining treatment from a young man injured in
the Hillsborough disaster (Attardal v Jarvis Trust v Bamb, 1993), the court declared that death following food
and fluid refusal by a patient with capacity, is an exercise
of self-determination and does not constitute an act of
suicide. Therefore medical staff who fail to administer
treatment in accordance with the patient’s wishes
do not aid and abet a suicide. The court did not have to
decline if it would have been lawful for the authorities to
force-feed the prisoner (Kennedy, 1995). However, if
a hunger striking prisoner was also detained under
the Mental Health Act and lacked capacity, they
could be force-fed (R v Collins ex parte Brady, 2001).
The European Court of Human Rights has also
explored this issue and held that force-feeding a
prisoner on hunger strike was not a breach of the
Convention, provided there was a ‘medical necessity’
and the method used was humane (Niemierzynski v
Ukraine, 2006).

The legal principles to be applied in Ireland have
recently been discussed in the significant cases of
Governor of X Prison v McD. (2015), Nash v Chief Executive

In Governor of X Prison v Mc. D. (2015), the prison was
not seeking to force feed Mr Mc.D., instead it was seeking
guidance from the court as to whether it was lawful to withhold medical and nutritional
assistance from Mr Mc.D. The prisoner had been
assessed by a psychiatrist to have full capacity, with no
mental illness but with borderline personality disorder.
Baker J. (High Court Judge) issued a declaration that
the prison could withhold assistance. She followed the
Mr Mc.D.’s capacity. These principles include the
following: (1) There is a presumption that an adult
patient has the capacity, that is to say, the cognitive,
ability, to make a decision to refuse medical treatment.
(2) In determining whether a patient is deprived of
capacity to make a decision to refuse medical treatment
the test is whether the patient’s cognitive ability has
been impaired to the extent that he or she does not
sufficiently understand the nature, purpose and effect
of the proffered treatment and the consequences of
accepting or rejecting it in the context of the choices
available (including any alternative treatment) at the
time the decision is made...’ (Fitzpatrick v F.K., 2008).

Having concluded that Mr Mc.D. had full capacity,
Baker J. noted that the European Court of Human
Rights case-law did not mean that failing to forcibly
administer food or medicine is a breach of human rights
(Governor of X Prison v McD., 2015, para. 104). Baker J.
went on to approve of the reasoning of Thorpe J. (High
Court Judge, England) in Secretary of State for Home
Department v Robb (1995), including his emphasis on
the competent individual’s right to self-determination.
It was held that it was well established that an adult
d Person with full capacity is entitled to refuse
medical treatment, even if that refusal is likely to
inevitably lead to that person’s death. While it could
not be said that a person has a right to die by suicide,
the person has a right to freely elect to refuse food,
provided his/her choice is full, free and informed and
he/she does not require assistance to achieve that end
(para. 105). She distinguished this case from Fleming v
Ireland (2013), where it was held that a competent
Person does not have an entitlement to the benefit of
assistance to end her life. Baker J. also stated that the
prison should respect Mr Mc.D.’s advance directive
regarding his future care (para. 126), for the first time
providing a binding ruling on the legal status of
advance healthcare directives (Mulligan, 2015).

The reasoning in Governor of X Prison v Mc. D. was
quoted with approval in Nash v Chief Executive of the
Irish Prison Service (2015). In that case, the applicant was
reported to have been suicidal and had not been eating for a number of weeks. Kearns P (President of the High Court) noted: ‘there is no suggestion that the applicant lacks mental capacity to make his own decisions as to whether or not he wishes to end his life by starvation’. While the outcome of the case turned on other issues which are not directly relevant to this article, including possible threats to the applicant from other prisoners, the court approved of the reasoning in Governor of X Prison v Mc.D. and the Supreme Court decision in Creighton v Ireland (2010) to the effect that prisoners may continue to exercise a variety of constitutional rights which do not depend on liberty, including the right to bodily integrity. The court also clarified that threats of suicide may not be used by prisoners to achieve their own objectives: ‘Any suggestion that prisoners can or should be detained in the prison of their own choosing, or avoid of hunger strike or suicide threats to secure their own objectives, would create chaos in prisons and fatally compromise the proper administration of our prison system’.

However, a very different approach was taken by Humphreys J. (High Court Judge) in a more recent High Court decision, A.B v C.D. (2016), which concerned a prisoner, Mr D., who was admitted to hospital due to a self-inflicted injury to his neck. Mr D. was refusing life-saving treatment, was reported to have ‘likely schizophrenia and psychosis’ and was assessed as lacking capacity to refuse treatment. The hospital sought court authorisation for all necessary medical and surgical treatment to protect Mr D’s life and bodily integrity. Humphreys J. did not make an explicit finding as to whether Mr D. lacked capacity on the basis that he did not have sufficient information to decide on capacity and the case did not hinge on Mr D’s capacity in any event. Rather, he preferred to decide the case on the question of whether prisoners may refuse medical treatment where such refusal would put his/her life at risk and thereby, fall to complete the sentence handed down by the court. The court disagreed with Baker J’s approach to prisoner autonomy in Governor of X Prison v Mc.D. for various reasons. Humphreys J. analysed US case-law and concluded that the vast majority of US cases find no legal violation in forced medical treatment, feeding or nutrition of mentally competent adult prisoners. He also disagreed with Baker J’s reasoning in Mc.D. as it involved reliance on the English case of Secretary of State for the Home Department v Robb (1995) which in turn had heavily relied on the unrepresentative Californian case of Thor v Superior Court (1993). Ultimately, Humphreys J. made an order compelling treatment as ‘a prisoner in custody under a court order... is not simply entitled to refuse treatments where this would either directly or ultimately put his life at risk and thereby frustrate the verdict and order of the court’ (para. 52), that is, to ensure that a prisoner completes the prison sentence imposed by a court of law.

Despite this, Humphreys J. did not disagree with the outcome in Mc.D. as the court had granted a declaration that the Prison Governor was entitled to give effect to the prisoner’s wishes not to be fed or treated. Humphreys J. stated: ‘If a prisoner wants to starve to death or die by medical neglect, it is a matter for executive discretion as to whether to allow them to do so in all the circumstances: it might be too prescriptive in the modern era to declare a positive duty to force-feed a person of full age and capacity in particular, at least in all cases’ (para. 50).

Humphreys J. was also admonish that a prisoner ‘simply does not have any legal entitlement to cheat justice, and the court should not co-operate in him or her attempting to do so’. The approach of the court in A.B v C.D. is significantly out of line with current thinking on autonomy of prisoners in Ireland and is likely to be challenged in later cases.

This case also highlights a matter of complexity wherein courts make decisions based on ‘prisoner status of an individual (even if the individual is in hospital) as opposed to health professionals who view the individual as a ‘patient. In their determination, the court must be cognizant of the status of the individual as prisoner. Under Irish law the ‘normal constitutional rights of prison inmates are abrogated or suspended during the period of imprisonment...’ (State (McDough) v Fennelly, 1978; Murray v Ireland, 1991; Brennan v D.F.P. & ors, 2003). As such, cases involving prisoners must be approached differently than those involving non-prisoners. When considering cases involving prisoners, the court must consider whether the rights in question, including the right to self-determination or bodily integrity, have been abrogated, suspended or limited for the period of imprisonment. In his recent decision in A.B v C.D. (2016) Humphreys J. held that while a prisoner retains the right to bodily integrity in prison, it is not a sense that he or she cannot be harmed or neglected by the State... it by no means follows from a prohibition on harming prisoners that the prisoner’s right to autonomy have to be recognised’ (A.B v C.D., 2016).

Mental health legislation
Mental illness although overrepresented in Irish prisons (Kennedy et al., 2004), is rarely the underlying cause for food refusal (Brockman, 1999). If a prisoner has a mental disorder, he/she may be transferred from a prison setting to a Designated Centre, currently the Central Mental Hospital under s.15 of the Criminal Law (Insanity) Act 2006. Section 3 of this Act defines a Designated Centre. Mental disorder as defined in the Criminal Law (Insanity) Act, 2006 includes ‘mental
illness, mental disability, dementia or any disease of the mind but does not include intoxication’ (Irish Statute Book, 2006). This is broader than the definition for the same concept in the Mental Health Act, 2001 (Irish Statute Book, 2001), Section 54, which defines mental disorder as ‘mental illness, severe dementia or significant intellectual disability...’. Once in the designated centre, issues of treatment are governed by Part 4 of the Mental Health Act 2001 (Whelan, 2009). If the person has capacity, he or she can refuse treatment. If he/she lacks capacity, treatment may be administered under the terms of sections 54-60 of the 2001 Act, as amended by the Mental Health (Amendment) Act 2015. Section 57 of this Act states: ‘The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the case and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.’

There is no reported (the word ‘reported’ being used in a legal context) Irish case-law on the question of whether force-feeding constitutes treatment of a mental disorder. However, recent cases have been noted in media wherein the High Court has authorised tube feeding and ancillary measures for individuals with eating disorders (Carolan, 2015) or severe psychotic depression (Carolan, 2014). European and English cases mentioned earlier may provide some assistance to any future Irish court faced with this question (see also B v Croydon Health Authority, 1995).

Arguably the case for treatment under Mental Health legislation would not amount to the case of a true hunger strike as defined earlier (Crawley et al. 2007). However, should there be refusal of food as a direct consequence of mental disorder such as a paranoid delusion that food is being poisoned as in the case of someone with a paranoid schizophrenic illness, or a refusal of food as a suicidal act in the case of someone who is severely depressed, or indeed the refusal of food arising from a ‘morbid fear of fitness’ in the case of someone with an eating disorder, treatment of the underlying psychiatric condition would be in accordance with the provisions of Section 54-60 of the Mental Health Act, 2001 as amended by the Mental Health (Amendment) Act 2015. Hence the need to differentiate, by a thorough psychiatric evaluation, the concept of food refusal in the latter cases from a true ‘hunger strike’ motivated by a demand or protest.

Capacity legislation

The Assisted Decision-Making (Capacity) Act 2015 has been enacted into law by presidential assent on 30 December 2015 but most sections have yet to be commenced (some sections from Part 1 and Part 9 were commenced in October 2016). The assessment of capacity would be based on the functional test set out in the legislation, rather than the principles from Fitzpatrick v F.K. (2008) as outlined earlier.

The assessment of capacity would be a matter for the attending general practitioner/physician who may request psychiatric expertise. In practice, a joint consultation may be indicated wherein the physician provides information as to the potential risks of prolonged fasting, risks and benefits of treatment and the psychiatrist assists the general practitioner/physician in reaching a decision about the capacity. This is not an isolated event and good practice would involve gathering collateral information from multiple sources such as the prison officers, the prisoner’s family doctor and family members prior to the assessment to ascertain the presence or otherwise of mental or physical disorder. The test for capacity encompasses evaluating the individual’s ability to understand the information presented to him, retain this long enough to make a decision, weigh up the pros and cons of alternative courses of action and communicate their decision. The individual should have been advised of the likely consequences of their intended action, including the possibility of death and keeping in mind, any existing physical illness which may potentially hasten the latter. This test for capacity is specific to the matter being assessed and whilst the primary assessment would be of the capacity to refuse food and/or fluids, further assessments may be necessary in relation to the need for physical health monitoring such as the need for blood tests. The test for capacity is also time-specific, and repeated examinations of capacity may be necessary and indeed advisable, given the progression of both psychological and physiological changes as hunger strikes persist (Fessler, 2003).

The 2015 Act defines Capacity as ‘decision-making capacity’ and it is the ability to understand, at the time that a decision is to be made, the nature and consequences of the decision to be made by him or her in the context of the available choices at that time. Despite the fact that this is the first legislative adoption of the functional approach, this approach to the assessment of capacity has been used in practice in Ireland already (Health Service Executive, 2013; Medical Council, 2016).

The 2015 Act also proposes three types of decision-making support options to respond to the range of support needs that people may have in relation to decision-making capacity. With each of the three decision-making support options (assisted decision making, co-decision making or a decision-making representative) decisions can be made on personal...
welfare, property and finance or a combination of both (Department of Justice and Equality, 2015).

Following the decision in Governor of X Prison v Mc.D. or once this law is enacted, under the Assisted Decision-Making (Capacity) Act, an individual with capacity could make an advance refusal of treatment in case of deterioration in health following food refusal. Treatment, in the presence of a valid directive would then be illegal. However, in the case of a prisoner, this is less clear given the decision in A.B. v C.D. (2016). Based on the reasoning in that case, while the state is not mandated to force-feed prisoners, it is entitled to authorize force-feeding against the wishes of a prisoner with capacity or a prisoner with a valid advance healthcare directive in order to fulfill the court order, that is, to ensure he/she completes the prison sentence.

Conclusions and discussion

Psychiatrists in the prison setting may find themselves in a clinically, ethically and legally complex situation when faced with someone on hunger strike. The role of the psychiatrist in assessing prisoners on hunger strike is not limited to the diagnosis and treatment of mental illness but extends to assisting the assessment of capacity to refuse food as well as the motivation behind the hunger strike (Brockman, 1999; Getaz et al., 2012). From a clinical perspective, an interagency and multidisciplinary approach with regular case conferences may be helpful to guide decision making. Whilst there is a consensus governing the ethical position (World Medical Association, 2006; Gulati et al., 2017), in this paper, the relevant case-law and legislation, including the Criminal Law (Insanity) Act, Mental Health Act and the new Assisted Decision-Making (Capacity) Act that the Irish prison Mental Health Practitioner can draw upon in practice. With changing capacity legislation, there will likely be additional case-law to refer to in the coming years.

In practice however, most prison hunger strikes are short lived (García-Guirreño & Vera-Remaritinez, 2015) and, where they persist, and in particular, in complex circumstances wherein there is no mental illness but issues around capacity, the prison mental health practitioner may wish to seek legal advice from solicitors for the health service and their own medical indemnity organisation given the limited and complex national case-law extant at this time.

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Conflicts of Interest

The authors declare that there are no conflicts of interest.

Ethical Standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation, with the Helsinki Declaration of 1975, as revised in 2008. The authors assert that ethical approval for publication of this perspective paper was not required by their local REC.

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Cases


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The prevalence of major mental illness, substance misuse and homelessness in Irish prisoners: systematic review and meta-analyses


1 Graduate Entry Medical School, University of Limerick, Limerick, Ireland
2 Department of Psychiatry, University Hospital Limerick, Limerick, Ireland
3 Department of Mathematics and Statistics, University of Limerick, Limerick, Ireland
4 University Hospital Limerick, Limerick, Ireland
5 Department of Psychiatry, Graduate Entry Medical School, University of Limerick, Limerick, Ireland

Aims. To systematically review studies from Irish prisons that estimate the prevalence of major mental illness, alcohol and substance misuse, and homelessness at the time of committnal.

Methods. Healthcare databases were searched for studies quantifying the point prevalence for each outcome of interest. Searches were augmented by scanning of bibliographies and searches of governmental and non-governmental websites. Proportional meta-analyses were completed for each outcome.

Results. We found eight, six and five studies quantifying the point prevalence of major mental illness, substance misuse, and homelessness respectively. Considerable heterogeneity was found for each subgroup (except psychosis where substantial heterogeneity was observed) and random effects models were used to calculate pooled percentages. The pooled percentage for psychotic disorder was 3.6% (95% confidence interval (CI) 3.0-4.2%), for affective disorder 4.3% (95% CI 2.1-7.3%), for alcohol use disorder 26.3% (95% CI 19.9-37.4%), for substance use disorder 50.9% (95% CI 37.6-64.2%) and for those who were homeless on committnal 17.4% (95% CI 8.7-28.4%).

Conclusions. Estimates for the prevalence of psychotic illness and substance abuse amongst Irish prisoners are in keeping with international estimates of morbidity in prisons, whilst those for affective disorders are lower. The prevalence of homelessness in committed Irish prisoners is higher than some international estimates. Rates for psychoses, alcohol and substance misuse as well as homelessness in Irish prisons are significantly higher than the general population prevalence of theses vulnerabilities. A need for service development is discussed.

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Key words: Addiction, homelessness, mental disorder, prison, substance misuse.

Introduction

There are 10.35 million people held in penal establishments worldwide (Walshe, 2016). Recent large-scale systematic reviews have established that prisoners suffer multiple vulnerabilities including mental disorder, substance misuse and homelessness. Fazel & Seewald (2012), in a systematic review of the international literature, found that mental illness is over-represented in prisoners. They identified a pooled 6-month prevalence of psychosis of 3.6% in male prisoners and 3.9% in female prisoners. The pooled prevalence of major depression was 10.2% in male prisoners and 14.1% in female prisoners. No significant differences in rates of psychosis and depression between remand and sentenced prisoners were identified. The authors further found high levels of heterogeneity in the review, partly explained by higher rates of psychosis in low-middle-income countries. Fazel & Danesh (2002), in an earlier review of 6-month prevalence data from 12 countries, found that 3.7% of men (95% confidence interval (CI) 3.3-4.1) had psychotic illnesses and 10% major depression. Rates in women were 4.0% with psychotic illnesses and 12% major depression. Older prisoners, in addition, may have significantly higher rates of affective disorder, with one study reporting a prevalence of 30% for depressive disorder (Fazel et al. 2001). These prison estimates are significantly higher than international population point prevalence estimates for psychotic illness, which have been reported as 4.6/1000 (Saha et al. 2005) and major depressive disorder reported as 4.7% (Ferrari et al. 2013).

Suicides are also over-represented in the prison population. A study (Fazel et al. 2011) reviewing data from 12 countries found that in men, crude relative
rates of suicide were at least three times higher than the general population. Western European countries had similar rates of prisoner suicide, which were mostly higher than those in Australia, Canada and New Zealand. In women, inmate suicide rates varied widely and were raised compared with rates in the general population.

Substance and alcohol misuse are associated with the significant economic burden (Rehm et al. 2006) and are risk factors for offending (Grann & Fazel, 2004). Their prevalence in marginalised communities such as homeless populations and prisons is of international concern. A systematic review evaluating substance abuse and dependence (Fazel et al. 2006) across 13 prison-based studies, found that estimates of prevalence for alcohol abuse and dependence in male prisoners ranged from 18% to 30% and 10% to 24% in female prisoners. The prevalence estimates of drug abuse and dependence varied from 10% to 48% in male prisoners and 30% to 60% in female prisoners. This review excluded studies citing only lifetime prevalence rates. Compared with US general population estimates (Kessler et al. 1994), this review noted that male prisoners have a slight excess of alcohol dependence and a two- to 10-fold excess of drug dependence whilst estimates for female prisoners noted a two to a fourfold excess of alcohol dependence and 13-fold increase in drug dependence.

Incarceration is associated with homelessness, and homelessness can be a cause or consequence of incarceration (McCann, 2003). Homelessness is in itself associated with higher levels of mental illness and substance misuse (Fazel et al. 2008) with both these vulnerabilities affected by trends towards the closure of long-stay psychiatric hospitals or ‘asylums’ (Paulson, 2012). McNeil et al. (2005) found that 16% of those incarcerated in the San Francisco penal system were homeless. Greenberg & Rosenheck (2008), in a national study of US inmates, found that 12.4% had been homeless in the previous year, although not at the time of incarceration; and 2.9% were homeless at the time of incarceration. A United States Bureau of Justice Statistics study (Hughes et al. 2001) representing a nationwide survey of state prisoners expecting to be released in 1999, found that 12% reported being homeless at the time of their arrest. Estimates in the United Kingdom for homelessness at the time of committal are 15% (Williams et al. 2012).

The Irish Penal Reform Trust (2017) reported that there were 3674 people in prison custody in Ireland as of December 2016, with a rate of imprisonment of 79 per 100,000 of the population. The Irish prison population increased by 400% from 1970 to 2011. The 14 institutions in the Irish prison system consists of 11 traditional ‘closed’ institutions, two open centres and one ‘semi-open’ facility. Female prisoners are accommodated in two prisons nationally. The Irish Prison service (2015) reported that of those sent to prison, 79.4% were male and 20.6% were female. Approximately one-sixth of the total prison population comprised remand prisoners.

Mental disorder, substance misuse (Council of Europe, 2015) and homelessness (McCann, 2003) have been highlighted as key areas of need amongst Irish prisoners. Whilst the prevalence of these vulnerabilities are studied by health services, governmental and non-governmental organisations, they have not been systematically reviewed.

Whilst reviews of international literature often report a lifetime prevalence of these vulnerabilities, an analysis of need informing resource management requires estimates of point prevalence – What proportion of prisoners actively suffer from a psychotic, major affective disorder or substance misuse disorder at the time of assessment? What proportion are homeless at the time of committal to prison? This is in contrast to those that have a history of these vulnerabilities, which although relevant to their long-term needs, may be less pertinent when estimating immediate care needs. In this study, we systematically review published studies which estimate the reported point prevalence of major mental illness, alcohol and substance misuse at the time of assessment, and that of homelessness on committal in Irish prisoners.

Aims
To systematically analyse published data pertaining to three questions:

a. What is the reported point prevalence of psychotic illness and major affective disorder in Irish prisoners?
b. What is the reported point prevalence of alcohol or substance misuse disorder in Irish prisoners?
c. What was the reported point prevalence of homelessness on committal in Irish prisoners?

Methods
PRISMA Guidelines (Moher et al. 2009) were followed in the conduct of this review. A research librarian (ID) conducted searches of PsycINFO, MEDLINE, PubMed, EMBASE and Google Scholar (1 January 1966 to 31 December 2016) for publications citing Irish data (Republic of Ireland) on point prevalence of major mental illness, substance misuse, dependence and homelessness amongst prisoners using the search terms ‘mental’, ‘psych’, prevalence, disorder, prison*, substance*, alcohol, drug*, misuse, dependent*, abuse, home*, rfa, no fixed abode, prison*, inmate, jail, sentenced, remand, detainee* and also combinations of those.
We additionally searched websites of the Irish Prison Reform Trust, Mental Health Commission, Irish Prison Service and the Council of Europe. We augmented searches by reviewing research repositories including: Lumin (a repository specific to the Irish health service), Scopus and reviewing governmental reports.

As overarching general inclusion criteria, studies were required to (1) be drawn from the general prison population, (2) relate to adult (>18 years) males and/or females in an Irish prison, and (3) cite quantitative data with a clear numerator and denominator.

Additional specific inclusion/exclusion criteria included:

1. For the purpose of this study, ‘major mental illness’ included psychosis (schizophrenia, schizoaffective disorder, delusional disorder, psychotic depression, mania with psychosis, drug-induced psychosis) and affective disorder (major depressive disorder, bipolar affective disorder). Inclusion required the use of standardised diagnostic classification and/or psychiatric assessment. Studies based solely on self-reported symptoms were excluded, as were those drawn from select prison subpopulations (Giblin et al. 2012) and hospitalisation samples (O’Connor & O’Neill 1990; Linehan et al. 2002). Data on point prevalence were extracted, as opposed to lifetime prevalence. Therefore, samples reporting historical diagnoses based on retrospective chart review (Davoren et al. 2015) were excluded.

2. Studies on substance misuse and alcohol misuse were included where diagnoses were made using a standardised diagnostic classification and/or psychiatric assessment. For the purpose of this study, ‘misuse’ was defined as harmful use or dependence. Studies based solely on self-reported symptoms or drug testing (Long, 2008) were excluded, as were those drawn from prison subpopulations such as hospitalisation samples or screened sub samples where the screening tool used did not target substance misuse (McNerney et al. 2013). O’Neill et al. (2016). Data on point prevalence were extracted, as opposed to lifetime prevalence (O’Mahony, 1997). Therefore, samples reporting historical diagnoses based on retrospective chart review (Davoren et al. 2015) were excluded.

3. For the purpose of this study, homelessness was defined as included those living ‘homeless and rootless’ and in ‘unsettled accommodation’. Data on homelessness at the time of incarceration were extracted, as opposed to a lifetime history of homelessness. Studies drawn from prison subpopulations such as screened samples where the screening tool used did not assess homelessness (McNerney et al. 2013; O’Neill et al. 2016) and hospitalisation samples were excluded.

Data were independently extracted by two researchers (G.G., a Consultant Psychiatrist and N.K., a Senior Registrar in Psychiatry) for each included publication. There was no disagreement in data extracted by the two researchers.

**Statistical analysis**

For each outcome (psychosis, affective disorder, alcohol use, substance use, homelessness upon committal) a proportion meta-analysis was conducted to calculate the pooled percentage of prisoners who were suffering from each outcome. Inconsistency was measured across studies using the I² statistic, which reflects the percentage of variability in effect estimates due to heterogeneity, rather than sampling error; 30–60% is considered moderate levels of heterogeneity, 50–90% substantial heterogeneity and 75–100% considerable heterogeneity (Higgins & Green, 2011). Heterogeneity in meta-analysis refers to when the true effects being evaluated differ between studies. If the variation between the studies’ results is above that expected by chance, there is evidence of heterogeneity. The Cochrane Q test was used to test heterogeneity, where random effects models were used where there was evidence of significant heterogeneity and fixed effects models where there was no evidence of significant heterogeneity. Meta-analysis calculations were performed and graphical plots were created using the StatsDirect software.

**Study quality**

For each included study, the quality of the study was assessed using the adapted Newcastle-Ottawa scale (Wells et al. 2014). This is a commonly used quality assessment tool for non-randomised studies including case control and cohort designs. It has previously been adapted to use in cross-sectional studies (Herzog et al. 2013). However, due to the lack of validation for cross-sectional studies, we have used this as a descriptive indicator of study quality and not in statistical weighting.

**Results**

We reviewed 408 abstracts of which inclusion criteria were met for eight, six and five studies reporting the prevalence of major mental illness, substance misuse and homelessness on committal, respectively (Fig. 1). Study quality is reported using the adapted Newcastle-Ottawa scale in Table 1. Based on the evidence of significant heterogeneity in our review, random effects models were used for proportion meta-analyses.
Table 1. Study quality assessment (adapted Newcastle-Ottawa Scale)

<table>
<thead>
<tr>
<th>Studies</th>
<th>Year</th>
<th>Psychosis</th>
<th>Affective disorder</th>
<th>Substance misuse</th>
<th>Homelessness on committal</th>
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<tbody>
<tr>
<td>Smith et al.</td>
<td>1996</td>
<td>5</td>
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<td>Mohan et al.</td>
<td>1997</td>
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<tr>
<td>Seymour &amp; Costella</td>
<td>2005</td>
<td>–</td>
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<td>Linehan et al.</td>
<td>2005</td>
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<td>8</td>
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<tr>
<td>Duffy et al.</td>
<td>2006</td>
<td>8</td>
<td>8</td>
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<tr>
<td>Wright et al.</td>
<td>2006</td>
<td>7</td>
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<td>Curtin et al.</td>
<td>2009</td>
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<td>McInerney et al.</td>
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<td>Divon et al.</td>
<td>2015</td>
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<tr>
<td>O’Neill et al.</td>
<td>2016</td>
<td>7</td>
<td>7</td>
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</table>

Legend for rating: representativeness of sample (0–1) + sample size (0–1) + non-respondents (0–1) + use of validated tool (0–2) + assessment of outcome (0–2) + statistical methods (0–1), maximum score = 8.

Psychotic disorder

Eight studies, with a total sample size of 28,012 prisoners, reported suffering from a psychotic disorder (Table 2). The pooled percentage suffering from a psychotic disorder, from a random effects model, was 3.6% (95% CI = 3.0–4.2%) (Fig. 2a). There was substantial heterogeneity in the percentage of prisoners diagnosed with a psychotic disorder across studies ($I^2 = 54.8\%$, Cochran’s $Q, p = 0.03$). The prevalence in male samples was 3.81% ($n = 10,000/27,793$). Only two studies (Mohan et al. 1997;
Wright et al. (2006) evaluated prevalence in a purely female sample and estimates for females were 3.9% (n = 9/231). Estimates of prevalence in purely male samples could be extracted from four studies (Linehan et al. 2005; Curtin et al. 2005; McIver et al. 2013; O’Neill et al. 2016) and were 3.9% (n = 1043/26806).

Major affective disorder

Seven studies, with a total sample size of 7928 prisoners, reported an affective disorder (Table 3). The pooled percentage suffering from an affective disorder, from a random effects model, was 4.3% (95% CI = 2.1-7.1%) (Fig. 2b). There was considerable heterogeneity in the percentage diagnosed with an affective disorder across studies (I² = 91.9%, Cochran’s Q p < 0.001).

Prevalence from male samples was 2.33% (n = 180/ 7697). Only two studies (Mohan et al. 1997; Wright et al. 2006) evaluated prevalence in a purely female sample and estimates for females were 9.1% (n = 21/ 231). Estimates of prevalence in purely male samples could be extracted from two studies (Linehan et al. 2005; O’Neill et al. 2016) and were 2.1% (n = 154/6409).

Alcohol and substance use disorders

Six studies, with a total sample size of 1659 prisoners, reported alcohol or substance use disorders (Table 4). The pooled percentage suffering from alcohol disorder across the six studies, from a random effects model, was 28.3% (95% CI = 19.9-37.4%) (Fig. 2c). There was considerable heterogeneity in the percentage suffering from alcohol use disorder across studies (I² = 92.9%; Cochran’s Q p < 0.0001). The pooled percentage of prisoners reporting a substance use disorder across the studies, from a random effects model, was 50.9% (95% CI = 37.6-64.2%) (Fig. 2d). There was considerable heterogeneity in the percentage suffering from substance use disorder across studies (I² = 96.4%; Cochran’s Q p < 0.001).

Prevalence in male only samples was 37.1% (n = 564/ 1520) for alcohol use disorder and 51% (n = 775/1520) for substance use disorder. Two studies (Mohan et al. 1997; Wright et al. 2006) evaluated prevalence in a purely female sample and estimates for females were 17.2% (n = 24/139) for alcohol use disorder and 62.6% (n = 87/139) for substance use disorder. Estimates of prevalence in purely female samples could be extracted from only one study (Linehan et al. 2005) and were 34.5% (n = 80/232) for alcohol use disorder and 53% (n = 123/232) for substance use disorder.

Homelessness on committal

Five studies, with a total sample size of 1523 prisoners reported homelessness at time of committal (Table 5). The pooled percentage of homelessness from a random effects model was 17.4% (95% CI = 8.7-28.4%) (Fig. 2e). There was considerable heterogeneity in the percentage of homelessness in committal across studies (I² = 96.2%; Cochran’s Q p < 0.001).

Prevalence in purely male samples was 8.2% (n = 55/ 670). Only one study (Wright et al. 2006) evaluated prevalence in a purely female sample and estimates for females were 18.8% (n = 35/186). Estimates of prevalence in purely male samples could be extracted from two studies (Linehan et al. 2005; Davoren et al. 2015) and were 23.2% (n = 153/658).

Discussion

Prisoners can experience a range of barriers to successful re-entry into society (Sarma, 2014). Homelessness, mental illness and substance misuse are three such barriers, which our study shows as being prevalent in Irish prisons. To our knowledge, this is the first
systematic review estimating the current prevalence of these vulnerabilities amongst Irish prisoners.

Implications

A number of implications arise from these findings. This study confirms that a significant proportion of Irish prisoners present with a current psychotic or major affective disorder, which are potentially treatable mental illnesses. From a clinical view point, effective treatment of mental illness may reduce morbidity as well as potentially reduce mortality through suicide (Kapur, 2009), and potentially impact recidivism rates (Lovell et al., 2002). This finding strengthens the argument for the development of diversion services which, to date, are geographically variable and still evolving in Ireland (Gulati & Kelly, 2018). Ireland has the lowest
Table 3. Prevalence of major affective disorder

<table>
<thead>
<tr>
<th>Studies</th>
<th>Year</th>
<th>Location</th>
<th>Diagnostic criteria</th>
<th>% male</th>
<th>Remand/ sentenced/mixed</th>
<th>n (affective)</th>
<th>N (total)</th>
<th>Prevalence (95% CI) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith et al.</td>
<td>1996</td>
<td>Mountjoy</td>
<td>DSM III R</td>
<td>100</td>
<td>Mixed</td>
<td>235</td>
<td>0.0</td>
<td>(0.1, 1.6)</td>
</tr>
<tr>
<td>Mohan et al.</td>
<td>1997</td>
<td>Dochas</td>
<td>DSM IV</td>
<td>0</td>
<td>Mixed</td>
<td>45</td>
<td>13.3</td>
<td>(5.1, 26.6)</td>
</tr>
<tr>
<td>Linehan et al.</td>
<td>2005</td>
<td>Cloverhill, other remand centres</td>
<td>ICD 10/DSM III R</td>
<td>100</td>
<td>Remand</td>
<td>17</td>
<td>222</td>
<td>(7.5, 11.5)</td>
</tr>
<tr>
<td>Duffy et al.</td>
<td>2006</td>
<td>Multiple prisons</td>
<td>DSM IV/ ICD 10</td>
<td>100</td>
<td>Sentenced</td>
<td>438</td>
<td>3.2</td>
<td>(1.8, 5.3)</td>
</tr>
<tr>
<td>Wright et al.</td>
<td>2006</td>
<td>Dochas, Limerick</td>
<td>ICD 10</td>
<td>0</td>
<td>Mixed</td>
<td>186</td>
<td>8.1</td>
<td>(4.6, 13.0)</td>
</tr>
<tr>
<td>Curtin et al.</td>
<td>2009</td>
<td>Mountjoy, Cloverhill</td>
<td>ICD 10</td>
<td>100</td>
<td>Mixed</td>
<td>615</td>
<td>5.2</td>
<td>(3.6, 7.3)</td>
</tr>
<tr>
<td>O'Neill et al.</td>
<td>2016</td>
<td>Cloverhill</td>
<td>ICD 10</td>
<td>100</td>
<td>Remand</td>
<td>677</td>
<td>1.9</td>
<td>(1.0, 2.3)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>201</td>
<td>4.5</td>
<td>(2.1, 7.1)</td>
</tr>
</tbody>
</table>

CI = confidence interval; DSM = Diagnostic and Statistical Manual of Mental Disorders; ICD = International Classification of Disease.

Table 4. Prevalence of alcohol and substance use disorders

<table>
<thead>
<tr>
<th>Studies</th>
<th>Year</th>
<th>Location</th>
<th>Diagnostic criteria</th>
<th>% male</th>
<th>Remand/ sentenced/mixed</th>
<th>n (alcohol)</th>
<th>n (substance)</th>
<th>N (sample)</th>
<th>Prevalence (95% CI) (%)</th>
<th>Prevalence (95% CI) for alcohol (%)</th>
<th>Prevalence (95% CI) for substance (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mohan et al.</td>
<td>1997</td>
<td>Mountjoy, Women’s Prison</td>
<td>DSM IV</td>
<td>0</td>
<td>Mixed</td>
<td>45</td>
<td>2.2</td>
<td>(0.4, 1.1)</td>
<td>57.8 (42.2, 72.3)</td>
<td>2.2 (0.4, 1.1)</td>
<td>57.8 (42.2, 72.3)</td>
</tr>
<tr>
<td>Linehan et al.</td>
<td>2005</td>
<td>Cloverhill, other remand centres</td>
<td>ICD 10/DSM IV</td>
<td>100</td>
<td>Remand</td>
<td>232</td>
<td>34.5</td>
<td>(28.4, 41.0)</td>
<td>53.0 (46.4, 59.6)</td>
<td>34.5 (28.4, 41.0)</td>
<td>53.0 (46.4, 59.6)</td>
</tr>
<tr>
<td>Duffy et al.</td>
<td>2006</td>
<td>Multiple prisons</td>
<td>DSM IV/ ICD 10</td>
<td>100</td>
<td>Sentenced</td>
<td>438</td>
<td>45.7</td>
<td>(40.9, 50.5)</td>
<td>53.7 (48.9, 58.4)</td>
<td>45.7 (40.9, 50.5)</td>
<td>53.7 (48.9, 58.4)</td>
</tr>
<tr>
<td>Wright et al.</td>
<td>2006</td>
<td>Dochas, Limerick</td>
<td>ICD 10</td>
<td>0</td>
<td>Mixed</td>
<td>94</td>
<td>24.5</td>
<td>(16.2, 34.4)</td>
<td>64.9 (54.4, 74.5)</td>
<td>24.5 (16.2, 34.4)</td>
<td>64.9 (54.4, 74.5)</td>
</tr>
<tr>
<td>Curtin et al.</td>
<td>2009</td>
<td>Mountjoy, Cloverhill</td>
<td>ICD 10</td>
<td>100</td>
<td>Mixed</td>
<td>615</td>
<td>35.9</td>
<td>(32.1, 39.9)</td>
<td>60.3 (56.3, 64.2)</td>
<td>35.9 (32.1, 39.9)</td>
<td>60.3 (56.3, 64.2)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1659</td>
<td>28.3</td>
<td>(19.8, 37.4)</td>
<td>50.9 (37.6, 64.2)</td>
<td>28.3 (19.8, 37.4)</td>
<td>50.9 (37.6, 64.2)</td>
</tr>
</tbody>
</table>

CI = confidence interval; DSM = Diagnostic and Statistical Manual of Mental Disorders; ICD = International Classification of Disease.

per capita secure psychiatric bed availability in developed countries (Kennedy, 2016). Diversion services need an expansion of bed capacity within Irish mental health services (Kennedy, 2006; Gulati & Kelby, 2018) and changes in attitudes towards mentally disordered offenders (Duffy et al. 2005). Rates for psychotic disorders are in keeping with international estimates of prison morbidity (Fazel & Seewald, 2012), which are significantly higher than general population estimates (Saha et al. 2005).

Rates for affective disorders in our study were higher, as would be expected in purely female samples, but low for remand samples in Ireland. The overall rates were lower than international comparisons and this may be due to the skewing of results based on one study where no prisoner was found to be suffering from a major affective disorder (Smith et al. 1996) or the use of point prevalence estimates in our study as opposed to period prevalence estimates in international comparisons. However, this would not explain why the rates in remand samples were low and may inform the need to review whether current screening processes for affective disorder in remand prisons (Grubin et al. 2002) are adequate.

The burden of harmful use or dependence on alcohol and substances in Irish prisons is substantial. One in three prisoners had a current alcohol misuse or dependence and one in two, a problem with current substance misuse or dependence. This is in keeping with international prison estimates (Fazel et al. 2006) and substantially higher than Irish general population estimates (Irish Medical Organisation, 2015). Substance and alcohol misuse are seen as key risk factors for recidivism. Prison and probation services have invested in...
Table 5. Prevalence of homelessness on committal

<table>
<thead>
<tr>
<th>Studies</th>
<th>Year</th>
<th>Location</th>
<th>Diagnostic criteria</th>
<th>% male</th>
<th>Remand/sentenced/mixed</th>
<th>π (Homeless)</th>
<th>N (total)</th>
<th>Prevalence (95% CI) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seymour &amp; Costello 2005</td>
<td></td>
<td>Multiple Dublin prisons</td>
<td>Survey</td>
<td>95</td>
<td>Mixed</td>
<td>60</td>
<td>241</td>
<td>24.9 (19.6, 30.9)</td>
</tr>
<tr>
<td>Linehan et al. 2005</td>
<td></td>
<td>Cloverhill and other remand centres</td>
<td>Semi-structured interview</td>
<td>100</td>
<td>Remand</td>
<td>30</td>
<td>232</td>
<td>12.9 (8.9, 17.9)</td>
</tr>
<tr>
<td>Duffy et al. 2006</td>
<td></td>
<td>Multiple prisons</td>
<td>Semi-structured interview</td>
<td>100</td>
<td>Sentenced</td>
<td>25</td>
<td>438</td>
<td>5.7 (3.7, 8.3)</td>
</tr>
<tr>
<td>Wright et al. 2006</td>
<td></td>
<td>Dochas, Limerick</td>
<td>Semi-structured interview</td>
<td></td>
<td>Mixed</td>
<td>35</td>
<td>186</td>
<td>18.8 (13.5, 25.2)</td>
</tr>
<tr>
<td>Davoren et al. 2015</td>
<td></td>
<td>Cloverhill Dochas</td>
<td>Retrospective record review</td>
<td>74</td>
<td>Remand</td>
<td>123</td>
<td>426</td>
<td>26.9 (24.6, 28.4)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>273</td>
<td>1523</td>
<td>17.4 (8.7, 26.4)</td>
</tr>
</tbody>
</table>

CI = confidence interval.

The coexistence of severe mental illness, substance misuse and homelessness has been studied in international literature (Drake et al. 1991) and those often go hand in hand, interacting in ways that amplify the vulnerability of an individual. Homeless individuals with mental illness are unlikely to seek help and treatment, and those that also have an active substance misuse often excluded from temporary accommodation, with the consequent further social decline and increased risk of imprisonment. It would follow that efforts to find suitable accommodation through resettlement services should be undertaken in conjunction with treatment of mental illness and/or substance misuse in prisoners.

In summary, the extent of psychiatric and psychosocial morbidity in worldwide prisoners is of international concern as they are significantly higher than the general population prevalence. Our review found that levels of psychiatric and psychosocial morbidity in Irish prisoners are largely in keeping with worldwide prison estimates, and recommends improved screening for affective disorders, the development of diversion services and the consideration of integrated treatment plans addressing the psychiatric and psychosocial need.

**Strengths and limitations**

The strengths of this review include the search criteria which led to the identification of multiple samples for each outcome of interest within a relatively small jurisdiction.

The key limitation of this study is the high level of heterogeneity. While pooled prevalences are reported, and random effects model used to account for heterogeneity, we recommend interpreting these results with caution. Such a high level of heterogeneity would be expected in such a study in view of differences in study...
designs, study periods, sampling, diagnostic criteria (International Classification of Disease v. Diagnostic and Statistical Manual of Mental Disorders), category of prisoners (remand vs. sentenced v. mixed) and gender differences, as has been seen in previous meta-analyses (Fazel & Seewald, 2012). Furthermore, two included studies (McNerney et al., 2013; O’Neill et al., 2016) used case ascertainment through screening. In McNerney et al.’s study (2013), screening consisted of selecting all committees who at reception disclosed a history of previous psychiatric contact or prescription of psychiatric medication, a history of deliberate self-harm, who exhibited unusual or disturbed behaviour, those charged with homicide and individuals with a known history of treatment by prison psychiatric services. In O’Neill et al.’s study (2016), this was undertaken using the Grubin screening tool questions (Grubin et al., 2002) which has a reported sensitivity and specificity of 97% and 84%, respectively, in a UK sample. The use of screening for case ascertainment has the potential to bias prevalence estimates.

Future research may usefully be aimed at re-evaluating point prevalence of these vulnerabilities through an up to date nationwide cross-sectional study with robust study design and standardised outcome measures to limit heterogeneity.

Acknowledgements

The authors would like to thank Dr Anna Zornose, St Hugh’s College, University of Oxford, Dr Valerie Murphy, University College Cork and Professor Allish Hamnigan, University of Limerick for their assistance.

Financial Support

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Conflicts of Interest

All authors have no conflicts of interest.

Ethical Standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008. The authors assert that ethical approval for publication of this paper was not required by their local REC.

References


Dear Dr. Gulati:

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Yours sincerely,

David Kane
Associate Editor, International Journal of Prisoner Health
david.kane@bcu.ac.uk
09-Jan-2018

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david.kane@bcu.ac.uk
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Date: 30 October 2017 at 09:07:23 GMT
To: gautam.gulati@hse.ie
Reply-To: david.kane@bcu.ac.uk

30-Oct-2017

Dear Dr. Gulati:

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If you have an ORCID please check your account details to ensure that your ORCID is validated.

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Yours sincerely,

David Kane
Associate Editor, International Journal of Prisoner Health
david.kane@bcu.ac.uk
Symposia 409513  Prison Hunger Strikes & Psychiatry: Ethical, Legal & Clinical Issues Symposia

Dear Gautam Gulati

We are pleased to confirm that your submission has been accepted. Please notify any co-presenters of this confirmation notice.

We now ask you to confirm acceptance of our invitation to present at IAFMHS 2018 by email (2018conference@iafmhs.org) no later than 1st March 2018. We also encourage you and any co-presenters to register for the conference as soon as possible, taking advantage of the early bird rates available until the 1st April 2018.

A schedule for the conference will be available in April 2018. Further details regarding the conference can also be found on www.iafmhs.org.

We very much look forward to seeing you in Antwerp!

Dr. Catherine Wilson & Dr. Kori Ryan
On behalf of the Scientific Committee
29th May 2017

Dr Gautam Gulati, Dr Evan Yacoub and Dr Tony Kearns
HSE Mid West, Galway and Dublin
By email

Psychiatry in the Digital Age - Spring Conference 2017

Dear Gautam, Evan and Tony

Just a short note to thank you all very much for your most significant contribution to a successful event. We know how busy things are and we really appreciate you taking the time to travel to Kilkenny and present on Forensic services for people with intellectual disability.

We are delighted to share with you some very positive feedback from the delegates who attended your session

- “Very well presented”
- “Excellent session”

14/14 attendees at this session who responded to our questionnaire rated it as either Excellent / Good.

Please do not hesitate in contacting me or Grace direct if we can be of any assistance to you in the future.

With kind regards and appreciation.

Yours sincerely,

Dr William Flannery
Vice-President & Conference Academic Coordinator