A Collaborative Approach to Working with Vulnerable Prisoners: The Establishment and Operation of the High Support Unit at Mountjoy Prison

David Williamson*

Summary: The management of vulnerable prisoners, especially those with mental health difficulties, within the Irish prison system has been the subject of concern and criticism over a number of years. There has been particular concern about the situation in Mountjoy Prison as it has consistently suffered from issues of high prisoner numbers, high prisoner turnover and poor infrastructure. In 2011 the establishment of a High Support Unit within Mountjoy Prison was recognised by the World Health Organisation through awarding its work a prize in relation to healthcare initiatives within prisons. It was further recognised when it won the main award at the Irish Healthcare Awards for 2011 and also won a Taoiseach’s Award for Public Service innovation in 2012. This paper traces the background to the establishment of the High Support Unit, highlights the value of a multi-agency and multidisciplinary response in this area of criminal justice and considers the implications for the Probation Service in working with offenders facing mental health difficulties. The paper suggests a need to transfer the learning from Mountjoy Prison not just to other prisons in Ireland, but also to the integrated management of offenders in the community.

Keywords: Prison, forensic mental health, assessments, special observation cells, interdisciplinary working, high support, Probation Service, Mountjoy Prison.

Introduction

It has long been recognised that within prison and in the offender population in the community there are higher levels of mental illness and mental health difficulties than within the general population (Danesh, * David Williamson is a Senior Probation Officer in Dublin. Email: dgwilliamson@probation.ie
2002; Brinded, 2001; Meltzer, 2008; Duffy et al., 2006). This is especially true for remand, as opposed to sentenced, prisoners, but for both groups the levels of mental illness and mental health difficulties remain significantly above the levels for the general population. The demographic features of the prison population also show that there tends to be a higher level of drug and alcohol abuse in prison than in the general population (Fazel, 2006). These levels represent a significant challenge for those working with prisoners and also for those responsible for the management and design of prisons, but they are compounded by what appears to be a high level of comorbidity. Meltzer (2008) states that ‘All surveys in all countries where investigations into the mental health of prisoners have been carried out report high levels of comorbidity’. This comorbidity of mental illness, personality disorders and substance abuse presents many practical challenges within custodial settings, as it also does for the supervision and support of such offenders within community settings.

A 2008 study by the Criminal Justice and Health Research Group showed that within a probation population in Lincolnshire issues of mental health were significant, and that:

Levels of co-morbidity and dual diagnosis are known to be high in prison populations, but very little research has examined this in a probation population. Results of this study suggest that there is also a very high degree of comorbidity and dual diagnosis in a probation population. (Brooker, 2008)

This raises many questions about how such prisoners and offenders can be most easily identified and how they can best be treated, supported and managed. It also challenges us to consider the reasons behind the high levels of mental health problems within prisons and among offenders in the community, and to be critically aware of how we construct definitions of mental health and mental illness.

Mountjoy Prison has been the prison most frequently seen by the public as providing a benchmark for practice within the Irish penal system. It was in Mountjoy Prison that pressure for a change in approach to dealing with prisoners presenting with mental health difficulties led to the establishment of the High Support Unit, which has now become a model planned for adoption across the prison estate in Ireland.
Mental health and the Irish prison system

The current system of healthcare delivery in the prison system is one of mixed delivery. The Irish Prison Service (IPS) has moved in the past 10 years from a system of private contracting with GPs\(^1\) supported by Prison Service Medical Orderlies (Prison Officers with additional healthcare training) to one where a Healthcare Directorate, now incorporated into a Care and Rehabilitation Directorate, oversees qualified nursing support, including specialist addiction nurses, to support the ongoing GP provision.

In management terms each prison now has a Chief Nursing Officer at ACO\(^2\) level, and at Mountjoy Prison there is a Complex Healthcare Manager, who is also a senior nurse. Additional addiction services comprise medical staff sourced though the HSE,\(^3\) Addiction Nurses employed by IPS and Addiction Counsellors sourced on a contract basis from an independent specialist agency. These services operate on the principle that addiction services in prison must be comparable to those available in the community.

The National Forensic Mental Health Service (NFMHS) provides regular inputs to all Dublin prisons and to the Midlands Prisons Complex through teams consisting of a Consultant Psychiatrist, Registrars and a Forensic Community Mental Health Nurse.

In *A Vision for Change* (Department of Health, 2006) – the report of an expert group on mental health policy adopted as the blueprint for the development of mental health services – it is proposed that the delivery of prison-based mental health services should reflect that in the community: ‘Where mental health services are delivered in the context of a prison, they should be person centred, recovery oriented and based on evolved and integrated care plans’ (Department of Health 2006, p. 139). Recommendation 15.1.5 states that ‘Prison health services should be integrated and coordinated with social work, psychology and addiction services to ensure provision of integrated and effective care’ (Department of Health, 2006, p.142).

The Irish prison system has been the subject of review by a range of statutory authorities and international bodies such as the Inspector of Prisons, the Mental Health Commission, and the European Committee

---

\(^1\) General Practitioner: a medical doctor treating acute and chronic illnesses and providing care.  
\(^2\) Assistant Chief Officer – an Irish Prison Service management grade.  
\(^3\) Health Service Executive: responsible for the provision of healthcare in Ireland.
for the Prevention of Torture (ECPT) over the years, and a consistent level of concern has been expressed in relation to the level of healthcare supports in the system and frequently at Mountjoy Prison. This is not a recent phenomenon, as noted by Tim Carey in his history of Mountjoy Prison (Carey, 2000). He notes that

in 1884 a member of the Cross Commission of Inquiry into Prison Conditions in Ireland thought insanity in Mountjoy Prison ‘one of the most serious points’ brought to their attention. He stated that ‘it ought to have attracted the notice of the authorities to a greater extent than it appears to have done’. (Carey, 2000, p. 96)

Over 125 years later the Mental Health Commission inspection of the Forensic Psychiatry Service in Mountjoy Prison noted that ‘It was of concern to the Inspectorate that at times, the only resource available to the prison mental health service to safeguard vulnerable prisoners was to place prisoners in safety observation cells, sometimes for a period of weeks’ (Mental Health Commission, 2010). In addition, the 2010 report of the ECPT to the Irish Government requested ‘the Irish authorities to take all necessary steps to further enhance the level of care available to prisoners suffering from a psychiatric disorder’ (ECPT, 2010), having, in its 2002 report (ECPT, 2002), commented that:

In Cork and Mountjoy Prisons, and to a lesser extent at Cloverhill, prisoners in need of psychiatric care were frequently placed in unfurnished padded – or so-called cladded – cells (e.g. following their discharge from, or awaiting transfer to, the Central Mental Hospital). In general, the cells had poor lighting and were dirty. The persons concerned were provided with disposable chamber pots and with a mattress and blankets; however, the latter were often filthy. It would appear that on occasion the prisoners were left naked or in their underwear. In most cases, the persons concerned remained in the padded cells throughout the day. (ECPT, 2002, p. 20)

In relation to the situation pertaining at Mountjoy Prison, the Inspector of Prisons stated in his August 2009 report that

It is accepted that prisoners with serious mental health problems have the right to be treated in a non-forensic mental health environment.
Currently vulnerable prisoners are accommodated in the B Base and on C2 Landing with protection prisoners and in various special cells located around the prison. This is undesirable as they may not have adequate access to all the primary healthcare and mental health care services that they would have if they were located in a specific dedicated unit. (Inspector of Prisons, 2009, p. 30)

The situation in Mountjoy Prison prior to the establishment of the High Support Unit was that prisoners presenting as in need of psychiatric assessment and those with a possible increased risk of harm to self or others were placed in special observation cells (SOCs). These cells were also used to contain prisoners needing to be separated because of disciplinary issues. This further increased the risks to vulnerable prisoners.

It should be acknowledged that at Cloverhill Prison, the principal remand centre, there is a scheme providing for the location of prisoners deemed to be in need of psychiatric evaluation or support on a specific landing, and for fast tracking of reports to the courts with a view to the diversion of prisoners to community treatment where appropriate (McInerney and O’Neill, 2008). There has, however, been no other specific intervention within the prison system to address the needs of convicted prisoners vulnerable because of health-related issues.

Mountjoy Prison

Mountjoy Prison is a committal prison with a current operating capacity of 590, located close to the city centre in Dublin. It was built in 1850 and is now part of a complex of four prisons (Mountjoy, Dóchas Women’s Prison, The Training Unit and St Patrick’s Institution). The prison accepts committals from the greater Dublin area and manages prisoners serving all lengths of sentence. It has a central block – the original 1850 building – and this block is, as it was when it opened, made up of four wings radiating from the central circle, with three tiers. In addition to these wings there are two separate blocks that also house prisoners. The older of these additional units, commonly known as the ‘separation unit’, now predominantly houses prisoners in need of protection.

The more recent New Medical Unit (NMU) was built in 1993 to deal with those needing isolation because of health needs and later also in response to drug treatment needs. This unit has six landings, with nine cells per landing, and became the base for the Drug Treatment
Programme (DTP) and for detoxification programmes. It is in this unit that the High Support Unit has been established, benefiting not only from design features but also from the presence of the DTP, which is an eight-week rotating groupwork-based programme, with an abstinence approach, for prisoners dealing with addiction.

The prison population in Mountjoy was extensively studied in 1996 by Dr Paul O’Mahony (O’Mahony, 1997). Fifteen years later there are many striking similarities to the population described then. A significant change to this profile would appear to be the more ethnically diverse population that has come with the growth of immigration in Ireland.

What O’Mahony strikingly confirms in his sample is the high level of exposure to adverse life experiences. Of the representative sample of 124 prisoners he states that ‘only 12 prisoners had none of the following problems: a heroin habit, an alcohol problem, a past attempt at suicide, HIV or Hepatitis, a history as a Psychiatric inpatient or no employment last 3 months’ (O’Mahony, 1997, p. 137). He adds that ‘40% had experienced three or more and 12% an incredible 4 or more of these severe adversities’ (O’Mahony, 1997, p. 138).

Given these levels of adverse life experience and of the parallel reality of the high levels of social, economic and educational deprivation, it is perhaps not surprising that Mountjoy Prison, with its location and its history, remains a touchstone in our understanding of, and response to, imprisonment.

**Establishment of the High Support Unit**

Following the report of the Inspector of Prisons in August 2009 (Inspector of Prisons, 2009) discussions began within the prison on how a unit for vulnerable prisoners could be established, where it could be located and what its operating procedures would be. The term ‘vulnerable’ was specifically used, for while it was always clear that the vast majority of prisoners accessing the High Support Unit would have mental health difficulties, the unit could also be used for certain medical needs or in relation to detoxification approaches requiring additional monitoring. The central driver in this was the Healthcare Directorate of the Irish Prison Service, and discussions with stakeholders and local management continued into the summer of 2010.

In the summer of 2010, following the assignment of a new complex Governor to Mountjoy Prison, it was directed that the High Support Unit
was to be opened in line with the recommendations of the Inspector and the strategy statement of the IPS. It was identified that the F1 landing in the New Medical Unit would be the most suitable location for the unit. While standard operating procedures were being designed by a group comprising the Complex Healthcare Manager, NFMHS staff, local operational management, Psychology Service and the Probation Service, work proceeded to ensure that the fabric of the unit was suitable for meeting the identified needs of those who would be housed there. This meant refurbishment of cells and a review of features that posed particular risk (examining factors such as ligature points and security of fixtures).

Discussion also focused on how the daily operation of the High Support Unit could be enhanced by looking at the regime and décor in the unit. In addition staffing levels were agreed and training for operational staff to be assigned to the unit was rolled out. In December 2010 the unit was opened as a 10-bed unit. Giblin (2012) outlines the significant differences in staffing and approach in the HSU compared with an ordinary association area in Mountjoy Prison (Table 1).

Table 1. Access to mental health services on ordinary wings and High Support Unit (source: Giblin, 2012)

<table>
<thead>
<tr>
<th></th>
<th>Ordinary prison wing</th>
<th>High Support Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of cells</td>
<td>35</td>
<td>10</td>
</tr>
<tr>
<td>Number of Prison Officers per shift</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Attendance of prison Healthcare Manager</td>
<td>As required</td>
<td>Daily</td>
</tr>
<tr>
<td>Hours of lock-down (confined to cells)</td>
<td>16.5</td>
<td>16.5</td>
</tr>
<tr>
<td>Nurses attend on the wing</td>
<td>When requested</td>
<td>Daily</td>
</tr>
<tr>
<td>Community Mental Health Nurses attend on the wing</td>
<td>Clinics in main prison surgery for those with appointments</td>
<td>Three times per week and as requested</td>
</tr>
<tr>
<td>Psychiatrists attend on the wing</td>
<td>Twice-weekly clinics in the main prison surgery for those with appointments</td>
<td>Three times per week and as requested</td>
</tr>
<tr>
<td>Multidisciplinary/multi-agency reviews each week</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
For Probation Service staff, interviewing prisoners generally within the prison access is determined by the availability of prison staff to escort Probation Officers to designated offices close to wings. In the High Support Unit prisoners can be interviewed on the wing, generally in a small recreation room that has a large soundproofed window behind which is the control room for the unit, where Prison Officers are sited. Probation Officers are therefore able to interview and work with High Support Unit prisoners without needing an escorting Prison Officer.

When the High Support Unit was opened, one of the central innovations was the establishment of a weekly multidisciplinary meeting to review those housed in the unit and those being considered for transfer into the unit. The meeting also focused on the active treatment needs of prisoners on the unit as well as looking at treatment and support needs where a prisoner was being moved back to general location or was being considered for release into the community. As Giblin (2012) notes in reference to the High Support Unit: ‘Regular inter agency meetings which share information and make joint decisions regarding admissions and discharges are an essential component in the optimal functioning of such a facility within a sentenced prison’.

The weekly meeting was attended by a Consultant Psychiatrist, Senior Registrar, Community Forensic Psychiatric Nurse, Complex Healthcare Manager, Senior Probation Officer, the Governor responsible for Healthcare and the Assistant Chief Officer responsible for the Medical Unit.

Unit operation and outcomes

The rationale behind the establishment of the High Support Unit was to provide focused interventions with vulnerable prisoners that would allow for better assessment and management within the prison setting, as well as decreasing the pressure on transfer demands to specialist treatment facilities. One immediate goal was to seek to reduce the use of heavily criticised special observation cells within Mountjoy. As Giblin notes in her 2012 research, ‘There has been a significant reduction in the frequency of use of SOCs in the prison. The mean daily or monthly rate of use of SOCs has fallen by 59% since the High Support Unit became operational.’

While transfers to the National Forensic Service facility at the Central Mental Hospital Dundrum did not decrease, the High Support Unit’s
establishment did lead to more streamlined communication between the services and arguably better pre-hospital assessments. It also improved continuity of care, as all transfers to the Central Mental Hospital from Mountjoy Prison subsequent to its establishment came from the HSU, and 70% of transfers back to Mountjoy went into the HSU.

The High Support Unit has dealt with a significant number of offenders who had complex needs and significant mental (and occasionally physical) health issues. This allowed the Probation Service to have a much clearer understanding of how best to draw up intervention and supervision plans for these offenders and more easily and effectively to contribute to the complete assessment required.

Probation practice

In the establishment of the High Support Unit in Mountjoy Prison the clear driving forces were the Irish Prison Service and the National Forensic Mental Health Service. In designing the unit and looking at standard operating procedures, local prison management ensured that both the Psychology team based at Mountjoy Prison and the Probation Service team serving the prison were fully involved and attended all the meetings that looked at how the unit would operate and what inputs from the Service could be provided.

The local Probation Service team had to decide how significantly to become involved with the process. In making that decision a crucial factor for the team was an awareness of the particular challenges for the Service in the assessment and supervision of offenders with mental health problems. The decision was also influenced by an awareness of the number, and the criminogenic needs, of prisoners across the IPS estate who are subject to mandatory Probation supervision on release from custody. This number has grown exponentially as the use of section 99 of the 2006 Criminal Justice Act\(^4\) in sentencing has developed.

Section 99 provides authority for a court to make an Order sentencing a person to a period of imprisonment and to suspend some, or all, of the sentence on their entering a recognisance with conditions including Probation supervision for a specified period on release from custody. Figures from the Probation Service and Irish Prison Service indicate that

there are over 800 prisoners currently in the prison system with such orders and with recognisances that specify post-custody supervision by the Probation Service. Frequently additional conditions are attached to such orders in relation to treatment (generally addiction but also occasionally mental health).

For the Probation Service this development in sentencing has emphasised the need to manage offenders on a throughcare basis, linking custody and community in a new way. Establishment of the High Support Unit was informed by an understanding of Service goals and responsibilities, but also as a professional opportunity to enhance practice.

Probation Officers work with offenders in institutional and community settings. They have a core function of supporting public safety through seeking to reduce reoffending. This is done most frequently through working individually with offenders to address pro-offending behaviours and attitudes. The Probation Officers are also conscious of the impact on offending of social experience and are aware of the social construction of the concept of crime.

In doing this, Probation Officers bring a social work perspective to their work which informs the application of a range of risk and needs assessments and an individually focused range of interventions. These assessments, and the interventions that are determined to be appropriate in working with clients, are complemented in many cases by knowledge of the offender's history drawn from their previous contact with the Probation Service. These assessments and interventions emphasise and examine the individual in a social context, and this perspective complements the clinical assessment of the specialist medical staff within the High Support Unit.

Kendall argues that 'Within corrections, psychiatry has been the most influential medical subdiscipline', adding that there are

two unique approaches: medical–somatic and social-psychological … Both the medical–somatic and social-psychological approaches individualise crime. Whether the cause of crime is located in the body or the mind the focus is on changing the individual rather than the social structure. Therefore the two reinforce one another. (Kendall, 2004, p. 65)

Ensuring that this perspective and these professional skills are included in the service delivery within an HSU should be, I would argue, a priority
for the Probation Service. De Vaggiani (2007) argues in his paper on structural determinants of prison health that there needs to be a broader and more radical approach to prison health: ‘one that lifts the debate from the traditional orthodoxy based on medical, psychiatric and security imperatives to a new public health agenda that addresses key social and structural determinants of health’.

**Collaboration or co-operation?**

Hepworth *et al.* (2010) suggests that organisational relationships range from co-operation to collaboration and argues that ‘cooperation, coordination and collaboration are often used interchangeably to describe a relationship between organisations, but the nature of the relationship is different with respect to function, structure and durability’ (Hepworth *et al.*, 2010, p. 450). Is the development of the High Support Unit and its planned roll-out across the Irish Prison Service estate a true collaboration between the key agencies?

Trant, in an unpublished thesis (Trant, 2012), examines inter-disciplinary working within a Probation Service funded project and notes that one of the challenges for working in such a setting is that

staff are not merely representing different disciplines, they also represent different organizations who may have different agendas and contrasting philosophies. While all Programme staff work on the same team with a ‘common’ goal, they are ultimately accountable to individual employers. (Trant, 2012, p. 23)

The establishment of the HSU within Mountjoy Prison was, I suggest, a collaboration between the Irish Prison Service and the HSE, with which the Probation Service co-operated. Hepworth *et al.* (2010, p. 452) adapt a table from Graham and Barter (1999) which identifies the phases of collaboration as follows:

1. problem setting in which stakeholders within a domain are identified, with mutual acknowledgement and common definition of issues
2. agreement on direction and common values that guide individual pursuits, including expectations of outcome
3. implementation of the plan and skills – for example, conferring, consultation and cooperation – and understanding the inter-dependence between the various professionals involved
4. the creation of a long-term structure that enables the collaboration to sustain, evaluate and nurture the collaborative effort over time.

In the process of design and establishment of the High Support Unit there was a degree of problem setting in which there was some common definition of issues, namely the need to improve assessment and management of vulnerable prisoners and the goal of a reduction in the use of seclusion to manage risk. There was also agreement on common values guiding individual pursuits, but these were easier for the core collaborators, whose professional perspectives were medical and whose operational perspectives emphasise institutional responses to risk management.

In the implementation of the plan there was conferring with the Probation Service team within the prison, along with the offered cooperation. From a social work perspective the idea of the High Support Unit being a true collaboration is weakened by the absence of a long-term structure that supports the collaboration process. How the development of High Support Units across the prison estate is managed in the absence of a Probation Service input other than an informal local level represents a missed opportunity for improving delivery of services to a particularly marginalised group.

Comments by Giblin (2012) regarding staffing resources in the HSU focus on the situation for medical, nursing and operational prison personnel. It is worth briefly noting the Probation Service position. The Probation Service has assigned one Senior Probation Officer and five Probation Officer posts to Mountjoy Prison. The Service reprioritised its work in prisons in 2009 as part of a wider management exercise arising from increased demands in relation to court-mandated work and related resource constraints.

The Service now prioritises focus on service provision to prisoners with a court-mandated sanction involving post-release community supervision, the production of court and Parole Board reports, and work with female prisoners and with identified child protection concerns. The needs of prisoners with specific and severe mental health difficulties did not fall within this prioritisation. In the light of Giblin’s (2012) findings the Probation Service might reassess what resources might be needed to optimise the opportunities afforded by the High Support Unit model to address offending behaviour more effectively within this vulnerable population.
Conclusion

In 2010 a High Support Unit was established at Mountjoy Prison. It was designed to provide an environment in which vulnerable prisoners could be assessed, monitored and, crucially, supported with greater effectiveness than if they were in the general population within the prison. The High Support Unit has proved successful in reducing the use of special observation cells in the prison and has increased the communication and cooperation between the mental health services, general healthcare and the Probation Service in the prison.

On the basis of these demonstrated benefits, and in line with the recommendations of the Inspector of Prisons, it is now proposed that the model will be rolled out across the prison estate.

For the Probation Service there are additional aspects to consider. Co-operation between services within the prison has proved positive, but it also challenges the Probation Service, given the high level of demonstrated mental health issues within the community supervision as well as the in-custody populations, to consider how such co-operation might develop into collaboration and be developed across the Irish Prison Service estate. Such co-operation, ideally collaboration, will inevitably be impacted on at some level by the inherent structural power imbalances that exist within custodial settings. Such imbalances are reinforced by perceptions of professional status and expertise and thus there is more of a challenge for the Prison Service than for other services and agencies in being conscious of such imbalances and the impact they can have on practice.

The HSU, as a model of good practice, also needs be considered in relation to community settings and community supervision, where the Probation Service leads in the management of offenders. Developing better co-operation and perhaps collaboration poses challenges for services dealing with complex and challenging behaviours, where dual diagnosis is a significant issue and where the causative relationship between mental health and offending is a contested area. The depth of these challenges should not, however, deter the Probation Service from considering how they might be met.

In facing these challenges services can take an important message from one of the key lessons that have emerged from the establishment of the High Support Unit. Good interdisciplinary practice, based on an acknowledgement and acceptance of different professional skills and
perspectives, along with an understanding of different organisational imperatives, supports good practice. If we can take something into the community it is that the High Support Unit model of cooperation supports the Probation Service in the provision of more effective service delivery to a client group with particular and significant challenges and complex needs.

References


Brooker, C. (2008), *An Investigation into the Prevalence of Mental Health Disorder and Patterns of Health Service Access in a Probation Population*, Lincoln, UK: University of Lincoln


