Facing up to Mental Illness

Bill Toner, SJ

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Introduction

The moral character of a society can best be judged by the way it looks after the weakest and most vulnerable of its members. These include, for instance, the very poor, the homeless, travellers and gypsies, the unborn, children, asylum-seekers, the sick, the elderly, the imprisoned. There is no evidence that Ireland is, in general, significantly worse than many other countries in looking after its most marginalised groups. But neither is it significantly better. Recently it was severely indicted by the United Nations Committee on the Rights of the Child for the lack of policies and the inadequacies of services for vulnerable and at-risk children, as reported in Working Notes (Issue 31).

People suffering from mental illness are among the most vulnerable in our society and we have failed them in two main respects. In the first instance we have failed to protect their fundamental rights and freedoms in our procedures for detaining them against their will. In the second place we have failed to implement and enforce reasonable standards of care for them.

The Long Wait for a Mental Health Bill

Since 1992 the state has publicly acknowledged that, in relation to procedures for detention of people with mental illness, it is currently in breach of the European Convention for the Protection of Human Rights, as well as the relevant United Nations Principles. A Bill is currently in preparation designed:

to redefine the criteria for detaining mentally disordered persons;

to introduce procedures to review the decision to detain a person in a psychiatric hospital;

to give greater safeguards to protect detained persons.

While this measure to at last update the Mental Treatment Act, 1945, is to be welcomed, its progress is agonisingly slow, given that the relevant Green Paper was published in 1992, and a White Paper in 1995 (Note 1). It is doubtful if the Bill will be published in this millennium.

This Bill is very important, as there is a strong suspicion that we are still putting too many people in psychiatric hospitals against their will and keeping them there. On the latest date for which we have figures (31 December 1997) there were about 900 involuntary patients in Irish psychiatric hospitals, a figure which compares badly with other European countries. In relation to patients in psychiatric hospitals as a whole, comparative figures revealed in 1981 gave much cause for concern. In that year, for every 100,000 people in the population, comparative numbers of people in mental hospitals were as follows:

Denmark 166

England 176

France 228

IRELAND 406. (Note 2)

In fact a Commission of Inquiry in 1966 suggested that the number of in-patients in Ireland was the highest in the world! While this Commission raised the possibility that mental illness is more prevalent in Ireland, it also suggested the far more likely conclusion that "the public attitude towards mental illness may not be helpful to the discharge of patients and their reintegration into the community". In fact the detaining of people in psychiatric hospitals may have been part of a more generalised syndrome in Ireland where people who did not fit in were 'put away', whether in Magdalen Homes, orphanages or whatever. Older readers may recall the custom of some judges of letting petty criminals off on condition that they went to England! In 1940 we had 19,134 in-patients in public psychiatric hospitals compared with about 4,500 at present (Note 3).

Few things could better illustrate the marginalisation of mentally ill people than the delay in implementing the Mental Health Bill. No group in society is in a worse position to "fight its corner". People suffering from depression or schizophrenia, many of them in secure wards in hospitals, are not going to write letters to T.D.s or march on Leinster House. Representations from their friends and relatives and doctors tend, for various reasons, to be only sporadic, and support groups do not command a broad enough base to mount an effective challenge to government inertia.

Mental Health Services: The Slow Pace of Reform

While the reforms of mental health legislation in regard to detention are important, of equal relevance to most people suffering from mental illness is the availability of good treatment and after-care, and again progress in this area is agonisingly slow. In fact the principal concern of the Irish Council for Civil Liberties regarding the new Bill is not the issue of detention, but the absence of any firm proposals on standards of care of the mentally ill (Note 4). The ICCL, quoting the first of the UN Principles that all persons have the right to the best available mental health care, goes on to say:

The White Paper makes no effort to define the standards of care of the mentally ill, nor to ensure adequate monitoring of services by an independent body.

In 1984 a Study Group appointed by the Minister for Health issued its very fine Report The Psychiatric Services - Planning for the Future in which it examined and assessed mental health services and made many proposals (This Report is now out-of-print and virtually unobtainable). In the Foreword, the Minister for Health, Barry Desmond, wrote that "it is the Government's intention to implement the recommendations contained in this Report".

One of the guiding recommendations of the 1984 Report was that the psychiatric services should be community oriented, that is, that they should be located close to where people live and work. This

was to be a departure from the centralised and largely institutionalised services of the time. As one way of achieving this, a second recommendation stated that the service should be sectorised, with a population of about 25,000 in each sector. A multi-disciplinary team was to be based in each sector. On the following page is a diagrammatic summary of the overall shape of the psychiatric service envisaged in the Report. It is somewhat simplified. For instance not all possible lines of referral are drawn, psychiatrists also work out of out-patient clinics, and so on.

Fifteen years on, the 1984 Report still represents the standard for the psychiatric services to aim at. But the implementation of the Report has not been uniform. In this regard it is instructive to compare some of the recommendations of the 1984 Report with the current situation, as described most recently in the Report of the Inspector of Mental Hospitals for 1997 (see pp.4-7). It can be seen from this that many of the hopes of the 1984 report have not yet been fulfilled. (Note 5).

Shortcomings of the Psychiatric Services

It would be wrong to launch into an analysis of the shortcomings of the psychiatric services without paying tribute to the dedication and hard work of the many thousands of people who help others, in different ways, to cope with the crippling effects of mental illness. These include members of families, carers, GPs, psychiatrists, psychologists and other specialists, psychiatric nurses, members of religious orders, academics and commentators, health board workers, hospital administrators, voluntary helpers, civil servants, local authority workers and many others.

Yet in spite of the efforts of all these people, there are many deficiencies in the system. Most are due ultimately to a failure of public opinion to galvanise politicians sufficiently to put the necessary resources into mental healthcare.

One of the most important critiques of the psychiatric services is provided by the annual Report of the Inspector of Mental Hospitals, currently Dr Dermot Walsh. Carers, representative organisations, and community workers interviewed by Working Notes staff have identified other problems of well. Matters which seem to call for attention include the following:

The crisis intervention service has never been put into place. Regrettably people do not always succumb to mental illness between 9 and 5 on week-days, but often at week-ends and late at night It is not always feasible to bring mentally ill people into emergency departments of general hospitals. Ideally a psychiatric team, working in conjunction with the gardai where necessary, would be available to deal with local emergencies, especially in major cities and towns.

There is a shortage of suitable accommodation. This runs right through the service, from acute units to high-support residential facilities. In fact there is not strictly a shortage of beds in acute units, but almost half of them are occupied by non-acute patients (Note 6). This makes it very difficult for someone, except in an extreme emergency, to access a bed. Assessment of patients is coloured by the shortage of beds, and patients who really need residential treatment are assessed as capable of being treated in out-patient clinics.

The 'inappropriate occupancy' of acute wards is in fact caused by a shortage of suitable high-support residential facilities, particularly ones which are able to deal with 'difficult' patients or those with very low coping skills. This appears to be the 'Achilles Heel' in the plan to replace psychiatric hospitals by high-support facilities. It leads to patients being retained in admission wards for long periods, leading in turn to a shortage of emergency beds.

People who suffer from mental illness but who are well enough to live 'in the community', have major problems finding suitable accommodation. Waiting lists for the better hostels are huge. Few of those living outside a family setting are happy with their living conditions or feel they have a place they can call 'home'. Many live in flats or lodgings where they experience loneliness. Others live in low-support residences where they may be four to a room, sometimes without any privacy. It cannot be easy to recover from illness in this situation.

In 1993 there were 11,000 beds in psychiatric hospitals and units, and there are now about 7,000. While the official 'belief' is that 4,000 who would have been in psychiatric hospitals are now living 'in the community', many people, including many health workers, are concerned that many of these people are homeless, or are 'walking wounded' living lonely existences, or are living inappropriately with family members and sometimes causing them considerable stress or are in prison. There is considerable scepticism as to whether all these people are better off than they would have been in the traditional institutions.

It should be noted that the current inflation of house prices and building land is seriously affecting the ability of the psychiatric services to provide additional residential accommodation in communities. Rapidly increasing rents are also causing problems for mentally ill people living in a flat or trying to move into one.

There is still not sufficient support for carers. As the 1984 Report pointed out, the main burden of caring for a mentally ill person in the community, particularly a chronic psychotic patient living at home, may fall on the patient's family, and the cost to the family, in terms of emotional stress, can be considerable. The psychiatric team (where it exists locally) must have a commitment to supporting the relatives of patients who live at home and arrangements should be made so that they can take holidays from time to time. The care of people with mental illness is the responsibility of the whole community, not just the patient's family.

The way social welfare regulations are enforced can cause considerable distress to people who are mentally ill. For instance if a person on invalidity pension of £68 a week goes into hospital, between £40 and £60 of their payment can be stopped to contribute to hospital costs, depending on length of stay. A long-term patient in hospital receives only £8 a week to spend on such things as toiletries, cigarettes, newspapers and so only. But more significantly, the bills back home do not stop. People frequently lose their flats because they cannot afford to keep up payments. When they come out of hospital people can be faced with old bills for gas and electricity, phones or phone rental, and other items, but they are unlikely to receive any help with these. Obviously the last thing person struggling to recover from mental illness is to be burdened by financial anxieties.

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There is a severe shortage of suitable employment opportunities for people suffering from mental illness, or with a history of it. In general the labour market is allowed to dictate the availability of jobs. While sheltered employment schemes do exist, the allowances paid are small, and many people suffering from mental illness find it insulting to be asked to work long hours for the money offered. It is an enormous boost to the self-esteem and morale of people with mental illness if they are able to hold down a job. The biggest challenge is to change the attitudes of employers, who would need not only to create appropriate structures for employing vulnerable people, but also be more open to the idea of taking them on. The problem is not peculiar to Ireland. One U.S. study showed that 54% of personnel directors of companies quoted on the New York Stock Exchange would never, or only occasionally, employ somebody who was currently depressed (Note 7).

Treatment within the community is poor. It is difficult to get a GP to take on a mental patient, which puts a lot of pressure on the local clinic. Typical of the poor quality of delivery is the situation in one Dublin suburb where the out-patient clinic is in the local community centre. Even with an appointment a person might have to queue for two hours in full view of everyone who knows that they are queuing for psychiatric treatment. Given the stigma attached to psychiatric illness, this can put additional stress on ill persons and their carers.

Patients who attend clinics are likely to see registrars-in-training. These change every six months, so there is a lack of continuity in the doctor-patient relationship. This is more serious than in the case of physical illness where for instance any doctor can inspect x-rays. In this regard, the training plans of the Health Boards seem to have priority over the well-being of public patients.

In most cases there is no home follow-up by a community nurse after coming out of hospital. The nurse can only be seen at the clinic.

There appears to be is a reliance on medication over other forms of treatment. Part of the reason for this is that services are understaffed and doctors are under too much pressure. Frequently patients find it difficult to have a chat with the doctor, as the doctor is too busy, and the outcome may be to receive a month's supply of medication with an appointment to return when the medication is finished. In some cases the month's supply may be gone the same day. Doctors sometimes do not find the time to explain the effects, and side-effects, of medication. Some medicines do not 'kick in' for some time, and patients who take them continue to get worse before they get better. Because this has not been explained to patients or their carers, there have been cases where they have given up the medicine before it has had time to take effect.

Some doctors do not see themselves as having any responsibility for after-care, with the result that issues like accommodation and occupational therapy are not properly integrated into the treatment programme. It was reported that one psychiatrist who was asked by a carer about accommodation replied that this was like asking the Taoiseach to fix the traffic lights. Subsidiary and support services might be of a higher standard if more doctors brought their considerable moral influence to bear in these areas.

This last point relates to the wider critique that psychiatric services work in isolation from the social and other problems which patients present. Thus homelessness may be the cause of major stress. The psychiatric services tend to wash their hands of such patients on the grounds that their problem is primarily social. Similarly, someone who had difficulties in relationships, or with drug misuse, will get short shrift. This 'isolationism' of the psychiatric services fails to face up to the fact that for many people their problem is both a mental health problem and a social or personal problem. Dealing with one, without addressing the other, is futile.

Thus, rather than focusing on the overall problem, the psychiatric services tend to focus on the part of the problem that is specific to their expertise. Better coordination with social and other services seems essential.

A report by two researchers in Northern Ireland highlighted the extent to which homelessness coincided with mental illness in Belfast (Note 8). Thirty seven per cent of all homeless people resident in hostels and B&B residences were reported to have a mental health problem, and many more suffered from psychological distress. Of single homeless people, almost half had been homeless for more than a year owing mainly to alcohol/drug related problems, parental/marital dispute, or intimidation. One third of the group had received psychiatric inpatient care at some stage, though discharge from psychiatric hospital rarely featured as the immediate reason for homelessness. The report shows that it is difficult to disentangle mental illness from other social problems.

There are few, if any, Irish junior doctors in psychiatric services. Some hospitals have non-Irish staff only. This can give rise to communication and other difficulties. A better mix of doctors would give patients greater reassurance. The fact that few Irish doctors want to get into psychiatric services also says a lot about the general state of the services here, and the way they are seriously under-funded.

Children over 16 are classified as adults under the Mental Health Act. In all other respects, young people are considered to be children in law until they are 18. Adult services are usually totally unsuitable for 16 and 17 year olds. Promises to amend this anomaly have been made for several years, but to date it has not been remedied.

Services for children under 16 are excellent, but difficult to access. Long waiting lists are the norm.

Residential psychiatric services are sometimes in dilapidated buildings which are gloomy, depressing and in poor repair. The Inspector's Report makes sad reading in this regard. The conditions in some hospitals, detailed on p.4, would never be tolerated in an ordinary general hospital Such neglect betrays a failure in our society to value mentally ill people as much as physically ill people.

In fact there seems to be a lack of clear policy with regard to psychiatric hospitals, and the 1984 Report seems to contain contradictory comments and recommendations In general the Report sets its face against any attempt to perpetuate the hospitals:

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"If they are to provide tolerable living accommodation for patients, an extensive programme to restructure and replace the existing stock of buildings must be undertaken....Apart from the question of cost, we consider that investing on such a scale in psychiatric hospitals would be a disastrous path for this country to follow. It would perpetuate a pattern of care and treatment which is increasingly irrelevant... (15.10,11)

The danger is, that, as hospitals are improved, admissions of certain categories of patients may increase and the dilemma is how to bring about these improvements without perpetuating the form of care which has become associated with the hospitals (1.28).

On the other hand, in the section of the Report discussing the hospitals themselves, a different emphasis is to be found:

The improvement schemes of the last three years have already made a significant contribution to upgrading the physical condition of many psychiatric hospitals... (7.23). The psychiatric hospitals will have an essential function in this (psychiatric) service for many years to come and it should be made quite clear that the phasing-out of these hospitals is a gradual process which is dependent on the build-up of a range of alternative services (7.43.2).

At the end of 1997 there were still 4,698 patients in public psychiatric units. Numbers are currently declining at the rate of about 300 per year, which suggests that these hospitals are unlikely to be phased out before 2013. The difficulties in providing high-support residential units in the community which can adequately cater for the needs of many chronically ill patients (many of them currently filling acute beds) may yet force a re-think regarding the total closure of psychiatric hospitals (Note 9). As the report by Keogh et al.(1999) found "there (is) in general, a lack of a systematised spectrum of provision through the rehabilitation...across the continuum of support". The gap between the large or medium-size psychiatric hospital and the 15-20 bed high-support unit may involve too great a discontinuity in this spectrum.

It is to be noted that there is no great pressure to close the large private psychiatric hospitals such as St.Patrick's in Dublin, or St. John of God's in Stillorgan, which have 503 beds between them. It is not necessarily the size of the hospitals which causes the problems, but the way they are run. The most important consideration must be that patients get the best possible standard of care appropriate to their condition and prospects of recovery.

Residential services can be very boring. In some hospitals there seems to be nothing to do all day long. It is common for the TV room not to open till the evening. Many leisure facilities are shut down at week-ends. Patients walk around all day, bored to tears. It is difficult to understand how a person's mental state can be improved in these surroundings. The shortage of occupational therapists does not seem to be regarded with sufficient seriousness.

The psychiatric services understand their role as treating definable psychiatric illnesses, mainly by medication. However there is a grey area where people, though they do not have a definable illness, are stressed out, unable to cope, and often suicidal. Perhaps it is unfair to ask the psychiatric services, already over-stretched, to meet the needs of these people. Yet in the absence of any other

services, it is to the psychiatric services that these people turn. People in these situations need someone to talk to, perhaps for a lengthy period of time, and perhaps some medication on a temporary basis.

Most people interviewed by Working Notes staff mentioned the problems caused by shortage of nursing staff in hospitals and residential units, and the difficulties of recruitment. In the past few years the number of psychiatric nurses has fallen from 7,000 to 5,000. At a time of so many job opportunities for young people, psychiatric nursing is not one of the more popular options.. Although the requirement of a third level qualification for psychiatric nurses is to be welcomed, the lengthy training requirement, while living on a small allowance, has made this career unattractive. The Department of Health recently approved an intake of 201 trainee nurses, but only 91 places could be filled. There is an urgent need to introduce bursaries to encourage entry into the profession, as is the case in Great Britain.

Shortages of staff in other areas, such as occupational therapy, seem to be due more to inadequate funding of the psychiatric services than any other reasons.

The forthcoming Mental Health Act proposes a Commissioner for Mental Health, linked to the Department of Health, who would be a consultant psychiatrist. It has been pointed out that this represents a continuation of the current post of Inspector of Mental Hospitals and thus carries conflicts of interest. As it happens, the current holder of the post has been trenchant in his criticisms of the psychiatric services, but that is not to say that every future incumbent of this or a similar post would be so outspoken.

There is a strong case for an independent Mental Health Commission on the same lines as exists in Northern Ireland. In fact many aspects of the psychiatric services in Northern Ireland, such as the deployment of psychiatric social workers, are better organised and resourced than in the Republic. This area is likely to be a source of embarrassment in the context of greater cross-border dialogue and influence.

Public Attitude to Mental Illness

In a liberal democracy like Ireland, the most powerful factor in bringing about change of any kind is public opinion. People may choose to blame politicians for various shortcomings of our society, but politicians have a vested interest in keeping their ears fairly closely to the ground and are unlikely to completely misread the public mood.

Thus, the reason why psychiatric services in Ireland are not better is because the public do not care enough. Society is prejudiced against sufferers of mental illness and tends to set them apart from the rest of the community. Over the past four decades surveys of public attitudes on mental illness indicate that it is perceived as something to be feared, and that its sufferers tend to be mistreated and shunned. Even recent change show that change in public attitude is minimal (Note 10). As Professor Anthony Clare stated, "The mentally ill are now the most systematically stigmatised group in our society. They...are the true lepers of today" (Note 11). Many of the shortcomings of the

system of treatment betray a lack of belief that people with mental illness have the same rights as everybody else, and have done nothing to forfeit them.

Our treatment of our people who suffer mental illness is as unworthy of us as it is of them. It reveals traces of a primitive mind-set which has no place at the end of the second millennium. Hopefully we can begin the new one by accepting our responsibilities under the constitution to defend and protect all our people.

Notes

Our thanks are due to the many people who gave gladly of their time to discuss the many issues raised in this article, and who provided us with valuable information.. These people include representatives of support organisations, patients and former patients, professionals, representatives of nursing organisations, civil servants, and relatives of people suffering from mental illness.

Bill Toner S.J. (Editor, Working Notes).

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Hopelessness and Suicide in Prison

Tony O'Riordan, SJ

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Why do people kill themselves? Because they have lost hope. People who have hope can envisage a future and can see what they are going to do tomorrow, next week and even in the years ahead. This ability to look forward to the future with a degree of confidence is what keeps us going in life.

Sadly it seems as if a growing number of Irish people are lacking in hope. There has been a dramatic increase in the number of suicides in Ireland in recent years, particularly among young males. 359 suicides were recorded in the first 9 months of last year. It is estimated that the figure for the entire year will exceed 500. This will be significantly more than the number of people killed in road accidents in 1998, which is estimated at 460.

Considerable research has been carried out with a view to understanding the factors that lead to suicide. Dr. Patrick McKeon provides a useful overview of three interrelated factors; 'Psychiatric disorders, usually depression or an intoxicant problem, are present in 90% of people who take their own lives. However as not everyone with depression attempts suicide, it is clear that other factors are relevant. Suicide can best be explained by a domino effect of the three components, depression and related disorders, traumatic losses in life and finally the added depressing effect of alcohol abuse or illicit drugs. Depression would appear to be the most commonly experienced first sequence in the domino chain followed by the further demoralising effect of emotional trauma leading in turn to alcohol abuse. In young people it may be that the sequence starts with drug use.' In other words, what brings people to the brink of suicide is a combination of some form of mental illness, the inability to cope with difficult circumstances and alcohol or drug abuse.

People who commit suicide come from all walks of life. However, particular social factors are associated with suicide. Suicide rates are generally lowest in women, married individuals, and those in higher socio-economic groups. Young men, people living alone or isolated and those who feel alienated from society are more likely to kill themselves.

Prisoners: A Vulnerable Group

The sociological and personal profiles of prisoners puts them in a particular category of person likely to feel hopelessness. Most of the people we send to prison are young men from marginalised urban areas. They are multiply disadvantaged and most suffer from chronic drug addiction. While, in general, women are less likely to commit suicide, women in prison share many of the personal and sociological characteristics found among male prisoners, and as such, female prisoners are equally vulnerable to experience hopelessness.

A recent study shows that prisoners experience high levels of psychological difficulties and significant feelings of hopelessness. It found that one in two prisoners had thought about killing

himself at some point in his life and one in three had tried to do so. This study was carried out by a Psychologist in Clinical Training on placement with the Department of Justice Psychology service. It examined psychological distress, thoughts of suicide and self injury among male prisoners in Mountjoy and St. Patrick's Institution. Interviews were conducted with inmates during the first days in prison. The majority were from Dublin, one fifth were functionally illiterate, on average they had left school at 14 with no qualification. 15% had never been employed and the majority were unemployed prior to their current imprisonment. Close to three quarters of the sample misused drugs; a habit that, on average, began at the age of 12. The majority abused non prescription drugs, with 45% using heroin and 19% using cannabis. Using more than one drug was a common practice among most of the prisoners interviewed. 45% of the group admitted that they got in trouble with the law after using drugs.

In terms of physical health status, over a quarter stated that they had physical health problems and over a quarter stated that they had spent some time in a psychiatric hospital. Other significant findings about this group include:

52% had experienced suicidal thoughts in the past
8% of prisoners had a member of their immediate family die through suicide
33% had engaged in self injurious behaviour at some point in their lives
70 % of these had self injured on two or more occasions with two thirds of attempters stating that their intent to die in the last attempt was high.

In terms of attaining a measure of hopelessness the study used a scale called the Beck Hopelessness Scale. This categorises hopelessness, in a range from minimal to severe hopelessness. Over 80% of prisoners were in the hopeless range. 70% of the prisoners scored in excess of the mean score for the Irish population. The prisoners experienced high levels of depression, anxiety, and somatic complaints. Over 60% had feelings of personal inadequacy and inferiority

Clearly, there is a significant requirement for physical and mental health care for offenders prior to committal. Once in prison the need for this support increases. From the inmates perspective there are certain unique features of the prison environment which diminish hope and enhance suicidal behaviour:

- Fear of the unknown
- Distrust of the authoritarian environment
- Lack of apparent control over the future
- Isolation from family and significant others
- Dehumanising aspects of incarceration

There were 37 prison suicides in Irish prisons between 1988 and 1998. Official figures are not available but conservative figures suggest that there are approximately 200 reported incidents of attempted suicide and self harm in prison every year. Others put the level of self injury much higher, at 8-10 incidents a week in Mountjoy alone. Even if the lower figure is more accurate, 200 such incidents are a cause for concern. The most common form that such incidents take are attempted

hangings and self-mutilation involving sharp objects . It is difficult to assess how many of these incidents of self-harm represent serious attempts by inmates to kill themselves. Wishing to be transferred to a different part of the prison or to another prison might be the reason behind some incidents of self- injury. What can be said is that all acts of self-injury reflect personal breakdowns resulting from crises of self doubt, poor coping skills and hopelessness.

The Official Response

In 1989 the Government, concerned by the rising number of prison suicides, set up an Expert Group to look into the problem. The group reported in 1991 and made 57 recommendations. Many of these were elements of an approach to preventing suicides that relies primarily on a strategy of identifying prisoners considered high-risk. These prisoners, once identified, are monitored closely. As a result some possible deaths have been prevented through the increased vigilance of Prison Officers. However, there has not been any real decrease in the level of prison suicide in recent years.

This may be due to thto prepare them for their release without a planned programme for their management. Such a programme would encompass assessment of the prisoner on arrival; a plan of treatment of any illness or addiction; education and counselling family visits; pre-release arrangements and follow-up on release. This will require attention to the shortcomings of the medical and psychological services outlined in this article but it will also require resources to improve the occupational and educational aspects of our prisons.

Updating Prison Rules. In the Department's own words; "The 1947 Prison Rules are, by common consent, hopelessly obsolete and require urgent updating." This was written 5 years ago and no updating has taken place, (at least it gives a sense of what the Department understands by 'urgent'.) On the principle of 'what is best for the prisoner is ultimately best for society', there is a clear need to outline the regime that is to operate in our prisons and to ensure that the rights of prisoners are protected.

Prison as a Last Resort. A more radical course of action is to reduce the use of imprisonment as a response to offending behaviour and develop a spectrum of community-based corrective measures. Prison is not be the only way of punishing offenders. In many cases other methods, such as fines, have been found to correct behaviour more effectively than imprisonment. Other measures involving appropriate supervision of convicted offenders in the community, and measures that address the factors of disadvantage that lead so many young people to offend, are more likely to achieve rehabilitative outcomes in the long run. In this context, hopelessness and mental illness are more likely to be successfully treated provided that the appropriate range of such services is provided.

Conclusion

It is not possible to say, with certainty, that any of the suicides in our prisons since 1991 could have been prevented if a different approach was adopted, but more could have been done to reduce the level of risk among the general prison population. This could have been done by improving the

standard of medical care. Decisive action to (1) humanise our prisons and (2) change our practice in the way we use imprisonment is required if we are to challenge this sense of hopelessness and help prisoners cope more effectively and reduce the likelihood of suicide.

Currently we are investing up to £200 million to provide more prison places in a prison system that already costs over £150 million to run every year. While emphasis is being placed on building and design aspects of these new institutions, little advance consideration is being devoted to personnel requirements with the exception of Prison Officers.

Investing in bricks and bars may serve the limited purpose of keeping some vulnerable members of our society locked up for periods of time, but rehabilitative regimes require adequate personnel at various levels in the system. Often the poor physical conditions in our prisons are excused by the fact they are Victorian constructions that we have inherited. Will people in the next century excuse the regimes and services in prisons they will inherit, by stating that they are constructions of late twentieth century Irish people? Or will they deplore a system which favoured the easy option of infrastructure over rehabilitation?

Notes

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Joseph Duffy, Psychological Distress, Suicidal Ideation and Self-Injurious Behaviour Among Male Remand Prisoners. (Thesis completed in 1998 in Trinity College Dublin)

Prison Officers Association Figures.

These are small windowless stuffy unfurnished rooms which are used for a spell of solitary confinement. Prisoners are confined in these cells without books, radios or other personnel possessions having first to strip to their underpants. Meals are brought in to them and they are checked on a regular basis by officers. In theory these cells should only be used to restrain prisoners and prevent them from injuring themselves or others in practice they appear to play a key role in arbitrary punishment decisions by officers.

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