



Improving Prison Conditions by Strengthening the Monitoring of HIV, HCV, TB and Harm Reduction

Authors:
Catherine MacNamara, Lorraine Varley, Patricia Mannix McNamara

Mapping Report - Ireland



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Irish Penal Reform Trust

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Catherine MacNamara
Lorraine Varley
Patricia Mannix McNamara

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I. INTRODUCTION

1. Background and justification

The Human Immunodeficiency Virus (HIV), Tuberculosis (TB) and Hepatitis C (HCV) – are a major health concern in prisons, evidenced by the fact that prevalence rates tend to be substantially higher among prison populations than in the general population.

Prisons and other places of detention are high-risk environments for the transmission of these diseases. This is related to the over-incarceration of vulnerable and disadvantaged groups who carry a disproportionately high burden of disease and ill-health; the criminalisation of drug users and high levels of injecting drug use; overcrowded and substandard prison conditions; inadequate health care; and the denial of harm reduction services.

Several international, regional and national human rights mechanisms are in place to monitor and inspect prison conditions in order to prevent torture and ill-treatment – including the Subcommittee on the Prevention of Torture (SPT), under the Optional Protocol to the UN Convention against Torture (OPCAT), with National Preventive Mechanisms (NPMs), as well as within the Committee for the Prevention of Torture (CPT) of the Council of Europe, and national bodies in a number of European countries.

United Nations human rights bodies and the European Court of Human Rights (ECtHR) are increasingly finding that issues relating to infections in detention can contribute to, or even constitute, conditions that meet the threshold of ill treatment of prisoners. It is therefore critically important for human rights-based monitoring mechanisms that have a mandate to prevent ill treatment to meaningfully examine issues relating to infections in places of detention.

Over the past 20 years, from an Irish perspective, there has been significant improvement in medical services for the prison population. The Irish Prison Service (IPS), responsible for the prisoners and their health, has made significant investment since 1999 in better healthcare facilities for prisoners¹. In 2001 the IPS introduced drug treatment plans and healthcare plans, Hep B vaccine was made accessible to prisoners, nurses were employed, drug free units were expanded, and methadone treatment was implemented. In 2006 the IPS published a drugs policy ‘Keeping drugs out of prison’. However, there still remains a lack of information available that would assist public authorities in making decisions with regards to these services.

While some progress has been made in the adoption of monitoring mechanisms for infectious diseases in Irish prisons, this progress is arguably less than sufficient or consistent in meeting the standards of human rights-based prison monitoring. As has been acknowledged above, the absence of adequate medical services in prisons can contribute to, or even constitute, conditions that meet the threshold of ill treatment.

Presently, to our knowledge, inspection of infectious diseases is not formally included in the criteria for inspection of places of detention. Prison monitoring is often separated from health care inspection guidelines, thus leaving gaps in terms of coherent recording and monitoring. This separation is less than optimal in terms of services being positioned to provide an effective and coherent national response to prisoner need. This report is part of a larger international project that seeks to address this gap.

2. About this report

This report forms part of the EU co-funded project ‘Improving Prison Conditions by Strengthening Infectious Disease Monitoring’ implemented under the lead of Harm Reduction International in 2015 and 2016.

The project aims to reduce ill-treatment of persons in detention and improve prison conditions through improved and standardised monitoring and inspection mechanisms on HIV, HCV and TB.

The research component of the project includes a mapping the current situation relating to these diseases in prisons in seven European countries (Greece, Ireland, Italy, Latvia, Poland, Portugal and Spain) as well as a mapping of practices among monitoring mechanisms in target countries, with particular reference to infections in prisons.

The project also mapped existing regional and international public health and human rights standards relating to infections in prisons and developed a user-friendly tool, including a set of key indicators, to generate better informed, more consistent, and sustained monitoring of infections in prisons by national, regional and international human rights monitoring mechanisms.

More about the project and its products can be found on the Harm Reduction International website (www.ihra.net).

The current report, written by Catherine MacNamara, Lorraine Varley and Patricia Mannix McNamara, presents the mapping situation in Ireland.

3. Methodology and methodological challenges

A mapping exercise at national level in Ireland was conducted in order to investigate existing and available standards relating to human rights, infectious diseases and prison monitoring. Data were gathered through a grid covering: analysis of the existing monitoring bodies, organisation and objectives of monitoring; information collated on infectious diseases in prison; engagement of monitoring bodies in inspecting the infectious diseases issues in prisons. In particular, information was collected through a literature review, analysis of public documents, freedom of information requests, and consultation with experts in the prison service. The following report details the results of this data collection process.

II. NATIONAL CONTEXT

1. Overall political context

Ireland is a twenty-six county republic parliamentary democracy consisting of an Oireachtas (parliament), comprising the President of Ireland and two houses, Dáil Éireann (lower house) and Seanad Éireann (upper house). The Dáil legislates, subject to approval from the Seanad, and ratification from the President. Dáil Éireann is the house from which the Government is formed. The Seanad can initiate and/or revise legislation and also amend or reject any proposed legislation by the Dáil. Elections to Dáil Éireann are based on universal suffrage, with a minimum voting age of 18 years. An individual wishing to run as a candidate in an election must be a minimum of 21 years old. The Seanad has 60 members, 11 of these being appointed by the Taoiseach (prime minister), with the rest being elected from vocational panels and National Universities. Ireland has 11 Members of Parliament (MEP's) in the European Parliament, elected from three Irish constituencies.

Brief Historical Overview

The control of prisons in Ireland was ceded to the Irish Free State in 1922, with the functions of the General Prisons Board transferred to the Department of Justice in 1928.² Rates of imprisonment fluctuated in Ireland throughout the twentieth century, with average daily imprisonment as low as 400 in the late 1950s.³ Indeed, while the Probation of Offenders Act was introduced in 1907 to provide a statutory basis for the supervision of offenders in the community, there were no more than 6 probation officers employed at any one time up until the mid-1960s.⁴ Changes to penal policy in Ireland occurred during the 1960s and 1970s in particular, with the establishment of a number of 'open prisons' to encourage the rehabilitation of offenders.⁵ This coincided with an increase in incarceration in the Republic of Ireland and 1983 saw the Prison Rules (1947) modified to allow prison governors to accommodate more than one individual per cell.⁶

1984 saw education formally introduced in Portlaoise Prison, thus beginning the 'normalisation' of the prison regime.⁷ While this development was welcomed in the main, some form of education had existed in detention centres in Ireland, most notably the Borstal, since the 1920s.⁸ Currently, education centres operate in all Irish Prisons, a successful partnership facilitated by the Irish Prison Service in conjunction with the local Education and Training Boards (ETBs). The express aims of education in prison are to help those incarcerated to cope with their sentences, to prepare those incarcerated for life after release, to help those incarcerated achieve personal development and to foster an appetite for lifelong learning.⁹

Crime levels soared in Ireland in the mid-1990s, with further pressure exerted on the prison system to accommodate offenders, somewhat exacerbated by the 'zero tolerance'¹⁰ rhetoric of the day. More prisons were built and rates of incarceration

increased. Indeed, there has been a 400% increase in incarceration figures in Ireland since the 1970s.¹¹ At the point of the relinquishing of control of the day-to-day running of Irish prisons by the Department of Justice, Equality and Law Reform to the Irish Prison Service in 1999, there were 15 prisons and an average daily population of nearly 3,000 individuals.¹²

2. Economic Context

Population and Economy

- The estimated population of the ROI is over 4,600,000.

The current estimated population of the Republic of Ireland is just over 4,600,000 people¹³, with the largest population groupings for both males and females in the 30 – 34 age category¹⁴. Life expectancy at birth in Ireland is currently 81 years, one year greater than the OECD average¹⁵. Despite recent recession, economic conditions in Ireland are improving to the extent that Ireland currently has one of the fastest growing economies in Europe, with the Gross Domestic Product (GDP) increasing by 4.8% in 2014¹⁶. All sectors of the economy demonstrated a return to growth in 2014, with exports performing particularly well with a growth rate of 10.5%. While the economic outlook for Ireland remains positive for 2015 with a growth rate of above 4% predicted, this is in marked contrast to the years of economic austerity, which began in 2008¹⁷.

The Financial Crisis

- Ireland has experienced a severe economic recession (2008 – 2014).
- Currently this recession abates, with growth once again evident in the economy.
- Previous to this was a period of unprecedented economic prosperity (mid-1990s to mid-2000s).
- Governance of austerity has been in place since financial assistance from the EU/IMF in 2010.

Ireland experienced a period of economic prosperity from the mid-1990s to the mid-2000s, outperforming other European countries. These years saw unemployment fall to around 4%, a rate considered to be full employment¹⁸. From 2002 onwards, economic prosperity was largely attributed to the ‘property bubble.’ By 2006 most of the revenue collected by the state was relating to all areas of the property market. With the property market reaching its peak in 2007, unemployment increased for the first time in over fifteen years¹⁹. The Irish banking system came under increased pressure and in September 2008, the Irish government issued a blanket guarantee of banking liabilities²⁰. Banking debt coupled with unsustainable sovereign debt led the Irish government to negotiate a financial assistance package with the European Union (EU) and International Monetary Fund (IMF) in November 2010²¹. Totalling €85 billion, the ‘bailout’ initiated a series of banking sector reforms, fiscal sector consolidation and structural reforms²².

The Social Impact of the Recession

- There are currently approximately 700,000 people living in poverty in Ireland with 376,000 people living in consistent poverty.
- 1 in 8 children live in consistent poverty.
- 1,400,000 people live in deprivation in Ireland (Poverty and Social Exclusion UK (2016) define deprivation as the consequence of a lack of income and other resources, which cumulatively can be seen as living in poverty).²³

The impact of the financial crisis and the years of austerity in Ireland have had a devastating social impact on individuals, families and communities. Unemployment rates peaked at 14.8% in 2012²⁴, while the current standardised unemployment rate rests at 10.1%²⁵, the lowest recorded since February 2009. The most vulnerable in Irish society have been disproportionately impacted by the years of austerity since 2008. There are currently nearly 700,000 people living in poverty in Ireland, with 376,000 people living in consistent poverty²⁶. One in eight children in Ireland are living in consistent poverty. 1,400,000 people in Ireland are experiencing deprivation, while one in six people aged 65 or over negatively impacted²⁷.

Those who experience imprisonment generally emanate from the lower socioeconomic groupings and are typically some of the most vulnerable individuals in our society. Many have experienced drug use, a lack of educational attainment, high unemployment and poor quality housing, all of which are important determinants of health²⁸. Annual committals to Irish prisons have increased since 2008, when just over 13,500 committals were recorded²⁹. 16,155 committals were recorded for 2014, with a consistent average daily rate of below 4,000 individuals in custody recorded for 2014³⁰. In line with the structural reforms imposed by the EU/IMF financial assistance package, the Irish Prison Service has experienced budgetary reductions since 2008, despite an increase in the number of committals. The Irish Prison Service Budget for 2008 was €406,346,000³¹, while the budget for 2014 was €334,118,000³².

3. Health Context

The History of the Healthcare Provision in Ireland

The health service in Ireland began in the 18th century within the voluntary and private sectors. The first hospitals evolved in the 1700s as a result of doctors and others being concerned about the poor sanitation conditions of the infirm and poor. The hospitals were philanthropically funded. A growth in hospital and related services run by the religious orders occurred in the early 19th century. This was followed by the introduction of the 'poor houses', which provided infirmaries, dispensaries and medical officers to care for the poor³³.

Following the establishment of the Irish Free State, the poor houses were converted into county homes for people with medical and social needs. Health services in

Ireland at this point were not a financial priority and public health was delivered via the local government until 1970, funded through lotteries (hospital sweepstakes). The most significant success of the new state was the eradication of TB in the 1940s. The Department of Health was founded in 1947. The Irish government, impressed by Britain's National Health Service, published two White Papers proposing a similar health system in Ireland. These papers set the Irish state on course to become a Welfare State³⁴. The intervening years marked an important turning point in the development of health and social policy in the Irish state. The proposals received opposition from the Catholic Church and the Department of Finance. Subsequent governments were of the opinion that the State could not afford to fund the 'welfare state.' Successive governments opted instead for additional upgrading when the government could afford it.

The Health Act of 1953 introduced a mechanism for funding of voluntary and community organisations. A state-sponsored health insurance scheme was introduced in 1957 under the Voluntary Health Insurance Act (1957) by the then Minister for Health, Mr. Tom O'Higgins. It is the largest health insurance company in Ireland today. It is a statutory corporation whose members are appointed by the Minister for Health and is regulated by the Health Insurance Authority. This developed into the two-tier system of private and public provision that we see today within the health service. There are many who would argue that this is an inherently inequitable system because the capacity to purchase private health insurance privileges individuals in terms of access to and timeliness of service provision. The current Minister for Health has given indications of a desire to engage in measures to address such inequities, the success of which remains to be seen.

Organisational changes within the Irish health system

- Single governance called the Health Service Executive (HSE) established in 2005, subdivided into four administrative areas: HSE Dublin Mid-Leinster; HSE Dublin North East; HSE South; HSE West.

There have been two major organisational changes in the Irish health service, the first one in 1970, whereby eight regional health boards were established. This removed the health services from the remit of the local authorities in Ireland. The Health Boards were sub-divided into three areas: hospital services, psychiatric services and community care. The Health Boards constituted counsellors, medical personnel and individuals nominated by the Minister for Health. The medical card (GMS scheme) was introduced in Ireland in 1970 and was on the basis that cover would be curtailed to <40% of the population.³⁵ This resulted in a very complex health system of subsidised services, state and private health insurance, with payment at most points of entry.

In the 1990s, the Eastern Health Board was further sub-divided: North East, South Western and East Coast, resulting in eleven Regional Health Boards. Concurrent to this, a substantial number of semi-state agencies related to health evolved, incorporating specialised functions varying from regulation, to research, to health promotion.

The final re-organisational shift came about in 2004 following the approval of the Health Act (2004). The eleven Regional Health Boards were abolished and were replaced with a single organisation, the Health Service Executive, which came into being on January 1st 2005. There are four HSE administrative areas; HSE Dublin Mid-Leinster, HSE Dublin North East, HSE South and HSE West. These are in turn divided into thirty-two Local Health Offices. The HSE manages the delivery of the entire health service as a single national entity. An annual service plan is published outlining how service delivery is to be delivered each year. The HSE has responsibility for providing health and personal social services to the Irish population.

Access to healthcare in Ireland

- A two-tiered health system exists in Ireland.
- Public system – to which all persons living in the Republic are entitled, though not inclusive of GP care and subject to fees for certain care received.
- Medical cards are provided on a means-test basis to those in financial hardship and the medical card scheme entitles free healthcare services from the HSE, inclusive of GP fees.
- Private system– subject to participation in a voluntary health insurance scheme.

All persons living in the Republic of Ireland are entitled to receive health care through the public health care system. It is funded through general taxation. Some persons may be required to pay a subsidised fee for certain health care received, and is dependent on income, age and disability. All maternity services and childcare up to the age of six months are provided free of charge. Emergency care is provided at a cost of €100 for a visit to the Emergency Department if you are a self-referral. Medical card holders are entitled to free hospital care, GP visits, dental services, optical services, medical appliances and prescription drugs, which are subject to a minimum monthly charge. Medical card eligibility is based on an assessment of means. To qualify, weekly income must be below the income threshold. Any income, savings, investments and property (except for the residential home) are taken into account in the means test. However, the HSE can apply discretion where undue hardship will arise from the costs of a householder's particular medical or social circumstances³⁶. However, the aforementioned two-tier system of healthcare provision often results in public patients serving a longer waiting period for treatment than those with private health insurance³⁷.

Health in Ireland – How we Compare?

According to the Organisation for Economic Cooperation and Development³⁸ Ireland has a lower than average number of hospital beds. The report also highlighted that Ireland has fewer doctors - 2.7 doctors per 1,000 population; and has more nurses - 12.2 nurses per 1,000 population. The annual budget for health in Ireland is approximately €16 billion. Ireland has experienced significant falls in per capita health spending after strong growth prior to the global economic downturn. Ireland has reduced its spending on healthcare by 6.6% since the global crisis in 2009, resulting in increased waiting

times for access to treatment³⁹. The private sector health spending remained flat from 2000 to 2009, but has grown since by two percentage points⁴⁰.

Ireland ranks 14th highest out of 34 countries with regards to public and private health expenditure per capita⁴¹. At a national level, population health presents a clear depiction of a rapid reduction in mortality rates accompanied by a rapid rise in life expectancy over the past decade. In general, the populations' perceived perception of their health is good and according to the OECD, 83% of the Irish population report to be in good health⁴².

4. Criminal Justice and prison context

Annual committals to Irish prisons have increased since 2008. There were 16,155 committals recorded in 2014. Those imprisoned generally emanate from the lower socioeconomic grouping. Despite these increases, the Irish Prison Service has had budgetary reductions since 2008 despite the increase in committals.

Relevant legal frameworks

- Historically contained provision for corporal and capital punishment of offenders.
- Capital punishment was prohibited in 1990 with the last execution in 1954. Capital punishment is also prohibited by several human rights treaties to which Ireland is a party.
- In the 1997 Criminal Law Act, corporal punishment was abolished.
- There has been modernisation of Irish prisons throughout the 20th and 21st centuries.
- Currently the number of committals continues to rise.
- There are an estimated 3,800 individuals incarcerated in Ireland currently.

The status of the health of prisoners under the Irish prison system is historically difficult to trace, as until the formation of the Irish Free State in 1922, laws governing Irish prisons were made by Parliament in London. A series of reforms began in the early 19th century, resulting in the acknowledgement that execution and transportation were no longer viable options for punishing prisoners⁴³. However, the penal system inherited by the Irish Free State government in 1922 contained provision for both corporal and capital punishment of offenders⁴⁴. Major changes only began to take place within the Irish prison system under the Criminal Justice Act of 1960, but even at that stage educational, training, psychiatric and welfare services did not exist in Irish prisons⁴⁵, with many of these changes not coming about until after the Prison Act of 1970, which adopted a more rehabilitative policy towards prisoners and prisons as places of detention⁴⁶.

The use of prisons to incarcerate individuals convicted of offences began in the late 18th and early 19th centuries. However, once prisons were actually used for this purpose alone, problems began to arise within the system as the numbers of people sentenced

to a period of incarceration began to increase substantially⁴⁷. In the first thirty years of the Irish Free State, committal rates were relatively low, with the committal rate in 1958 being just 400 people. By 1980, committal numbers had risen to 1,200⁴⁸. Currently there are an estimated 3,800 people incarcerated in this country.

Human Rights and the Irish Judicial System

The Irish courts are somewhat empowered to consider health rights (albeit not explicitly). While the right to health has not been explicitly incorporated into national law, Ireland has ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR) which imposes right to health obligations.

Structurally the Constitution of Ireland / Bunreacht na hÉireann sets out the laws, values and democratic structures for Ireland. The Constitution sets out a number of fundamental rights in Articles 38-44. All legislation passed by the Oireachtas must be compatible with these rights: *Right to life* (Article 40.3); *Equality before the law* (Article 40.1); *Right to a fair trial* (Article 38.1); *Right to liberty* (Article 40.4); *Right to freedom of expression, assembly and association* (Article 40.6.1); *Protection of the family* (Article 41). The Irish Courts have interpreted the Constitution as including certain human rights referred to as unenumerated rights (not explicitly set out in the Constitution but which are given meaning by the Courts), and include: *Right to bodily integrity*; *Right to freedom from torture, inhuman or degrading treatment or punishment*; *Right to work and earn a livelihood*; *Right to privacy* (Irish Human Rights and Equality Commission, 2015). The constitution also recognises and declares that people living in Ireland have certain fundamental personal rights. These rights are natural human rights and are confirmed and protected by the Constitution⁴⁹. These rights do not explicitly intersect with health but may be vicariously addressed through the stated rights and the fundamental personal rights.

Prison system

- 14 institutions operated by the Irish Prison Service in the Republic of Ireland – 11 closed, 2 open, 1 semi-open.

There are currently 14 institutions operated by the Irish Prison Service in the Republic of Ireland⁵⁰. Of these, 11 are traditional ‘closed’ prisons; 2 are ‘open’ centres, while 1 centre is described as ‘semi-open.’ Female prisoners are detained at the Dóchas Centre (Mountjoy Campus) and at Limerick Prison.

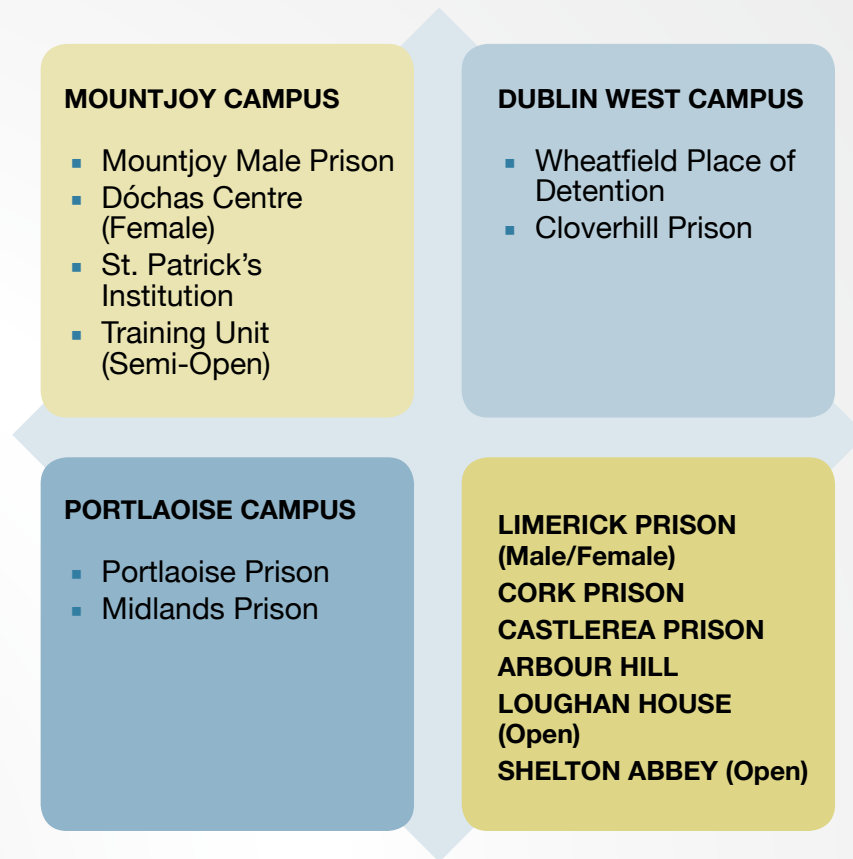


Fig. 1 Prisons in Ireland (2015)

At the beginning of July 2015 there were 3,771 individuals in custody in Ireland. Of the 14 institutions operated by the Irish Prison Service, 4 were operating at a capacity above that recommended by the Inspector of Prisons⁵¹. The rate of imprisonment in Ireland is approximately 88 per 100,000. The prison population increased by 400% between 1970 and 2011. 60% of those serving sentences in Ireland of six months or less are poor and often homeless. There are currently 15 children imprisoned in adult prisons in Ireland⁵², which is in breach of international human rights standards⁵³.

Illicit Drug Use in Ireland – Notable Legislation

- Increases in illicit drug use in Ireland is evident since the 1970s, with legislative and policing measures expanded since the 1990s to address illicit drug use.
- The Criminal Justice Act of 1999 (with amendments in 2006) specified new offences in relation to the possession and importation of controlled substances. This legislation has been criticised by the Law Reform Commission, as it has led to an increase in incarceration of mainly low-level offenders.

Illicit drug use in Ireland has been increasing since the 1970s. While there was a notable increase in cannabis usage at the time, it was not until the late 1970s and early 1980s that the use of opiates, mainly heroin, became evident. Early legislation in relation to illicit drug use took the form of the 1977 Misuse of Drugs Act⁵⁴. This legislation made the distinction between possession for personal use and possession

for sale or supply⁵⁵. While drug misuse in Ireland was still relatively low, it was during the 1970s that both government-funded and voluntary sector drug treatment facilities were established to tackle problem drug use⁵⁶. The Coolmine Therapeutic Community was established in 1973 and was the only voluntary body concerned with the treatment of problem drug use in Dublin for nearly a decade⁵⁷.

A change in the pattern of drug use, most notably heroin abuse, was highlighted in the early 1980s. The Bradshaw Report (1983) indicated that in North Central Dublin, 10% of 15-24 year olds had used heroin in the year prior to the study being carried out. This figure rose to 12% amongst 15 – 19 year olds⁵⁸. Subsequent government legislation (Misuse of Drugs Act, 1984), provided heavier punishments for drug offences, indicative of the ‘victim-blaming’ stance adopted by policy-makers of the time. Legislative and policing measures were expanded upon throughout the 1990s. The Criminal Justice Act (1994) made provision for the seizing and confiscating of assets acquired through the proceeds of drug trafficking⁵⁹. The Garda National Drugs Unit was established in 1995 to tackle national and international drug trafficking.

Drug seizures have remained steady in Ireland over the last two decades, with slight variances in yearly figures relating to cannabis, ecstasy, cocaine and heroin. Legislation in the area has failed to halt trafficking of drugs into, and indeed through, Ireland, with media reports alluding to the failure of the State to win the so-called ‘War on Drugs’⁶⁰. Both the Criminal Justice Act of 1999 and the amended version in 2006 created new offences in relation to the possession and importation of controlled substances with a value of €13,000 or more. However, this legislation has garnered criticism in recent times as it has led to an increase within the prison system of mainly low-level offenders. The Law Reform Commission has recommended a review of sentencing procedures⁶¹, as while there were over 15,000 controlled drug offences in Ireland in 2013 compared to just over 9,000 in 2003⁶², successive Criminal Justice Acts have not led to a reduction in drug-related criminality. This is reflective of the failure of the ‘War on Drugs’ at a global level, with the criminalisation of drug use and possession not serving as a deterrent from illicit drug use, but rather contributing to a range of social and health problems amongst some of the most vulnerable and marginalised communities worldwide⁶³. However, it is important to note that the presence of illicit drugs and the associated harm from prolonged use over the past thirty years has altered the reality of prisons throughout Europe and globally⁶⁴.

Illicit Drug Use in Ireland – Policy Perspectives

- The National Drugs Strategy (2009 – 2016) was brought into effect in Ireland to tackle problem drug use.
- Prisons are specifically targeted for action in the National Drugs Strategy.
- The Drug Treatment Court is a specific branch of the District Court designed to develop an integrated cross-service strategic response involving court-supervised treatment programmes as an alternative to custodial sentencing. A recent review has indicated that this court is underutilised.

- In 2013 there were nearly 600 individuals incarcerated for controlled drug offences. No information is publically available in respect of the numbers in prison who are or were engaged in sex work.
- The delivery of drug treatment services and of equivalence of care between prison health services and those in the community presents a number of challenges for Irish prisons.

The National Drugs Strategy 2009-2016⁶⁵ has adopted a multi-sectoral approach to tackling drug-related issues in Ireland. Various government departments, the community sector and the voluntary sector work collectively to address a range of issues associated with substance misuse and the drugs trade in Ireland. The objective of the strategy is to tackle the harm caused to individuals, families and communities by problem drug and alcohol use in Ireland through focusing on supply reduction, prevention, treatment, rehabilitation and research⁶⁶. The strategy makes explicit reference to harm reduction in several action items. Action 28 advocates the promotion of harm reduction measures among drug users. Action 55 states that national research priorities should include research into harm reduction approaches based on evidence-based approaches covering international developments. In addition, the strategy states that accessible harm reduction services within the community pharmacy setting are a vital part of the HSE's National Operational Plan. Prisons are also advocated as settings for harm reduction interventions.

The first National Drugs Strategy 2001-2008⁶⁷ created Regional Drug Task Forces (RDTF) to ensure that a task force covers all areas of Ireland. Local Drug Task Forces (LDTF) preceded the regional forces, which had been originally set up in localities with the highest levels of substance misuse. There are now fourteen LDTFs and ten RDTFs in Ireland⁶⁸. These Task Forces comprise of a range of representatives from An Garda Síochána, the Probation Service, Education and Training Boards (ETBs), the Health Service Executive (HSE), voluntary and community sector representatives, and elected local representatives. The task forces determine the extent of drug use in their areas and provide a coordinated response at community level⁶⁹.

Recent research has indicated that across all RDTF areas, cannabis was the most widely used illegal drug in the year prior to the survey, with men more likely to consume illegal drugs, alcohol and tobacco. Women are more likely to consume prescription or over-the-counter medicines⁷⁰. 'Illicit Drug Markets in Ireland'⁷¹ highlights the impact of the illicit drugs trade on communities in Ireland, with participants expressing a level of fear, detachment, alienation and disempowerment within their own communities. While young adults (15 – 34 years) are more likely than older adults (35 – 65 years) to use illegal drugs⁷², it would also appear young people in communities are becoming increasingly involved in the illegal drugs trade, where worsening levels of violence and related anti-social behaviour are impacting negatively on individuals and communities across Ireland⁷³.

The Place of Irish Prisons in the National Drugs Strategy 2009-2016

Prisoners are products of their communities and in most cases will return to those same communities, making the lives of those in prison and those in the community inextricably linked. Incarceration for any length of time does not mean that a prisoner abandons their role within their family or community for good, nor does it mean that they lose their right to access the same services as they would in the community. The United Nations (1990) 'Basic Principles for the Treatment of Prisoners' asserts that each state is obligated to uphold the rights of prisoners to medical treatment and preventative measures equivalent to those in the community. The reality in many institutions however, means that structural determinants such as the prison environment, political climate in the country and social conditions within the prison put prisoners at increased risk of experiencing health decline over the period of their incarceration⁷⁴. While there were over 15,000 arrests for controlled drug offences in 2013, the vast majority were for possession for personal use⁷⁵. The same year saw nearly 600 individuals serve a custodial sentence for controlled drug offences (17 female; 572 male)⁷⁶.

Those serving prison sentences in Ireland have not always been included in national policy, such omissions serve to further intensify the inequities experienced by one of the most vulnerable population groups within our society. Prisons as a setting and prisoners as a target population were completely omitted from the National Health Promotion Strategy⁷⁷, while there was ambiguity demonstrated in the National Health Strategy, 'Quality and Fairness: A Health System for You'⁷⁸, as to who exactly was responsible for ensuring the healthcare needs of those incarcerated in Ireland were provided for adequately.

National Drugs Strategy Action 8 – Improving Security Measures in Prisons

Prisons as settings and prisoners as a population group are targeted for action in the National Drugs Strategy 2009 – 2016⁷⁹. A recent progress report to the end of 2013 highlighted specific action areas for prisons and indeed progress made. 'Action 8' refers to the continuation of improvement of security and detection measures in all prisons across Ireland, with notable actions including the creation of a 'Canine Detection Unit' and the segregation of serious drug and criminal gang leaders in high security units. Actions are certainly on-going in these areas with recent media reports highlighting attempts by the Irish Prison Service to prevent drugs from reaching prisons, such as a proposed increase in the Canine Detection Unit from 20 dogs to 38 by the end of 2015⁸⁰, and a proposed drugs 'hotline' that could lead to the supply of confidential information that could allow for the interception of drugs being smuggled into Irish prisons⁸¹.

The Irish Prison Service published a drugs policy and strategy paper, entitled 'Keeping Drugs Out of Prison: Drugs Policy and Strategy' in May 2006. The then Minister for Justice Michael McDowell had articulated a commitment to a totally drugs-free prison system. A drugs-free prison system had been the explicit aim of the Irish government

since 2002 and in September 2004 Minister McDowell promised to introduce the measures needed to end the supply of drugs in prisons, and claimed that in this way the prisons would be made drug free within 18 months⁸². Loughan House Place of Detention was proposed as an entirely 'drug-free' prison by the end of 2013. The authors contacted the Irish Prison Service for confirmation as to whether this action was achieved, but at the time of writing this report, the service has failed to respond to the query. An entirely drug free prison is somewhat utopian in nature because where there is demand, drugs will continue to become available in prisons. Prisons must address both supply and demand, including a range of support and treatment options. Drugs free prison policy also facilitates barriers to a pro-treatment ethos, particularly by way of restrictions on harm reduction approaches such as needle exchange⁸³.

The Irish Prison Officer's Association (POA) however has recently criticised the perceived lack of action in certain areas, notably the failure to isolate gang leaders, given the alleged level of influence they exert over other inmates, notably in the area of drugs and other contraband⁸⁴. Indeed, Connolly and Donovan (2014) assert that time spent in prison may contribute to future involvement in illicit drug markets, a phenomenon also reflected internationally, as those incarcerated can make acquaintances with whom they subsequently engage in drug-dealing upon release, further reflecting the inextricable links between prisons, prisoners, and the communities to which they return⁸⁵.

National Drugs Strategy Action 13 – The Drug Treatment Court

'Action 13' of the national drugs strategy refers to reviewing the operation and effectiveness of the Drug Court. With the first person referred in 2001, the Drug Treatment Court is a specialised District Court, offering long-term court-monitored rehabilitation as an alternative to a prison sentence⁸⁶. In the 'Report of the Committee of Inquiry into the Penal System' (1985), Whitaker highlighted the fact that imprisonment offers limited protective, deterrent or corrective value and should only be employed as a last resort. This report recommended a range of non-custodial penalties as an alternative to prison such as community service, compulsory rehabilitation and compulsory participation in training programmes, all of which were to be operable within the community⁸⁷.

The level of referrals to the Drug Treatment Court appears low, with 374 referrals from 2001 to 2009. The most recent review (2010) highlighted the fact that only 14% of suitable referrals have graduated successfully from the programme⁸⁸. However, international research points to some distinct problems associated with drug courts of which the national strategy should take more note. The analysis by the Drug Policy Alliance of drug courts yields some critical conclusions. The analysis finds that drug courts have not demonstrated cost savings, reduced incarceration, or improved public safety. Drug courts do not typically divert people from lengthy prison terms, in fact some drug court participants end up incarcerated for *more time* than if they had been conventionally sentenced in the first place, often due to failing a drug test or missing an appointment related to treatment⁸⁹. In addition Irish drug courts have adopted the

disease model of addiction but continue to penalise relapse with incarceration. As a result, they have done a poor job of addressing participants' health needs. The Drug Policy Alliance (2011) advocate that drug courts have absorbed scarce resources that could have been better spent to treat and supervise those with more serious offenses or to bolster demonstrated health approaches, such as community-based treatment.

National Drugs Strategy Action 43 – Treatment and Rehabilitation Options within the Irish Prison System

The prison environment is a high-risk environment for the transmission of communicable diseases, namely HIV, Hepatitis C, and Tuberculosis⁹⁰ mainly due to structural conditions within prison systems such as over-crowding, lack of sanitation, and limited access to healthcare services⁹¹. Again highlighting the links between prisons, prisoners and communities, communicable diseases tend to spread more rapidly among groups that experience high levels of socioeconomic disadvantage, many of whom may subsequently enter the prison system⁹². As a result, prisoners become more susceptible to communicable diseases because they have no control over their environment or the individuals with whom they interact⁹³.

The continuation of the expansion of treatment, rehabilitation and other health and social services in prisons is an area targeted for action in the National Drugs Strategy 2009 – 2016. 'Action 43' refers to the need for the 'seamless provision of treatment services' as an individual moves between prison and the community⁹⁴. Developments in the area include the availability of drug treatment services in all closed prisons, though they can vary by institution. Available programmes include the Drug Treatment Programmes, Slow Detox and Stabilisation, and Relapse Programme⁹⁵. The Irish Prison service advocates that treatment programmes provided within the prison environment are patient-focused, with the objectives of harm reduction, stabilisation of the patient's addiction, and with a longer-term aim of assisting the return of the patient to a drug-free lifestyle⁹⁶. Specific harm reduction measures for prisons identified in the national drugs strategy include access to addiction counselling from specific addiction counsellors; additionally funded addiction counselling by community groups while in prison and upon release to the community; additional specialist sessions in addiction psychiatry (in two sites: Mountjoy and Cloverhill/Wheatfield) which is cited as improving quality and coordination of drug treatment. In one site (Mountjoy) a dedicated pharmacy service is responsible for the management of all medicines (mainly methadone) used as substitution treatment in the management of addiction. The Irish Prison Service states that treatment in Mountjoy is on an equivalent basis to that available in the community because it includes six specialist nurses who have a distinct role with regard to addiction assessment, treatment planning and delivery and evaluation of care, and a clinical addiction team involving all of the disciplines engaged in drug treatment services⁹⁷. The National Drugs Strategy also identifies that the IPS is seeking to enhance specialist input, similar to Mountjoy, in all prisons, but particularly at Cloverhill/Wheatfield and other prisons where demand for drug treatment services is high.

The delivery of drug treatment services and indeed ensuring equivalence of care between prison health services and those in the community presents a number of challenges for Irish prisons⁹⁸. The link between drug use and the incidence of infectious diseases cannot be underestimated, which is why harm reduction is essential. Drummond *et al* (2014)⁹⁹ have recently reported the prevalence of drug use within Irish prisons as much higher than in the general community. This is in keeping with previous studies of the Irish prisoner population where a high level of drug use for males (72%) was identified compared to the general population (14%)¹⁰⁰. In the 2014 study by Drummond *et al*, cannabis was the most widely reported drug, yet the lifetime prevalence of heroin use was cause for concern at 43% of those surveyed¹⁰¹. The rate of heroin usage peaked in the 25 – 34 years old category, with female prisoners more likely to have reported using heroin and methadone in their lifetime, in the previous twelve months, and in the previous thirty days.¹⁰²

This study also focused on the incidence of blood-borne viruses amongst the Irish prisoner population, the first study of this kind since the late 1990s. Prevalence of Hepatitis B (1 in 300 prisoners) and HIV (1 in 50 prisoners) were found to be higher than in the general population, but low when compared to the actual prisoner population in this country¹⁰³. Prevalence of Hepatitis C (1 in 8 prisoners) was shown to be lower than previous studies have indicated. Interestingly, this study has highlighted that if harm reduction services are available in prison, nearly all of those who need assistance will use such services. This could indicate that in the area of drug treatment, the Irish Prison Service has the opportunity to go beyond equivalence with the general community and provide services such as detox, substitution treatment, and counselling far beyond the scope that can be provided within the general community. If high quality treatment is available throughout the period of incarceration, negative health impacts, substance dependency and misuse can be targeted prior to the individual's re-entry into the community, possibly limiting the danger of overdose upon release¹⁰⁴.

The Criminalisation of Sex Work in Ireland

Under current legislation the exchange of money for sexual services is not illegal in Ireland. However, living off the earnings of prostitution, soliciting, brothel keeping and organising prostitution are illegal. These are set out in the Criminal Law (Sexual Offences) Act, 1993. The amended act is gender neutral in that it applies to both male and female prostitutes and applies to all parties including clients¹⁰⁵. In addition the Criminal Law (Public Order) Act of 1994 (Section 23) prohibits the advertising of brothels or of the service of prostitution, and includes material posted on the Internet¹⁰⁶. The links between sex work and hepatitis C and HIV are well documented. Cox and Whittaker in an Irish study (2009) identify levels of reported contact with health services as high (64 per cent) among the sex workers in their sample, but also indicate were levels of self-reported Hepatitis C Virus (HCV) (78%) and Human Immunodeficiency Virus (HIV) (21%) infection among the population sampled¹⁰⁷. This has implications for reception to prison upon incarceration and makes the case for routine screening of all entrants to prison. It also has implications for health care provision amongst detainees who have been sex workers.

III. HIV, HCV AND TB IN IRISH PRISONS

- A legislatively enacted national Health Surveillance Centre is authorized to collect and collate data on notifiable diseases.
- In 2014 there were 449 reported cases of Hepatitis B nationally, 721 cases of Hepatitis C were reported, 322 cases of tuberculosis reported, and 379 cases of HIV reported.
- It was not possible to identify the prevalence rates in the prison setting nationally, as while data was requested from the Irish Prison Service, at the time of writing this report such data was not forthcoming.
- Harm reduction measures currently employed by the IPS include opioid substitution therapy (OST) and addiction counselling. Addiction Based Counselling Services are provided by Merchant's Quay Ireland in thirteen Irish prisons¹⁰⁸.

1. Policy Context

In Ireland, under the Infectious Diseases Regulations Act 1981 and subsequent amendments, the Health Surveillance Centre is authorised by law to collect information from medical practitioners and laboratories about diagnoses of certain infectious diseases known as 'notifiable diseases'. The aim of this Act is to protect the health and safety of the population. The infectious diseases regulations apply to all settings, including prisons.

The collection of infectious disease data is standardised on a national basis. Upon diagnosis, all medical practitioners are required by law to notify the Medical Officer of Health (MoH). Notifications are made electronically through the Computerised Infectious Disease Reporting System (CIDR). All CIDR information is protected by appropriate security and confidentiality mechanisms and complies with Data Protection legislation. Figures in the data do not discriminate between the general public and prisoners. The data is disaggregated by sex and age. There are specific national guidelines on the prevention and control of TB and Ireland follows the European Centre for Disease Prevention & Control (ECDC).

2. Data on HIV, HCV and TB in Irish Prisons

The Health Protection Surveillance Centre (HPSC) provides national statistics for incidences of infectious diseases in Ireland. In 2014 there were 449 reported cases of Hepatitis B nationally, 721 cases of Hepatitis C were reported, 322 cases of tuberculosis and 379 cases of HIV reported.¹⁰⁹ It was not possible to identify disaggregated statistics specific to prisons from the HPSC data. The HPSC recommended to the authors of this report to contact the Irish Prison Service and the Department of Justice in order to identify prevalence rates among the prisoner population. A request under Freedom of Information was sent to both bodies. The Department of Justice referred the authors back to the Irish Prison Service. The authors continue to await a response from the

Irish Prison Service. It was possible to access some data via published research studies and these are delineated here. However, the authors advise some caution due to the difficulty in drawing generalised conclusions because testing procedures varied between the studies. The test for Hepatitis B conducted by Allwright *et al* (1999) used Hepatitis B core antibody testing, a measure of any exposure, whereas, the most recent study by Drummond *et al* (2014) investigated current infection using Hepatitis B surface antigen testing, and therefore the results are not directly comparable¹¹⁰. This indicates the need for national collation of prevalence data in the prison population, which may currently exist, however accessing such data proved particularly difficult.

This notwithstanding, Allwright *et al* (1999) identified Hepatitis B prevalence at 9%, Hepatitis C at 37% and HIV at 2% among the prisoner population. When these statistics were disaggregated by injecting drug use, it is noteworthy that prevalence rates of Hepatitis B among IDU's were 18.5%, Hepatitis C is 81.3% and HIV is 3.5%¹¹¹. More recently, Drummond *et al* (2014) identified prevalence of Hepatitis B at 0.3%, Hepatitis C at 13% and HIV at 2%¹¹².

It is noteworthy that there are no hospital facilities within Irish prisons, and prisoners have to be transferred under security escort for treatment. This is cause for concern because effective measures for HIV and Hepatitis C prevention are not readily available to prisoners due to medical services remaining inadequate or inconsistently accessible¹¹³. The Irish Prison Service provision for HIV and Hepatitis C prevention measures does not meet standards of best practice models in Europe and North America¹¹⁴ and according to Lyons the current response of the Irish Prisons Service to the HIV and Hepatitis C crisis falls far short of the Service's stated objective of the provision of primary health care (prevention, treatment and health rehabilitation) to offenders of at least an equivalent standard to that available to citizens in the general community. The National Drugs Strategy recognises the importance of harm reduction for the community, and similar emphasis and parallel prioritisation of harm reduction for prisoners is necessary, as is equality of access and indeed consistent access to primary health care.

High incidences of TB outbreaks associated with multi-drug resistance and HIV co-infections have been observed in prison populations in recent years. These rates have been attributed to low socio-economic status, alcohol and substance misuse, HIV infection and to having arrived from areas of high endemicity rates¹¹⁵. Optimally, TB screening should take place in prisons on a routine basis. The TB Guidelines¹¹⁶ recommended the use of a self-reported questionnaire on reception to prison, followed by appropriate clinical tests. It is recommended that screening should be provided at the beginning of every prison sentence in order to track active cases and treat them accordingly before they integrate with the general prison population. The prison services should have cooperation and handover procedures in place to ensure continuity of care before any prisoner with TB is transferred. Due to poor ventilation, overcrowding, and the transient nature of the prisoner population both between and within prison facilities, the likelihood of exposure to TB is increased. This then

exacerbates difficulties for the implementation of any control strategy¹¹⁷, as well as negative health implications for staff in their place of employment.

3. Harm Reduction

Defining Harm Reduction

“‘Harm Reduction’ refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community”¹¹⁸. The principles of harm reduction involve accepting that drug use is part of society and, rather than ignoring or condemning drug users, harm reduction measures work to minimise the harmful effects of drug use¹¹⁹. The aim of adopting harm reduction measures is to empower users to share information and support each other in strategies that meet their actual conditions of use¹²⁰. The International Harm Reduction Association identifies that “there is a need to provide people who use drugs with options that help to minimise risks from continuing to use drugs, and of harming themselves or others. It is therefore essential that harm reduction information, services and other interventions exist to help keep people healthy and safe”¹²¹. In relation to injecting drug use, harm reduction approaches seek to prevent the spread of HIV and other infectious diseases that result from sharing non-sterile equipment¹²². Harm reduction interventions can include education or information-giving in relation to the harms associated with a particular lifestyle behaviour, screening and assessment for infections associated with risky lifestyle behaviours, substitution therapy, needle exchanges and drug consumption rooms¹²³. Harm reduction is underpinned by fundamental respect for the dignity of all human beings. The International Harm Reduction Association advocates clearly that “people who use drugs do not forfeit their human rights, including the right to the highest attainable standard of health, to social services, to work, to benefit from scientific progress, to freedom from arbitrary detention and freedom from cruel inhuman and degrading treatment”¹²⁴. Harm reduction promotes responses to drug use that respect and protect fundamental human rights.

Harm reduction measures currently employed by the IPS include opioid substitution therapy (OST) and addiction counselling. Access to OST is considered to be ‘high’ in Irish prisons¹²⁵. Addiction Based Counselling Services are provided by Merchant’s Quay Ireland in 13 prisons around Ireland¹²⁶. Services offered by Merchant’s Quay in Irish prisons include brief interventions, motivation therapy, twelve-step programmes, relapse prevention and cognitive behavioural therapy¹²⁷.

As outlined by Harm Reduction International, drug use is criminalised in all European countries with the exception of Portugal and drug use remains particularly high within prisons across Europe¹²⁸. A survey of the literature in relation to the monitoring of drug usage in prisons across Europe has indicated that between 15 – 30% of the prison population have reported ever having injected drugs¹²⁹. Incidentally, the highest

prevalence levels of drug usage reported in the year prior to the review being carried out were attributed to Ireland and the United Kingdom, with usage rates of as high as 88% reported¹³⁰.

Harm Reduction Measures in Ireland

In many European countries the introduction of harm reduction measures such as needle exchanges and sterilising equipment for needles have virtually eliminated needle sharing and injecting drug-related HIV¹³¹. A recent review of needle exchange provision in Ireland indicated that there were 24 static sites, 14 outreach sites and 129 pharmacies participating in needle exchange (NSP) services in Ireland¹³². Figures for 2012 demonstrate that there were over 65,000 transactions¹³³ at NEP services, equating to nearly 14,000 individuals¹³⁴ accessing harm reduction services of this nature. This report also highlights a reduction in HIV diagnoses amongst injecting drug users (IDUs), from 71 in 2004 to 13 in 2012. Out of these 13 individuals, 69% were also diagnosed with HCV¹³⁵. There has been an increase in new HIV diagnoses in Ireland, with figures for 2014 indicating an 11% increase on 2013¹³⁶. Of 168 new diagnoses, 27 are amongst injecting drug users¹³⁷. The rate of HCV notifications in Ireland appears to be decreasing however, with just over 1,000 cases diagnosed in 2012, a decrease of 17% from 2011¹³⁸.

The HSE has also indicated a willingness to introduce further measures to tackle harm associated with injecting drug use. Plans are currently being finalised for a 'Naloxone Demonstration Project,' which will provide Naloxone to 600 injecting drug users in order to prevent opioid overdose¹³⁹. Successful take-home Naloxone programmes have been implemented in Scotland and Wales since 2009, with 365 overdose reversals recorded in Scotland up to March 2013¹⁴⁰. Prisoners are recognised as being at high risk of drug overdose upon release from prison; however there is currently no literature available to indicate that the Naloxone Demonstration Project will be extended to include the prisoner population. Harm reduction measures may be expanded in the general community, with a recent announcement by the current Minister of State with responsibility for Drugs Strategy, Mr. Aodhán Ó Ríordáin, in relation to a proposed radical departure in drug policy in Ireland. In an effort to tackle public drug taking, the Minister indicated the possibility of the introduction of medically supervised drug consumption rooms, a recommendation that had first been mooted in 2005¹⁴¹.

The Need for Harm Reduction Measures for Prison Populations

Needle exchange programmes were introduced in prisons across Switzerland in 1992, Germany in 1996 and Spain in 1997. Moldova has been considered a world leader in the area of harm reduction measures in prisons since the introduction of opioid substitution therapy and syringe exchanges in 1999¹⁴². In many of these countries, the only prisoners to be excluded from these programmes are those with mental illness or who are known to be extremely violent, as this could create a security risk for other inmates and staff. In many cases, syringe exchange programmes have led to increased

referrals to drug treatment for offenders and have not led to security or safety issues for prison staff¹⁴³.

Lifetime prevalence of injecting drug use amongst prisoners in Ireland has been recorded at 25%¹⁴⁴, indicating that prisoners in Ireland are certainly at risk of transmission of blood-borne infections as a result of accessing non-sterile injecting equipment. With needle exchanges not currently being employed as a harm reduction measure within Irish prisons, even though there is current evidence to indicate that certain prisoners are still injecting drugs, and indeed using needles for tattoos, it is incomprehensible that these practices would be permitted to continue in an unsafe manner, thus exposing those incarcerated in this country to a range of infectious diseases including HIV and HCV.

According to the 'Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia', prisoners are placed at increased risk of HIV infection, while HIV positive prisoners are at increased risk of contracting other communicable diseases¹⁴⁵. Many countries, including Ireland, are failing to protect prisoners and provide adequately for their care. This declaration recommended harm reduction measures such as drug treatment, sterile syringes, needle exchanges, and the provision of safe tattooing equipment in order to reduce the spread of HIV and Hepatitis C. In order to care for the needs of those already living with disease and a weakened immune system, the Dublin Declaration recommended that conditions of confinement be improved with measures put in place to tackle overcrowding, poor sanitation and bad ventilation, while also ensuring that sufficient numbers of healthcare personnel be available to deal with the health needs of all prisoners¹⁴⁶.

IV. MONITORING HIV, HCV AND TB IN IRISH PRISONS

- The health of prisoners comes under the jurisdiction of the IPS and not the Department of Health.
- The Office of the Ombudsman has no remit to investigate complaints relating to prisons.
- The Irish Human Rights and Equality Commission is a statutory body established (2014) to protect and promote human rights in Ireland.
- Ireland signed up to the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in 2007 and, despite reaffirming its commitment to introducing legislation in this area, limited progress has been made since 2007.
- To date the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has carried out 6 visits to Ireland; the most recent one was carried out in September 2014, and identified the healthcare provision in some prisons as being in “a state of crisis”¹⁴⁷. Following their 5th visit in 2009 and their subsequent report published in 2010, they identified clear failures in the prison service specific to healthcare, prisoner protection, and safe and humane custody¹⁴⁸.
- An Inspector of Irish Prisons was appointed in 2002, with the Office of the Inspector of Prisons established as an independent statutory body under the Prisons Act 2007. The Inspector cannot investigate or adjudicate on individual prisoner complaints but can investigate the circumstances relating to a complaint where necessary.
- The Inspector of Prisons does not have power of disclosure; reports are published by the Minister for Justice and Equality.
- Prison Visiting Committees examine the quality of accommodation and services provided to prisoners and report to the Minister for Justice and Equality.

1. Prisoner Health legal and policy framework

Ireland’s health policy is centred on equity, people-centredness, quality and accountability, and aims to “develop a system in which best health and social well-being are valued and supported, include every person and institution with an influence or role to play in the health of individuals, groups, communities and society as a whole”¹⁴⁹. Prisoners have diverse and complex health needs. Compared to general adult populations, prison populations have poorer physical, mental and social health, and experience considerable social exclusion.

The health of prisoners is outside the remit of the Department of Health but it makes reference to the health of the prison population and advises implementation of recommendations made by ‘Report of the Expert Group on the Structures and Organisation of Prison Healthcare Services in Ireland 2001’ as a priority, giving overall responsibility for these actions to the Irish Prison Service, which is responsible for

health in prisons. The report, published by the Department of Justice, Equality & Law Reform, made recommendations for the future of prison healthcare in Ireland¹⁵⁰. The report was initiated due to the increasingly recognised challenges involved in delivering healthcare in prisons and the findings of previous reports on prison healthcare in Ireland. As early as 1994, it was acknowledged that the organisation and provision of medical services in Irish prisons had failed to keep pace with developments in both medical and ethical standards.

In keeping with statutory requirements, Public Health Services must be informed of all notifiable diseases. The prison health care staff, relevant visiting specialists and services, and external specialist services, in line with good practices and guidelines, provide care.

There is evidence to suggest that the efforts made to improve the provision of healthcare services in Irish prisons have slowed down in comparison to those that are available to the general Irish population¹⁵¹. A number of structural deficiencies remain such as;

- Access to staff and facilities;
- Medical examination on admission and recording of injuries;
- Drug related issues;
- Use of special observational cells; and
- Psychiatric care in prison

Prison Healthcare Policy

The healthcare standards for the Irish Prison Services were completed in 2011 and the aim is to provide prisoners with access to the same quality and range of health services as those that are available to the general population. Nine healthcare standards were developed:



Fig. 2 Nine healthcare standards of the Irish Prison Service

2. Human-rights based monitoring mechanisms

The Ombudsman

The Office of the Ombudsman in Ireland investigates complaints from individuals who believe they have been unfairly treated by certain public bodies including government departments, the Health Service Executive and local authorities¹⁵². Legislation pertaining to the remit of the Ombudsman was adopted in 1980 and subsequently amended in 2012. Based on the impartiality and fairness of the Office, the Ombudsman can demand any information, document or file and require any official to provide information in relation to a complaint received. In relation to investigating public bodies

that deal with justice in Ireland, the Office of the Ombudsman does not have the remit to investigate complaints relating to the Irish Prison Service¹⁵³.

The Irish Human Rights and Equality Commission

The Irish Human Rights and Equality Commission (IHREC) was established on November 1st 2014 to protect and promote human rights and equality in Ireland¹⁵⁴. It is an independent, statutory body, whose origins lie in the Good Friday Agreement, and is a requirement under legislation both in the Republic of Ireland and Northern Ireland. Human rights recognise the dignity and equal worth of each person, with the IHREC working to protect the human rights of individuals as set down in the Irish Constitution, the European Convention on Human Rights, and any other conventions and treaties that the Irish government has agreed to uphold. The Irish Prison Service and the Irish Human Rights Commission collaborated on developing and delivering a bespoke Human Rights Training Course for prison staff, to ensure that not only the conditions of detention reach acceptable standards, but that the culture within Irish prisons values the humanity and dignity of the prisoners in its care¹⁵⁵. Designed to be delivered to all staff working in the custodial environment, it addresses all of the treaties and instruments of the UN relating to human rights and the European Convention of Human Rights, focusing specifically on the conduct and attitudes of prison staff, and examines the rights of prisoners particularly in relation to issues such as:

- Article 3 - Freedom from torture and degrading treatment
- Article 4 - Freedom from forced labour
- Article 6 - Right to a fair trial
- Article 8 - Right to respect for private and family life and correspondence
- Article 13 - Right to effective remedy

The training also focuses on different scenarios that may be present within the prison environment such as torture, women in prison, and/or juveniles in detention, using methodologies such as case studies and group discussion or role-play. While this training does not make explicit reference to health or infectious diseases, it is of note that since 2007 the Irish Prison Service has offered a module as part of recruit training in the Higher Certificate in Custodial Care. Up to 850 officers have completed this training programme. It is further of note that there is now an 'Infection Prevention Control Group' in existence, from which future training may emanate.

Commitment to human rights within the Irish Prison Service is evident as the Director General of the Irish Prison Service indicated at the launch of this bespoke training. He advocated that the Human Rights Awareness Programme was a vital component of the 3 Year Strategy and that training prison staff would ensure that "Respect for human rights is not just about the physical conditions of detention but also, and more importantly, it is the manner in which we treat our prisoners each day. It is about treating prisoners with humanity and with respect".¹⁵⁶

National Preventive Mechanisms and OPCAT

National Preventive Mechanisms (NPMs) are the national component of the preventive system established by the OPCAT (Optional Protocol to the Convention against Torture). NPMs are mandated to conduct regular visits to all places where persons are deprived of liberty. These visits should lead to reports and concrete recommendations to improve the protection of persons deprived of liberty. NPMs can also make comments on laws and regulations and propose reforms¹⁵⁷. Ireland signed up to the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in 2007¹⁵⁸ but, despite reaffirming its commitment to introducing legislation in this area, limited progress has been made since 2007¹⁵⁹. While the global financial crisis and a change of government in Ireland impacted progress on Ireland's ratification of OPCAT in 2010 and 2011, the 'Inspection of Places of Detention Bill' is currently listed in the government's legislative programme as 'Publication Expected – Not possible to indicate at this stage'¹⁶⁰. The failure by successive Irish governments to ratify OPCAT and indeed adopt a National Preventive Mechanism are a threat to the protection of human rights for prisoners in Ireland, with the Irish Penal Reform Trust (IPRT) indicating that such legislation would act as a safeguard against potential inhumane treatment in places of detention in Ireland¹⁶¹.

National Monitoring Mechanisms for Prisons in Ireland

The Office of the Inspector of Prisons

The first independent Inspector of Irish Prisons was appointed by the government in 2002, with a remit to include the examining of the quality of prison regimes and the health, safety and welfare of inmates¹⁶². The Office of the Inspector of Prisons was established as an independent, statutory body under the Prisons Act (2007). The key role of the Inspector is to carry out regular inspections of prisons in Ireland, which can be announced or unannounced. The Inspector cannot investigate or adjudicate on individual prisoner complaints but can investigate the circumstances relating to a complaint where necessary. The Inspector of prisons in his reports, and indeed in his latest report (2014), indicates that the prevalence of drugs and other contraband in prisons is a matter of grave concern. In addition, the Inspector stated that he has drawn attention in various previous reports to the healthcare being provided in prisons reiterated that he has previously (and continues to) comment critically on the varying levels of such care in different prisons.¹⁶³ The Inspector of Prisons' reports on investigations into deaths occurring in prison custody reveal a number of deaths related to suspected overdose, both within prison and shortly after release from prison.

Prison Visiting Committees

Prison Visiting Committees comprise of individuals from across society, who visit the prison to which they are appointed and report to the Minister for Justice on an annual basis. Appointments are made by the Minister for Justice, and are for a period of

three years. Members of the Visiting Committee look at the quality of accommodation and the services provided to prisoners in each institution¹⁶⁴. It is noteworthy that IPRT is concerned that the Prison Visiting Committee system does not adopt a standard approach to reporting, and that the level of detail and thoroughness of reports are inconsistent between Committees. While some reports do not make specific reference to health or drug use, others do. For example, the 2013 Wheatfield report recommends that it is important that the prison authorities are aware of prisoners who have on-going conditions that may continue to develop.¹⁶⁵ It also identifies the importance of communication lines between prisoners, medical staff and the prison authorities being kept open and clear. The report identifies issues regarding a backlog in prisoners requiring the services of the psychologist. The prison also accommodates addiction counselling for inmates and the committee recommends the expansion of same. The report identifies drug use as an on-going problem in Wheatfield and advocates that the prison authorities get all the resources they require to continue their work against drugs in prison.

Irish Prison Service Prisoner Complaints Policy

The Irish Prison Service operates a complaints procedure to ensure that prisoners have an accessible and effective means of making complaints. A standard complaint form is available to all prisoners and a complaint box, to be emptied each day, is available in all prisoner accessible areas. Complaints are categorised by the Governor and subsequently addressed by specific individuals dependent on the level of severity of complaint. Complaint categories range from 'A' (assault, use of excessive force against a prisoner, discrimination etc.) to 'F' (prisoners can make complaints to IPS headquarters in relation to failure to grant temporary release, prison transfers etc.) Category D complaints relate to complaints against professionals such as dentists, doctors etc.¹⁶⁶It was not possible to access the content of complaints to ascertain if there were complaints relating to health and/or infectious diseases specifically.

Regional: The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) was established under the 1987 Council of Europe Convention. While not an investigative body, it provides a non-judicial preventive mechanism to protect persons deprived of their liberty against torture and other forms of ill treatment. It thus complements the judicial work of the European Court of Human Rights. The fifth report by the CPT in relation to Ireland was to date by far the most critical, concluding that the prison system failed to meet the most basic human rights standards of safe and humane custody¹⁶⁷. The issues pertaining to prison healthcare predominantly received serious criticism.

“This report shows a litany of broken commitments and inaction in relation to chronic problems over the past two decades. There has been a failure of

leadership to address the problems within or prisons. The bottom line is that prisoners and the general public are left with a prison system that is unacceptable and which has exposed Ireland to international shame. The next government must prioritise addressing the problems in our prisons, and commit to getting prisoner numbers down.”¹⁶⁸

To date six visits to Ireland have occurred, most recently in September 2014¹⁶⁹. During the CPT’s visit to Ireland in 2010, they identified significant human rights issues in Irish prisons. The IPRT responded in their media press release that ‘the critical issue of prison healthcare and complaints receive particularly serious censure’¹⁷⁰. In 2010 the CPT in making specific reference to health stated:

The CPT’s delegation found that the central management of prison health care services as well as the provision of the health care in at least certain individual establishments remain weak and that there was still too little synergy between the different medical specialisations. The lack of any epidemiological information on the prison population hampers the ability to evaluate prisoners’ real health needs as regards medical and nursing care. The CPT continues to consider that in order to better identify the health-care needs within the prison service, the ***compiling of an annual report on the state of the medical services in the Irish Prison Service would be beneficial*** [emphasis in original].¹⁷¹

In terms of adequate and timely access to health care, the CPT indicated that there were many cases of prisoners not receiving proper health care. This they attributed to: inadequate screening; inadequate attendance time of doctors in these establishments; absence of rigour in following up on recommendations made in hospital letters or in reviewing prisoners after their discharge from hospital back to prison; lack of follow-up of those persons with chronic diseases; and poor record keeping. In terms of infectious diseases they cite a specific incidence of a prisoner having been assaulted (bitten and stabbed) by another prisoner who was known to be Hepatitis C positive: no discussion or risk assessment was undertaken regarding post-exposure follow-up as to whether he required treatment to prevent him from becoming infected with any other blood-borne viral infections which might co-exist with hepatitis¹⁷².

V. CONCLUSIONS

- The social impact of the recession in Ireland has been devastating for individuals, families and communities. Nearly one third of Ireland's population are experiencing deprivation or poverty. Those who experience incarceration are more likely to emanate from lower socioeconomic groupings.
- The criminalisation of drug possession in Ireland has not acted as a deterrent for those involved in the illicit drugs trade in Ireland. This reflects the global failure of the 'War on Drugs.' Incarceration of mainly low-level offenders on long sentences has served to expand the prison population further.
- The link between sex work and Hepatitis C and HIV are well documented. This has implications for reception to prison upon incarceration and makes the case for routine screening of all entrants to prison. It also has implications for health care provision amongst detainees who have been sex workers.
- Prisons as settings and prisoners as a population group have been omitted from certain health policies and strategies in Ireland. There is strong representation of Irish prisons in the current National Drugs Strategy (2009 – 2016). Improvements have been made in the area of drug treatment and rehabilitation of offenders.
- The healthcare of prisoners is outside the remit of the Department of Health, with responsibility for the health and wellbeing of prisoners in the hands of the Irish Prison Service. In certain areas of healthcare, the Irish Prison Service has the opportunity to provide a health service that goes beyond that of equivalence with the community.
- Prisoners have diverse and complex health needs. Compared to general adult populations, prison populations have poorer physical, mental and social health and experience considerable social exclusion. The prison environment can further compound these inequalities, thus impacting the health and human rights of those incarcerated in Ireland.
- High prevalence rates of drug usage have been reported in international literature in relation to Irish prisons. Harm reduction measures in Irish prisons include OST and Addiction Counselling. Currently, needle exchange programmes are not available in Irish prisons, which the authors deem a violation of the principle of equivalence.
- While it was possible to access some data in relation to prevalence rates of infectious diseases in Irish prisons via published research studies, the Irish Prison Service failed to respond to a Freedom of Information request in relation to infectious diseases and monitoring procedures in Irish prisons. A study conducted in 1999 identified Hepatitis B prevalence at 9%, Hepatitis C at 37% and HIV at 2% among the prisoner population. When these statistics were disaggregated by injecting drug use, it is noteworthy that prevalence rates of Hepatitis B among IDU's were 18.5%, Hepatitis C is 81.3% and HIV is 3.5%.¹⁷³ A 2014 study identified prevalence of Hepatitis B at 0.3%, Hepatitis C at 13% and HIV at 2%.¹⁷⁴

- Ireland has yet to ratify the OPCAT, and does not have an NPM. These failures are a threat to the protection of human rights of prisoners in Ireland.
- Monitoring mechanisms for Irish prisons include the Inspector of Prisons, Prison Visiting Committees and the European CPT.

Recommendations

- There is an urgent need for national collation of data in relation to infectious disease prevalence amongst the prison population in Ireland. While such prevalence data may indeed exist, transparent access to such data is a necessity. Additionally, such data should be disaggregated along the prohibited grounds of discrimination.
- It is imperative that specific work be undertaken to challenge the current situation with regard to monitoring in Irish prisons. Information on specific screening procedures on reception to prison could not be garnered for this report, thus the authors recommend the development of a transparent operational policy for the monitoring of infectious diseases within Irish prisons.
- Given the transient nature of the prisoner population, both within the prison system and indeed upon release back to the community, there is need to ensure continuity of care. The inextricable links between the health of prisoners and communities cannot be denied, thus every attempt must be made to provide continuity of care for those diagnosed with infectious diseases.
- In order to meet the challenges of infectious diseases and ensure respect for prisoners' human rights, including the right to humane treatment and the highest attainable standard of health, expansion of current harm reduction measures in all Irish prisons, based on specific need, is recommended. While improvements in this area have been noted in this report, further efforts in the area of syringe exchange and Naloxone should be addressed. This is essential in order to meet the principle of equivalence.
- Implementation of the recommendations of the CPT is necessitated as a matter of urgency.
- Further research in the following areas is needed as a matter of urgency:
 - The health of the Irish prisoner population, including prevalence rates of infectious diseases.
 - Specific and transparent monitoring tools for infectious diseases in Irish prisons are required.
 - A survey of available health services within the Irish Prison Service, to include a needs assessment for further future expansion of such services.

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Irish Penal Reform Trust

MACRO, 1 Green Street, Dublin 7, Ireland.
www.iprt.ie

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