



Critical Social Thinking: Policy and Practice, Vol. 1, 2009

Dept. of Applied Social Studies,
University College Cork,
Ireland

Transfer of Care? A Critical Analysis of Post-Release Psychiatric Care for Prisoners in the Cork Region

Noelle Cotter, B.Soc.Sc.

Abstract

This paper presents a critical analysis of post-release psychiatric care for prisoners in the Cork region. It focuses on barriers to continuity of mental health / psychiatric care upon release from prison, specifically regarding those who have accessed mental health services whilst incarcerated. There is a severe lacuna in published material surrounding continuity of care for prisoners in Ireland; the research discussed in this paper, in some small way, attempts to address this. Based on the research undertaken, this paper argues that a lack in service provision following deinstitutionalisation in Ireland, coupled with the Irish Governments continued failure to fully implement the multi-disciplinary community care teams which were recommended in both ‘Planning for the Future’ and ‘A Vision for Change’, has led to the emergence of transinstitutionalisation within the Irish Prison System. This in itself holds serious implications for individuals with psychiatric problems. The findings show that there is little or no transfer of care from prison to the community for prisoners with psychiatric or mental health difficulties and as such, policy recommendations are considered vital in three key areas: Cork Prison, the Forensic Psychiatric Service for the Southern region, and issues relating to accommodation.

Key words/phrases:

Post-release continuity of psychiatric care; prison; deinstitutionalisation.



Introduction

Both internationally and in Ireland, the prevalence of psychiatric problems and general health difficulties within prisons is unusually high. Numerous studies and reports support this. In 2005, the National Forensic Mental Health Service (NFMHS) conducted a study into mental illness in Irish Prisons, the results of which were published in their final report 'Mental Illness in Irish Prisons: Psychiatric Morbidity in Sentenced, Remanded, and Newly Committed Prisoners'. This research confirmed that there is a high prevalence of mental illness amongst the Irish prison population. Astonishingly, this was the first systematic and representative study of mental health in the Irish prison populace, conducted using standardised research diagnostic methods. The findings of the NFMHS study support previous research carried out by Paul O' Mahony (1997), which also indicated that a large percentage of the prison population suffer with psychiatric problems and mental illness.

In March 2006, the Irish Penal Reform Trust (IPRT) submitted a report to the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) in preparation for the committee's visit to Ireland in October 2006. Regarding the issue of mental health, the IPRT expressed their concern over what they viewed to be the '*continued use of prisons to warehouse people with mental illness in vast numbers*' (IPRT, 2006:7). This is not a new criticism. The Inspector of Prisons and Places of Detention has, in many of his annual reports (2004, 2005, and 2006), been highly critical of the mental health facilities and services which operate within our prison service. In addition, a 2005 study, conducted for the Probation and Welfare Service on the association between homelessness and imprisonment (Seymour and Costello, 2005), articulated its concerns regarding the levels of mental illness amongst the Irish prison population. This study revealed that thirty five percent of homeless persons who were committed to prison at the time of the research had been diagnosed with a mental illness and two thirds of this number had been inpatients in a psychiatric institution at some time.



While there are many studies that focus on mental illness in Irish prisons, and the systematic failings in addressing this issue, there is little literature or research which concentrates exclusively on continuity of care post realise.

Methodology and Methods

A multi-theoretical framework with critical and interpretative dimensions was employed for the research. This particular approach was chosen as it is concerned with oppression, exploitation, and contradiction. It is also concerned with power relations and locating people within social structures. Critical theory holds the belief that its participants (humans) are prevented from reaching their potential, as they are somewhat alienated forms, constrained, merely actors playing their part (Sarantakos, 1993: Jenkins, 1998). It points out the importance of subjective meanings carried by actions and institutions in the social world (Outhwaite, 2005) and is associated with the work of Max Weber and Georg Simmel. Interpretive research also enables social criticism and social action. It seeks to acquire insider knowledge and is concerned with what it means to be a social actor of a particular kind and how these actors understand their situations. Most importantly, this approach was employed as it has been described as '*a theory which can have the ability to diagnose and inform change*' (May, 2001:43).

The data gathered was of a qualitative nature. Semi structured interviews were carried out with six professionals working in the area of mental health, with a view to gaining increased understanding of how precisely professionals working in various fields evaluate service provision and policy with regard to the chosen area of research.

Respondent A is employed in a homeless hostel in the southern region. Respondent B is employed by the Irish Prison Service in Cork Prison. Respondent C is a professional who works in the area of Forensic Psychiatry in the southern region. Respondents D and E are Mental Health Social Workers who work for the Court Liaison Service and the Court Diversion Scheme.

Set questions were put to all five interviewees that related to the areas in which they worked. In addition, all five respondents were asked core questions which concerned service provision and barriers in service provision. As a means to forming a comparative and comprehensive basis for the research, a broad range of literature surrounding pre- and post-release matters was reviewed, while taking into consideration examples from the UK.

To locate how and where individuals with mental health problems are to be placed upon release from prison, and where they fit into society if they wish to continue with their mental health care, this paper argues that we must first gain an insight into how professionals working within the field view the services they deliver. Investigating professional experiences of provision and access to services is essential in understanding how and why barriers occur, and where they are most prevalent. Approaching the research from this perspective permitted increased insight into the situation and made it possible to establish if there was a transfer of care from prison to the community. Utilising this approach proved invaluable in achieving the aims set out for the research.

Deinstitutionalisation

From 1847 onwards, Ireland had, according to Mark Finnane, taken a *'leading role in the foundation of asylums'* and by the early twentieth Century committal to lunatic asylums had become *'a common enough feature of Irish life'* (Finnane, 1981: 15: 129).

The improvement of committal laws in the 1940s awarded the responsibility of committal to the medical profession. Throughout the 1930s and 1940s new therapies and advancements in psychiatry occurred contributing to the downfall of the traditional asylum in Ireland (Robins, 1986:198). However, Finnane argues that the advancement which occurred in the public provision of services for the mentally ill during the nineteenth century had a *'perverse effect'*...as by the 1960s Ireland had integrated asylums into the public health care system as mental hospitals, and was reported to have one of the *'highest rates of psychiatric hospitalisation in the world'* (Finnane, 1981:222).



Critical Social Thinking: Policy and Practice, Vol. 1, 2009

During the 1960s, advances in medication allowed for individuals to be treated using anti-depressants, along with the creation of day hospitals, out-patient clinics, rehabilitation workshops and hostels, this enabled those who would have previously been in-patients in mental hospitals to live and remain in the wider community. By 1961 there were more individuals being treated as out-patients than in-patients, and 60 percent of all committals to mental hospitals at this time were on a voluntary basis. Despite this, the number of hospitalisations between 1963 and 1978 in Ireland was still two and a half times that of our neighbours in England. Robins argues that the evidence clearly indicates that Ireland had inherited *'not a high level of mental illness, but rather an excessive commitment to the mental hospital'* (Robins, 1986:198).

The establishment of Health Boards in 1970 led to improvements, not only in the general health service, by removing the responsibility from Local Authorities, but also to greater developments in the area of mental health provision. Care and provision for those who suffered from mental illness and psychiatric difficulties began to make the move from the hospital to the community. Community-based services, such as community psychiatric nursing was established. Home visits were facilitated, and if hospitalisation was required, the emphasis was on psychiatric wards in general hospitals, as opposed to mental hospitals. Developments such as these accelerated the move away from the traditional mental hospitals of years gone by, and by 1986 the demise of district mental hospitals had commenced, with the announcement that Carlow and Castlerea district mental hospitals were to close (Robins, 1986:205/207).

The aim of deinstitutionalisation was to *'prevent inappropriate mental hospital admissions through the provision of community-based alternatives for treatment; to discharge to the community all those in institutions who had been given adequate preparation for such a change; and to establish and maintain community supports for people receiving mental health services in the community'* (Bachrach, 1997 & Mental Health Commission 2006:9).



Critical Social Thinking: Policy and Practice, Vol. 1, 2009

These community based alternatives to hospitalisation have, with the help of multi-disciplinary provision, undoubtedly contributed toward society's improved view of those who have mental health/psychiatric difficulties. Forensic Mental Health Services now operate in regions throughout the country. These services are concerned with those who have mental health difficulties and have been assessed to be in need of increased expertise and in certain instances, increased levels of security. Regional Forensic Mental Health Teams are specialist multi-disciplinary teams with expert forensic training. As well as providing secure in-hospital care, their remit is to also work in the community and operate a treatment service and a continuing care and monitoring service.

While the move away from hospitalisation was a welcome development in the provision of services in Ireland and the recent creation of Regional Forensic Mental Health Service Teams is undoubtedly a huge step forward in this area, major concerns remain surrounding delivery and implementation. Dr. Susan Finnerty, Acting Inspector of Mental Health Services in 2006, refers to these concerns which relate to implementation and delivery of Mental Health Services in Ireland.

In her annual report for the same year she raised her concerns over the '*absence and deficiencies in multidisciplinary teams*' throughout the country. In addition she noted that resources to the sector appear to be allocated unevenly, on an *ad hoc* basis, with little overall planning of services in some catchments areas. The Inspector goes on to express concerns relating to the shortfall of community resources and multi-disciplinary teams, both of which she marks as essential to the successful operation and delivery of community mental health services. Commenting on the Irish mental health service the Inspector said:

'The lack of coherent overall plans for services over the next five years is worrying. The ad hoc nature of mental health provision has been noted in the past and there is no sign currently that this situation will change.'



There is genuine frustration and disillusionment from those delivering the service at their lack of information and participation in planning.

Community mental health does not work without resources. In-patient units will continue to be the first-line treatment locations, long-stay wards will not close and there will be little or no access to alternatives to medication if community mental health and other multidisciplinary teams are not resourced. It is not good enough to condemn these practices and not give those who are delivering the service the wherewithal to provide alternatives and it is not fair to service users to promote community treatment, counselling, home-based treatment and rehabilitation and then not provide these services' (Finnerty, 2006:86).

These sentiments were echoed by all six respondents in the research.

Transinstitutionalisation

All respondents to the research identified the process of deinstitutionalisation as having a contributory hand in the high levels of mental illness that are today identifiable in the Irish prison system.

Respondent A argued that in some cases Irish Prisons are now being used as a substitute for Mental Hospitals. Respondent C noted that there was a deficit in facilities upon the closure of the old Mental Hospitals which left many long-stay psychiatric patients without suitable accommodation. Respondent D also noted that although the large mental hospitals were closed, there were no provisions were made for individuals who would need treatment and containment throughout their lives. This respondent described these failings in provision as 'Transinstitutionalisation'. This refers to the deinstitutionalising of individuals with mental health difficulties from the large mental asylums and hospitals, but due the severe lack of provision of services for these individuals in the community, they find them selves contained in another institution: prison.



It was noted by four of the respondents that judges often see no other option than to send those who have psychiatric difficulties to prison if they have offended, as there are few alternatives for treatment in the community and few treatment places available.

Previously individuals with serious psychiatric difficulties and mental illness would have been committed to, or treated in, a large mental hospital. However, the purpose of deinstitutionalisation was to provide care in the community, so the hospitals and asylums were closed down. The findings of the research indicate the concept of 'Transinstitutionalisation' to be a very real problem in Irish society, and particularly within the Irish prison system. It would appear that the prison system has, in certain instances, become somewhat of a substitute for the large mental institutions of previous decades.

While Transinstitutionalisation can be attributed to failings in the provision of community services, numerous other issues emerged as significant in creating and contributing to barriers that prevent transfer of care to the community.

Early release policies in Cork Prison have a detrimental effect on those who have psychiatric difficulties and mental health problems. Early release can prevent the implementation of vital post release care plans for prisoners, as staff who have been working with the prisoner toward their release date are often not informed of the premature release. Many individuals fail to remain in the community due to the circumstances which surround their early release. Prisoners may be released early, not leaving enough time for the post release service or other services in the prison, to fully implement, or finish making the necessary arrangement for the transition of the prisoner back into the community. This can have chaotic consequences, which can often result in individual re-offending and returning to the prison system.



Whilst early release can be identified as detrimental to prisoners' outcomes, there is little or no transfer of care from prison to the community for prisoners with psychiatric or mental health difficulties to begin with, unless they are identified as having homeless issues. Lack of provision in the transferring of care from prison to the community was recognised by all five respondents as having a negative impact on the continuity process. Respondent B noted that if a prisoner is being released home and they have psychiatric difficulties, they are referred to their General Practitioner (G.P.). Their G.P. can then make provisions to refer the individual to a psychiatrist in the community. However, a consultation or appointment with a psychiatrist on the outside could take anything up to six weeks. In respondent A's opinion, people in this situation are *'very much left to their own devices'*.

In addition, a lack of a proper referral system from the prison to outside psychiatric services upon release was reported as contributing to ex prisoners with psychiatric problems having difficulties remaining in the community. Current measures, whereby a prisoner with a psychiatric problem is referred to their GP was reported to be wholly inadequate. This waiting period is a critical time for individuals with psychiatric problems/ mental illness, and is the stage post release where people are most likely to falter, re-offend, or experience increased psychiatric difficulties.

Failings in follow up procedures post-release emerged as a significant element in the breakdown of post-release continuity of care. Only extremely vulnerable individuals are easily monitored. This situation is contributing to individuals with psychiatric difficulties returning to the prison system. Also identified was a breakdown in communication between agencies and service providers surrounding the sharing of information relating to follow ups for prisoners post-release. In one example given by respondent A, the community psychiatric nurse was not aware that an ex prisoner under her care had returned to prison. It was found that if individuals with psychiatric difficulties engage with monitoring services post-release, their chances of remaining in the community are



significantly increased. However, throughout the course of the research it became clear that progress monitoring was not a priority, as professionals interviewed within all areas are working under serious resource constraints and with limited time. These factors understandably influence the amount of monitoring work that can be undertaken.

Many of the issues that contribute to a lack of transfer of care centre on policy and procedures relating to Cork prison. However, there are also factors within the wider community that pose significant problems. A short fall in appropriate accommodation and facilities for ex prisoners with psychiatric difficulties emerged as the main obstacle in the provision and continuity of post-release psychiatric care. There is little accommodation, supported or otherwise, available for single men in the community. Prison authorities have little option than to refer people to homeless hostels as a means of attaining treatment for prisoners with homeless issues who also have psychiatric difficulties, as there are few alternative routes available for post-release treatment. In addition, there is little that is accessible for those not experiencing homeless issues. All five interviewees identified a lack of appropriate accommodation as a major hindrance to those seeking continuity of psychiatric care post-release.

Perhaps one of the most obvious obstacles that creates barriers and hinders the transfer of care to the community is that of limited resources and funding. This is one of the largest obstructions to the continuity and delivery of psychiatric care for prisoners post-release. All respondents acknowledged that the current Health Service Executive embargo on recruitment was not likely to be lifted anytime soon. The issues and problems created by limited resources was a recurring theme throughout the course of the research. Professionals and services providers, both voluntary and statutory, are limited in the quality and quantity of service they can deliver because of the very real constraints imposed on them by insufficient resources. All professionals interviewed engage in very real efforts to deliver the best service they possibly can, and do so to the very best of their ability, but the data reflects serious frustrations at having to operate and deliver services, at community and individual level, under such constraints.



The National Forensic Team for the Health Service Executive South operates from Carrig Mór on the north side of Cork City. The Forensic Service works with forensic psychiatric patients, both individuals under submission orders and voluntary admissions. The Forensic Team also provide community in-reach psychiatric services. The team has been established for over two years. Carrig Mór, from where the team operate, is a twenty bed intensive psychiatric care unit, yet ten of the beds are occupied by long stay patients. This means that there are only ten active beds in operation to facilitate the areas of; North Lee, North Cork, West Cork, the Homeless Speciality Team, and County Kerry. There are few places provided for the treatment of individuals in the community. Where services are available, such as the Carrig Mór unit, beds which should be utilised to facilitate psychiatric referrals from the prison and community are occupied by long stay psychiatric patients. Resources not being utilised to their full potential, when coupled with limited funding, only intensifies the difficulties that surround transfer of care.

Conclusion

The prevalence of mental illness in Irish prisons is quite high. This is not a new revelation. If individuals who have psychiatric difficulties are incarcerated it presumed that these individuals will require continuing treatment or care upon release. But there is little or no transfer of care from prison to the community for prisoners with psychiatric or mental health difficulties, unless they are identified as being homeless. This paper argues that *transinstitutionalisation* is a very real practical experience for the people at the coalface-, namely the inmates that suffer from psychiatric problems in the Irish prison system. There are simply not enough options in the community which offer treatment to such individuals upon release. The Irish Prison system is being used as an alternative means of treatment for many individuals with psychiatric problems who find themselves in the criminal justice system. While it is acknowledged that there are few alternative choices to commitment to prison in certain circumstances, committing people to prison to attain treatment is unacceptable.

After 1970, the move away from the institution was hailed as a positive progression in mental health service provision, with community models of care being earmarked as the way forward. Policy documents from the 1980s and late 1990s reinforced the idea that care administered through multi-disciplinary teams in the community was the best form of delivery, for patients and care providers alike. But documents remain just that unless there is adequate funding and resources allocated for implementation. Barriers which prevent ex prisoners with psychiatric problems accessing services in the community will not, and can not be removed without commitment from the Government to direct policy in this area and carry out its implementation. The Current Health Service Executive embargo, when coupled with a sector which was previously under-resourced to begin with, has resulted in post release continuity of psychiatric care for ex prisoners being virtually ignored. In conclusion to the research, this paper argues that it is time for us as a society to invest in our mental health service, provide accessible and quality services in the community, and ensure transfer of care from the prison to the community. Not only would our prison population decrease, but we would no longer be failing in our duty of care to the most vulnerable members of our society.

On the basis of the above findings, the following policy recommendations are considered vital in three key areas: the Southern Forensic Psychiatric Service for the Southern region, Cork Prison, and issues relating to accommodation.

Recommendations

Recommendation 1. The Southern Forensic Service.

- Lift the current HSE embargo, as this is having a profoundly negative effect on the quality and delivery of service in all relevant sectors.
- Utilise the facilities and community in reach services which the Forensic Team provides and link these services to the needs of the prisoners in Cork Prison.
- Create a referrals system for prisoners with psychiatric difficulties from Cork Prison to Carrig Mór upon the prisoners' release.



- Provide funding for and establish appropriate accommodation, such as a hostel, for the long stay psychiatric patients who are currently being cared for in Carrig Mór. This would double the number of Forensic Service beds available for referrals from the prison and the community. At present it is not the norm that the centre would take referrals from the prison as the bed capacity is limited.
- Establish a separate hostel for the forensic referral patients who do not require in patient treatment, so that individuals may be assessed without being subjected to being behind locked doors on a ward.
- Create a separate Forensic Referrals Team to meet the forensic psychiatric needs of the general population. This second outside team would operate separately of the team based in the unit, and work with patients coming out of prison and patients that require second opinions.
- Extend the service offered by the second referrals team so its remit would include working in homeless hostels and shelters in the southern region.
- Recruit a second senior Doctor for the Forensic Team who would be based in Carrig Mór. This would allow the current Doctor to see more forensic referrals in the community.

Recommendation 2. Cork Prison.

- Provide funding so that the Post Release Service Coordinator position in Cork Prison can be approved as a statutory full time position that would deal solely with preparing prisoners for their release and helping prisoners implement their post release care plans.
- Establish a mandatory system of developing release plans which are tailored to the needs of the individual prisoner so as to enhance the person's chances of linking in with services and treatment in the community.
- Establish a pre release programme in the prison that includes in the curriculum advice and practical information regarding managing mental health problems upon release.



- Review the current early release policies in the Cork Prison so that policy will endeavour not to release prisoners early without a post release care and service plan being in place. This would provide staff in the education unit, addiction unit and post release service with a definite release date to work toward with the prisoner.
- Establish links between Cork Prison and the Forensic Team in Carrig Mor.
- Establish a referrals system directly from the prison psychiatric service to psychiatric services in the community, eliminating the current process where by prisoners with mental health problems may experience waits of up to six weeks for consultations upon release. To also establish a referrals system directly from the prison psychological services to psychological services in the community.
- Improve the current links from the prison surgery to community mental health teams, to improve the current assessment procedures and establish proper written referrals from the prison surgery and prison psychiatrist to outside services to ensure continuity of care upon release.
- Establish a follow up system which enables post release service staff in the prison to check in with prisoners who avail of the service, not just the extremely vulnerable individuals in hostels.
- Further extend prison in-reach programmes to Cork Prison, and to create extensive Court Liaison Services to work in the prison.

Recommendation 3. Accommodation.

- Provide funding for and establish (a) permanent appropriate accommodation for single men in Cork City and County, and (b) temporary transitional supported accommodation for prisoners who have psychiatric / mental health problems, so that they may adjust to living in the community and overcome this transitional period.
- Provide funding for and establish an extensive multidisciplinary team to work with individuals in the above recommended accommodations.



Critical Social Thinking: Policy and Practice, Vol. 1, 2009

- Create better links and improve communication between Cork Prison and homeless hostels in the southern region regarding prisoners and service delivery.



Bibliography

- Bachrach, L. (1997) *Deinstitutionalization: An analytical Review and sociological Perspective*. Rockville: M.D. National Institute of Mental Health, Division of Biometry and Epidemiology.
- Barham, P. (1997) *Closing the Asylums: The Mental Patient in Modern Society*. London: Penguin.
- Bryman, A. (2004) *Social Research Methods*. New York: Oxford University Press Inc.
- Butler, S. (1987) 'The Psychiatric Services: Planning for the Future, A Critique', *Administration*, Vol. 35 (1), pp 47-69.
- Carroll-Burke, P., (2000) *Colonial Discipline: The Making of the Irish Convict System*. Dublin: Four Courts Press Limited.
- Community Technical Aid (2004) '*Getting out, Staying out*'. Dublin: Community Technical Aid. Accessed at <http://www.iprt.ie> (Date visited: 20/11/2007).
- Crowley, F. (2003) *Mental Health: The Neglected Quarter*. Dublin: Amnesty International. Accessed at <http://www.amnesty.ie> (date visited: 02/02/2008).
- Cummins, I. (2006) 'A Path Not Taken: Mentally Disordered Offenders and the Criminal Justice System', *The Journal of Welfare and Family Law*, Vol. 28, No's 3/4 September-December, pp 267-281.
- Department of Health and Children (2006) *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: Stationary Office.
- Department of Justice (1985) '*Report of the Committee of Inquiry into the Penal System*'. Dublin: Stationery Office.
- Department of Justice, Equality and Law Reform (2004) *First Annual Report of the Inspector of Prisons and Places of Detention for the year 2002-2003*. Accessed at <http://www.justice.ie/publications/prisons> (Date visited: 21/11/2007).
- Department of Justice, Equality and Law Reform (2005) *Third Annual Report of the Inspector of Prisons and Places of Detention for the year 2004-2005*. Accessed at <http://www.justice.ie/publications/prisons> (Date visited: 21/11/2007).



Critical Social Thinking: Policy and Practice, Vol. 1, 2009

Department of Justice, Equality and Law Reform (2006) *Fourth Annual Report of the Inspector of Prisons and Places of Detention for the year 2005-2006*. Accessed at <http://www.justice.ie/publications/prisons> (Date visited: 21/11/2007).

Finnane, M. (1981) *Insanity in Ireland: Insanity and the Insane in Post Famine Ireland*. New Jersey: Barnes and Noble Books.

Finnerty, S. (2005) *Mental Health Commission Annual Report 2005, including the report of the Inspector of Mental Health Services*. Accessed at [http://www.mhcirl.ie/docs/annual2005/MHC_Report\(Bk1\).pdf](http://www.mhcirl.ie/docs/annual2005/MHC_Report(Bk1).pdf) (date visited: 16/0/2008).

Finnerty, S. (2006) *Mental Health Commission Annual Report 2006, including the report of the Inspector of Mental Health Services*. Accessed at <http://www.mhcirl.ie/docs/Books1-6.pdf> (date visited: 16/02/2008).

Hunter, R. (Ed) (1968) *The Construction and Governance of Lunatic Asylums: John Connolly*. London: Dawson's of Pall Mall.

Irish Examiner (2008) 'Man hired to slash HSE wages gets 1m contract' in *The Irish Examiner* 22/03/2008. Accessed at <http://www.archives.tmc.ie> (date visited: 24/03/2008).

IPRT (2006) *Submission of the Irish Penal Reform Trust to the European Committee for Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) in preparation for the 2006 CPT visit to Ireland*. Accessed at <http://www.iprt.ie/iprt/1862> (date visited: 08/02/2008).

Irish Health (24/01/2008) 'Government Failing Mental Health-MHC', in *Irish Mental Health*, Accessed at <http://www.irishhealth.com> (date visited: 18/02/2008).

Irish Prison Service (2006) *Irish Prison Service Annual Report 2005*. Accessed at <http://www.irishprisons.ie/publicationsItem.asp?pubID=28> (date visited: 13/02/2008).

Kennedy, H.G. (2005) *Mental Illness in Irish Prisons: Psychiatric Morbidity in Sentenced, Remanded, and Newly Committed Prisoners*. Accessed at <http://www.wrtdf.ie/downloads/2005-mental-illness-irish-prisoners.pdf> (date visited: 02/02/2008).

Kvale, S. (2006) *Interviews: an introduction to qualitative research interviewing*. Thousand Oaks, California: Sage.



- Lincon, Y.S. (2002) 'Emerging Criteria for Quality in Qualitative and Interpretative Research' in Denzin, N, *The Qualitative Inquiry Reader*. California: Sage Publications Limited, pp 327 – 346.
- May, T., (2001) *Social Research: Issues, Methods and Process*. Berkshire: Open University Press.
- McFadyen, I. (1999) 'Safe, sound and supportive: forensic mental health services', *British Journal of Nursing*, Vol. 8, no 21, pp 1436-1440.
- Mental Health Commission (2006a) *Multi-disciplinary Team Working: From Theory to Practise*. Dublin: The Mental Health Commission. Accessed at <http://www.mhcirl.ie> (date visited: 16/02/2008).
- Mental Health Commission (2006b) *Forensic Mental Health Services for Adults in Ireland*. Dublin: The Mental Health Commission. Accessed at <http://www.mhcirl.ie> (date visited: 16/02/2008).
- Mental Health Ireland (2007) *One Year on from A Vision for Change*. Accessed at <http://mentalhealthireland.ie> (date visited: 15/02/2008).
- Mind (2003) *Mental Health and Social Exclusion: The Mind Response*. London: Mind. Accessed at <http://www.mind.org.uk/NR/rdonlyres/85776B32-5381-46CF-8CEE-F5A5BCAA2C84/0/mentalhealthandsocialexclusionSept2003.pdf> (date visited: 14/02/2008).
- Neary, M. (2002) Director-General of Her Majesties Prison Service, at the British Institute of Human Rights. 2002.
- NESF (2002) *Re-integration of Prisoners: Forum Report No 22*. Dublin: The National Economic and Social Forum.
- Norman, B. (2000) *Designing Social Research*. Cambridge: Polity Press.
- O'Brien, P. (1998) 'The Prison on the Continent: Europe 1865-1965' in Morris, N., & Rothman, D.J., (Ed's) *The Oxford History of the Prison: The Practice of Punishment in Western Society*. New York: Oxford University Press, pp 176-201.
- O' Loingsigh, G., (2004) *Getting Out, Staying Out*. Dublin: Community Technical Aid. Accessed at <http://www.expac.ie/textfiles/Get.pdf> (date visited: 12/12/2007).



Critical Social Thinking: Policy and Practice, Vol. 1, 2009

- O'Mahony, P. (1997) *'Mountjoy Prisoners; A Sociological and Criminological Profile'*. Dublin: Stationery Office
- Outhwaite, W. (2005) 'Interpretivism and Interactionism', in Harrington, A. *Modern Social Theory, An Introduction*. New York: Oxford University Press, pp 110-132.
- Owens, A. (2007) *The Mental Health of Prisoners: A Thematic Review of the Care and Support of Prisoners with Mental Health Needs*. London: HM Inspectorate of Prisons. Accessed at <http://www.inspectorates.homeoffice.gov.uk> (date visited: 03/01/2008).
- Quinn, M. (1990) *Qualitative Evaluation and Research Methods*. California: Sage Publications Limited.
- Robertson, G., Pearson, J., and Gibb, R. (1995) *Entry of Mentally Ill People into the Criminal Justice System*. London: Home Office.
- Robertson, G. (1988) 'Arrest Patterns among Mentally Disordered Offenders', *British Journal of Psychiatry*, Vol. 153, pp 113-116.
- Robins, J., (1986) *Fools and Mad: A History of the Insane in Ireland*. Dublin: The Institute of Public Administration.
- Rogers, A. (2003) *Mental Health and Inequality*. New York: Palgrave and Macmillan.
- Seymour, M. and Costello, L. (2005) *A study of the number, profiles and progression routes of homeless persons appearing before the courts and in custody*. Dublin: Centre for Social and Education Research.
- Social Exclusion Unit (2006) *Mental Health and Criminal Justice: Fact Sheet No. 10*. London: The Office of the Deputy Prime Minister. Accessed at <http://www.cabinetoffice.gov.uk> (date visited: 04/01/2008).
- The Department of Health and Children (2001) *The Mental Health Act*. Dublin: Stationery Office. Accessed at <http://www.dohc.ie/legislation/acts/?year=2001&number=25> (date visited: 19/02/2008).
- The Irish Penal Reform Trust (2001) *'Out of Sight, Out of Mind: Solitary Confinement of Mentally Ill Prisoners'* Dublin: IPRT. Accessed at <http://www.iprt.ie> (Date visited: 21/12 2007)



Critical Social Thinking: Policy and Practice, Vol. 1, 2009

The Mental Health Commission (2008) *Your Guide to the Mental Health Act 2001*.

Accessed at <http://www.mhcirl.ie/acthome.htm> (date visited: 19/02/2008).

Teplin, L. A. (1984) 'Criminalising mental disorder: The comparative arrest rate of the mentally ill', *American Psychologist*. Vol. 39, No. 7, pp. 794-803.

Walker, N. (1991) *Why Punish? Theories of Punishment Reassessed*. Oxford: Oxford University Press.