Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

# OFFICIAL REPORT
(Hansard)

## Inspection of Prison Healthcare: Hydebank Wood Young Offenders' Centre and Ash House Women's Prison

19 October 2011

**NORTHERN IRELAND ASSEMBLY**

# COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

## Inspection of Prison Healthcare: Hydebank Wood Young Offenders' Centre and Ash House Women's Prison

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**Members present for all or part of the proceedings:**
Ms Michelle Gildernew (Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Mr Mark H Durkan
Mr Sam Gardiner
Ms Pam Lewis
Mr Kieran McCarthy

**Witnesses:**

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|---|---|---|
| Ms Catherine Daly | ) | Department of Health, Social Services and Public Safety |
| Mr Michael Williamson | ) | |
| Ms Mary Hinds | ) | Health and Social Care Board |
| Mr Desmond Bannon | ) | South Eastern Health and Social Care Trust |

**The Chairperson:**

Catherine, it is good to see you again: there is no rest for the wicked today. How are you, Mary? Desmond and Michael, it is good to see you. We heard from the Regulation and Quality

Improvement Authority (RQIA) for about 45 minutes on the 113 recommendations. I think that you are going to make a short presentation, and a number of members have indicated that they have questions. I will open the meeting to the Floor, and then I will ask a number of questions. Who is kicking off?

**Ms Catherine Daly (Department of Health, Social Services and Public Safety):**

I will kick off with quick introductions. The team today is: Michael Williamson, from the policy area in the Department; Dessie Bannon, director of adult services with responsibility for mental health services, disability services and prison healthcare in the South Eastern Health and Social Care Trust; and Mary Hinds, director of nursing and allied health professionals with responsibility for prisoners and palliative care. Chair, if you are happy, Dessie will give the presentation and then we will all be happy to take any questions.

**The Chairperson:**

OK. Thanks a million, Catherine.

**Mr Desmond Bannon (South Eastern Health and Social Care Trust):**

I thank the Committee for the invitation this afternoon. I want to talk a bit about the context of prison healthcare, some issues that we have found since the transfer, some of the work that we have been trying to do to improve prisoner healthcare and some of the plans for the future.

The transfer of healthcare from the Northern Ireland Office (NIO) to Health and Personal Social Services (HPSS) was completed in April 2008. It was based on a partnership agreement between the Northern Ireland Prison Service, the South Eastern Health and Social Care Trust, the commissioner of services, and the Department. The national policy that lay behind the transfer of prisoner healthcare to the NHS was developed around 2005. It aimed to achieve healthcare delivery in prisons equivalent to that delivered to citizens in the community — that is, to a primary care level, with referral to secondary care services in the community as and when required.

The outworking of the partnership has uncovered some particular challenges relating to the overall responsibility for healthcare and governance in prisons; the employment of healthcare staff by the prison services; employees' terms and conditions; codes of conduct, responsibility and accountability; the extant policies, procedures and protocols; and the level of service

provided to prisoners, particularly vulnerable prisoners, women and young people.

The current model significantly inhibits the trust's ability to manage the healthcare services effectively. No operational or management healthcare staff in any of the prisons are employed by the trust. That significantly reduces our ability to manage staff practice and ensure good governance. However, we have been working closely with staff, the Northern Ireland Prison Service and its staff-side representatives to encourage staff to transfer to trust terms and conditions. A working group is taking forward that important piece of work, and we anticipate the successful transfer of staff to the trust by 1 April 2012.

I will now talk about some of the issues in relation to prisoner healthcare and case mix. Imprisoning someone is not a neutral act. Many prisoners suffer from anxiety, depression, personality disorders and serious mental illness. Suicidal ideation and self-harm are prevalent, and providing care and treatment in a correctional environment is challenging. The board's commissioning intent highlights significant need, particularly in relation to mental health.

Up to 5,000 prisoners, including sentenced and remand prisoners, use healthcare services each year. The following figures outline the high level of need. Some 1,000 prisoners will have a personality disorder; 130 prisoners will have a psychosis; 750 will have some form of neurosis; 12 prisoners will have tried to kill themselves in the past seven days; 110 will have thought about that within the past seven days; around 160 prisoners will have tried to kill themselves in the past year; 712 people will have an addiction; and 545, separate to that, will also have an addiction, alcohol and drug problems.

As indicated earlier, the workforce capacity review indicates that the level of need cannot be met by the current staff establishment. Therefore, a workforce plan is being developed and will be submitted to our commissioners in due course. Many reports on providing treatment in a custodial setting highlight the particular difficulties there are in providing care and treatment for personality disorders, particularly for people with challenging behaviour. The very nature of a personality disorder alienates people from social groupings and societal norms. Specific regimes to manage the more serious personality disorders need to be in place to provide a therapeutic environment. No such facility exists in Northern Ireland. The Bamford review highlighted that gap in service provision, and the consequences of it are that staff are being asked to manage the most difficult and dangerous of prisoners in an inadequate setting. Staff who should be delivering

primary care and other services are being drawn into managing crises, thereby affecting and potentially destabilising the delivery of healthcare across the prison sector.

Many of our young offenders have a significant history of challenging behaviour, and staff do their best to provide treatment and support, but that is not sufficient. The trust has submitted a bid to our commissioners to enhance child and adolescent psychiatry services in prison healthcare. The 'Prison Health Performance Indicators' document states that the national quality and outcomes framework standards should be met in relation to secondary prevention of coronary heart disease; hypertension; diabetes; chronic obstructive disorder; pulmonary disease; epilepsy; hyperthyroidism; asthma; chronic kidney disease; obesity; and smoking. At present, management of prisoners with those conditions is reactive and ad hoc. That is due to a combination of our staffing levels and the time-consuming process of managing medicines. It is envisaged that, to meet agreed standards, a proactive approach should be adopted in the form of regular chronic disease management clinics and evidence-based health promotion sessions. In Maghaberry at present, we have 10 prisoners with palliative care needs. We also have nurses with previous experience and a particular interest in that area of care. We need to release the nurses to give them time to care for the people they wish to care for.

Many inmates across the three prisons receive prescribed medication. In many cases, the drugs they take are for sedative or tranquilising effects rather than for addressing physical ailments. Attempts to manage that in a clinical manner are received with hostility. More than 90% of the complaints received by the trust relate to medicines management. Additionally, the administration of medicines to such a large population in a security focused environment is very time consuming for professional staff and, given the levels of healthcare staffing, it is difficult for us to comply with best practice sometimes. On occasions, up to 60% of nursing time can be taken up by the administration of medicines.

A high percentage of our prisoners have a history of alcohol and drug misuse, and prison is not a drug-free environment. Indeed, some of our youngest prisoners move on to harder drugs in prison to help them to escape detection while they are in prison. Prisoners due for release are at a high risk of overdose on discharge from prison, and many of the drugs smuggled into prison are very dangerous compounds. More work needs to be done to promote harm minimisation.

In relation to learning disability services, many prisoners come from the most deprived

sections of society and there are high levels of illiteracy and a number of prisoners with low IQ. To date, we have no learning disability services in prisons. The trust is conducting a needs assessment exercise in that regard, using a learning disability screening questionnaire which will inform our workforce plan.

Ethnic minorities are also becoming a more significant work within prisons, and much work has been undertaken by the Prison Service to promote diversity. We believe that, in healthcare, we can further contribute to the creation of a culture of diversity.

All of the above issues contribute to a range of adverse outcomes, such as: increased drug dependency; higher levels of mental health problems and suicide both within and post prison; repeat offending and subsequent readmission to prison; and lower levels of reintegration into society.

The trust welcomes the RQIA report and is implementing many of its recommendations. However, it is important for members to understand the programme of transformational change on which the trust has already embarked. Our key priorities have been: to develop the prison healthcare strategy; to develop a strong working partnership with the Northern Ireland Prison Service; to strengthen our governance arrangements; to develop a culture of continuous service improvement; to develop in partnership with the Prison Service; to grow a culture of caring; strengthen multidisciplinary working and introduce skill mix; to make best use of our current resources and to make bids for additional resource; to improve medicines management; and to develop new and appropriate services.

The trust has been proactive in working towards those goals. We have appointed additional nursing staff to assist in medicines management and to begin in-reach mental health services. We have trained pharmacy assistants to support the issuing of medicines, thereby freeing nursing time to develop primary care and mental health services. We have appointed additional forensic and consultant psychiatry in Maghaberry and in Hydebank Wood. We have appointed discharge co-ordinators to ensure good connectivity and ongoing care and treatment in the community across the prisons establishments. We have appointed a clinical lead in primary care to drive forward the development of primary care services and medicines management. We have awarded the pharmacy contract to a new provider and appointed a lead pharmacist in the trust to support good governance in medicines management. We have put in place a new nursing line-management

structure to take forward individualised care planning, supervision and improved accountability. This new structure will ensure that professional practice is of an acceptable standard.

We have also appointed an audit facilitator and a service improvement lead. We have transferred prison healthcare IT systems to a trust platform to allow for better use, and management, of information. We awarded the addictions contract to Opportunity Youth. That allows us to provide better services to prisoners with drug and alcohol addiction problems across the prisons establishment, including Hydebank Wood. We have appointed additional addiction specialist nurses across the prison sector, and we recently advertised for an addictions nurse for Hydebank Wood. We have also appointed an occupational therapist for Hydebank Wood, who will take up that post on 5 December 2011. We have developed substitute prescribing services led by an experienced consultant in addiction services.

We are working in partnership with the prison services, and the trust has appointed a senior trainer to take forward work on developing a culture of care through safer custody and a range of training programmes, including basic life support and mandatory training. We have introduced a performance management system that is based on national offender management scheme performance indicators. That was first piloted in Maghaberry, where we found significant gaps in performance. Following audit, an action plan was put in place. A further audit showed significant improvement, and when benchmarked against the top eight high-security prisons in the UK, Maghaberry was in the top three. That audit is now being applied to Hydebank Wood and Magilligan prisons.

The trust submitted a successful bid to our commissioner for resources to deal with personality disorders, and we will formally open the Donard day facility in Maghaberry in November. That programme, which cares for the most vulnerable in prison, has the potential to radically change the model for service provision in prisons. If it is successful, we will look to develop a similar model in Hydebank Wood.

In partnership with the prison service, the trust has completed a demand and capacity exercise in Hydebank to inform the development of a model of nursing workforce. Early outcomes indicate to us that there is the potential for improved productivity through additional training-skill mix and the reorganisation of some of our systems and processes. It also indicated a deficit in mental health learning disability, child and adolescent mental health and addiction services in

relation to the needs of the prison population.

The trust is developing a strategy which may require significant investment in healthcare and the development of a range of partnerships to develop address such a high level of need.

**The Chairperson:**

May I stop you there, Dessie? Have you much more to go? I am conscious that members want to ask questions.

**Mr Bannon:**

I have two pages; about 15 minutes.

**The Chairperson:**

We will stop it there, if we may, and perhaps you will provide members with copies of the written submission.

**Mr Brady:**

I am sorry, but I have to go to another meeting. Thanks for the presentation. One of the things that you highlighted, and it was mentioned in the previous presentation, is the lack of designated care professionals in the prison system. You said that a lot of youngsters have challenging behavioural problems and that the specialists who deal with those problems were not there. Prison staff are there for a particular purpose. Addressing that problem is a step forward. The appointment of a consultant forensic psychiatrist was also mentioned, and that is a big step in dealing with particular issues. There seems to be a disproportionately large divide between what prison staff have to do and the role of the healthcare professionals who are coming in, such as nurses, who are under pressure, and pharmacists, who deal with specific issues — you mentioned that there was a lot of drug abuse in prison. That needs to be addressed, because the RQIA report found that one of the big issues was drugs, such as diazepam and cannabis. People get addicted, particularly to diazepam, and have to be weaned off. It is almost —

**Mr Bannon:**

A vicious circle.

**Mr Brady:**

— a cycle that obviously needs to be addressed to bring the thing forward at all.

The suggestions made are and will be beneficial, but is there a time frame for this? We are failing young people in the system at the moment. Hydebank deals with youngsters who are sentenced to four years or less. By the time that this is up and running, I presume that they will have gone through the system and, as you said, may be on harder drugs and out again. That leads to the vicious circle of recidivism and them, perhaps, coming back into the system.

**Mr Bannon:**

Our new psychiatrist will take up post on 2 December, and our addictions nurse will be in post before the end of this financial year. The forensic psychiatrist Dr Ian Bownes, who currently works half time for the trust, will be working full time for the trust by the end of November.

**Mr Brady:**

That is all happening very quickly.

**Mr Bannon:**

Our lead pharmacist is in place and is already working with us on rewriting policy to ensure that medicines management is appropriately dealt with and targeted. We are very sensitive to patients and patient need because many people are coming into prison already taking benzodiazepines and other drugs.

**Mr Brady:**

We said earlier that if the proper infrastructure were in place for young people with mental health problems, a proportionate number of them would probably not have to go into prison.

Sometimes, you get the impression that drugs are prescribed because it might be too much trouble not to prescribe them. Maybe that is something that you are going to look at.

**Mr Bannon:**

That is what we are saying. Many of the complaints that come through to the trust are about us trying to manage that difficult situation.

**Mr Brady:**

We need to get to the core of the problem; address the reasons why people need those drugs, and cut back on them, therefore saving time and trouble. Again, I apologise that I have to leave.

**Mr Dunne:**

I have a few points. I understand that the audit inspection was done in March, but when did you get sight of the report?

**Mr Bannon:**

We got sight of the first draft about two months ago.

**Mr Dunne:**

I understand that the inspection carried out by the RQIA is the first of its type. The chief executive's foreword in the report states:

"This change programme is incomplete. It needs a sustained commitment from policy leads, commissioners and service providers if it is to realise the benefits intended from the change process."

Do you agree that that is part of the weakness in the whole organisation? There are 113 recommendations in the report, which is quite alarming. I appreciate that some of them are probably observations and that others need immediate action; and you went through a whole list of issues, which are actions that you have already responded on. However, to me, an organisation needs to have standards. Do you feel that the staff in the organisation who are responsible for the healthcare side fully understand the standards and have had proper training, etc, to have a real grasp of what is required? I appreciate that this is a change process and that this report is probably drastic — the phrase "over the top" might be too strong — and is probably a bit premature for the stage that you are at. Is that fair?

**Ms Mary Hinds (Health and Social Care Board):**

I will give Dessie a break and then he can join in. I represent the commissioners, so I will give you some reassurance. We have 12 commissioning service teams, and one of them has been designed and set up specifically to look after prison health because we recognise that it is a priority and that a significant amount of action has to be taken. You are absolutely right that we are going through a transition period in which the service is sitting in the South Eastern Health and Social Care Trust whereas the staff are employed by another organisation. That makes change and transition quite complex.

**Mr Dunne:**

It sounds like a risk area.

**Ms Hinds:**

It is very challenging for everybody, but there is a partnership board. The Northern Ireland Prison Service sits alongside the trust and the commissioners, so there is a sense of partnership working to get to the nub of some of the issues. Dessie described some of the actions that have been taken in the interim to try to move that on. People who work in healthcare in prisons want to do the right thing by those whom they care for, but they have worked in what could be described as a closeted environment, and it is very easy for any professional to get slightly disconnected from their professional practice working in that type of environment.

The role that the nurses and staff have taken on, which Dessie can describe better than I ever could, is partly clinical and partly discipline. Moving to an environment in which the focus is entirely on clinical, which is what they should be doing, will be challenging. Dessie and the team have set up a robust senior nursing structure, albeit that, currently, they do not manage the nurses directly. We can already see a difference in the professional practice of the staff on the ground and in their interactions with prisoners and with one another.

Members know better than me that we do not have a bottomless pit of resources. However, we do provide limited resources to support training and development, particularly in practice development where nursing is concerned, to get nurses to recapture professional pride, experience and access to training to which they may not have had access before.

Catherine will probably agree that there is willingness at policy, commissioner, trust, executive and chief executive levels and in the Prison Service to try to make it better. You are right: this is hugely complex. We have to try to bring everybody with us, and we have to try to keep the focus on prisoners and their health rather than on institutions or professionals. It is easy to get sidelined to both of those.

**Mr Bannon:**

There were very good reasons transferring healthcare from the Northern Ireland Prison Service, and the prison service generally, to the NHS. It was found that people who worked in closed

institutions were falling behind in professional practice. They were not keeping up to date with new training, new methods and new forms of care. People with mental health problems were particularly falling behind with respect to services. Women and children's services were underdeveloped. The same applied to medicine, not only nursing. There was a strong drive to reintegrate with the NHS, where staff would be exposed to professional standards and where we could bring influence to bear and improve the level of service and people's esteem. As Mary said, prison staff were fulfilling two roles; a nursing one and a security one. Clearly, as staff transfer to the trust, they will work purely in a healthcare role, which will allow us to address many of the deficits that we have already outlined.

**Mr Dunne:**

I take it that you have a plan. You mentioned something about an action plan to deal with all of these issues.

**Mr Bannon:**

Each service improvement board has a significant action plan, with objectives, dates and named individuals. They are held to account through the organisation's performance framework, of which the chief executive is part. We meet every month to review progress and see how we are doing against a range of objectives across 18 workstreams, including mental health services, performance, governance, primary care, medicines management, health promotion and community development.

**Mr Dunne:**

Is there an internal audit review team?

**Mr Bannon:**

As I mentioned in the presentation, the national offender management scheme has a performance indicator framework that is used across all of the prisons. There are 32 standards that range across primary care, mental health services, health promotion, community development, addictions, governance and performance. The scheme measures across that whole range of indices. We applied the first audit in Maghaberry. We audited again, and we got an external auditor to benchmark that against the rest of the UK. As I said in the presentation, we want to have a continuous improvement strategy, so we need to continually benchmark ourselves against others to see whether we are getting better. The re-audit showed significant improvement in

Maghaberry. We still have some way to go, but improvement had been made. We have now done the same in Hydebank Wood and in the women's prison. Action plans are being drawn up to improve that. We will then benchmark against similar prisons in the rest of the United Kingdom. We are looking for continuous improvement. That will be done annually. We have appointed an audit facilitator as part of our service improvement drive so that that type of process is built into our annual cycle of work.

**Mr McCarthy:**

When responsibility was transferred from the NIO in April 2008, did the funding come with it?

**Mr Bannon:**

Yes.

**Mr McCarthy:**

There is no excuse then. You should be able to provide everything that was there previously. I thought that you were going to say that it did not, but there you go.

**Ms Hinds:**

Funding did come over, and it did so over a period of time; it did not come all at once. I should not leave this room without reminding everybody that our mental health services are underfunded. We know that, and it is reflected in the Prison Service. Dessie and the team are making sure that every penny that goes into healthcare in prisons is used productively for healthcare. You only had to listen to the list of appointments that Dessie said he had made with modest investment to know that. Through colleagues in the Department and the commissioning teams, he has managed to make a big difference. That is about refocusing the work that the staff are doing and concentrating on the work that the staff should be prioritising: healthcare.

We are trying to make the best of the resources that we have. Dessie referred to the fact that his team has submitted a bid for child and adolescent mental health services, which has been supported by the commissioner. We are trying to find the resources. We do not have a golden pot, but we are working with colleagues to try to prioritise that bid. We expect another bid from the trust at some point, but the trust is working well to give us that bid at the appropriate time and in the appropriate way. Throwing money at anything will not fix it. So we have to work with the staff that we have — they are talented and committed individuals — maximise their contribution

to healthcare in the prisons and then look for the gaps.

**Mr McCarthy:**

The witnesses in the previous evidence session told us that only 50% of the recommendations from the 2007 review were fulfilled, which is a rather low rate. Do you expect to do better with this review?

**Mr Bannon:**

Yes; we will work hard to implement all the recommendations.

**Mr McCarthy:**

I wish you all the best.

**Mr Gardiner:**

Do you have sufficient funding for medical care?

**Ms Hinds:**

It is a package of funding for medical, nursing, pharmacy, and so forth. At times, there has perhaps been an emphasis on a medical model when such a model is not required. Remember: we are providing primary-care-based services, and there are many roles to which pharmacies, occupational therapists, physios, nurses and others can contribute. The team is looking at the current provision of medical services in the prisons as part of the overall workforce plan. It is not just about nursing; it is about the total package.

**Mr Gardiner:**

I am not just talking about nursing; I am talking about the medication that you administer to the prisoners. Do you have sufficient funding for that? Are you up to date?

**Ms Hinds:**

Yes.

**Mr Gardiner:**

I have worked with people in that situation: they can be high at times and, as you probably know, very depressed at other times.

**Mr Bannon:**

When responsibility for prisoner healthcare transferred to the South Eastern Trust, we had a contract with the private sector. We thought that there were efficiencies that we could deliver. We re-tendered that contract and delivered some efficiencies, which allowed us to employ a pharmacist. With other efficiencies from other programmes, we were able to appoint a primary care lead. So we are coming at the issue from two sides. The primary care lead will ensure that the prescription processes are right and proper and that the medicines that are being administered are appropriate. On the other side, the pharmacist will make sure that our processes and policies are correct for the administration of medicines, that we get best value from taxpayers' money and that we try to work with prisoners to reduce their dependence on drugs. That is why we are trying to develop day facilities in Donard. If we can have therapeutic activity, diversional therapy, cognitive behavioural therapy and other methods that ease prisoners' anxieties and depressions and treats their illness, that is much better than giving them a tablet.

**Mr Gardiner:**

I appreciate that. However, you can appreciate that prisons can be very depressing. Some people need medication and may have been on medication before they were admitted. Are you guaranteeing that medication will be provided if it is required?

**Mr Bannon:**

Absolutely; yes.

**The Chairperson:**

Mary, I am disappointed to hear you say that there is not a pot of money that you can tap into. About three months ago, Raymond McCartney asked a question in the Assembly that made the Minister aware of the large numbers of prisoners who are on medication. Now that the Minister is aware of the issue, I had hoped that he would have bid for a pot of money in the October monitoring round to help to make that transition better and to reduce the high percentage of prisoners who are on medication. From reading the report, it is good to know that cognitive behavioural therapies and other methods to keep people busy and keep their minds active are being considered.

However, there is a lack of access to exercise, fresh air and time in the gym. Desmond talked

about obesity, diabetes and pulmonary heart conditions. Exercise and a good diet are big factors in keeping those conditions under control. We should not have to wait until people are so sick that they need to be medicated. We want prevention across the board, including prisons. Putting additional gym equipment in each facility is a no-brainer, and it would help people to exercise. Has any work been done to find out how much capital money would be needed to correct the regime in prisons so that people have access to such facilities, or is there a ballpark amount of money that you would need now that the transition has been made to health and social care? What would you do if there were a pot of money, and how much would you need to benefit prisoners?

**Mr Bannon:**

There are significant gym facilities in the prisons. However, it is a matter of ensuring that prisoners can access those facilities. We work closely with the Northern Ireland Prison Service, and it is embarking on its strategic efficiency and effectiveness programme. Clearly, it wants to affect significant change.

**The Chairperson:**

Why are there access issues? Does it relate to supervision in the gym and the staff not being there to do that?

**Mr Bannon:**

Yes. By and large, those functions sit with the Northern Ireland Prison Service. Sometimes, the prisons are locked down, and consequently prisoners do not have access. We work with our colleagues in the Northern Ireland Prison Service to try to ensure, when it is feasible and possible, that people do have access to such facilities. Through Mary, we have secured £125,000 for next year to allow us to invest in health promotion and community development activity, so we will be turning our minds to more of that in the coming year.

**The Chairperson:**

Do you have access to the reasons for the lockdowns?

**Mr Bannon:**

It is usually because there has been a violent incident, a drug issue or a security issue. It is usually security-based.

**The Chairperson:**

As Mickey pointed out to the RQIA representatives, sometimes the only way a young man can get attention is to wreck his cell. Again, there is a circle of actions. If people are frustrated because they cannot get access to the help that they need in the prison, they take action, which results in a lockdown. Preventative measures should be put in place to ensure that those actions do not happen in the first place.

How well do you work with the Prison Officers' Association (POA) or the representative body? Obviously, its members will have to work better with health professionals if the regime is to change.

**Mr Bannon:**

We have been working closely with the Prison Officers' Association. When the transfer of healthcare first took place, we were not in a position for healthcare staff to transfer. We would have liked that to happen at that time. We have been working with the Northern Ireland Prison Service, the Prison Officers' Association and staff on the ground to work through those relationships and to try to ensure that we and the healthcare staff who transferred to us can devote all our time to the delivery of healthcare.

We are also working with the wider prison system. As I said earlier, we have appointed a joint trainer who trains not only our healthcare staff but the prison staff to develop a culture of care. Probably one of the most striking things that you will see in prison is a phenomenon called "malignant alienation". When prisoners are acting out and wrecking their cells, a reaction of enforcement and alienation simply perpetuates that behaviour. We have been working with prisoners and prison officers. Recently, we trained a core of prison officers who are working with us in the new Donard facility. In the past few weeks, there was an incident in which a prisoner became unsettled and his behaviour was challenging. The prison officers managed to de-escalate the situation and talk him down. Subsequently, we reviewed the incident. The prison officers said that, six months ago, they would have downed him.

**The Chairperson:**

They were able to deal with it through the proper training.

**Mr Bannon:**

For me, that is the start of a culture of change. It is the start of a culture of care in which, through training, development and example, some very challenging behaviours can be managed in a different way.

**The Chairperson:**

Desmond, you mentioned that an addictions nurse would be in place by the end of the financial year. Is that not a wee bit far away? Why will it take —

**Mr Bannon:**

It takes time to recruit and, sometimes, to get through security. It takes a little longer to recruit staff in the Prison Service than it does, I suppose, in the NHS. That person will be our third addictions nurse. He or she will be very welcome to help us to deal with some of the issues that you mentioned with regard to drug dependence.

**The Chairperson:**

We would be very keen to see all of you working with the RQIA to implement all of its 113 recommendations. We would be interested in visiting the jail to see how that process is moving on. It is a welcome step that the Department of Health, Social Services and Public Safety is involved in providing healthcare for some of our most vulnerable young people and women. Certainly, a constituent of mine in Maghaberry prison has difficulty even accessing drugs for his heart condition. I generally take those issues straight to David Ford as and when they happen. The level of accountability is bound to improve now. We would be very anxious that people in the criminal justice system, many of whom are there because of mental health issues and conditions such as bipolar disorder, are dealt with in the same way as others. We are not here to demonise people in the system. We are here to help to protect them. We want measures taken throughout the Department to ensure that people in the criminal justice system are not left behind when it comes to developing legislation, and so forth. We are keen to work with you on that issue. We will watch closely to see how you are getting on. Thanks a million.