

Mental Illness: The Neglected Quarter

*A report by Amnesty International (Irish Section)
Promoting the rights of the one in four people affected by
mental illness in Ireland*

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*Compiled by Fiona Crowley, Policy Officer
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Preface

How many times have we heard the plea: *"If only we had known...."* Such an excuse is now no longer tenable.

Throughout the world, people with mental illness, from depression to schizophrenia, are regularly consigned to a life of discrimination. The chronic shortage of resources includes a serious lack of trained staff, and few avenues of complaint for violations against this most vulnerable and marginalised segment of society. The right to good mental health care should not be a neglected right.

Here in Ireland we have known about the problems in the mental health care area for many years. What is most striking is the extent to which reviews, reports and strategies have never been adequately or comprehensively implemented.

That is why Amnesty International is adding our campaigning voice to all those who have been fighting this cause for so long.

Countless individuals and organisations assisted us in our preparation for this report, but are too many to name. They know who they are, and they know that we are grateful. We are particularly indebted to our advisory group, Edward Boyne, Dr Justin Brophy, Christina Burke, Conor Power, and John Saunders who provided invaluable expertise and direction.

I recall what Gabor Gombos, the Hungarian mental health rights activist, says:

"I remind myself that many of the mistakes in mental health care come from a helping attitude. But they want to help you without asking you, without understanding you, without involving you, 'in your best interest.'"

Seán Love
Director
Amnesty International (Irish Section)
2003

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INTRODUCTION

“One in four people in the world will be affected by mental or neurological disorders at some point in their lives. Around 450 million people currently suffer from such conditions, placing mental disorders among the leading causes of ill-health and disability worldwide.

Treatments are available, but nearly two-thirds of people with a known mental disorder never seek help from a health professional. Stigma, discrimination and neglect prevent care and treatment from reaching people with mental disorders... Where there is neglect, there is little or no understanding. Where there is no understanding, there is neglect.”

World Health Organisation (WHO) Press Release
28 September 2001¹

Background

Amnesty International is concerned at the inattention paid by the Government of the Republic of Ireland (Ireland) to a series of national and international reports critical of its failure to fully respect the human rights of people with mental illness.²

Much progress has, of course, been achieved in the Irish mental health services in recent years. For centuries, in Ireland as throughout much of the world, people with mental illness were separated from the rest of society and placed for long periods in large institutions with little or no treatment, or worse, with radical and dangerous

¹ ‘The World Health Report 2001: Mental Disorders Affect One In Four People, Treatment available but not being used’, WHO/42. WHO operates on the ICD-10 system in defining ‘mental disorders’: see International statistical classification of diseases and related health problems, tenth revision 1992 (ICD-10), Vol. 1: Tabular list. Vol. 2: Instruction manual, Vol. 3: Alphabetical index (1992a), Geneva, WHO.

² Mental Health Ireland defines mental illness as follows: “Mental illness can be defined as the experiencing of severe and distressing psychological symptoms to the extent that normal functioning is seriously impaired, and some form of help is usually needed for recovery. Examples of such symptoms include anxiety, depressed mood, obsessional thinking, delusions and hallucinations. Help may take the form of counselling or psychotherapy, drug treatment and/or lifestyle change.” (www.mentalhealthireland.ie)

Regarding mental *health*, in its 2001 report , ‘Mental Health: New Understanding, New Hope’, WHO observed: “Mental health has been defined variously by scholars from different cultures. Concepts of mental health include subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualisation of one’s intellectual and emotional potential, among others. From a cross-cultural perspective, it is nearly impossible to define mental health comprehensively. [...] Modern science is discovering that, while it is operationally convenient for purposes of discussion to separate mental health from physical health, this is a fiction created by language. Most ‘mental’ and ‘physical’ illnesses are understood to be influenced by a combination of biological, psychological and social factors. Furthermore, thoughts feelings and behaviour are now acknowledged to have a major impact on physical health. Conversely, physical health is recognised as considerably influencing mental health and well-being.”

therapies applied to them. Today, the situation in Ireland has improved with a shift towards community-based care, and greater protection for those in institutions. Nevertheless, despite significant efforts, Irish mental health care policy and service provision remain out of step with international best practice and, as such, fail to fully comply with international human rights law.

The past few years has seen a heightened impetus at the international level to address the inequalities experienced by people with mental illness, and a drive for recognition of this issue as a human rights one. In 2001, World Health Day on 7th April was for the first time dedicated to mental health, with the theme 'Stop Exclusion-Dare to Care'. The process of moving away from routine institutionalisation of people with mental illness has not lead to a consistently adequate standard of care throughout the world, either in community-based or in-patient care. In its 2001 annual report, 'Mental Health: New Understanding, New Hope', the World Health Organisation (WHO) said of mental health care throughout the world:

*"De-institutionalisation has not been an unqualified success, and community care still faces some operational problems. Among the reasons for the lack of better results are that governments have not allocated resources saved by closing hospitals to community care; professionals have not been adequately prepared to accept their changing roles; and the stigma attached to mental disorders remains strong, resulting in negative public attitudes towards people with mental disorders. In some countries, many people with severe mental disorders are shifted to prisons or become homeless."*³

In this report, WHO made a renewed call to governments to live up to the standards expected of them in their national mental health systems. For instance, it said that public education and awareness campaigns should be launched in all countries, the mental health of the population should be monitored, and more research into biological and psychosocial aspects of mental health was needed.⁴ It also laid down 'Three Scenarios for Action' for states according to their needs and resources.⁵ Unfortunately, in two years of relative prosperity, little action appears to have been taken by Ireland on key recommendations made by WHO.

In this report, Amnesty International will outline some criticisms of the treatment in Ireland of people with mental illness, and measure them against international

³ The World Health Report 2001, 'Mental Health: New Understanding, New Hope'.

⁴ Ibid.

⁵ Ibid. Scenario C is aimed at industrialised countries with a relatively high level of resources, and proposals include improvement in the management of mental disorders in primary health care, individualised care in the community for people with serious mental disorders, community care facilities offering 100 per cent coverage, development of advanced mental health monitoring systems, provision of special facilities in schools and the workplace, and launch of campaigns to educate the public about mental illness.

human rights standards.⁶ While it will be seen that some of the basic rights of people with mental illness have been compromised by commission when the Irish state has acted in a manner that is incompatible with international standards, for instance by treating people in inappropriate or restrictive environments; for the most part, the Government has failed to act when basic rights have been threatened, for instance by failing to provide adequate resources, or to introduce legislation to protect those rights. Ultimate responsibility for compliance with international law lies with the government, not with individual government departments, health boards, civil servants or service providers.

Outlined in Chapter 9 is the stigma attached to mental illness within all sections of Irish society, which has allowed the long-overdue reform of the mental health care system to remain hindered. While the primary duty towards people with mental illness under international law rests with the government, Irish society can play its part. There must be widespread recognition that the systematic discrimination against people with mental illness is an abuse of their human rights, and that this situation of inequality will persist for as long as society tolerates it.

In reviewing this area, Amnesty International has been struck by the dedication of those caring for people with mental illness throughout the country: psychiatrists, psychiatric nurses, care workers, psychologists and other specialists, hospital administrators, Health Board workers, and civil servants in the Department of Health and Children, who are serious in their desire to ensure the best possible service is provided. This can be a difficult and thankless task, particularly after sensational revelations about exceptionally bad conditions or abuses. Amnesty International hopes to highlight difficulties they are faced with every day, and thereby contribute to the development of a better working environment.

Amnesty International also acknowledges the work of other countless thousands who, in different ways, must cope with the effects of any deficiencies in the mental health care system: members of families, carers, GPs, members of voluntary

⁶ Amnesty International uses certain phrases of popular usage throughout this report, many of which do not enjoy universal currency or support. For instance, it uses the term 'people with mental illness' to describe a portion of the population that is wider than 'mental health service users' since many will never have had the good fortune to access such services. Similarly, it is wider than 'survivors', another term favoured by some advocates. This does not mean that Amnesty International subscribes to or endorses what has been called a medicalised model of mental illness or its treatment, but employs popular phraseology merely for ease of comprehension by those unfamiliar with the current debate about language usage. Furthermore, as an organisation working to promote rights laid down in international treaties and instruments, it must, to a large degree, employ the language used in those treaties when so doing. As many of the rights in UN treaties are given flesh by reports and comments issued by agencies established under the auspices of the UN, such as the World Health Organisation, Amnesty International uses the language of those comments and reports. This does not imply that Amnesty International endorses all of the language in these documents.

organisations, and many others. Above all, Amnesty International pays tribute to people with mental illness themselves; often service users have driven the agenda for change, and many improvements that have taken place have been achieved by the work of groups of service users, such as the programme of peer advocacy developed by the Irish Advocacy Network. Many voluntary groups such as GROW and Aware provide much needed support and assistance to their fellow service users and others have stepped into the breach to fill needs that the government has failed to do, such as the provision of sheltered housing.

Methodology

From May to October 2002, Amnesty International conducted a wide-ranging review of how the rights of people with mental illness are respected in Ireland: the legal provisions and procedures by which they are governed and protected, their living conditions in psychiatric institutions and units, the standard of care generally available in the mental health services, the therapies administered, and the treatment experienced in the wider community. It simultaneously engaged in an extensive consultation process with many agencies and individuals involved in the area in order to ascertain their impressions of the Irish mental health system. It met with interested non-governmental agencies at a specially convened roundtable in November 2002 to extend its consultation more broadly. During the entire process, it worked closely with Schizophrenia Ireland, an Irish NGO involved in support and advocacy for people with severe mental illnesses and their families, and one intimately acquainted with the Irish mental health system. Amnesty International also established an advisory panel of experts, including the Director of Schizophrenia Ireland, an eminent consultant psychiatrist (who is also Chair of the Irish Psychiatric Association), a barrister (who is also Convenor of the Mental Health Working Group of the Irish Council for Civil Liberties), a mental health legal researcher, and a psychotherapist (who is also a Board Member of the Irish Penal Reform Trust) to assist in its information gathering and help to produce this report. Amnesty International is grateful for the time and energy devoted by so many people to this project.

This report is designed as a compilation of concerns and recommendations emanating from this review process – solid conclusions of national and international bodies and individuals expert in the field of Irish mental health care, placed in the context of Ireland’s binding obligations under international human rights standards. In many places throughout this report, there is a discernible lack of statistical data or other information; as discussed in Chapter 9, this is due to the poverty of research and data collection in many areas of mental health care in Ireland, which itself impinges on the quality of service planning and delivery. Furthermore, because of this deficit in available information, in some chapters, this report relies heavily on the work of a few agencies, such as that of the non-governmental homeless agencies in Chapter 7.

Mental Illness as a Disability

Ireland's treatment of people with mental illness is part of a wider pattern of discrimination against people with all forms of disability, which will be explored in Chapter 2. Amnesty International focuses, in this report, on the subgroup of people with mental illness, due *inter alia* to the more pronounced imbalance perceived in the relationship between people with mental illness and the state. This imbalance springs from the particularly strong stigma attached to mental illness,⁷ and the nature of mental illness itself which can frequently impair, in less visible ways, the ability of the person to effectively exercise or vindicate his or her rights. This report will nevertheless refer liberally to general disability issues and standards.⁸

Some scope for enhancing protection for people with mental illness is offered in recent Irish equality legislation,⁹ which prohibits discrimination in employment, and access to goods and services on certain grounds including the ground of disability, the definition of which encompasses mental illness. While this equality legislation is welcome, it does not fully implement the non-discrimination requirements of international human rights law.¹⁰ More legislation is needed to afford full protection to all people with mental illness, and Amnesty International, in Chapter 2 of this report, urges Ireland to take an expansive, rights-based approach to the proposed disability legislation. So too, at the international level, a number of disability instruments offer guidance on what is expected of states in their treatment of people with mental illness. Work on a new UN convention on the rights of people with disabilities is currently in progress, which, when complete, offers new hope for the advancement of the rights of people with mental illness in Ireland. As discussed in Chapter 2, Amnesty International hopes that the Irish government will ensure that this convention, which Ireland has been championing, is quickly adopted, and will ratify and incorporate it into Irish law as soon as possible thereafter.

Mental Health Act, 2001

In 2001, the new Mental Health Act was passed, but, to the disappointment of many, in a form far short of what the original 1995 White Paper, 'A new mental health act', promised, in that it obliges the Irish authorities only to ensure that the involuntary detention of psychiatric in-patients in 'approved centres' is reviewed for legality after a certain period, and take specified action in the event of illegal detention; it does not lay down minimum standards of treatment or care, nor any procedures for

⁷ See Chapter 9.

⁸ For example, in its 2002 Concluding Observations on Ireland's second periodic report (17 May 2002, UN Doc No E/C.12/1/Add.77), the UN Committee on Economic, Social and Cultural Rights (CESCR) found a "persistence of discrimination against persons with physical and mental disabilities, especially in the fields of employment, social security benefits, education *and health*." (Emphasis added.)

⁹ Employment Equality Act, 1998 & Equal Status Act, 2000, Government Publications Sales Office.

¹⁰ Such as Article 2 of the ICESCR or Article 2 of the ICCPR. See Chapter 2.

their monitoring, for example. At the time of writing, the Act is not yet in force, so it is difficult to predict how it will operate in practice. Meanwhile, Ireland's treatment of the involuntarily detained continues to be governed by an antiquated set of laws which, the government has conceded, fail to meet the requirements of international law. When the Act comes into force, there are concerns that it may not prove as effective as it should be with regard to this function, particularly given the traditional under-resourcing in this sector.

However, of major significance in the Mental Health Act is the establishment, with effect from 5 April 2002, of a statutorily independent Mental Health Commission, which, in addition to establishing tribunals to review the legality of involuntary psychiatric admissions and detentions, has the statutory duty to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services in Ireland. Amnesty International is heartened by recent public statements by its Chair, Dr John Owens,¹¹ indicating that the Commission will make full use of this power to ensure, insofar as it can, that best practice is respected and the best available mental health care afforded to people with mental illness in Ireland.

Conclusion

Whatever problems exist in Ireland's treatment of people with mental illness are not uniquely Irish: in most countries of the world, the level of care still falls far short of full respect for the human rights of people with mental illness. It is no answer to these shortcomings however, to say that all countries appear to failing equally in their duty towards people with mental illness. Ireland has committed itself under international law to take all necessary measures to ensure that the human rights of those with mental illness are promoted, protected and granted in reality. Fundamental human rights are universal and inalienable, and must be respected no matter what the international state of play.

¹¹ For example, at a conference on 17 September 2002 in Tullamore held by the Midland Health Board on the new Act, Dr Owens elaborated on this role.

Chapter 1

INTERNATIONAL STANDARDS

“All persons have the right to the best available mental health care, which shall be part of the health and social care system.”

Principle 1

UN Principles for the Protection of Persons with Mental Illness

Introduction

Ireland has responsibilities towards everyone in its jurisdiction under international law. These international obligations exist in addition to those in Ireland’s domestic law and 1937 Constitution, and where there is a conflict, international law is superior. Even if international treaties are not expressly reflected in domestic law, they are nevertheless binding on states once ratified.

In the adoption of the Universal Declaration of Human Rights (UDHR), 1948 in the aftermath of the Second World War, the international community recognised that every person possesses certain rights simply by virtue of being human, that every state has an obligation to guarantee respect for these rights to everyone on their territory, and that an international order should, therefore, exist to ensure their protection. These rights are both universal and interdependent, and no person may waive them or otherwise have them removed, except in times of national emergency such as war. Each general international human rights treaty protects the rights of persons with mental illness through the principles of equality and non-discrimination.¹²

Flowing from the non-binding UDHR, two binding international treaties emerged: the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). Regional human rights mechanisms subsequently evolved to provide legal protection on a more local level; in the European context, the Council of Europe was founded in 1949, from which the 1950 European Convention on Human Rights and Fundamental Freedoms (ECHR) emerged. In addition to such mechanisms, intergovernmental organisations have been established under the auspices of the UN in the past fifty years, such as the World Health Organisation.

The United Nations and Mental Illness

The primary and first source of international human rights under the UN system is the UDHR, which encompasses civil, political, economic, social and cultural rights.

¹² For a comprehensive guide to, and analysis of, international and regional human rights instruments pertinent to mental health, see ‘The Role of International Human Rights in Domestic Mental Health Legislation’ (2002), Rosenthal E & Sundram C J, submitted to the World Health Organisation.

Article 1 of the UDHR states: "All human beings are born free and equal in dignity and rights." Article 2 states: "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind" The 30 Articles of the UDHR, therefore, apply equally to everyone, regardless of where they live, their ethnicity or religion, whether they are rich or poor, and regardless of any disabilities or illnesses that they may be deemed to have.

Civil and political rights, such as the right to liberty, to a fair trial, and to vote, were then laid down in the ICCPR, and a committee of experts established to oversee its implementation in national jurisdictions, the UN Human Rights Committee (HRC). Economic, social and cultural rights of all people enshrined in the UDHR, such as the right to an adequate standard of living, the highest attainable standard of physical and mental health, to education, and to take part in cultural life, were laid down in the ICESCR, with a similar supervisory committee established, the UN Committee on Economic, Social and Cultural Rights (CESCR). These UN committees are supported by the UN High Commissioner for Human Rights (UNHCHR), which also issues comments that are instructive as to how human rights should be respected.

Ireland has ratified both the ICCPR and the ICESCR, and is consequently obliged under international law to guarantee to every person on its territory, without discrimination, all the rights enshrined in both.¹³ Regarding what is required of

¹³ Article 2(1) of the ICCPR states: "Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognised in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status".

Article 2(2) of the ICESCR states: "The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

The CESCR, in its Concluding Observations on Ireland's second periodic report was very critical of Ireland's treatment of people with disabilities, and remarked on the "persistence of discrimination against persons with physical and mental disabilities", and that "the principles of non-discrimination and equal access to health facilities and services was not embodied in the recently published National Health Strategy".

Note that the requirement of non-discrimination does not equate to a requirement of equality in that states are entitled to treat different categories of people differently so long as this differential treatment does not amount to unlawful discrimination. There is however, an additional and separate requirement of equality before the law in Article 26 of the ICCPR, which provides: "All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

states in implementing the ICESCR,¹⁴ the CESCR has emphasised:

*“The obligation of States parties to the Covenant to promote progressive realisation of the relevant rights to the maximum of their available resources clearly requires Governments to do much more than merely abstain from taking measures which might have a negative impact on persons with disabilities. The obligation in the case of such a vulnerable and disadvantaged group is to take positive action to reduce structural disadvantages and to give appropriate preferential treatment to people with disabilities in order to achieve the objectives of full participation and equality within society for all persons with disabilities. This almost invariably means that additional resources will need to be made available for this purpose and that a wide range of specially tailored measures will be required.”*¹⁵

Many of the rights in both treaties are elaborated and explained in other, secondary UN instruments, some of which will be mentioned in this report, such as:

- The MI Principles¹⁶
- Standard Rules on the Equalisation of Opportunities for Persons with Disabilities¹⁷
- Declaration on the Rights of Mentally Retarded Persons¹⁸
- Declaration on the Rights of Disabled Persons¹⁹
- UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment²⁰

¹⁴ Rosenthal & Sundram, note 1 above, observe: “It is a common misconception that the rights of people with mental disabilities are particularly linked with ‘economic and social’ rights because many of their concerns relate to human rights in mental health care systems. ... the rights established in the ICCPR are as relevant to people with mental disabilities as the rights established under the ICESCR. More important, many of the same abuses violate both the ICCPR and the ICESCR. The closer one examines any given right, the more it is clear the rights in the covenants are overlapping and mutually reinforcing. For example, a government may be under an obligation to create community-based services for people with mental disabilities under the ICESCR. The failure to create community-based services is likely to lead to ‘arbitrary detention’ in psychiatric facilities under the ICCPR.”

¹⁵ UN Committee on Economic, Social and Cultural Rights, General Comment No. 5, ‘Persons with Disabilities’; (Eleventh session, 1994), UN Doc E/C.12/1994/13 (1994), at para 9.

¹⁶ UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care adopted by General Assembly Resolution 46/119 of 17 December 1991.

¹⁷ Adopted by General Assembly Resolution 48/96 in 1993.

¹⁸ General Assembly Resolution 2856 (XXVI), 26 UN GAOR Supp No 29 at 99, UN Doc A/8429 (1971). While still relevant to people with learning difficulties and mental illness, this Declaration is considered to be quite dated, for example, in that the term ‘mental retardation’ is widely regarded as derogatory, where ‘intellectual disability’ is generally favoured today.

¹⁹ Adopted by General Assembly Resolution 3447 (XXX), 30 UN GAOR Supp (No 34) at 88, UN Doc A/10034 (1975).

²⁰ Adopted by General Assembly Resolution 43/173 of 9 December 1988. This instrument reflects the fact that special standards govern detention of all forms, including involuntary committal to psychiatric facilities, and will be discussed along with other relevant standards in Chapters 4 and 8.

Other international treaties ratified by Ireland are relevant to the treatment of people with mental illness, and will be mentioned throughout this report. The UN Convention Relating to the Status of Refugees, further elaborated in guidelines by its supervisory agency, the United Nations High Commissioner for Refugees, obliges Ireland to take certain steps in its treatment of asylum seekers and refugees with, or at risk of, mental illness.²¹ Similarly the UN Convention on the Rights of the Child carries certain additional obligations in respect of children, the overarching requirement being that, in all decisions made in respect of a child, the best interests of that child must be a primary consideration.²² The UN Convention on the Elimination of All Forms of Racial Discrimination, ratified by Ireland in 2000, also affords protection to minority ethnic groups, including Travellers.²³

The Right to Mental Health

The starting principle in this report is Article 12 of the ICESCR, which provides “the right of everyone to the enjoyment of the highest attainable standard of ... mental health”, and identifies some of the measures states should take “to achieve the full realisation of this right”. Articles 23 and 24 of the CRC also recognise the right to health for all children and identify several steps for its realisation.

The MI Principles

UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (hereafter referred to as MI Principles)²⁴ were

²¹ See Chapter 3.

²² See Chapter 6.

²³ See Chapter 3.

²⁴ Note 5 above. In this report, Amnesty International refers to the MI Principles while recognising that they do not enjoy universal support. It has been suggested in many quarters that they are in need of revision for a number of reasons. Some argue that they support the dominance of a medical model of mental illness, in their endorsing medical explanations and treatments for ‘mental illness’ in contemporary mental health systems, and being predicated on unproven assumptions about the bio-medical nature of ‘mental illness’, for example by referring to the medical term ‘patient’ throughout, and because medication is the only type of treatment specified and has the whole of Principle 10 dedicated to it. It is also argued that the Principles endorse involuntary detention and, while elaborating on the right to treatment, do not give everyone the right to refuse treatment. It is also the view of some that Principles 11 (Consent to Treatment) and 16 (Involuntary Admission) in fact contravene certain provisions of the Universal Declaration of Human Rights. It is also felt that the Principles were developed with little consultation with mental health service users/survivors, and hence lack credibility. They have however, been utilised by international nongovernmental organisations, such as Mental Disability Rights International in its assessment of the mental health systems of a number of countries.

For a criticism of the efficacy of the MI Principles, see ‘Human Rights law in the field of mental health: a critical review’, Harding T W, *Acta Psychiatr Scand* 200: 101: 24-30, which says:

“The ‘centrepiece’ of international human rights law in the field of mental health is often said to be the United Nations Principles for the Protection of Persons with Mental Illness of 1991. Some observers appreciate the symbolic importance of these principles in providing visibility to the needs of the mentally ill, in stressing the right of access to adequate mental health care and in establishing the principle equivalence between psychiatry and the rest of medicine. However, the Principles appear basically flawed in several respects:

- they do not have the status of a formal international treaty;
- States are not required to adopt the Principles as ‘minimum standards’ for the protection of

adopted in 1991, and, though a General Assembly Resolution and therefore not legally binding, elaborate the UN's interpretation of the basic rights and freedoms of people with mental illness that must be secured if states are to be in full compliance with the ICESCR.²⁵

The MI Principles apply to all persons with mental illness, whether or not in in-patient psychiatric care, and to all persons admitted to psychiatric facilities, whether or not they are diagnosed as having a mental illness. They provide criteria for the determination of mental illness, protection of confidentiality, standards of care, the rights of persons in mental health facilities, and the provision of resources. MI Principle 1 lays down the basic foundation upon which states obligations towards people with mental illness are built: that "all persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person", and "shall have the right to exercise all civil, political, economic, social and cultural rights as recognised in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights and in other relevant instruments". It also provides that "all persons have the right to the best available mental health care".

UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities

These are another useful guide to Ireland's obligations under the ICESCR,²⁶ in that they assist in interpreting its provisions. In providing that "states should involve organisations of persons with disabilities in all decision-making relating to plans and programmes concerning persons with disabilities or affecting their economic and social status",²⁷ they require wide consultation by the state with people with disabilities, and their effective participation in the development of actions concerning them.²⁸

mentally ill persons;

- In some respects, notably on the issue of consent to treatment, the Principles remove patients' rights rather than reinforce them;
- The Principles do not provide for redress not any form of monitoring, inspection or supervision by an independent international body.

Thus, it appears that even at an international level the deep-seated societal ambivalence towards the mentally ill has

taken root and that so-called 'human rights' principles have little material effect on the lives of psychiatric patients

and create double standards in the exercise of choice."

²⁵ General Comment No. 5, 'Persons with Disabilities', was adopted by the CESCR on 9 December 1994 (Eleventh session, 1994) to outline the application of the ICESCR to people with mental and physical disabilities, and recognised the MI Principles as one of the instruments to ensure respect for the full range of human rights for persons with disabilities.

²⁶ General Comment No. 5 *ibid* states that these Standard Rules should also be used as a guide to interpreting the ICESCR's obligations, singling it out as "a particularly valuable reference guide in identifying more precisely the relevant obligations of states".

²⁷ Rule 14(2).

²⁸ See Chapter 2.

Rule 15 provides:

“States are under an obligation to enable persons with disabilities to exercise their rights, including their human, civil and political rights, on an equal basis with other citizens. States must ensure that organisations of persons with disabilities are involved in the development of national legislation concerning the rights of people with disabilities, as well in ongoing evaluation of that legislation.”

Council of Europe

In addition to the UN mechanisms outlined above, Ireland is bound by certain human rights principles laid down by the Council of Europe, a regional system of international human rights law comprising 43 Member States throughout Europe.²⁹ Chief amongst the Council of Europe’s treaties is the 1950 European Convention on Human Rights and Fundamental Freedoms (ECHR), which has a supervisory body, the Council of Ministers, and a court in Strasbourg, the European Court of Human Rights, which adjudicates on complaints of states’ breaches of the ECHR.

Another important such instrument is the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, which pertains specifically to places of detention. It has an expert committee, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), which visits states parties to the Convention on both periodic and ad hoc bases to review their compliance with the ECHR in relation to those held under any form of detention.³⁰ The CPT also issues annual reports, which provide further guidance on the standards expected of states parties; for example, in its

²⁹ This is distinct from the European Union, which also has evolved some recent relevant measures. In April 1994, the Parliamentary Assembly of the European Council of the EU adopted Recommendation 1235 concerning Psychiatry and Human Rights, wherein the Ministerial Committee called for the adoption of new recommendations. Thereupon the Ministerial Committee formed the new Working Group on Psychiatry and Human Rights. In January 2000, the working group of the Steering Committee on Bioethics published the White Paper on Protecting the Human Rights and Human Dignity in the Field of Psychiatry. This White Paper serves as a basis for discussion to lay down guidelines, which should be incorporated into new legislation from the European Council. One such measure that emerged is Recommendation No. R (98) 7 concerning the Ethical and Organisational Aspects of Health Care in Prison.

³⁰ After country visits, the CPT issues reports which are made public with the permission of the national government; two such reports on Ireland have been published to date, and a third is due pursuant to a periodic visit to Ireland by the CPT in 2002. In these country reports, in addition to pronouncing on individual states’ performance, the CPT makes general comments relevant to all states in the performance of their duties under this Convention.

Eighth Annual Report, it elaborated standards for conditions and treatment in psychiatric institutions, where it stated: "The aim should be to offer material conditions which are conducive to the treatment and welfare of patients; in psychiatric terms, a positive therapeutic environment..."³¹

The World Health Organisation

In 2001, the World Health Organisation (WHO) ran a year-long campaign on mental health. As the United Nations' health agency, its comments reflect the UN's understanding of what is meant by "the best available mental health care" in MI Principle 1. That year, for the first time, WHO's main report, technical discussions at the World Health Assembly, and World Health Day, all focused on one topic – mental health – revealing the urgency and importance attached at the international level to this subject. The WHO 2001 annual report 'Mental Health: New Understanding, New Hope' provides a detailed account of what is expected of all states in their treatment of people with mental illness, and lays down a comprehensive package of recommendations for states to implement according to their means.³²

Recommendations

Amnesty International urges the Irish Government to act promptly and decisively on all treaty-based expert committee reports.³³ It should reflect all binding international norms in its national legislation and practice.³⁴ It should implement all relevant recommendations in the programme of action laid down in the 2001 annual WHO report, and all recommendations made in this report.

31 8th General Report on the CPT's activities covering the period 1 January to 31 December 1997, Ref: CPT/Inf (98) 12[EN], published on 31 August 1998.

32 In its 1996 'Guidelines for the promotion of Human Rights of persons with Mental Disorder' (Geneva, WHO Division of Mental Health and Substance Abuse), WHO has laid out a checklist for states' observance of their obligations under the international human rights system.

33 It should also incorporate or reflect the ICESCR in domestic legislation, as requested by the CESCR in its concluding observations on Ireland's second periodic report: "Affirming that all economic, social and cultural rights are justiciable, the Committee reiterates its previous recommendation ... and strongly recommends that the State party incorporate economic, social and cultural rights in the proposed amendment to the Constitution, as well as the other domestic legislation. The Committee points out that, irrespective of the system through which international law is incorporated into the domestic legal order (monism or dualism), following ratification of an international instrument, the State party is under an obligation to comply with it and to give it full effect in the domestic legal order. In this respect, the Committee would like to draw the attention of the State party to its General Comment No. 9 on the domestic application of the Covenant." (Concluding observations on Ireland's second periodic report, 17 May 2002, UN Doc No E/C.12/1/Add.77.)

34 The UN HRC has expressed "its continuing concern that not all Covenant rights are guaranteed in the domestic law of the State party. The consequent lack of domestic recourse will limit the power of the proposed [Irish] Human Rights Commission to take action in the courts to enforce those rights not covered." (Concluding Observations of the Human Rights Committee: Ireland, 24/07/2000, A/55/40.)

Chapter 2

DISABILITY & EQUALITY

“Persons with functional limitations or disabilities are particularly vulnerable to exclusion and marginalisation. Because of their physical or mental limitations, persons with disabilities are frequently more at risk of having their rights violated and denied.”

UN High Commissioner for Human Rights
18 May 2001³⁵

Introduction

In this chapter, Amnesty International examines the treatment of people with mental illness by the Irish government within the wider context of its treatment of people with disabilities. Amnesty International uses the term ‘people with disabilities’ in accordance with contemporary United Nations (UN) and World Health Organisation (WHO) usage. The UN defines disability as summarising “a great number of different functional limitations occurring in any population in any country of the world. People may be disabled by physical, intellectual or sensory impairment, medical conditions *or mental illness*.”³⁶ The WHO 2001 International Classification of Functioning, Disability and Health (ICF) reflects the “new paradigm” emerging in relation to disability, providing what it describes as “a framework for understanding the dimensions of disablement and functioning at

³⁵ Report of the UN High Commissioner for Human Rights to the Economic and Social Council, UN Doc. No. E/2001/64 at para 48.

³⁶ (Emphasis added.) UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities adopted by the UN General Assembly in 1993 (A/RES/48/96). See also UN Committee on Economic, Social and Cultural Rights, General Comment No. 5, ‘Persons with Disabilities’; (Eleventh session, 1994), UN Doc E/C.12/1994/13 (1994).

three different levels: body, person and society".³⁷ Relevant Irish equality legislation also defines mental illness as a disability.³⁸

Background

In the past, a patronising view has been taken of disabilities by policy makers:

*"Traditional approaches to disability have depicted it as a health and welfare issue, to be addressed through care provided to persons with disabilities in the form of charitable handouts and similar measures. Persons with disabilities have been viewed as abnormal, deserving of pity and care, and not as individuals who are entitled to enjoy the same opportunities to live a full and satisfying life as other members of society. As a consequence, persons with disabilities have been marginalised and excluded both from the mainstream of society, and have been denied, or significantly limited in the enjoyment of, their fundamental human rights and freedoms."*³⁹

In the 1970s, the evolution in the UN's thinking on disability issues towards a greater emphasis on non-discrimination and equal access rights prompted a number of initiatives that embraced the emerging international recognition of the human rights of persons with disabilities and the push for equalisation of opportunities for them.⁴⁰

³⁷ International Classification for Functioning, Disability and Health, WHO, 2001. It classifies functioning at the level of body/body part, whole person, and whole person in social context, and is based on an integration of the two opposing models: the medical model and the social model. In it, disability serves an umbrella term for impairments, activity limitations or participation restrictions. A person's functioning and disability is conceived of as a dynamic interaction between health conditions and contextual factors – these contextual factors include both personal and environmental factors, the latter being the facilitating or hindering impact of features of the physical, social and attitudinal world. "It has been accepted as one of the United Nations social classifications and is referred to in and incorporates *The Standard Rules on the Equalisation of Opportunities for Persons with Disabilities*. Thus ICF provides an appropriate instrument for the implementation of stated international human rights mandates as well as national legislation." (Introduction, ICF)

"ICF puts all disease and health conditions on an equal footing irrespective of their cause. A person may not be able to attend work because of a cold or angina, but also because of depression. This neutral approach puts mental disorders on a par with physical illness and has contributed to the recognition and documentation of the world-wide burden of depressive disorders, which is currently the leading cause, world-wide, of life years lost due to disability." ('WHO publishes new guidelines to measure health', Press Release WHO/4815, November 2001.)

³⁸ For instance, the definition of 'disability' in Section 2(1) of the Equal Status Act, 2000 includes: "the total or partial absence of a person's bodily or mental functions, including the absence of a part of a person's body", or "a condition, disease or illness which affects a person's thought processes, perception of reality, emotions or judgement or which results in disturbed behaviour".

³⁹ Report of the United Nations Consultative Expert Group Meeting on International Norms and Standards Relating to Disability, convened by the United Nations in cooperation with Boalt Hall School of Law, University of California at Berkeley and the World Institute on Disability (Oakland, California USA) at Boalt Hall School of Law, University of California at Berkeley 8-12 December 1998.

⁴⁰ For a comprehensive account and analysis of the evolution, operation in practice, and potential of UN disability instruments, see 'Human Rights and Disability: The current use and future potential of United Nations human rights instruments in the context of disability', Quinn G & Degener T with Bruce A, Burke C, Castellino Dr J, Kenna P, Kilkelly Dr U, Quinlivan S, HR/PUB/02/1, United Nations, New York and Geneva, 2002.

A Declaration on the Rights of Disabled Persons⁴¹ was adopted by the UN in 1975, Article 3 of which states:

“Disabled persons have the inherent right to respect for their human dignity. Disabled persons, whatever the origin, nature and seriousness of their handicaps and disabilities, have the same fundamental rights as their fellow-citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and full as possible.”

The advancement of these human rights was intensified during the 1981 International Year of Disabled Persons, which was followed by the United Nations Decade of Disabled Persons 1982-1993. A major outcome of the former was the World Programme of Action concerning Disabled Persons (1982), which took ‘equalisation of opportunities’ as its guiding principle for the achievement of full participation of persons with disabilities in all aspects of social and economic life. The UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (1993)⁴² was a major outcome of the Decade of Disabled Persons, and is an instrument for national legislation and policy-making.⁴³

“National legislation, embodying the rights and obligations of citizens, should include the rights and obligations of persons with disabilities. States are under an obligation to enable persons with disabilities to exercise their rights, including their human, civil and political rights, on an equal basis with other citizens. States must ensure that organisations of persons with disabilities are involved in the development of national legislation concerning the rights of persons with disabilities, as well as the ongoing evaluation of that legislation.”⁴⁴

As discussed in Chapter 1, UN General Comment No. 5⁴⁵ recognises that these Standard Rules should be used as a guide to the requirements of the legally binding UN International Covenant on Economic, Social and Cultural Rights. As the UN has gradually recognised the importance of promoting equalisation of opportunities for disabled persons to participate on the basis of equality in social life and development, it has become evident that the rights of disabled persons require more comprehensive treatment than in the context of rehabilitation and social services and

⁴¹ Adopted by General Assembly Resolution 3447 (XXX) of 9 December 1975.

⁴² Adopted by General Assembly Resolution 48/96 in 1993.

⁴³ The reaffirmation of the human rights of persons with disabilities in the UN Durban Declaration and Programme of Action (2001) urges “States to take necessary measures to ensure their full enjoyment of all human rights and to facilitate their full integration into all fields of life”, reflecting the enhanced recognition given to the human rights of persons with disabilities; so too do other recent UN documents, such as the Vienna Declaration and Programme of Action (1993), the Copenhagen Declaration and Programme of Action (1995), and the Beijing Declaration and Platform for Action (1995).

⁴⁴ Rule 15 of the UN Standard Rules, note 8 above.

⁴⁵ UN Committee on Economic, Social and Cultural Rights, General Comment No. 5, ‘Persons with Disabilities’; (Eleventh session, 1994), UN Doc E/C.12/1994/13 (1994).

should include the full range of human rights: civil, political, economic, social and cultural rights.

A move consequently occurred from the patronising and paternalistic approach to people with disabilities represented by the medical model of disability, framed within a medical and welfare framework, denoting people with disabilities as 'ill' and focusing on care rather than their wider social needs - viewing them as inherently different from the rest of the population - to regarding them as citizens with the same rights as everyone else. This shift was reflected at the international level not alone in moves to place the rights of persons with disabilities within the category of universal human rights, but also in the evolution of international standards relating specifically to people with disabilities. This 'paradigm shift' has important implications for the way in which Ireland's law and policy in relation to disability should have developed, in requiring legal recognition of the many ways in which the existing social environment places barriers in the way of persons with disabilities who seek to carry out the usual activities of everyday life and to participate in the full range of activities in society. Thus, this emerging social model of disability "sees the problem not as residing in the person with a disability, but as resulting from the structures, practices and attitudes that prevent the individual from exercising his or her capabilities: the cure to the problem of disability lies in restructuring society".⁴⁶

The Emerging UN Disability Convention

Over the years, there have been several unsuccessful drives to secure political co-operation in the UN towards a new convention specifically addressing the rights of people with disabilities. Finally, in November 2001, the UN General Assembly adopted Resolution 56/119 calling for the creation of an Ad Hoc Committee to consider proposals for such a convention on the rights of people with disabilities. Ireland has been taking a very pro-convention stand on this at the international level,⁴⁷ in marked distinction to its national approach thus far to disability rights

⁴⁶ Report of the United Nations Consultative Expert Group Meeting on International Norms and Standards Relating to Disability, note 5 above.

⁴⁷ At a conference in Dublin on 26th February 2002 on the theme, 'Towards a United Nations Convention on the Human Rights of Persons with Disabilities', John Rowan, Head of the Human Rights Unit of the Department of Foreign Affairs, in a speech entitled 'Elements in the approach of the Department of Foreign Affairs to the establishment of a UN Convention on the Rights of Persons with Disabilities', said:

"The Third Committee of the UN General Assembly in New York last November saw the adoption of a resolution on an International Convention to Promote and Protect the Rights and Dignity of Persons with Disabilities. This resolution was sponsored by Mexico and we offer the Mexican Government our congratulations on achieving this significant breakthrough. It is our intention, with the support of our EU partners and other countries transcending all regional boundaries, to build on this achievement at the forthcoming session of the UN Commission on Human Rights. As you may be aware, Ireland takes the lead on the biennial resolution on the rights of persons with a disability at the CHR and we will be drawing on a wide range of sources: the work and advice of Bengt Lindqvist; the seminal study of Professor Gerard Quinn; the Mexican resolutions at the Third Committee and the Commission on Social Development as well as the input of our own colleagues to fashion a resolution which takes the issue forward. The following are among the new elements we are considering

legislation.⁴⁸ However, this process could take many years and, if a convention emerges, it would be dependent on Ireland's ratification and incorporation to be of relevance to people with disabilities in Ireland.⁴⁹

Situation in Ireland

Ireland's general treatment of people with disabilities is often at variance with the relevant international standards, and this section of the Irish population experiences widespread discrimination in the rights afforded to them. The UN Committee on Economic, Social and Cultural Rights (CESCR), in its Concluding Observations on Ireland's second periodic report⁵⁰ was very critical of Ireland's treatment of people with disabilities, and remarked on the "persistence of discrimination against persons with physical and mental disabilities, especially in the fields of employment, social security benefits, education and health", and expressed its concern that "the principles of non-discrimination and equal access to health facilities and services was not embodied in the recently published National Health Strategy". The UN Human Rights Committee (HRC), which supervises compliance with the International Covenant on Civil and Political Rights (ICCPR), has also recently recommended "that further action be taken [by Ireland] to ensure full implementation of the [ICCPR] in ... [e]nsuring the full and equal enjoyment of Covenant rights by disabled persons, without discrimination, in accordance with article 26".⁵¹

One Irish social policy analyst has said, "disability is a trigger for poverty and exclusion from health, education and employment".⁵² Furthermore, where they may

introducing into the text of the draft:

- a welcome for the UNGA Third Committee resolution
- a recommendation of the Quinn study outcome to UNGA Third Committee, 2002
- an endorsement of twin-track approach advocated in the Quinn study
- a call on the Ad Hoc Committee to hold a second meeting in Geneva before CHR 2003, and periodically thereafter.
- a reference to the need for a special rapporteur on disability at CHR.
- a reference to the need for a single core integral disability website hosted by OHCHR
- a call on the Treaty Monitoring Bodies to make General Comments on the issue (along the lines of the Committee on Economic, Social and Cultural Rights).
- a call to obtain enhanced engagement by the Treaty Monitoring Bodies on disability rights."

⁴⁸ See below.

⁴⁹ For a review of this process, see Quinn & Degener, note 5 above: "The Report argues that a new UN treaty for peoples with disabilities would focus attention on disability and tailor general human rights norms to meet particular circumstances of persons with disabilities. It would add visibility to the disability issue within the human rights system and State parties would be clearer on their precise obligations in the disability field. Civil society would also be able to focus on one coherent set of norms rather than six different sets of norms." (NUI Galway press release 'Report from NUI, Galway calls for new UN Treaty to protect people with Disabilities', 24 January 2003.)

⁵⁰ 17 May 2002, UN Doc No E/C.12/1/Add.77.

⁵¹ Concluding observations of the Human Rights Committee: Ireland, 24/07/2000, A/55/40.

⁵² Dr Jane Pillinger, 'Disability and the Quality of Services: Irish and European Perspectives', Paper for Policy Institute Seminar, on behalf of the National Disability Authority, Trinity College Dublin, 16 April 2002.

experience additional inequalities, for example based on gender, ethnicity, or social status,⁵³ people with disabilities in Ireland may be at risk of dual or even multiple discrimination.

People in Special Facilities

Discriminatory treatment of people with disabilities is evident in the case of those living or spending time in special facilities in Ireland, including psychiatric facilities. The CESCR has expressed its concern “that a large number of persons with mental disabilities, whose state of health would allow them to live in the community, is still accommodated in psychiatric hospitals together with persons suffering from psychiatric illnesses or problems, despite efforts by the State party to transfer them to more appropriate care settings”.⁵⁴ This is a particularly serious failure in relation to this segment of the Irish population. In its 2002 Programme for Government, the current Irish Government has promised to address this issue,⁵⁵ and Amnesty International urges it to do so at a matter of the utmost urgency. Also, the treatment and living conditions of people with intellectual disabilities in special residential care are not subject to any formal, routine state monitoring and inspection procedure.

The CESCR was also “particularly concerned that people with disabilities, including those working in sheltered workshops, do not have the status of employees and therefore do not qualify for the minimum wage arrangements; if, however, they do benefit from minimum wage arrangements, they are liable to lose their rights to free medical care”.⁵⁶ People with disabilities have the right to “be protected against all exploitation, all regulations and all treatment of a discriminatory, abusive or degrading nature”,⁵⁷ a right not fully respected in Ireland.

Disability Legislation

Many national organisations are pushing for a wider statutory basis for the protection of human rights of people with disabilities in Ireland, with an emphasis

⁵³ The UN HRC has voiced its concerns “at the continuing inequalities faced by women in Ireland, which are reflected in the under-representation of women in certain occupations and in political life and in the generally lower salaries paid to women as compared with men”, and, with respect to the Travelling community, it “continues to be concerned about the generally lower living standards of members of this community, their low levels of participation in national political and social life and their high levels of maternal and infant mortality”, and urges Ireland to “continue its efforts to take positive action to overcome discrimination and to ensure the equal enjoyment of rights by members of the Travelling community and in particular to improve their access to health ...”. (Note 17 above) See also generally ‘Rights and Justice Work in Ireland: A New Base Line’ (2002), Harvey B, The Joseph Rowntree Charitable Trust.

⁵⁴ 2002 Concluding Observations on Ireland’s second periodic report, note 16 above.

⁵⁵ “We will complete the programme of expansion of appropriate care places for people with disabilities, with, in particular, the ending of the inappropriate use of psychiatric hospitals for persons with intellectual disabilities.” ‘An Agreed Programme for Government between Fianna Fáil and the Progressive Democrats’, June 2002.

⁵⁶ 2002 Concluding Observations, note 16 above.

⁵⁷ Article 10, UN Declaration on the Rights of Disabled Persons, note 7 above.

on the delivery of services and equality as a right;⁵⁸ and Amnesty International urges the Irish government to follow this course in its future policy and legislation formulation. This is also the model laid out in several recent UN initiatives, such as the Standard Rules on the Equalisation of Opportunities for Persons with Disabilities and the Declaration on the Rights of Disabled Persons; the human rights approach of these documents promotes the concept that people with disabilities have the right to expect appropriate services to be delivered on an equal footing with everyone else; while service providers have the duty to provide the required services if they are to comply with human rights standards. There is consequently an international legal imperative to put in place disability policies and legislative provisions, with a wide range of rights for people with disabilities, and duties for government institutions and agencies clearly laid out. The rationale behind such specific legislation is the discrimination so widely experienced by people with disabilities:

“Persons with disabilities often are excluded from the mainstream of the society and denied their human rights. Both de jure and de facto discrimination against persons with disabilities have a long history and take various forms. They range from invidious discrimination, such as the denial of educational opportunities, to more subtle forms of discrimination, such as segregation and isolation because of the imposition of physical and social barriers. Effects of disability-based discrimination have been particularly severe in fields such as education, employment, housing, transport, cultural life and access to public places and services. This may result from distinction, exclusion, restriction or preference, or denial of reasonable accommodation on the basis of disablement, which effectively nullifies or impairs the recognition, enjoyment or exercise of the rights of persons with disabilities.”⁵⁹

Official Irish policy towards people with disabilities is based on a 1996 report by the government-appointed Commission on the Status of People with Disabilities, ‘A Strategy for Equality’,⁶⁰ a progress report on which, ‘Toward Equal Citizenship’, was published in December 1999. While recommendations that emerged from the 1996 Commission report led to the establishment of a statutory body, the National Disability Authority, they led also to the much criticised Disability Education Bill and Disability Bill, 2001, both of which were utterly inadequate in their respect for

⁵⁸ For example, the Forum of People with Disabilities, National Association of Mentally Handicapped in Ireland (NAMHI), People with Disabilities in Ireland (PwDI) and Disability Federation of Ireland (DFI), came together to lead a campaign for a comprehensive Disability Bill, ‘The Get Your Act Together Campaign’, which received the endorsement and support of a broad range of individuals and other organisations, both statutory and voluntary, such as the National Disability Authority (NDA), Comhairle, the Irish Council of Civil Liberties (ICCL), the National Association for the Deaf (NAD) and Vantastic.

⁵⁹ ‘The Role of Disability Legislation’, www.un.org/esa/socdev/enable/disovlf.htm.

⁶⁰ ‘A Strategy for Equality: Report of the Commission on the Status of People with Disabilities’ (1996), Commission on the Status of People with Disabilities, Government Publications Sales Office, Dublin.

the above international principles, and were subsequently withdrawn.⁶¹ At present, existing law fails to fully address all forms of discrimination encountered by people with disabilities in Ireland, and further legislation is required.⁶²

The Disability Education Bill

In the aftermath of the 2001 Supreme Court decision in the *Sinnott* case⁶³ that the constitutional right to primary education applies to children only, and ceases at the age of 18 years even where a person has a severe disability, there was much public anger. In response, the Irish Government undertook to quickly introduce two promised pieces of legislation: one intended to deal with the general rights of people with disabilities, the other with the rights of people with disabilities in relation to education. A Special Needs Education Forum was to be convened in 2001, to provide a mechanism for groups, organisations and individuals to contribute to the elements which were make up the state's comprehensive response to the needs of people with disabilities. This forum was not established, in disregard of the right of “[d]isabled persons ... to have their special needs taken into consideration at all stages of economic and social planning” in Article 8 of the UN Declaration on the Rights of Disabled Persons. The emergent Disability Education Bill was roundly condemned by Irish disability groups for its very limited provision of education rights. For example, the Association for Higher Education Access and disability (AHEAD), the national body representing students with disabilities in the third level education sector in Ireland, called “for the immediate withdrawal of the bill and its

⁶¹ The Commission’s report, *ibid*, recommended: “A Disabilities Act should rule out all discrimination in relation to:

- Services provided by public bodies;
- Services provided by private bodies;
- Employment;
- Education.

A Disabilities Act should highlight the following key features:

- A social understanding of the concept of disability rather than an overly medical approach.
- Allowing for difference. The Act must go beyond a formal approach to equality to recognise that true equality requires a recognition and acceptance of difference. Therefore, the Act should require public and private bodies, employers and educators to make 'reasonable accommodation' to meet the specific needs of people with disabilities.
- The core importance of equality. The Disabilities Act should override other general legislation so as to ensure that the principle of equality is achieved.
- Enforcement and access to alternative forms of dispute resolution. Legislation is only as good as its enforcement mechanisms. The Disabilities Act should be enforced by the National Disability Authority ... and mechanisms for alternative dispute resolution should be established so that individuals can have easy access to mechanisms which can resolve any disputes under the Act.”

⁶² For example, social researcher, Dr Pauline Conroy, is quoted in a January 2002 Disability Federation of Ireland Conference Report thus: “Ireland’s legislative framework in relation to the rights of people with disabilities is very problematic, because we have to date used a piecemeal framework, which at the moment encompasses at least six existing pieces of legislation and two more Bills pending rather than one comprehensive Act. The result of this piecemeal approach is that existing legislation is not comprehensive enough, not enforced, or not delivered.” (The conference was entitled ‘Get Your Act Together’ and the report is available at www.disability-federation.ie/Budget/FinalGYATReport.htm.)

⁶³ 12 July 2001.

replacement by a rights-based, person-centred new bill as envisaged by the Report of the Commission on the Status of People with Disabilities ...".⁶⁴

The CESCR, in its 2002 Concluding Observations on Ireland's second report, has advised the Irish government to "enact legislation that extends the constitutional right to free primary education to all adults with special educational needs".⁶⁵ Amnesty International urges Ireland to take immediate action on this recommendation.

The Disability Bill

The enactment of legislation securing the wider fundamental rights of people with disabilities was part of a series of measures to which the government had committed itself at the culmination of a public consultation process in 1997, and its outline was framed by the then newly established Commission on the Status of People with Disability. The Department of Justice, Equality and Law Reform published the outcome of this process, the Disability Bill, 2001, but it was immediately apparent that it lacked a human rights-based approach. It was heavily criticised for this grave omission by the CESCR, and for "the fact that it contained a clause purporting to remove the rights of people with disabilities to seek judicial redress if any of the Bill's provisions were not carried out".⁶⁶ The Irish Department of Finance had successfully prevailed on the government to introduce this clause stating:

*"The Department of Finance cannot accept these recommendations which imply the underpinning by law of access to and provision of services for people with disabilities as a right. This right, if given a statutory basis, would be prohibitively expensive for the Exchequer and could lead to requests from other persons seeking access to health and other services without regard to the eventual cost of providing these services."*⁶⁷

Amnesty International considers these sentiments unacceptable from any government department; the fact that the Irish Government yielded to this view, in marked contrast to its international obligations outlined above, is of considerable concern.

The Bill was abandoned in 2002, and another is currently in preparation, with a new consultation process begun. What sort of legislative proposal will emerge from this process is quite uncertain in relation to its respect for human rights standards, but

⁶⁴ 3 April 2002, www.ahead.ie/press/educpwdbill.html.

⁶⁵ Note 16 above.

⁶⁶ Ibid.

⁶⁷ In the December 1999 'Toward Equal Citizenship' progress report mentioned above, in reply to recommendations nos. 31, 41, 43, 44 and 45 thereof.

clearly, any revived Bill must not again seek to qualify equal rights for people with disabilities.⁶⁸

Equality Legislation

Ireland possesses two pieces of equality legislation: the Equal Status Act, 2000 and the Employment Equality Act, 1998, the latter prohibiting discrimination against people with disabilities⁶⁹ in access to, or conditions of employment; and the former in the provision of goods and services. A statutory body was established to monitor their implementation, the Equality Authority, and an Office of the Director of Equality Investigations (ODEI) to hear cases of complaints of their breach. The protection potentially afforded to people with disabilities by these agencies is consequently extensive. The ODEI has as yet received relatively few complaints on the ground of disability.⁷⁰ The Equality Authority has extensive powers to conduct research into, and make recommendations on, how to put in place best practice and finally secure to this sector full freedom from the discrimination they undoubtedly are experiencing. For instance, since the state is prohibited from discriminating in the provision of services, and yet is patently falling far short of securing the delivery of adequate services to all people with disabilities, these two agencies are key to the delivery of public services in an accessible, non-discriminatory way. All state agencies could be required to demonstrate how they have adopted measures to remove discriminatory barriers. This is doubly needed in the context of people with disabilities at risk of multiple discrimination in the manner of delivery of public services by government agencies.

Irish legislation does not go as far as disability laws in the UK and Canada in its requirements of public bodies. The Disability Discrimination Act in the UK, in addition to the negative duty to refrain from discrimination, provides the legally enforceable positive duty to promote equality, requiring public bodies to themselves conduct audits of their own performance in devising and implementing policies to mainstream equality.

⁶⁸ The Minister of State with responsibility for disability issues is charged with its drafting, whose promise in July 2002 that a rights-based approach would be adopted in any new Bill, and not to introduce legislation which “imposes duties without imposing remedies”, Amnesty International initially welcomed. (In the Irish Times newspaper, 10 July 2002, the Minister of State was quoted thus: “I can't see myself as an individual bringing in legislation which imposes duties without imposing remedies. I am not capable of bringing that in.”) Amnesty International is concerned by recent public statements by the Minister for Justice, Equality & Law Reform that a full rights-based agenda might not, in fact, be pursued, indicating an intention to follow the original path once again.

⁶⁹ In addition to 8 other prohibited grounds of discrimination.

⁷⁰ For example, in its 2001 Annual Report, it recorded that, during that year, it had been presented with just 18 complaints on the ground of disability, of which 4 were complaints made against education providers, and 18 against service providers (other than pubs, nightclubs and hotels; shops; education; or insurance providers). In the same year, it received 641 complaints on the ground of being a member of the Travelling community.

A new EU Framework Directive on Employment could positively influence the operation of the Employment Equality Act, so that it is more in line with that envisaged by the Commission on the Status of People with Disabilities in requiring public bodies to promote and mainstream equality. One commentator suggests that this framework Directive “could also put a stronger emphasis on the social (as opposed to medical) construction of disability [and] higher standards for the public sector to be a model employer”.⁷¹ In light of this, it is to be hoped that Ireland will implement this measure speedily and to the fullest extent when it comes into effect.

Conclusions & Recommendations

Discrimination against people with disabilities is, of course, not a uniquely Irish experience. In addition to the international moves described above to address the underlying causes for this, the year 2003 has been designated European Year of People with Disabilities by the European Union, and it is hoped that the Irish Government will take this opportunity to address the many deficiencies in its national system for the protection of their rights. The CESCR has observed “no insurmountable factors or difficulties preventing the State party from effectively implementing the Covenant”.⁷² The UN HRC has said that Ireland must take further action in “ensuring the full and equal enjoyment of Covenant rights by disabled persons, without discrimination”.⁷³ Amnesty International urges the Irish Government to have taken strong action on this recommendation before Ireland’s third periodic report to the HRC, due by 31 July 2005. The challenge for Ireland is to shape its policies and laws around evolving international standards, norms and best practice, not to formulate them by reference to past behaviour.

In furthering the advancement of the rights of persons with disabilities in Ireland, it is imperative that full participation of people with disabilities is involved:

“Fundamental to the achievement of the goal of an inclusive society and the development of strategies that reflect the rights and needs of persons with disabilities is the question of process. Persons with disabilities must be full participants in the bodies and procedures by which both general laws and policies, as well as disability-specific ones, are formulated. This is essential for ensuring the responsiveness, legitimacy and effectiveness of such laws and policies, as well as reflecting the rights of persons with disabilities to full participation in the life of the community, including all forms of public decision-making.”⁷⁴

⁷¹ Note 18 above.

⁷² Note 16 above.

⁷³ Concluding Observations of the Human Rights Committee, note 17 above.

⁷⁴ Report of the United Nations Consultative Expert Group Meeting on International Norms and Standards relating to Disability, note 5 above.

Amnesty International strongly recommends that Ireland begin the process immediately of adopting new Disability legislation, along the same line taken in drafting the UN convention on the right of people with disabilities. In observance of the above comments of the CESCR, Irish legislators should take a human rights-based approach, and refrain from inserting a similar clause as that in section 47 of the Disability Bill, 2001, purporting to deny people with disabilities the right to judicial redress. Article 13 of the Declaration on the Rights of Disabled Persons states: "Disabled persons, their families and communities shall be fully informed, by all appropriate means, of the rights contained in this Declaration". Amnesty International recommends that, once legislation is adopted, all measures be taken to promote it amongst the population sector it is designed to protect. It further recommends that existing equality legislation be used to its full extent.

Amnesty International urges the Irish Government to take immediate and effective action on each of the relevant CESCR's 2002 recommendations.⁷⁵ By the time of Ireland's third periodic report to it, due by 30 June 2007, it is to be hoped that each recommendation from the 2002 report will have been dealt with to the satisfaction of this committee.

⁷⁵ 2002 Concluding Observations, note 16 above.

Chapter 3

COMMUNITY MENTAL HEALTH SERVICES

"It is widely accepted that community care is more effective as well as more humane than inpatient stays in mental hospitals. Surprisingly, a large number of economically developed countries with extensive mental health infrastructure still have a large proportion of their psychiatric patient beds in mental hospitals. Whereas Ireland, Israel, Netherlands and Spain have 80-95% of the total psychiatric beds located in mental hospitals; this figure for France, Germany and Japan is 60-75% and for Australia, Canada and USA is around 40%."

World Health Organisation⁷⁶

Introduction

There have been significant advances in Ireland's mental health care system in recent years: in the provision of community psychiatric nursing services, community residences, day hospitals and day care centres, voluntary nursing associations and other rehabilitation facilities. Particularly since the publication of the report, 'Planning for the Future',⁷⁷ in 1984, there has been continued growth of community-based facilities, alongside the provision of acute psychiatric units attached to or associated with general hospitals, to replace services previously provided in large psychiatric hospitals throughout the country. Progress is ongoing with the setting up of new mental health centres, day hospitals, and other day facilities.

Funding has also been made available to support groups and organisations such as Schizophrenia Ireland, Mental Health Ireland, the Irish Advocacy Network, GROW and AWARE to heighten awareness and develop services such as carers' support groups.

Yet, notwithstanding these advances, it must be acknowledged that there are many serious deficiencies in community mental health services. The consequences can impact severely on the quality of life for people with mental illness, ultimately amounting to a lack of respect for basic human rights.

Mental Health Authorities

The 11 regional Health Boards were established under the Health Act, 1970 and charged with responsibility for the delivery of health services. They assumed the functions formerly carried out by local authorities, which, under the Mental Treatment Act, 1945, had responsibility for mental health services. A majority of the members of each Health Board are public political representatives. Within each Health Board, mental health services are organised in catchment areas, whose populations range from 40,000 to over 250,000. Catchment areas are, in turn, divided

⁷⁶ 'Mental Health: New WHO Country Data Show Resources Fall Short of Needs', Press Release WHO/30, 23 April 2002.

⁷⁷ 'The Psychiatric Services: Planning for the Future' (1984), Department of Health and Children.

into sectors, each with a population of 20,000 to 50,000. Each sector has a mental health team, led by a Clinical Director, who is a consultant psychiatrist, and is responsible for the organisation of mental health services in each catchment area.

The Health Boards are statutorily obliged under the Health Act, 1970 to provide an adequate mental health service within their region, encompassing the prevention, diagnosis and treatment of mental illness. They report to the Department of Health and Children, which oversees general policy and funding. The Health Boards Executive, a statutory body established in February 2002, has as its main purpose the pursuit of “the strategic development of a modern, equitable, high-quality and person-centred health service”.⁷⁸ While each of these agencies are involved in the planning and delivery of services, responsibility for complying with international human rights treaties remains with central government.

International Standards

Principle 1 of the UN Principles for the Protection of Persons with Mental Illness (MI Principles)⁷⁹ lays down the overarching standard expected of all nations: “All persons have the right to the best available mental health care....”

As explained in Chapter 1, the MI Principles reflect the United Nations’ interpretation of the basic rights and freedoms of people with mental illness that must be secured if Ireland is to be in full compliance with the International Covenant on Economic Social and Cultural Rights (ICESCR).⁸⁰ They provide a catalogue of exacting protections, including criteria for the determination of mental illness, treatment, standards of care, the rights of people with mental illness in mental health facilities, and the provision of resources. In compliance with the ICESCR, Ireland is also obliged to secure “the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country”.⁸¹

De-Institutionalisation

The number of people in psychiatric hospitals in Ireland at any one time has plummeted over the decades: in 1958, there was an all time high of 21,075 in-patients in public psychiatric hospitals compared with about 4,500 at present.⁸² A government Commission of Inquiry in 1966 suggested that the number of in-patients

⁷⁸ Minister for Health and Children, Written Answers to Dáil Questions, 20 March 2002, www.gov.ie/debates-02/20march/D200302C.PDF. The Executive was established under Part V, Section 21 of the Health (Eastern Regional Health Authority) Act, 1999.

⁷⁹ UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, adopted by General Assembly Resolution 46/119 of 17 December 1991.

⁸⁰ See Chapter 1.

⁸¹ Committee on Economic, Social and Cultural Rights, General Comment 14, UN ESCOR, 2000, UN Doc No E/C.12/2000/4, at para 36.

⁸² On 31 March 2001, there were 4,321 residents in in-patient psychiatric care according to ‘Irish Psychiatric Hospitals and Units Census 2001’ (2002), Daly A & Walsh D, Health Research Board.

in Ireland at the time as a proportion of its population was among the highest in the world. The subsequent reduction in in-patient psychiatric beds, it has been suggested,“ was largely due to the death of long-stay patients, and to a lesser extent to the community resettlement of long-stay patients...”⁸³ In the 1980s, the process of de-institutionalisation occurred in Ireland at about the same time as elsewhere in the world, with a move from placing people in large psychiatric hospitals towards a more community-based model of service provision. However, this process has met with some difficulties internationally, with sufficient resources not made available to ease the transition to community care. The World Health Organisation (WHO) warns:

*“While de-institutionalisation is an important part of mental health care reform, it is not synonymous with de-hospitalisation. De-institutionalisation is a complex process leading to the implementation of a solid network of community alternatives. Closing mental hospitals without community alternatives is as dangerous as creating community alternatives without closing mental hospitals. Both have to occur at the same time, in a well-coordinated incremental way.”*⁸⁴

In other words, psychiatric beds should not be reduced in favour of community-based alternatives until those alternatives are established and fully operational. A press release announcing the 2001 Health Research Board (HRB) psychiatric hospitals and units census noted however:

*“The number of admissions to psychiatric hospitals and units has changed little over the last twenty years according to HRB databases. In all there were 24,282 admissions in the year 2000 ... and 70% of these were re-admissions. This exemplifies both the enduring or recurrent nature of much major mental illness and the need for a greater expansion of community based alternatives to long stay hospital care....”*⁸⁵

The fact, therefore, that the number currently in in-patient care in Ireland has fallen so dramatically does not mean that mental health care is being adequately provided elsewhere. While one might believe that those who would have been in psychiatric hospitals are now being successfully cared for in the community, “many people, including many health workers, are concerned that many of these people are homeless, or are 'walking wounded' living lonely existences, or are living inappropriately with family members and sometimes causing them considerable stress or are in prison”⁸⁶.

⁸³ ‘We Have No Beds: An Enquiry into the Availability and Use of Acute Psychiatric Beds in the Eastern Health Board Region’ (1999), Keogh F, Roche A & Walsh W, Health Research Board, Department of Health and Children.

⁸⁴ The World Health Report 2001, ‘Mental Health: New Understanding, New Hope’, WHO, Geneva.

⁸⁵ HRB Press Release, ‘Irish Psychiatric Hospitals and Units Census 2001’, 12 May 2002.

⁸⁶ ‘Facing up to Mental Illness’, Jesuit Centre for Faith and Justice, Working Notes Issue 34, April 1999.

The 2001 WHO report, 'Mental Health: New Understanding, New Hope',⁸⁷ says: "a sound de-institutionalisation process has three essential components:

- Prevention of inappropriate mental hospital admissions through the provision of community facilities;
- Discharge to the community of long-term institutional patients who have received adequate preparation;
- Establishment and maintenance of community support systems for non-institutionalised patients."

De-institutionalisation in Ireland has failed to live up to this standard. Ireland still has excessively high admission rates to psychiatric hospitals, both voluntary and involuntary, due, in large part to a lack of community-based alternatives. At the same time, there is a shortage of acute hospital beds for those in need of emergency admission due to inappropriate non-acute admissions – i.e. where people who do not require emergency in-patient care are nevertheless admitted to hospital – because of a lack of appropriate services for a range of needs. There is a high rate of mental illness within the homeless population, and a high proportion of acute beds are inappropriately taken up by long-stay and homeless people who have nowhere else to go. Many of Ireland's older hospitals still accommodate older long-stay patients and long-stay patients with intellectual disabilities even where they are known to be suitable for community placement. Rather than being well-coordinated and methodical, Ireland's de-institutionalisation policy and practice has been uncoordinated, piecemeal and ad hoc.

Community Care

The WHO 2001 annual report provides a detailed account of international best practice in the planning and delivery of mental health care, and what is expected of all states in their treatment of people with mental illness; and lays down a comprehensive package of recommendations for states to implement according to their means.⁸⁸ This agency has given its seal of approval to community-based care as a first recourse, and only where admission to hospital is therapeutically necessary should community care be bypassed:

"Community care has a better effect than institutional treatment on the outcome and quality of life of individuals with chronic mental disorders. Shifting patients from mental hospitals to care in the community is also cost-effective and respects human rights. Mental health services should therefore be provided in the community, with the use of all available resources. Community based services can lead to early intervention and limit the stigma of taking treatment. Large custodial mental hospitals should be replaced by community care facilities, backed by general hospital psychiatric beds and home based support, which meet all the needs of the ill that were

⁸⁷ See Chapter 1.

⁸⁸ See also the 1996 'Guidelines for the promotion of Human Rights of persons with Mental Disorder' (Geneva, WHO Division of Mental Health and Substance Abuse), in which WHO lays out a checklist for states' observance of their obligations under the international human rights system.

the responsibility of those hospitals. This shift towards community care requires health workers and rehabilitation services to be available at community level, along with the provision of a crisis support, protected housing, and sheltered employment.”⁸⁹

Various studies have shown that, while for some, acute in-patient care is essential, a comprehensive community-based service has better results for many people with mental illness than acute hospitalisation.⁹⁰ For those not in need of hospitalisation, it must be said that such a community-based service is, in fact, the “best available mental health care”, and is, therefore, an entitlement under international human rights law. This is also a requirement of MI Principles 7⁹¹ and 9(1),⁹² which would be breached in the case of those instead hospitalised. The very high rate of psychiatric in-patient admission in Ireland - currently 75 per 100,000 of total population, compared to a rate of 49 per 100,000 for England and Wales and 26 per 100,000 for Italy - suggests a failure to respect the rights of many.⁹³ There is also a wide divergence in the admission rates between the Health Board regions. The 2001 HRB Census said:

“There were a number of differences in findings between Health Boards. For example, the South Eastern Health Board had the highest rate of hospitalised residents (239.1 per 100,000 population), while the South Western Area Health Board had the lowest (99.1 per 100,000 population). The percentage of patients detained on an involuntary basis in psychiatric hospitals and units ranged from 23% in the North Western and Southern Health Boards to 11% in the South Eastern, reflecting differing provision and usage of community alternatives to in-patient care. ... these [census] publications point to the uneven pace of development between Health Boards, and indicate the necessity of continuing scrutiny of the extent and quality of community placed alternatives to what was formally an extensive system of institutional care.”⁹⁴

⁸⁹ 2001 annual report, note 9 above.

⁹⁰ See ‘We Have No Beds’ (1999), note 8 above, pp13 – 15 for a review of research.

⁹¹ “Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives.”

⁹² “Every patient shall have the right to be treated in the least restrictive environment”

⁹³ Schizophrenia Ireland has said that it is “concerned that the high rate prevalent in Ireland reflects a poor level of support and treatment regimes for persons living in the community which in turn leads to an over reliance on the hospital bed and the use of involuntary admissions when crisis situations present”. (‘Submission to the European Committee for the Prevention of Torture and Inhuman or Degrading treatment or Punishment (CPT)’ (2002).)

⁹⁴ ‘Irish Psychiatric Hospitals and Units Census 2001’ (2002), Daly A & Walsh D, Health Research Board, Department of Health and Children, Government Publications Sales Office, Dublin.

The 1984 government strategy, 'Planning for the Future',⁹⁵ lists seven essential components of community care, which are broadly similar to the above WHO specifications:

- Prevention and early identification
- Assessment, diagnostic and treatment centres
- In-patient care
- Day care
- Out-patient care
- Community-based residences
- Rehabilitation and training

None of these have yet been adequately and consistently provided in Ireland. The South Western Area Health Board noted in 2001, for example:

*"... 'Planning for the Future' recommended 250 acute in-patient places - we currently have 121. It recommended 375 day hospital spaces - we currently have 94. It recommended 375 day centre spaces - we currently have 261. We have 253 residential support places in high, medium and low support facilities. Based on our Board's population, this should be 300 high support, 300 medium support and 300 low support places."*⁹⁶

▪ *Prevention and early identification*

Amnesty International has been advised by mental health professionals that, in their experience, many people admitted to psychiatric in-patient care are seriously ill in large part because they have not been identified and treated at an earlier stage, which may have prevented their situation from deteriorating to an acute level. The government report 'We have no beds' found in the then Eastern Health Board area: "Domiciliary and home-care services for assessment, treatment and intervention purposes, which might reduce inappropriate admissions, were available in a very limited number of services."⁹⁷

Prevention of re-admissions to in-patient care has also been shown to occur when families of those with serious mental illness have been educated about the illness and how to manage it, yet this is not routine procedure. A study of carers' views in five European countries, including Ireland, by the European Federation of Associations of Families of People with a Mental Illness found:

"For almost all 'areas of care' or themes, between 22% and 44% of carers were unsatisfied or very unsatisfied. The low satisfaction found for "Advice on how to handle specific problems" and "Information" agrees with the findings of other studies.

⁹⁵ Note 2 above. See also 'We Have No Beds', note 8 above, Appendix 4: Components of a Comprehensive Psychiatric Service.

⁹⁶ 'Board meeting - 4th December 2001 - A proposed Action Plan for Adult Mental Health Services in the South Western Area Health Board', Report No. 16/2001.

⁹⁷ Note 8 above.

*The findings in the areas of "Help for the patient with preserving and regaining social functioning", "Help in regaining structure and routine in their life" and "Prompt assistance in their own environment" shows the need for early intervention and outreach work in the community."*⁹⁸

As pointed out in 'Planning for the Future', the main burden of caring for a person with mental illness in the community, particularly a person with chronic mental illness living at home, may fall on the patient's family, and the cost to the family in terms of emotional stress, can be considerable. Failure to provide assistance to relatives of people with mental illness who live at home can impact negatively on the mental health of all concerned.

▪ *Assessment, diagnostic and treatment centres*

Treatment within the community remains poor in many areas: it relies overly on medication alone, and treatment plans are not always adopted in consultation with patients in line with the 1998 'Guidelines on Good Practice'.⁹⁹ Despite the emphasis on primary care in the 2001 government Health Strategy,¹⁰⁰ general medical practitioners (GPs) are often overburdened with mental illness,¹⁰¹ which puts a lot of pressure on local mental health clinics. Where GPs are treating people with mental illness, Amnesty International has learnt that in many areas they do not enjoy the back-up and support of the range of additional services they should, and there are in many areas long waiting lists for referrals to secondary psychiatric care. One Irish organisation has noted:

*"Typical of the poor quality of delivery is the situation in one Dublin suburb where the out-patient clinic is in the local community centre. Even with an appointment a person might have to queue for two hours in full view of everyone who knows that they are queuing for psychiatric treatment. Given the stigma attached to psychiatric illness, this can put additional stress on ill persons and their carers."*¹⁰²

The psychiatric crisis intervention service has never been put into place, despite plans to do so in the 1984 strategy, to deal with local emergencies. One of the findings of 'We have no beds' was that: "Community-based, emergency out-reach, 24 hour, seven-day-week, crisis intervention services were generally unavailable." While this report refers to the then Eastern Health Board area - where, as a large urban area and a high homeless population,¹⁰³ it is particularly needed - the same

⁹⁸ 'Breaking the Silence: Carers' views on the help given during the first episode of psychosis, A European perspective', Madrid, October 2001.

⁹⁹ 'Guidelines on Good Practice and Quality Assurance in Mental Health Services' (1998), Department of Health and Children. See Chapter 5.

¹⁰⁰ 'Quality and Fairness - A Health System for You', Department of Health and Children. See Chapter 9.

¹⁰¹ It is estimated that up to 40 per cent of consultations with GPs involve mental health problems, but there are no official figures available on this.

¹⁰² 'Facing up to Mental Illness', note 11 above.

¹⁰³ See Chapter 7.

can be said of much of the rest of the service. The result is that at weekends and at night many people are inappropriately admitted instead to acute psychiatric units.

- *In-patient care*

While many people with mental illness will be best served by community-based care, for others, admission to acute in-patient care is necessary, and is the “best available mental health care” required by international law. In Ireland, there is a shortage of hospital beds for acute admissions, with the result that many are left waiting for the care they need, or people in hospital are inappropriately moved. This will be elaborated in Chapter 4.

- *Day Care*

The Inspector of Mental Hospitals’ report for 2001 observed:

“... difficulties arise in relation to the concept of day hospital assessment and treatment. Our experience countrywide is that health professionals are confused in their conceptualisation of what a day hospital should be about, what patients it should treat and what treatments should be available. In many instances, so-called day hospitals do not deal with a broad range of psychiatric disorder, particularly the more serious disorders, and do not provide a broad range of treatments; ideally, a day hospital should provide every treatment that is available in an in-patient setting. Many premises are too small or do not have sufficiently large internal spaces to deal with more serious illness.”¹⁰⁴

In response to this report, Schizophrenia Ireland declared that it was “astonished at this situation where those people who have the most severe mental illnesses are receiving the least amount of treatment and intervention”.¹⁰⁵

- *Out-patient care*

As outlined in Chapter 4, the widespread under-provision of community mental health services has led to people being admitted inappropriately to hospital beds because there are insufficient services situated in the community.

Patients who do attend clinics are likely to see registrars-in-training, which change every six months, resulting in a distinct lack of continuity in the doctor-patient relationship, which as outlined in Chapter 5, is vital to the treatment compliance and recovery of a person with mental illness according to WHO. Amnesty International has received many complaints from patients regarding this issue, and the training plans of Health Boards should not be allowed to take priority over the well-being of patients. Amnesty International has also been advised that, in most areas, there is no home follow-up by a community mental health nurse after discharge from hospital, who can only be seen at a clinic.

¹⁰⁴ ‘Report of the Inspector of Mental Hospitals for the year ending 31st December 2001’, Department of Health and Children, Government Publications Sales Office, (2002). The Inspector of Mental Hospitals currently has a number of functions under the Mental Treatment Act, 1945, including visiting and inspecting all psychiatric institutions at least once a year. The office of the Inspector will cease to exist when the Mental Health Act, 2001, comes into effect, some of whose functions will be taken over by the Mental Health Commission and others by the Inspector of Mental Health Services.

¹⁰⁵ ‘Schizophrenia Ireland’s Response to the Inspector of Mental Hospitals Report 2001’ (2002).

- *Community-based residences*

There is a shortage of suitable accommodation right throughout the mental health service, not alone in acute units, but also in community-based residential facilities and hostels.¹⁰⁶ The latest Report of the Inspector of Mental Hospitals observes that the development of community based residential accommodation is somewhat uneven throughout the country, a problem adverted to in many previous reports of the Inspector.¹⁰⁷ Preliminary results from a survey of service providers by the Irish Psychiatric Association has found a significant mismatch between the availability of community-based residences and the number of people with mental illness who would be suitable to take up these places, resulting in a considerable number of people having to remain in large outmoded hospital accommodation.¹⁰⁸ This leads to a very high rate of admission to in-patient care, contrary to MI Principle 9(1), and may lead to increased numbers of people with mental health problems becoming homeless.¹⁰⁹

- *Rehabilitation and training*

'We Have No Beds' found in the EHB region "a shortage, in some cases, a virtual non-existence, of rehabilitation places" for patients inappropriately occupying acute beds. Schizophrenia Ireland has said: "We have long been conscious that many people in our mental health care services do not have adequate rehabilitation services."¹¹⁰ The widespread lack of rehabilitation and occupational therapy for people with mental illness both in in-patient care and in the community risks irreparably compromising their recovery, and is inconsistent with many of the rights in the ICESCR.¹¹¹ The Inspector of Mental Hospitals referred to the distinct lack of rehabilitation services in his report for 2000, an assertion that remains valid today.¹¹²

¹⁰⁶ 'We Have No Beds', note 8 above, for example, found a "serious shortage of community-based continuing care residential places".

¹⁰⁷ Schizophrenia Ireland, in its response to the report, note 30 above, said: "We feel the reasons for this problem is a mixture of poor resourcing of capital development programmes for community residential accommodation and the issue of not in my backyard syndrome whereby local residents have raised planning objections to the development of community based residences. This in our eyes reflects an ignorance on behalf of the community of the need and desire of people with mental illness to lead a normal life."

¹⁰⁸ This research was conducted for the IPA by Dr Veronica Keane, and is not yet published at the time of writing.

¹⁰⁹ See Chapter 7.

¹¹⁰ Note 30 above.

¹¹¹ It also conflicts with MI Principle 3: "Every person with a mental illness shall have the right to live and work, to the extent possible, in the community."

¹¹² See however in his report for 2001, the Inspector notes: "The importance of the issue of a specialised approach to rehabilitation of persons suffering from enduring mental illness, with its accompanying impairments and handicaps, has been recognised by the creation of consultant posts specialising in rehabilitation."

Specialised Services

In addition to specialised services for homeless people, prisoners and children, which are described later, many others are deficient in Ireland, including:

- *Drug and Alcohol Services*

According to WHO standards, all states should “ensure the accessibility of effective treatment and rehabilitation services, with trained personnel, for people with hazardous or harmful alcohol consumption and members of their families”.¹¹³ It emphasises that: “Early recognition of problem drinking, early intervention for problem drinking, psychosocial interventions, ... teaching new coping skills in situations associated with a risk of drinking and relapse, family education and rehabilitation are the main strategies proven to be effective for the treatment of alcohol-related problems and dependence.”¹¹⁴ These forms of intervention, however, are underprovided in the Irish health services. Instead, there is a reliance on in-patient psychiatric care for the treatment of alcohol dependence - as Eurocare, an alliance of European agencies, has noted:

*“The Green Paper on Mental Health, published by the Government in June 1992, commented that, in the years since the publication of ‘Planning for the Future’ in 1984, some Health Boards have developed local alcohol/drug services and recruited addiction counsellors to work in sector services. But it also pointed to the extremely high rate of admission to psychiatric hospitals for alcohol-related disorders in some Health Boards and suggested that such rates demonstrated the need to develop alternative treatment facilities in the community.”*¹¹⁵

The report of the Inspector of Mental Hospitals for 2001 recorded that the Inspectorate was “struck by the number of people with ‘alcohol problems’ who remain needlessly in acute psychiatric beds, contributing in some cases to perceived acute bed shortages”.¹¹⁶ The 1999 report, ‘We Have No Beds’, also pointed to the

¹¹³ WHO European Charter on Alcohol, drawn up at the European Ministerial Conference on Health, Society and Alcohol hosted by WHO, Paris, France, 12-14 December 1995.

¹¹⁴ 2001 report, note 9 above.

¹¹⁵ ‘National Alcohol Policy Ireland’, Eurocare - Advocacy for the Prevention of Alcohol Related Harm in European, available at www.eurocare.org/profiles/irelandsect2. It also notes the lack of research in this area: “The dearth of alcohol research in Ireland, with youth research the exception, means that we over-rely on international research. We continue to need clarification on important alcohol related issues such as the economic, social and psychological causes and effects of alcohol consumption, the extent of alcohol dependence and treatment effectiveness. We also have many unanswered questions in relation to the most effective alcohol prevention models in different alcohol cultures with a group and settings approach. Alcohol research must be improved to provide important measures for public health assessment and to allow for both effective and efficient use of resources.”

¹¹⁶ The Inspector’s report cautions: “... ‘detoxification’ from alcohol toxicity is inappropriate and, in severe toxicity, an unsafe procedure, in a psychiatric setting. Where toxicity is severe, with the likelihood of severe withdrawal symptoms and possible neurological complications, the safest place for such persons is on general medical wards, not in an isolated psychiatric setting.”

need to address the “uneven availability and responsiveness of alcohol services across the EHB area”.¹¹⁷

In relation to drug use, the WHO 2001 report advocates: “Counselling and other behavioural therapies are critical components of effective treatment of dependence ... Medical detoxification is only the first stage of treatment for dependence, and by itself does not change long-term drug use. Long-term care needs to be provided, and comorbid psychiatric disorders treated as well, in order to decrease rates of relapse.” It further notes the economic benefit of such an approach: “Drug dependence treatment is cost-effective in reducing drug use (40-60%), and the associated health and social consequences, such as HIV infection and criminal activity. [...] Treatment has been shown to be less expensive than other alternatives, such as not treating dependants or simply incarcerating them.” The lack of drug dependence services in Ireland other than methadone maintenance treatment, for which there is a mismatch between demand and provision, is, therefore, doubly unfortunate.

- *Psychiatry for older persons*

The Inspector of Mental Hospital’s report for 2001 observed: “Considerable progress has been made in the last few years in providing specialised services for psychiatric illness in older persons, with the appointment of consultant psychiatrists for this sub-specialty.” It also noted: “In many cases, a full multi-disciplinary team has not been available to the later-life services, thus restricting the range of their functions. Day hospitals providing such services are required, preferably adjoining general in-patient hospital facilities for the elderly; for the most part, these have not yet been put in place.”

On the number of older people in in-patient care, the Inspector also notes:

“Currently, close to forty per cent of persons resident in psychiatric units and hospitals are over sixty-five years and in some instances, particularly among the long-stay patients, this figure exceeds fifty per cent. Many, but not all, of these older persons now show little sign of behavioural disturbance related to psychiatric disorder and, among the more elderly of them in particular, their needs and disabilities relate to their age rather than to any psychiatric disorder. Their continued residence in long-stay psychiatric facilities is neither appropriate nor best suited to their needs. Their remaining on the psychiatric register is neither helpful clinically nor appropriate from a civil rights point of view. The Inspectorate has been urging the transfer of their care either to community residences where that is possible or to suitable in-patient continuing care facilities for older persons or, when they remain in psychiatric structures, their de-designation from the psychiatric register and the provision of their medical care by general practitioners.”

¹¹⁷ Conversely, the report of the Inspector of Mental Hospitals for 2001 refers to “the extensive provision of community-based alcohol treatment services”.

- *Asylum Seekers and Refugees*

Also mentioned in Chapter 6, positive measures are required for asylum seekers and refugees, who have specific mental health needs, as described in the Irish Journal of Psychological Medicine:

“Asylum-seekers too present particular challenges, as they come from a wide variety of cultural backgrounds and have sharply diminished community support. They may already have experienced human rights abuse, torture and displacement in their homeland. On arrival in a new country, they may well do on to face confinement in detention centres, enforced dispersal and ongoing discrimination. Clearly, the delivery of appropriate, acceptable mental health care to this population is a critical and complex task, requiring strategic planning and flexible resourcing.”¹¹⁸

In Ireland, while local needs assessments have been conducted in several health board areas,¹¹⁹ asylum seekers and refugees are not routinely provided with specialised psychological or psychiatric services.¹²⁰ Awareness raising among this population of the general services available is also necessary. A study of asylum seekers in Cork concluded: “Awareness raising work is particularly needed to highlight the existence of psychological health services in Cork such as psychologists (who are trained to deal with cases of severe trauma), shelters, and organisations such as the Rape Crisis Centre. The research found that asylum seekers are unaware of all such services and the assistance available to them in Cork which might help them to deal with previous trauma as well as the problems experienced as an asylum seeker in Ireland.”¹²¹

- *Travellers and other Ethnic Minorities*

MI Principle 7(3) states: “Every patient shall have the right to treatment suited to his or her cultural background.”

Article 3 of the UN Convention on the Elimination of All Forms of Racial Discrimination obliges Ireland “to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of ... [t]he right to ...medical care”. Article 2(2) thereof states: “States Parties shall, when the circumstances so warrant, take, in the social, economic, cultural and other fields, special and concrete measures to ensure the adequate development and protection of certain racial groups or individuals

¹¹⁸ ‘Mental health and human rights: challenges for a new millennium’, Kelly B D, Editorial, *Ir J Psych Med* 2001; 18(4): 114 – 115 at 114.

¹¹⁹ For example, a report published by the Southern Health Board on the health needs of asylum seekers in that region found indications of significant mental health problems in that population. (‘A better world healthwise – a needs assessment of immigrants in Cork and Kerry’ (2002), Department of public health, SHB.)

¹²⁰ For information on the Centre for the Care of Survivors of Torture (CCST), a nongovernmental agency established in 2001 dedicated to the care and rehabilitation of survivors of torture, see their website: www.ccst.ie.

¹²¹ ‘The Needs of Asylum Seekers in Cork’ (2002), Collins A, NASC, The Irish Immigrant Support Centre.

belonging to them, for the purpose of guaranteeing them the full and equal enjoyment of human rights and fundamental freedoms.”

The Irish Travelling community has been recognised by the UN as a distinct ethnic minority group, so that any unwarranted discrimination against Travellers in their enjoyment of basic human rights on grounds of their ethnicity is prohibited as ‘racial discrimination’ under the above Convention. Travellers, in addition to their unique customs and way of life which must be respected, have a different general mental health profile to the settled population, and consequently quite different mental health care needs.¹²² A recent analysis of the mental health of Travellers observed:

*“Travellers are widely acknowledged as one of the most marginalised and disadvantaged groups in Irish society. Travellers fare poorly on every indicator used to measure disadvantage: unemployment; poverty; social exclusion; health status; infant mortality; life expectancy; accommodation and living conditions.”*¹²³

As will be explained in Chapter 9, many of these factors are also indicators of mental ill-health. Furthermore, according to this study, the disproportionately high rate of imprisonment of Travellers in Ireland’s criminal justice system leads to certain identifiable mental health implications arising from this and the normalisation of this experience.¹²⁴ Yet, while it is estimated that there are 4790 Traveller families in Ireland, comprised of 21158 individuals,¹²⁵ Amnesty International is disappointed to see that there is little research available on the mental health needs of this section of the Irish public. “Little is known concerning the extent to which Travellers are over or under-represented in general adult psychiatric services. Less is known regarding the true prevalence of mental illnesses in the Traveller population.”¹²⁶

Furthermore, there is an a widespread lack of specialised mental health care services for this significant minority group, leading to their poor uptake of these services.¹²⁷

¹²² For instance, a high level of psychological distress in Traveller women, which was particularly higher in those with the worst accommodation and environmental facilities, was found in ‘The Psychosocial Health of Irish Traveller Mothers’, Heron et al, *Cultivating pluralism: Psychological, Social and Cultural perspectives on a changing Ireland*, MacLachlan M, O’Connell M (eds), Oak Tree Press, 2000.

¹²³ Irish Travellers and forensic mental health’, Linehan S, Duffy D, O’Neill H, O’Neill C & Kennedy H G, *Ir. J. Psych. Med.* 2002; 19(3).

¹²⁴ See Chapter 8.

¹²⁵ Traveller Accommodation Unit, Department of Environment and Local Government, Dublin (1999).

¹²⁶ ‘Irish Travellers and forensic mental health’, note 48 above. This study also reported: “Travellers admitted to the Central Mental Hospital had less severe mental illness than white Europeans, and more learning disability. This distinguished them from other ethnic minorities in the same series who showed a marked excess of severe mental illness when compared with white Europeans.”

¹²⁷ “Travellers show a high utilisation of general practitioner and accident and emergency services, and a low utilisation of other hospital services including aftercare, preventive services and specialised services such as psychiatric care.” *Ibid.*

On minority ethnic groups generally, in its submission to the government's National Action Plan against Racism public consultation, the Irish Psychiatric Association said:

*"There is extensive evidence suggesting that racially distinct communities have significantly higher rates of mental illness.¹²⁸ [...] Services need to significantly gear up to give a sophisticated and effective mental health care to racially distinct communities by improving access to supportive agencies and culturally sensitive services."*¹²⁹

Amnesty International endorses its recommendations: *inter alia* that the mental health services should be systematically informed and trained for the reality that culturally sensitive mental health care is now a requirement of modern Ireland; that the extra needs of minority ethnic communities should be assessed widely and properly provisioned for; and that these communities should have prompt and equal access to good health care and should encounter policies that foster equitable, prompt and reasonable assessments of their true needs.

- *Hearing impaired*

The 1984 strategy report 'Planning for the Future'¹³⁰ outlined the need for specialised psychiatric services for people with hearing impairments, in line with other countries, particularly the USA, to provide assessment, diagnosis and treatment at a centre where all staff members are skilled in communicating with people with hearing impairments. It provided a template for such a service in Ireland and yet, nineteen years later, such a service has not been comprehensively developed. This again is contrary to the obligation to ensure that everyone has "best available mental health care".¹³¹

- *Lesbian, Gay and Bisexual People*

A recent Equality Authority report has noted that within the health field, fear of prejudice and discrimination restrict access to health services of lesbian, gay and bisexual people, and that their marginalisation "indicates the need for a supportive,

¹²⁸ The paper explains: "This is partly due to the high rates of mental illness they bring to the community which hosts them, for reasons of trauma and additional disadvantage from their point of origin. [...] These further disadvantages are compounded by the experience of racism and discrimination by host communities. This is amplified by difficulty in access to trusted medical care for a multitude of reasons. This translates to high rates in untreated illness leading to alcoholism, drug abuse, suicide and other negative outcomes. These disadvantages translate into second and third generation racially distinct groups and represent enduring and long-term potential disadvantage."

¹²⁹ 'Submission from The Irish Psychiatric Association to The National Action Plan against Racism Consultation', 27th September 2002.

¹³⁰ Note 2 above.

¹³¹ MI Principle 1.

appropriate and accessible health service".¹³² It notes:

"... the hostility, prejudice and systemic exclusions that are all too often the experience of lesbian, gay and bisexual people. [...] Bringing about inclusion requires strategies to move us from the assumption that a generic service or provision will suit everyone equally These strategies suggest that the public profile of an organisation or service deliverer be examined; likewise its policies and procedures, the content and levels of professional development and training that are available, and finally, if necessary, the question of specific programmes targeting certain groups – in this case lesbian, gay and bisexual people – also need to be examined."

Given the high suicide rate in the United States of young people struggling with their sexual orientation identified in this report,¹³³ it is important that planning and delivery of the mental health services take into account the particular experiences of lesbian, gay and bisexual people. Research into their mental health needs and service provision is currently lacking, however. The report observes, for instance, that the Report of the National Task Force on Suicide "contains no reference or recommendation on the relationship between sexual orientation and youth suicide despite the issue being raised with the Task Force by GLEN in 1996", and concludes: "It is relevant to explore the relationship between sexual orientation and youth suicide with a view to alerting professionals of appropriate preventive measures." It recommends that a national mental health strategy should take account of the needs of lesbian, gay and bisexual people and the marginalisation attached to homosexuality.

Conclusion & Recommendations

Amnesty International is concerned that the widespread inadequate provision of community based mental health services breaches MI Principles 3 and 7(1), and thus, is inconsistent with Ireland's obligations under the ICESCR. Conclusions in the 1999 government report, 'We Have No Beds'¹³⁴ amount to a serious indictment of Ireland's community based mental health care services – while this report refers to the EHB area, many of its findings apply more widely. It will be outlined in Chapter 9 how many of these deficiencies are due to insufficient funding, while others are due to poor service planning; often it is a combination of both.

Unfortunately, many people with mental illness are not always in a position to assert their rights, for a number of reasons, chiefly the nature of mental illness itself. Family members or friends are not always best placed to act on their behalf.¹³⁵ "States are under an obligation to enable persons with disabilities to exercise their rights,

¹³² 'Implementing Equality for Lesbian, Gays and Bisexuals' (2002).

¹³³ "US research indicates that up to 30 per cent of suicide attempts and completed suicides are made by young people struggling with their sexual orientation." Ibid.

¹³⁴ Note 8 above. See specifically conclusions 4 to 13 therein.

¹³⁵ See Chapter 4.

including their human, civil and political rights, on an equal basis with other citizens".¹³⁶ Consequently, Ireland is obliged to assist all people with mental illness in doing so, not alone by making services available, but their use accessible. A comprehensive system of personal advocacy for all who need it should be considered to allow this to happen.¹³⁷

Amnesty International urges the Irish government, as a matter of priority, and learning from international best practice, to:

- ❑ Commence a thorough and comprehensive review of mental health care services to ensure that they meet international human rights standards and standards of professional best practice;¹³⁸ with due regard to cultural needs, implementing the promises made in the 2001 Health Strategy;¹³⁹ and with an emphasis on community-based care, incorporating the recommendations made in the 1999 'We Have No Beds' report and meeting the requirements laid down in Appendix 4 thereof; and, when complete, implement all recommendations promptly and thoroughly.
- ❑ Immediately act upon all criticisms and recommendations laid out in the report of the Inspector of Mental Hospitals for 2001, and those in earlier reports still pertinent.
- ❑ Take immediate action to provide, until such time as the above review is complete, the complete range of individualised community-based services promised in the 1984 strategy, 'Planning for the Future', finally ensuring that all seven of its target components are met in full.
- ❑ Introduce a comprehensive and adequately resourced system of personal advocacy, to assist people with mental illness to assert their rights in a manner consistent with MI Principles 12(1) and (2).
- ❑ Provide a legislative mechanism for people with mental illness to vindicate their right to the best available community mental health care.¹⁴⁰

¹³⁶ Rule 15 of the UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities. See Chapter 1.

¹³⁷ For a comprehensive analysis of personal advocacy, its various models, and how it operates in different countries, see 'Advocacy: A Rights Issue' (2001), Forum of People with Disabilities, Ireland.

¹³⁸ See Chapter 9 for a more comprehensive outline.

¹³⁹ 'Quality & Fairness: A Health System for You', Department of Health and Children.

¹⁴⁰ See Chapter 9.

Chapter 4

PSYCHIATRIC IN-PATIENT FACILITIES

“The aim should be to offer material conditions which are conducive to the treatment and welfare of patients; in psychiatric terms, a positive therapeutic environment... The quality of patients' living conditions and treatment inevitably depends to a considerable extent on available resources.”

European Committee for the Prevention of Torture
and Inhuman or Degrading Treatment or Punishment¹⁴¹

Introduction

The shift from a predominantly in-patient to a more community-based model of mental health care, and the process of de-institutionalisation in Ireland was outlined in Chapter 3. Many of the points raised throughout this report relate to both in-patient and out-patient care. In this chapter, Amnesty International highlights concerns and recommendations relating specifically to Irish psychiatric hospitals and units.

The primary source of information on standards and practices in Ireland's psychiatric in-patient facilities is the annual report of the Inspector of Mental Hospitals,¹⁴² described by the government as “an objective account of standards of care and accommodation in the mental health services”.¹⁴³

Many of the difficulties recounted in this chapter will come within the sphere of authority of the new Mental Health Commission. Amnesty International is pleased to note that the newly appointed Chair of the Commission has promised that, in its awarding of the status of ‘approved centres’ under the Mental Health Act, 2001, the Commission will demand that adequate standards will be met, not alone in relation to the physical conditions of the hospitals and units, but also in the quality of treatment afforded within them.¹⁴⁴

¹⁴¹ 8th General Report on the CPT's activities covering the period 1 January to 31 December 1997, Ref: CPT/Inf (98) 12[EN], published on 31 August 1998.

¹⁴² The most recent report of the Inspectorate covers the period up to December 2001, and was published on 13th September 2002. This office will shortly be replaced by the Inspectorate of Mental Health Services, to be established by the Mental Health Commission under the Mental Health Act, 2001, which Amnesty International hopes will fulfil its function as assiduously as the current Inspectorate.

¹⁴³ Department of Health and Children website at: www.doh.ie/aboutus/sections/mehe.

¹⁴⁴ For example, at a conference in Tullamore on 17 September 2002 held by the Midland Health Board, Dr Owens elaborated on this role.

International Standards

In addition to the right to the highest attainable standard of mental health and to the best available mental health care, people in in-patient psychiatric care have specific rights afforded to them. Principle 13(2) of the UN Principles for the Protection of Persons with Mental Illness (MI Principles)¹⁴⁵ states: “The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age and in particular shall include: (a) Facilities for recreational and leisure activities; (b) Facilities for education.” MI Principle 14(1) provides: “A mental health facility shall have access to the same level of resources as any other health establishment, and in particular ... [q]ualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a programme of appropriate and active therapy....”

Certain additional obligations apply in relation to people involuntarily admitted to and detained in psychiatric hospitals and units, such as MI Principles 16 and 17, outlined below; and the UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment,¹⁴⁶ Principle 1 of which states: “All persons under any form of detention ... shall be treated in a humane manner and with respect for the inherent dignity of the human person.”

The UN Declaration on the Rights of Mentally Retarded Persons¹⁴⁷ provides additional protection for people with intellectual disabilities in psychiatric in-patient care.

Access to In-Patient Care

While many people with mental illness will be best served by community-based care, for others, admission to acute in-patient care is necessary, and is the “best available mental health care” required by international law. In Ireland, there is a shortage of hospital beds for acute admissions, with the result that many are left waiting for the care they need, or people in hospital are inappropriately moved.

For example, the 1999 study of the situation in the then Eastern Health Board (EHB) area, ‘We have no beds’,¹⁴⁸ found that the lack of community alternatives led

¹⁴⁵ UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care adopted by General Assembly Resolution 46/119 of 17 December 1991.

¹⁴⁶ Adopted by General Assembly Resolution 43/173 of 9 December 1988. It also stresses that “[p]risoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation”.¹⁴⁶

¹⁴⁷ Adopted by General Assembly Resolution 2856 (XXVI), 26 U.N. GAOR Supp. No. 29 at 99, U.N. Doc. A/8429 (1971). While still relevant, and useful for people with learning difficulties and mental illness, this Declaration is considered to be quite dated, for example, in that the term ‘mental retardation’ is widely regarded as derogatory, where ‘intellectual disability’ is generally favoured today.

¹⁴⁸ ‘We Have No Beds: An Enquiry into the Availability and Use of Acute Psychiatric Beds in the Eastern Health Board Region’ (1999), Keogh F, Roche A & Walsh W, Health Research Board, Department of Health and Children.

directly to the inappropriate occupancy of almost half (45 per cent) of the available acute beds by patients not requiring acute hospitalisation.¹⁴⁹ Two-thirds of the patients inappropriately occupying acute beds in the psychiatric service could have been placed elsewhere, had community-based residential facilities been available. The fact that this was not possible led to a situation where 91,500 inappropriate bed days a year were lost to those who actually needed them. One consequence of this was “an increasing number of reports of EHB psychiatric services which had no beds for patients who were acutely ill and who needed hospitalisation”. Another was the emergence of “a system of borrowing beds for short term purposes from one service by another”, an arrangement described as “unsatisfactory for patients, representing poor quality of service delivery to acutely ill persons”. It was concluded in the study that there was probably a sufficient number of beds for those in need of them, but that this number would suffice only if more community-based services were provided; if not, more beds were required. To provide more beds would, of course, be a reversal of the trend towards less reliance on in-patient care. However, in a subsequent government commitment to the creation of 850 new hospital beds,¹⁵⁰ none were in fact allocated to the mental health services; meanwhile only little has advanced in the way of community alternatives to hospitalisation.

The results of this ‘catch-22’ situation can be unfortunate for the quality of patient care for those appropriately admitted. The 1999 study found, as a direct consequence of this scenario, “some wards that constituted less than ideal treatment environments for acutely ill patients because of the presence of individuals who were very disruptive and demanding, and insufficient flexibility in the system to respond to patients’ changing need in the course of their illness”. In respect of many of those denied admission, it concluded: “Because of the pressure on acute beds in some areas it was often not possible to offer respite care for patients with serious mental illness in an effort to avoid relapse.”

Physical conditions

As stated above, MI Principle 13(2) affirms: “The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age.”

¹⁴⁹ “This accumulation of patients in acute beds was largely due to difficulties in moving patients on to more appropriate services. In 41% of cases the service required had no vacancies and in 42% of cases the service did not exist.”

¹⁵⁰ Minister announces 850 beds under Public Private Partnership in the Health Sector, Department of Health and Children press release, 29 July 2002.

The report of the Inspector of Mental Hospitals for 2001,¹⁵¹ while noting a number of welcome advances that had been made during that year in addressing many of the more extreme instances observed in previous reports, details a catalogue of substandard hospitals and units, overcrowding and poor living conditions, of which the following are examples. The accommodation provided for patients with intellectual disabilities in St. Luke's Hospital was described as: "conditions that were less than satisfactory". Some of the residential accommodation in St. Finian's Hospital, Killarney was "of poor quality and badly in need of alternatives"; St. Stephen's Hospital, Sarsfield Court was described as an "unsatisfactory premises"; and the psychiatric unit in University Hospital, Galway "badly needed refurbishment". These are matters that could easily be addressed and simply require funding. The day hospital at St John of God, Dublin was "overcrowded and was unable to cope with the ever-increasing amount of work in the space available".

Safety & Quality of Life

The Inspector's report for 2001 highlighted grave concerns about the physical health care of psychiatric in-patients:

"Research has shown, time and again, that psychiatric patients enjoy poorer health and have higher mortality than the general population. There are several factors contributing to this. The onus on those responsible for the physical health of patients resident, particularly long-term, in psychiatric hospitals or community residences, is all the more pressing because of this consideration. It is incumbent on service deliverers to have frequent assessment of the physical health of in-patients. It is disquieting to the Inspectorate to have to record that physical health examination of in-patients, as documented in case note material, is often infrequent, desultory and superficial in nature. It is self-evident that some psychiatric patients may not complain of subjective distress."

This report also noted:

- The occurrence of sudden deaths in psychiatric in-patients due to asphyxia from the inhalation of food or other material, mainly in older patients, reveals a need for "training of staff in the appropriate procedures in cases of foreign body airway obstruction and the care necessary in feeding many older, feeble patients with poor swallowing capacity".
- Suicides among psychiatric patients at a local level are not the subject of any formal audit, and there is a need for "local services carefully to audit cases of suicide so that lessons may be learned to make risk assessment and management more potent and effective in the future".
- MI Principle 13(1) provides the right to privacy in in-patient care, but the majority of patients interviewed by the Inspectorate complained of a lack of privacy, particularly in the bathroom areas.

Amnesty International urges that these matters be immediately addressed.

¹⁵¹ 'Report of the Inspector of Mental Hospitals for the year ending 31st December 2001', Department of Health and Children, Government Publications Sales Office, (2002).

Admission and Assessment Policies and Practices

As mentioned earlier, the 1999 government report, 'We have no beds' found that almost half of the patients surveyed were judged not to require the acute beds they were occupying. It found: "Not all hospitals [in the EHB area] had written admission and discharge policies. Those that were available were of varying quality. There was little evidence of audit or other monitoring procedures to ensure the effective implementation of these policies." It also discovered:

- The decision to admit to acute beds was often taken by inexperienced staff, with less than one third made by consultants.
- Only 53 per cent of patients received a full psychiatric assessment prior to referral for admission. For the remaining 47 per cent of patients, assessment was made on admission, thus the opportunity to direct these patients to alternative forms of care was often missed.
- There was evidence that patients bypassed the usual filters for admission in various ways. A considerable proportion of admissions were self- or relative-referrals (29 per cent), and 48 per cent of admissions occurred out of office hours, between 6pm and 8am.

Amnesty International urges that action be taken on its recommendations: that written admission policies be developed, not just for in-patient services, but for all residential and acute services; special attention is paid to pre-admission assessments, preferably in community-based settings;¹⁵² and discharge policies be drawn up, and their implementation monitored.

Involuntary Admission and Detention

In Ireland, in addition to an excessively high rate of admission to in-patient care generally, there is a rate of involuntary admission and detention amongst these, which, the Inspector of Mental Hospitals has deemed "unnecessarily high".¹⁵³ The Inspector's report for 2001 also says:

"Over the years, the Inspectorate has striven to reduce the number of persons remaining involuntarily detained who would more suitably be hospitalised on a voluntary basis. The practice still continues, although to a lesser extent."

The Mental Health Act 2001, when it comes into force, will require that all involuntary detentions be automatically and periodically reviewed by mental health tribunals. Because of the workload this will impose on the tribunals, during 2001, the Inspectorate of Mental Hospitals again circulated all clinical directors of psychiatric facilities, asking them to request their consultants to review all patients currently

¹⁵² Naturally, this will hinge on the provision of a greater number of these centres.

¹⁵³ Report for 2001, note 11 above: "The Inspectorate remained concerned about the relatively high rate of involuntary admission and detention prevailing in this country. ... [the] proportion was unnecessarily high."

involuntarily detained, particularly long-stay patients, with a view to changing their status from non-voluntary to voluntary where this was appropriate. This problem was also adverted to by the Chair of the Mental Health Commission, who pointed out that the generally high admission rate in Ireland, and the high number of involuntary admissions and detentions, will make the tribunal's task more arduous.¹⁵⁴ Amnesty International would like to see this process happen as speedily as possible, particularly given the human rights implications of unnecessarily detaining people against their will. Amnesty International would like to remind the Irish authorities that MI Principle 15(1) provides: "Where a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission."

The Inspector's report for 2001 observed, "where a patient had been admitted involuntarily, their status should be reviewed more frequently and assiduously." Under Irish mental health law as it currently stands, grounds for, and provision for the review of, detention of those involuntarily detained are in breach of international human rights standards in relation to the deprivation of liberty. The 2001 Act has amended the law in relation to involuntary admission and detention to psychiatric in-patient care; when brought into force, it will ensure that the detention of all people involuntarily admitted to psychiatric facilities will be reviewed after 21 days. In 2000, the UN Human Rights Committee requested Ireland to provide for "prompt review of detention on mental health grounds, i.e. within a few days" in compliance with Article 9 of the International Covenant on Civil and Political Rights.¹⁵⁵ Amnesty International remains concerned that the period provided in the Act may be too long under international standards in relation to the deprivation of liberty.¹⁵⁶

The Act has expressly provided the right to information about the circumstances of the detention and any proposed treatments, which is most welcome. The additional right of an involuntarily detained patient to be informed of the right to review of his/her detention, and the right to legal representation before the tribunal, which will be paid for by legal aid where appropriate, is also welcome.

¹⁵⁴ Speaking at a conference on 17 September 2002 in Tullamore held by the Midland Health Board on the new Act.

¹⁵⁵ The background to this Act lies in a government White Paper on mental health reform produced in 1995, which recommended a number of substantial proposals for reform in relation to how psychiatric inpatients were admitted and detained against their will, one of which was a review by mental health tribunals of the involuntary detention of patients after 7 days. The Mental Health Bill that emerged from this White Paper in 1999 proposed mandatory review for legality only after 28 days of detention, which was criticised by the UN committee as an excessively long period. The Mental Health Act eventually incorporated a compromise period of 21 days.

¹⁵⁶ Several national organisations are also unhappy at what they believe to be an inordinately lengthy period of unreviewed detention. The Irish Council for Civil Liberties (ICCL), for instance, believes that it does not conform with the Irish constitutional right to liberty, and that legal review of detention should occur within 36 or 48 hours of involuntary admission to hospital, in 'Briefing on Mental Health Law and Proposed Changes' (2001), ICCL Mental Health Working Group.

When the Act comes into force, there are some concerns that it may not prove as effective as it should be with regard to this review function, particularly given the traditional under-resourcing in this sector. For this reason, Amnesty International urges that the fullest assistance and co-operation, and all necessary resources, be extended by the Irish Government to the Mental Health Commission.

Exercise of rights

MI Principle 12(1) provides:

“A patient in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the patient understands, of all his or her rights in accordance with the present Principles and under domestic law, and the information shall include an explanation of those rights and how to exercise them.”

MI Principle 21 states:

“Every patient and former patient shall have the right to make a complaint through procedures as specified by domestic law.”

Psychiatric patients have a right under Irish legislation to write letters of complaint to the Minister for Health and Children, the President of the High Court, or the Inspector of Mental Hospitals. The Inspector records in his 2001 annual report that the Inspectorate “has been at pains to ensure that notices informing patients of these rights are prominently displayed in all in-patient locations and, in addition, that patients are informed of these rights on admission, both verbally and by means of information leaflets and booklets which the Inspectorate has indicated should be available in all hospitals and units”. Nevertheless, the Inspector reported that in 2001: “In many of our interviews with selected patients, the majority informed us that they were not fully aware of their rights under the Mental Treatment Act 1945 or amending legislation, or of how to make a complaint if they felt aggrieved.” This indicates a fundamental failure to fully secure to these patients the rights in the above MI Principles, and indicates a need for a statutory complaints system, for example through the appointment of a Mental Health Ombudsperson.

Until then, Amnesty International urges that patients are fully assisted and informed of the existing complaints system, and that a system of monitoring is introduced and complied with to ensure that each complaint is handled in accordance with a formal complaints policy and procedure.

MI Principles 12(2) and (3) state:

“If and for so long as a patient is unable to understand such information, the rights of the patient shall be communicated to the personal representative, if any and if appropriate, and to the person or persons best able to represent the patient's interests and willing to do so.

A patient who has the necessary capacity has the right to nominate a person who should be informed on his or her behalf, as well as a person to represent his or her interests to the authorities of the facility.”

A comprehensive system of personal advocacy based on patients' best interests should be provided to all those admitted to in-patient psychiatric care, and especially to those involuntarily admitted or detained.¹⁵⁷ Personal advocacy for those involuntarily detained has been described thus: "In this experimental model of advocacy, a personal advocate represents the needs and best interests of each individual patient from the time of admission until the time of discharge from involuntary care. This is associated with better compliance with aftercare and improves patients' and staff members' experience of involuntary admission."¹⁵⁸

Children in Adult Psychiatric Facilities

Amnesty International is seriously concerned that Ireland is in breach of Article 24(1) of the UN Convention on the Rights of the Child by placing children and juvenile offenders in adult psychiatric facilities.¹⁵⁹ All those inappropriately detained in such psychiatric institutions should be removed, and placed in more appropriate accommodation.

Intellectual Disabilities

In May 2002, the UN Committee on Economic Social and Cultural Rights (CESCR) expressed its concern "that a large number of persons with mental disabilities, whose state of health would allow them to live in the community, is still accommodated in psychiatric hospitals together with persons suffering from psychiatric illnesses or problems, despite efforts by the State party to transfer them to more appropriate care settings."¹⁶⁰ The Inspector of Mental Hospitals commented in his report for 2001:

"We have over many years regarded the practice of continued care of intellectually disabled patients in long-stay psychiatric facilities as inappropriate and have recommended their transfer to appropriate services, residential and otherwise, to enable them to get the skilled and specialised care not generally available in psychiatric hospitals. Fortunately, some progress has been made in alleviating this problem in recent years and in 2001 a substantial number of such persons were transferred ... However, not inconsiderable numbers of such persons remain in unsuitable accommodation in St Senan's Hospital, Enniscorthy, St Luke's Hospital, Clonmel, and St Brigid's Hospital, Ardee."¹⁶¹

¹⁵⁷ The Irish College of Psychiatrists is in favour of such a system for those involuntarily detained: "Consideration for a system of advocates, independent of the Mental Health Services, for patients both involuntary, detained and 'de facto' detained would be welcomed." 'Comments on An Bille Meabhair-Sláinte, 1999, Mental Health Bill, 1999'.

¹⁵⁸ 'Mental health and human rights: challenges for a new millennium', Kelly B D, Editorial, *Ir J Psych Med* 2001; 18(4): 114 - 115 at 114. For a comprehensive analysis of personal advocacy, its various models, and how it operates in different countries, see 'Advocacy: A Rights issue' (2001), Forum of People with Disabilities.

¹⁵⁹ See Chapter 6.

¹⁶⁰ Concluding Observations on Ireland's periodic report, E/C.12/1/Add.77, 17 May 2002.

¹⁶¹ Note: the Inspector says, in relation to "the special situation obtaining in St Ita's Hospital, Portrane, where a partially specialised service for the 300 such persons in the St Joseph's service in St Ita's continues. This service is still administered as part of the overall psychiatric service, but it is the Inspectorate's position that a separate and reinforced administration with enhanced clinical specialisation is necessary to optimise the service available to this group of persons."

The 2001 Health Strategy promises a 'complete programme' to transfer people with intellectual disabilities who are currently in psychiatric hospitals to 'appropriate accommodation' as soon as possible and by the end of 2006 at the latest. Notwithstanding this commitment, while people with intellectual disabilities remain inappropriately accommodated in psychiatric institutions, Ireland is in violation of human rights standards. Amnesty International urges Ireland to promptly comply with the CESCR's 2002 recommendation, when it reiterated the request it made on the occasion of its 1999 report, "that the State party speed up the process of transferring persons with mental disabilities who are not suffering from serious psychiatric illness and who are still living in psychiatric hospitals, to more appropriate care settings".

Many people with intellectual disabilities with a diagnosed mental illness are not accommodated in psychiatric hospitals, but in de-designated former psychiatric units and hospitals, or in privately owned facilities run by voluntary bodies and religious organisations. There is no government inspectorate system for these facilities. Even though their admission and detention cannot be said to be voluntary given their lack of capacity, they will not be covered by Mental Health Act when it comes into force, and their psychiatric treatment or places of accommodation will not be subject to monitoring as 'approved centres' within its remit, a situation which should be rectified.

Conclusion & Recommendations

The primary responsibility for promoting the dignity, and physical and mental health of people in in-patient care lies with the government, not with individual service providers or mental health professionals. Many of the concerns outlined above will come within the authority of the new Mental Health Commission and Amnesty International hopes that, in its awarding of the status of 'approved centres' under the Mental Health Act, 2001, it will demand that adequate standards will be met, not alone in relation to the physical conditions of the hospitals and units, but also in the quality of treatment afforded within them.

Amnesty International recommends that, as a matter of priority, the Irish authorities should:

- ▣ Address all deficiencies alluded to in the reports of the Inspector.
- ▣ Take immediate action to address the lack of acute psychiatric beds, primarily by providing a complete range of community-based services.
- ▣ Amend the Mental Health Act, 2001 Act 21-day review period in line with international standards.
- ▣ Introduce an effective and well-publicised system of complaints in compliance with international law.
- ▣ Establish a comprehensive and adequately resourced system of personal advocacy for psychiatric in-patients to assist them in vindicating their rights.

- ❏ End the inappropriate placing of children and juvenile offenders in adult psychiatric facilities.
- ❏ Ensure the prompt transfer of persons with intellectual disabilities who are not suffering from serious psychiatric illness and who are still living in psychiatric hospitals, to more appropriate care settings.
- ❏ Ensure that the physical health care and treatment of psychiatric in-patients is adequate and that regular monitoring and assessment by medical and other specialists is a standard practice.

Chapter 5

INDIVIDUALISED TREATMENT & INFORMED CONSENT

“The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary....”

MI Principle 9(2)¹⁶²

Informed Consent

In addition to MI Principle 9(2) above, MI Principle 11 stipulates that no treatment shall be given to a patient without his or her informed consent,¹⁶³ and continues:

“Informed consent is consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on:

- (a) The diagnostic assessment;*
- (b) The purpose, method, likely duration and expected benefit of the proposed treatment;*
- (c) Alternative modes of treatment, including those less intrusive;*
- (d) Possible pain or discomfort, risks and side-effects of the proposed treatment.”*

It is clear then, that, in order for a person to give informed consent to a course of treatment, quite exacting standards in relation to the provision of information are demanded of the service provider. Failure by the state to ensure that proper guidelines and monitoring procedures are in place in relation to these component requirements of informed consent to psychiatric treatment, and are being adhered to, amounts to a failure to comply with these principles.

Treatment Plans

The Department of Health and Children’s 1998 ‘Guidelines on Good Practice and Quality Assurance in Mental Health Services’ states: “Treatment plans should be discussed with patients, the nature of any treatment fully outlined and the treatment plan, including any medication recorded in the case notes.” However, treatment plans are not always prepared in Ireland, as noted in the Inspector of Mental Hospital’s report for 2001.¹⁶⁴

¹⁶² UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care adopted by General Assembly Resolution 46/119 of 17 December 1991.

¹⁶³ Except as provided for in paragraphs 6, 7, 8, 13 and 15 thereof.

¹⁶⁴ ‘Report of the Inspector of Mental Hospitals for the year ending 31st December 2001’ (2002), Department of Health and Children, Government Publications Sales Office.

Patient participation in treatment plans is limited: many complain that they do not have enough time with their physician, and that they rarely have their treatment discussed with them or are provided with written information, which prejudices the right to informed consent to treatment in MI Principle 11. Patients who attend out-patient clinics are likely to see registrars-in-training, who change every six months, producing a lack of continuity in the doctor-patient relationship, noted in Chapter 3.

The 2001 annual WHO report¹⁶⁵ lists factors that improve medication and treatment compliance, particularly essential in serious mental illness, and that should be observed:

- ✓ A trusting physician relationship;
- ✓ Time and energy spent on educating the patient regarding the goals of therapy and the consequences of poor adherence;
- ✓ A negotiated treatment plan;
- ✓ Recruitment of family and friends to support the therapeutic plan and its implementation;
- ✓ Simplification of the treatment regime; and
- ✓ Reduction of the adverse consequences of the treatment regime.

Consequently, all service users should be provided with a written individualised treatment plan, including medication history and user feedback on perceived efficacy and side effects. Allied to this is a need for a comprehensive system of personal advocacy to assist some people with mental illness, particularly while seriously ill, to ensure that correct procedures are being followed.

Range of Therapies

The 2001 WHO report recommends the comprehensive and widespread availability of “a full range of therapies considered essential to modern psychiatric care: psychotherapy, psychosocial rehabilitation, and vocational rehabilitation and employment”.¹⁶⁶ While medication is considered essential in the treatment of many serious mental illnesses, failure to provide a range of additional treatments is inconsistent with many of the MI Principles, in particular the right to the “least restrictive or intrusive treatment” in Principle 9(1). Yet, both within and outside psychiatric in-patient facilities, there appears to be widespread over-reliance on medication alone as therapy, rather than the provision of a range of additional and alternative therapies referred to above.¹⁶⁷ A recent Schizophrenia Ireland survey of service users found “a paucity of alternative non medication based interventions”, and observed:

“The lack of availability of non-medical interventions is a source of ongoing debate in Irish mental health care. A possible reason for ambivalence towards non-medical

¹⁶⁵ The World Health Report 2001, ‘Mental Health: New Understanding, New Hope’, WHO, Geneva.

¹⁶⁶ Ibid.

¹⁶⁷ For instance, the Inspector of Mental Hospitals report for 2000 mentioned “the predominance of drug treatment which is often the only treatment available”.

interventions is that there is no broad consensus as to their efficacy.¹⁶⁸ However, sometimes the best way to establish efficacy is to ask the people who experience a particular treatment.”¹⁶⁹

It found that the vast majority of respondents who had experienced certain non-medical therapies¹⁷⁰ found them to be either very helpful or very helpful. It is now accepted at the international level that modern psychiatry should offer a range of therapies:

“ The management of mental and behavioural disorders ... calls for the balanced combination of three fundamental ingredients: medication (or pharmacotherapy); psychotherapy;¹⁷¹ and psychosocial rehabilitation.¹⁷² The rational management of mental and behavioural disorders needs a skilful titration of each of these ingredients.”¹⁷³

Pharmacotherapy

Few dispute the efficacy of medication in the treatment of many mental illnesses: “The discovery and improvement of medicines useful for the management of mental disorders, which occurred in the second half of the 20th century, have been widely acknowledged as a revolution in the history of psychiatry.”¹⁷⁴

¹⁶⁸ Citing ‘Clinical effectiveness: What we need to do’ (1997), Gournay K, *Psychiatric Care*, 4 (5), pp221-224.

¹⁶⁹ ‘A Question of Choice - Ireland: Service Users’ Experience of Medication and Treatment’ (2002).

¹⁷⁰ I.e., counselling, peer group support, and creative therapy.

¹⁷¹ The WHO 2001 report explains: “Psychotherapy refers to planned and structured interventions aimed at influencing behaviour, mood and emotional patterns of reaction to different stimuli through verbal and non-verbal psychological means. Psychotherapy does not comprise the use of any biochemical or biological means. Several techniques and approaches – derived from different theoretical foundations – have shown their effectiveness in relation to various mental and behavioural disorders. Among these are behaviour therapy, cognitive therapy, interpersonal therapy, relaxation techniques and supportive therapy (counseling) techniques...”

¹⁷² The WHO report explains: “Psychosocial rehabilitation is a process that offers the opportunity for individuals who are impaired, disabled or handicapped by a mental disorder to reach their optimal level of independent functioning in the community. It involves both improving individual competencies and introducing environmental changes ... Psychosocial rehabilitation is a comprehensive process not just a technique. The strategies of psychosocial rehabilitation vary according to consumers’ needs, the setting where the rehabilitation is provided (hospital or community), and the cultural and socioeconomic conditions of the country in which it is undertaken. Housing, vocational rehabilitation, employment, and social supports are all aspects of psychosocial rehabilitation. The main objectives are consumers’ empowerment, the reduction of discrimination and stigma, the improvement of individual social competence, and the creation of a long-term system of social support.”

¹⁷³ WHO 2001 report, note 4 above.

¹⁷⁴ Ibid. “There are basically three classes of psychotropic drugs that target specific symptoms of mental disorders: antipsychotics for psychotic symptoms; antidepressants for depression; anti-epileptics for epilepsy; and anxiolytics or tranquillizers for anxiety. Different types are used for drug-related and alcohol-related problems. It is important to remember that these medicinal drugs address the symptoms of diseases, not the diseases themselves or their causes. The drugs are therefore not meant to cure the diseases, but rather to reduce or control their symptoms or to prevent relapse.”

Nevertheless, it is essential that extreme vigilance is exercised in their use.¹⁷⁵ The report of the Inspector of Mental Hospitals for 2001 “urged caution in relation to drug prescribing, the frequent review of the necessity for prescribed medication and of any side effects deriving from it, and avoidance of poly-pharmacy.” The Inspector has also recorded in his report for 2000: “A wide range and diversity of drug prescribing in psychiatric illness was noted. Junior doctors, in particular, were subject to considerable pressures to prescribe newer products and appeared to lack guidance for appropriate and effective prescribing in certain circumstances.”¹⁷⁶

Whereas information on prescribed medication should be provided to people with mental illness under the MI Principles, a 2002 report of a survey by Schizophrenia Ireland of people receiving outpatient treatment observed a “continual lack of quality information being given to service users”.¹⁷⁷ 32.9 per cent of the sample polled said that their doctor did not talk to them about their medication, and only half (50.5 per cent) were given a written record of their medication and when to take it. Almost two thirds (65.8 per cent) said that their doctor did not provide them with written information about possible side effects,¹⁷⁸ a fact that the report found “very discouraging”. Only 36.5 per cent said that they were ever offered a choice of medication. This seriously prejudices the right to informed consent to treatment, as outlined above.

According to WHO, “each intervention should have a determined duration, that is, it should last for the time required by the nature and severity of the condition, and should be discontinued as soon as possible...”¹⁷⁹ this also a requirement of MI Principle 9, that medication be “reviewed regularly, [and] revised as necessary”. All mental health service users should receive an independent review of their prescribed medication on at least an annual basis in line with MI Principle 9(2). While it is likely that the majority of people are on correct doses of the most appropriate drug, even for them there is much benefit in such reviews to allay any concerns they, or their families, may have.

¹⁷⁵ Specifically in relation to the drug Thioridazine (Melleril), the Irish Medicines Board (IMB) issued a notice during 2001 advising that it should be prescribed only when other treatments have proven unsuitable. The IMB also recommends that patients be thoroughly assessed physically, including having electro-cardiograms and blood tests performed before receiving the drug and periodically during treatment. The Inspector advises in his report for 2001 that, “before any patient with physical health problems, or suspected problems, is started on anti-psychotic or anti-depressant or other relevant medication, he or she be the subject of a thorough physical examination”.

¹⁷⁶ This comment remains valid.

¹⁷⁷ Note 8 above.

¹⁷⁸ This study noted, “people on the newer antipsychotics were nearly twice as likely to receive written information than people on the older medications”.

¹⁷⁹ 2001 report, note 4 above.

The Schizophrenia Ireland survey found that polypharmacy – the concurrent prescription of more than one drug – remains widespread, and cited serious problems associated with this practice, including confusion between therapeutic efficacy and side effects, and a heightened risk of a drug interaction developing.¹⁸⁰ It found that “over 65% of respondents were on two or more medications, over 30% were on three or more and finally that 13% were on four or more medications for mental health problems”. The report of the Inspector for 2001 concluded that three sudden deaths in in-patient care that year “were possibly the consequence of drug interaction”.

The government should adopt and promulgate standards and guidelines in relation to the prescription and review of medication, and ensure that they are adhered to by individual practitioners.¹⁸¹ The 1998 government ‘Guidelines on Good Practice’ mentioned above do not provide assistance in this respect as they specifically exclude consideration of medical treatment.¹⁸²

Intellectual Disability Facilities

The Irish College of Psychiatrists noted: “The vast majority of the adult population with Intellectual Disability/Mental Handicap are legally incompetent, are neither voluntarily or compulsorily detained within their residential centres and have no capacity to give informed consent to any type of medical or psychiatric intervention and between thirty to fifty per cent are on psychotropic medication without consenting to same....”¹⁸³ Yet, they are outside the remit of the Mental Health Act, the mandate of the Inspector of Mental Health Services and the Mental Health Commission. Legislation should be widened to provide for the monitoring of all residential health centres where patients with mental illness are receiving psychiatric treatment without informed consent; and placing their rights in relation to consent to treatment on a statutory footing.

¹⁸⁰ Note 8 above.

¹⁸¹ Diagnostic assessment of mental illness by psychiatrists in Ireland follows internationally accepted procedures laid down in the ICD-10 (see Chapter 1, note 1) and the ‘Diagnostic and statistical manual of mental disorders’, 4th edition (DSM-IV), American Psychiatric Association (1994), Washington DC.

¹⁸² “These guidelines specifically exclude consideration of the medical treatment of patients. This matter must remain the exclusive domain of individual clinicians.”

¹⁸³ ‘Comments on the Mental Health Act 2001’ (2001), Irish College of Psychiatrists.

Recommendations

Amnesty International particularly urges the Irish Government to:

- ❑ Ensure that a comprehensive range of therapies, in addition to pharmacotherapy, is available to everyone with mental illness, in line with WHO standards.
- ❑ Ensure that all service users are provided with a written individualised treatment plan, including medication history and user feedback on perceived efficacy and side effects.
- ❑ Publish standards and guidelines in relation to the prescribing of medication, addressing polypharmacy, and providing an independent review of prescribed medication on at least an annual basis.
- ❑ Extend the remit of the Mental Health Act, the Inspector of Mental Health Services and the Mental Health Commission, to monitor the standards in all residential health centres where patients with mental illness are receiving medical treatment without informed consent.

Chapter 6

CHILDREN & ADOLESCENTS

“Approaches to the promotion and development of sound mental health for children, and the identification and treatment of psychological and psychiatric disorders, have been patchy, uncoordinated and underresourced.”

Annual Report of the Chief Medical Officer
Department of Health and Children¹⁸⁴

Introduction

The World Health Organisation said in its 2001 annual report:

“Contrary to popular belief, mental and behavioural disorders are common during childhood and adolescence. Inadequate attention is paid to this area of mental health. ... it seems that 10-20% of all children have one or more mental or behavioural problems.”¹⁸⁵

Ireland ratified the UN Convention on the Rights of the Child (the CRC) in 1992, and made a commitment to fully respect the rights of children provided in the CRC, and to provide a specialised regime to identify, treat and protect children with or at risk of mental illness, and to detain children only as an exceptional measure of last resort.

In Ireland, there is a lack of data on the mental health needs of children; the provision of child psychiatric services is inadequate; adult psychiatric hospitals are used inappropriately to treat children; and children with behavioural problems and psychiatric needs are detained in prisons and places of detention without having those needs addressed, contrary to international human rights law.

International standards

The general standards outlined in Chapter 1 apply equally to children. Additional rights and obligations specific to children are contained in the CRC, which provides the overriding criterion that, in all actions concerning children, “the best interests of the child shall be a primary consideration”.¹⁸⁶ It further provides “the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health”,¹⁸⁷ and “that a mentally or

¹⁸⁴ ‘The Health of our Children’, Second Annual Report of the Chief Medical Officer of the Department of Health and Children, published on 19 September 2001.

¹⁸⁵ The World Health Report 2001, ‘Mental Health: New Understanding, New Hope’, Geneva. The report adds: “A caveat must be made to these high estimates Childhood and adolescence being developmental phases, it is difficult to draw clear boundaries between phenomena that are part of normal development and others that are abnormal.”

¹⁸⁶ Article 3(1): “In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.”

¹⁸⁷ Article 24(1).

physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community".¹⁸⁸

The CRC goes on to provide "the right of the disabled child to special care and ... the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance ... which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child".¹⁸⁹ This assistance "shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development".¹⁹⁰

As in other human rights instruments, a further guiding principle in the CRC is that of non-discrimination:

"States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status."¹⁹¹

In relation to children taken into the care of the state, the CRC provides that "*a child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State*".¹⁹²

In relation to children in detention, it says:

*"No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall ... be used only as a measure of last resort and for the shortest appropriate period of time."*¹⁹³

¹⁸⁸ Article 23(1).

¹⁸⁹ Article 23(2).

¹⁹⁰ Article 23(3).

¹⁹¹ Article 2(1).

¹⁹² Article 20(1).

¹⁹³ Article 37(b). The provisions of Article 37 are repeated throughout other UN standards on children. For example, the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (1990) states that detention "should be used as a last resort" and "be limited to exceptional cases". The United Nations Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules) (1985) reiterate that any detention should be brief and state this should only occur where the child has committed "a serious act involving violence".

“Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age.”¹⁹⁴

Children in detention are also protected by the United Nations Rules for the Protection of Juveniles Deprived of their Liberty,¹⁹⁵ which apply to every person under the age of 18, and provide:

“The juvenile justice system should uphold the rights and safety and promote the physical and mental well-being of juveniles. Imprisonment should be used as a last resort.”¹⁹⁶

“Every juvenile shall receive adequate medical care, both preventive and remedial, including ... mental health care.”¹⁹⁷

“Personnel should be qualified and include a sufficient number of specialists such as educators, vocational instructors, counsellors, social workers, psychiatrists and psychologists.”¹⁹⁸

Situation in Ireland

Amnesty International is concerned that Ireland does not comply with its international obligations in its treatment of children with, or at risk of, mental illness. The UN Committee on the Rights of the Child, which monitors compliance with the CRC, said in its last report on Ireland in 1998: “The Committee is concerned about the lack of a national policy to ensure the rights of children with disabilities and the lack of adequate programmes and services addressing the mental health of children and their families.”¹⁹⁹ While recent significant advances have been made in Ireland’s mental health care system, psychiatric services for children and adolescents remain underprovided in most areas of the country.

Research

Research into the mental health needs of children is very poor:²⁰⁰

“The absence of epidemiological information relating to children’s mental health on a national basis is a significant limitation in our current system. No routine information system captures information on children’s mental health problems, with the exception of the national psychiatric in-patient reporting system, which provides

¹⁹⁴ Article 37(c).

¹⁹⁵ Adopted by General Assembly Resolution 45/113 of 14 December 1990.

¹⁹⁶ Rule 1(1).

¹⁹⁷ Rule 49.

¹⁹⁸ Rule 81.

¹⁹⁹ Concluding observations of the Committee on the Rights of the Child: Ireland, 04/02/98, CRC/C/15/Add.85.

²⁰⁰ For instance, the homeless agency, Focus Ireland “found an absence of an adequate database on young people in the care of health boards and on leaving health board care”. (‘Left Out on Their Own: Young people leaving Care in Ireland’ (2000).)

information on children admitted to psychiatric hospitals. However, since mental health problems in children rarely require admission, this source of information is of limited value. A highly developed information system is required, in order to underpin approaches to quality assurance and evaluation of mental health prevention and treatment services, to monitor trends in incidence, and to identify risk factors and risk groups.”²⁰¹

The UN Committee on the Rights of the Child also voiced general concern about “certain lacunae in the statistical and other information collected by the State party, including with respect to the selection and development of indicators to monitor the implementation of the principles and provisions of the Convention” in its 1998 report.²⁰²

On the likely incidence of mental illness in children, the Second Annual Report of the Chief Medical Officer of the Department of Health and Children, said:

“As regards psychological/psychiatric conditions, while data are not comprehensive, some epidemiological studies show that as many as 18 per cent of the child population under the age of 16 years will experience significant mental health problems at some period of their development; but a much smaller proportion, of the order of 3-4 per cent, will actually suffer from a psychiatric disorder such as anorexia nervosa or a crippling, obsessive, compulsive state. Recent data compiled in the USA suggest that one in ten children and adolescents have a mental illness serious enough to cause some level of impairment in any given year.” ²⁰³

Given this anticipated level of mental illness in children, the provision of adequate and sufficient children’s mental health care services should be a priority.

Homelessness and Poverty

In Chapter 7, the correlation between homelessness and mental illness is explored. A national homelessness non-governmental organisation, Focus Ireland, has

²⁰¹ ‘The Health of our Children’, note 1 above.

²⁰² Note 16 above.

²⁰³ Ibid. The Focus Ireland pilot study, note 17 above, said: “Prevalence studies assessing the rate of psychiatric disorders in children vary between five and 26 per cent depending on the population studied and the measures used (Rutter, Taylor & Hersov, 1994).” (Referring to ‘Child And Adolescent Psychiatry, Modern Approaches’, Rutter M, Taylor E, Hersov L (1994) Blackwell Science, Oxford.) Also regarding mental illness prevalence in this age group in Ireland, see ‘Competencies and Problems of Irish Children and Adolescents’, Fitzpatrick C, Deehan A, *European Child & Adolescent Psychiatry*, 8 (1999) 1, 17-23: “The parents of the 7-9 year olds rated their children as having significantly lower total problem scores than their American counterparts, but for 13-15 year olds there were no differences in total problem scores between the Irish and American samples, whether rated by parents or the adolescents themselves. Total problem scores and externalizing scores increased with age ... a pattern in which Irish young people differed from those in most other cultures. Despite differences in sampling and methodology, the Irish results are similar in many respects to those seen in a number of other European studies.”

highlighted the problem of child homelessness in Ireland,²⁰⁴ and the particularly high rate of homelessness of children once they leave the state's residential care.²⁰⁵ The UN Committee on the Rights of the Child has also stated particular concern about the incidence of homeless children in Ireland.²⁰⁶

The UN Committee has also commented:

*"With respect to the principle of non-discrimination (article 2 of the Convention [on the Rights of the Child]) the Committee is concerned by the disparities with regard to access to education and health services. While recognising the steps already taken, the Committee notes with concern the difficulties still faced by children from vulnerable and disadvantaged groups, including children belonging to the Traveller community, children from poor families and refugee children, as to the enjoyment of their fundamental rights, including access to education, housing and health services."*²⁰⁷

Services for Children Aged 16 or Under

In many areas in Ireland, services for children under 16 years of age are few, difficult to access, and extremely long waiting lists are the norm.²⁰⁸ This can lead to unfortunate situations for children and their families - a newspaper article in 2000 reported, for instance: "A seriously disturbed [14-year old] teenage boy is to be flown to a special therapeutic unit in Scotland next week because there is no appropriate place for him in this State."²⁰⁹

The Irish College of Psychiatrists believes that the lack of dedicated adolescent services reduces the children's services ability to treat younger children so that "waiting lists for Child Psychiatry services are lengthened further by the need to respond urgently to adolescents".²¹⁰

A government appointed Working Group on Child and Adolescent Psychiatric Services, in its first report in February 2001, stated that "internationally acknowledged best practice for the provision of child and adolescent psychiatric

²⁰⁴ Ivan Mahony, Section Manager, Young Person's Services, Focus Ireland, in 'No homes to go to', *Poverty Today*, March/April 2000, No. 46, states: "The current state of child homelessness in Ireland is nothing short of a national disgrace. Section 5 of the Child Care Act 1991 conferred a legal duty on health boards to provide accommodation for all homeless children in their area. Yet the number of homeless children re-referred (i.e. those who remain homeless for periods of time) through both health boards and non-statutory services is staggering."

²⁰⁵ 'Left Out on Their Own: Young People Leaving Care in Ireland' (2000), Kelleher P, Kelleher C & Corbett M, Focus Ireland. It found a number of reasons for this including: lack of family and social support networks; institutionalisation or dependency; and inability to find or maintain a home due lack of experience or lack of home-making skills.

²⁰⁶ Note 16 above.

²⁰⁷ Ibid.

²⁰⁸ 43 per cent of children in residential care studied by Focus Ireland in the above report, note 22 above, were listed as waiting between three and nine months to receive an appointment with the relevant child and adolescent psychiatric service in their area.

²⁰⁹ Irish Times, 1 August 2000.

²¹⁰ 'Position Statement on Psychiatric Services for Adolescents'.

services is through the multi-disciplinary team”, but that “many of the child psychiatric teams currently in place throughout the country do not have the full complement of team members”.²¹¹ The report found a large discrepancy²¹² between the then existing numbers of appropriate beds and the required numbers.²¹³ These findings present a picture that does not conform to Ireland’s obligations under the CRC.²¹⁴ The Working Group recommended “a significant expansion in the number of child and adolescent teams nationally” (it estimated that an additional 25 such teams were required nationally), and a considerable number of additional beds.

Services for Adolescents

The Irish College of Psychiatrists has said:

“Psychiatric disorders increase in incidence and prevalence during adolescent years. The incidence and prevalence of deliberate self-harm and attempted suicide also increase with increasing age throughout the adolescent phase. Epidemiological studies show that psychological disturbances of varying intensity exist in up to 20% of adolescents. ... [and] 2-5% of the total adolescent population have moderate to severe disabling conditions such as major psychiatric disorders.”²¹⁵

The UN Committee on the Right of the Child has expressed its concern “about the incidence of teenage suicide” in Ireland.²¹⁶ Yet, there is a widespread lack of dedicated adolescent psychiatric services, inconsistent with Article 24(1) of the CRC. Irish child psychiatry provides services for children up to the age of 16 years, but the Irish College of Psychiatrists believes: “Existing Child psychiatry is not equipped to deal with the older adolescent age group because of the significant increase in major psychiatric illnesses which occurs in this age group. Traditionally existing Child Psychiatry services provide out-patient services only and have very limited medical and nursing back-up with no in-patient beds or day hospitals.”²¹⁷

For children over the age of 16 years, services are provided by the adult psychiatric services, “which are not resourced to deal with adolescents because of the lack of developmental perspective and the serious lack of appropriate multidisciplinary

²¹¹ ‘First report of the Working Group on Child and Adolescent Psychiatric Services’ (2001), Department of Health and Children.

²¹² Based on an estimate by the Irish College of Psychiatrists that there should be four beds for children under 12 years of age and six for adolescents up to 16 years of age per 250,000 population.

²¹³ It found that, for under 12 year olds, 58 were required, but only 23 existed; and for 12 to 16 year olds, 86 were required, and just 32 existed; making a total of 144 required but just 55 existing.

²¹⁴ It also fails to meet the requirement to provide “a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country”, in UN Committee on Economic, Social and Cultural Rights, General Comment 14, UN ESCOR, 2000, UN Doc No E/C.12/2000/4.

²¹⁵ ‘Position Statement on Psychiatric Services for Adolescents’.

²¹⁶ Note 16 above.

²¹⁷ Note 32 above.

input which would centre around family, school and social interventions".²¹⁸ In a 1999 government report, most catchment areas surveyed in the then Eastern Health Board were seriously short of adolescent psychiatric facilities and there were none at all in some areas.²¹⁹ That this problem extends to elsewhere in the country is evidenced in a report of an inspection carried out by the Irish Social Services Inspectorate in September 2002 of a Southern Health Board special care unit.²²⁰ The report observed that a continuing national difficulty exists in accessing psychiatric services for adolescents aged between 16 and 17 years. It denounced as unacceptable the fact that all that was available to this age group in the centre visited was an emergency adult psychiatric service through the accident and emergency department of a hospital. In respect of one young person in need of psychiatric treatment, the report referred to a "litany of difficulties" encountered by the centre in accessing this; and concluded:

"It is not the first time the inspectorate have come across difficulties in relation to special care units accessing psychiatric services. A review of the steps taken to access services for just one young person showed that the services are cumbersome and fragmented."

The report of the government Working Group on Child and Adolescent Psychiatric Services does not address this gap and states, "liaison with adult psychiatry colleagues is also important as these patients may need to be referred to the adult service, usually at sixteen years".²²¹ Mere liaison is clearly not enough; where many of the 'patients' may be properly referred to adult psychiatry when they get older, children need specialised services to meet the specific demands of their age profile in line with the CRC.

Adolescents with mental illness and a learning disability are a distinct group considered by the Irish College of Psychiatrists to have special needs that are not being dealt with in an adequate or consistent fashion:

"... because of their developmental level, their mental health needs are not best served by treatment in the same setting as adolescents of normal intelligence. Mental Health Services to this group vary in each Health Board area, e.g. some consultant psychiatrists have responsibility for adolescents although they are adult psychiatrists who provide a cradle to grave mental health service for persons with Learning

²¹⁸ Ibid.

²¹⁹ 'We Have No Beds: An Enquiry into the Availability and Use of Acute Psychiatric Beds in the Eastern Health Board Region', Keogh F, Roche A & Walsh W, Health Research Board, Department of Health and Children, 1999.

²²⁰ 'Gleann Alainn Special Care Unit - Third Annual Inspection Report - Southern Health Board' (2002).

²²¹ Note 28 above.

Disability. In other areas this service is provided by consultant child psychiatrists with special interest in Learning Disability.”²²²

Forensic Psychiatry Services and Detention

There is a distinct lack of forensic psychiatric services for children and adolescents. Recent reports in the Irish media reveal circumstances amounting to several breaches of the human rights standards outlined above, including:

“A very disturbed [16-year old] teenage girl who spent 12 weeks in Mountjoy Women’s Prison in the absence of any suitable place for her has now been placed in an adult psychiatric hospital having been described as ‘psychotic’, the High Court heard yesterday.”²²³

“The judge also heard that an extremely disturbed teenage girl remains detained in the locked ward of an adult psychiatric hospital while construction of a special unit for her, as ordered by the High Court, continues.”²²⁴

Incidents such as these are not uncommon,²²⁵ and violate international law, in particular Rule 53 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty outlined above: “A juvenile who is suffering from mental illness should be treated in a specialised institution under independent medical management. Steps should be taken, by arrangement with appropriate agencies, to ensure any necessary continuation of mental health care after release.”

²²² Note 32 above. This report advises: “In general adolescents with learning disability are quite a complex group with complex and disparate set of problems. Close separate examination of this particular sub-group is needed to ensure that their needs are met adequately.” It recommends, “in addition to specific child psychiatrists and multi-disciplinary teams looking after the mental health needs of children and younger adolescents, community out-patient services for adolescents (14-17 years) with learning disability should be provided by multi-disciplinary teams led by adolescent psychiatrists with a special interest in learning disability. Because of their vulnerability adolescents with learning disability and psychiatric disorder would be best served by treatment where necessary in in-patient units specially designed for this group.”

²²³ Irish Times newspaper, 15 October 2002.

²²⁴ Irish Times newspaper, 1 August 2000.

²²⁵ Other reports include: “A High Court judge yesterday remarked on what he saw as a situation of near chaos surrounding provision of psychiatric and psychological services for disturbed children detained at the new “state-of-the-art” Ballydowd special care unit in Lucan, Co Dublin. Mr. Justice Kelly referred to bureaucratic wrangling, “hit and miss” arrangements, confusion over catchment areas and endless unsuccessful attempts over nine months to have the Eastern Regional Health Authority issue a contract of service to a psychiatrist.”

“A vulnerable boy [who marked his 15th birthday while in the facility] with mild mental handicap is entering his sixth week in St Patrick’s Institution, where he is detained alone in a basement because there is no suitable secure place available for him. A psychiatrist told the High Court yesterday the child has voiced thoughts of suicide and his condition was worsening daily. Mr. Justice O’Donovan said the South Western Area Health Board had had five weeks to find a more suitable alternative for the child, in St Patrick’s last month, but “don’t appear to have done a whole lot”. Because the boy was below the legal age for admission to St Patrick’s, he had to be kept apart from the other inmates and was alone all the time. The boy was in the isolation unit in the basement and wanted to go home. ... None of the child’s needs, apart from security, was being addressed, [consultant psychiatrist] Dr Gargan said.” (Irish Times, 27 July 2001)

A further media report stated:

“In the absence of any alternative, A High Court judge has said he must direct the continuing detention in St Patrick’s Institution [for Young Offenders] for another four weeks of an extremely disturbed teenage boy, an alleged victim of sexual abuse, with no criminal convictions. The 16-year old youth has already been in the prison for some five weeks and has been described as a serious suicide risk. ... [The judge] was told ... the Central Mental Hospital could not take him [and] ... a consultant forensic psychiatrist at the hospital, said its services are already greatly strained.”²²⁶

This would appear to amount to an additional violation of the right of a child to be allowed to recover from abuse or violence in Article 39, a key provision of the CRC.²²⁷

Juveniles in Adult Psychiatric Institutions

Children under the age of 18 years with mental health care needs should generally not be placed in adult psychiatric facilities. Where a child is detained, for whatever reason, Article 37(c) of the CRC provides:

“Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so”

That such children are in fact so placed is a matter of considerable concern to Amnesty International, and fails to live up to Ireland’s obligations under Articles 23(1) and 24(1) of the CRC. The Irish non-governmental organisation, the Children’s Rights Alliance, recently drew the attention of the European Committee for the Prevention of Torture to the following example:

“A 16 year old boy has been detained in an adult psychiatric hospital due to the lack of any secure psychiatric facilities for adolescents in the country. A report from the hospital described the placement as detrimental to his welfare. The boy had previously been detained on a civil order in a remand centre where, according to a psychologist’s report, he was at serious risk of self-induced harm and had to be removed from the remand centre. He recently attempted suicide and had to be resuscitated. (Irish Times, 3.05.02)”²²⁸

The Inspector of Mental Hospitals commented in his report for the year 2000 on what amounted to a further erosion of this principle: “During the past year there

²²⁶ Irish Times, 11 July 2002.

²²⁷ “States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.”

²²⁸ ‘Submission by the Children’s Rights Alliance to the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment’, 17 May 2002.

have been several instances where young persons have been directed to adult psychiatric units. For the most part these have been young persons who are out of control but who do not suffer from a formal psychiatric illness. Therefore, they are misplaced in an adult psychiatric setting."²²⁹ Placing juvenile offenders who do not have a mental illness in psychiatric institutions is a serious cause for concern amounting to a violation of Articles 20 and 37(c) of the CRC outlined above, and Amnesty International hopes that this practice has been discontinued.

The Irish College of Psychiatrists has also commented that the shortage of childcare residential services has resulted in inappropriate referrals to the psychiatric services:

"Difficulties with out of control children present themselves as problems for the both the child and adult psychiatric services. Essentially there is a large group of children with very severe behavioural difficulties that are not amenable to conventional psychiatric treatment. They are often inappropriately referred to psychiatric services hence producing very high dependency rates. The shortage of child care residential services has impinged on the demand for psychiatric services. National plans to develop high support units for such children will eventually alleviate some of this problem."²³⁰ In addition a whole range of community support services and support services to residential group homes are required. Shortage of these services tends to lead to escalation of problems thereby creating an extra demand for psychiatric services."²³¹

Furthermore, adolescents with a mild learning disability are considered by the Irish College of Psychiatrists to be a distinct subset of those who offend, and it feels that a national forensic adolescent services should be developed for this group.²³²

Asylum Seekers & Refugees

The rights enshrined in the CRC apply also to asylum seeking and refugee children, "without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's ... status".²³³ The unique situation of juvenile asylum seekers and refugees is such that rigorous attention must be paid to their mental health care, given the needs of this vulnerable group of children, to comply with international human rights law. This has been recognised in a recent inquiry by the Australian Government:

"The experiences of child asylum seekers raise specific mental health and development issues. The social conditions that give rise to a child's flight from her or his home country may include experiences of war, persecution, death, sexual assault, violence, fear, flight and displacement. Many child asylum seekers will have witnessed harm to

²²⁹ 'Report of the Inspector of Mental Hospitals for the year ending 31st December 2000', Department of Health and Children, Government Publications Sales Office, (2001).

²³⁰ Government plans to develop high support units for such children have been experiencing some recent setbacks due difficulties accessing and maintaining suitable staff.

²³¹ Note 32 above.

²³² Ibid.

²³³ Article 2(1).

family members or directly suffered abuse or violence prior to or during flight. A child may also experience the fears and insecurities which attach to migrant flight, an uncertain future and exposure to different cultures, languages and religions.”²³⁴

Even where they have not experienced such distress directly, if the child's primary carer experiences mental health problems, such as stress or trauma, the child may exhibit similar symptoms.²³⁵ The impact of the asylum process itself on the mental health of asylum seekers has been well documented; several studies have documented that asylum seekers present as “a highly traumatised population at risk of persisting emotional disturbance”.²³⁶ The impact, in particular, of the policy of dispersing asylum seekers throughout Ireland to designated centres which are often isolated from the local community, and with a small financial allowance to supplement their full-board accommodation, has been studied by the Irish Refugee Council, which found high levels of stress and stress-related illnesses in these children.²³⁷

The United Nations High Commissioner for Refugees (UNHCR) instructs that asylum seeking or refugee children who suffer “emotional distress or mental disorders [should] benefit from culturally appropriate mental health services and treatment”.²³⁸ Ireland appears to fall short of this requirement, not alone because of the deficiencies in general child mental health care pointed out above, but because of the lack of any comprehensive programme of counselling and mental health care for this vulnerable group.²³⁹ Asylum seeking children who arrive in Ireland unaccompanied by their parents or an adult guardian, are at particular risk.

UNHCR also stresses that “the more trauma or stress the parents or care-taker has been subjected to, the greater the danger that children risk neglect or abuse”,²⁴⁰ so the mental health needs of the care-givers must also be addressed as part of the comprehensive mental health care of asylum seeking and refugee children.

²³⁴ ‘Background Paper 3: Mental Health and Development, National Inquiry into Children in Detention’, Australian Commission for Human Rights and Equal Opportunities.

²³⁵ See, for instance, McCallin, ‘The Psychological Well Being of Refugee Children’, p84; A Mahjoub, *The Theory of Stress as an Approach to Studying Psychological Responses in a War Environment*, cited in McCallin, *The Psychological Well Being of Refugee Children*, pp36-37.

²³⁶ ‘The Psychological Cost of Seeking and Granting Asylum’, Silove D & Steel Z, in *International Handbook of Human Response to Trauma*, (2000), Shalev A H, Yehuda R & McFarlane A C (eds), Kluwer Academic/ Plenum Publishers, New York, p435.

²³⁷ ‘Beyond the Pale: Asylum-seeking Children and Social Exclusion in Ireland’ (2001), Fanning, Veale & O’Connor, Irish Refugee Council.

²³⁸ UNHCR *Refugee Children: Guidelines on Protection and Care* (1994), Geneva, Chapter 4.

²³⁹ See Chapter 3.

²⁴⁰ Note 55 above.

Preventive Mental Health Care & Early Intervention

In ensuring the mental health of the child, Ireland as a State Party to the CRC and to related international instruments²⁴¹ is required to “develop preventive health care”,²⁴² that is, detecting and treating physical and mental illness in the child, in addition to providing education and guidance to parents on children’s health. The identification of children at risk of developing mental health problems is important so as to facilitate management of the condition at the earliest opportunity. Mental health preventive and early intervention services for Irish children and adolescents at risk of mental illness remain sadly lacking.

The Irish College of Psychiatrists has stated that the current child psychiatry service “deals largely with adolescents at the expense of working with younger children, thereby preventing very useful early intervention which has a huge preventive value”.²⁴³ As noted by the Chief Medical Officer’s report, early intervention requires wider awareness-raising regarding the effects of mental illness:

*“As in other areas of child health, early intervention is an important component of the overall approach to protecting the mental health and normal development of children. In order to facilitate early intervention, we must maximise the ability of parents, teachers, carers, health professionals and other key persons to identify potential mental health problems at an early stage. This requires that awareness is raised among the public and, in particular, among parents. Further consideration is also required to determine how best to reduce the stigma associated with mental illness, in order to remove barriers to early identification and help-seeking. In addition to raising awareness, it is necessary to provide training for primary health care and educational professionals to recognise early signs and symptoms of mental health problems in children.”*²⁴⁴

The education system may be a useful focal point for mental health assessment and referral, as mental health care is more likely to be accepted as a normal part of the child’s life if integrated into curricula from an early age. Schools are also ideally placed to promote and protect children’s mental health:

“Socially disadvantaged children are at higher risk of mental health problems in childhood and later life. However, several social interventions, for example high quality pre-school and nursery education, have been shown to provide lasting cognitive, social and emotional benefits. Early childhood programmes for children lead to improved cognitive development (thinking and reasoning), improved social development (relationship to others), improved emotional development (self-image, security) and improved language skills. Learning and performance at school is also

²⁴¹ See too Principle 4(1), MI Principles.

²⁴² Article 24(2)(f), CRC.

²⁴³ Note 32 above. The reason for this, it says, is: “... because of the changing profile of problems with age, existing child psychiatry services tend to find that the younger adolescent group, i.e., the 13-15 year olds tend to dominate the service because of their high dependency and high rate of emergency presentations with acute illness and suicide attempts etc.”

²⁴⁴ ‘The Health of our Children’, note 1 above.

enhanced. Children showing behavioural problems in school or at home can benefit from school-based interventions and parent training programmes.”²⁴⁵

The government Working Group on Child and Adolescent Psychiatric Services observed, “there does not appear to be any formal liaison or agreed protocols between the child and adolescent psychiatric services and the education system”.²⁴⁶ Amnesty International urges the government to incorporate effective and continuous mental health education into the curricula of all stages of the education system, with an emphasis on stigma reduction.²⁴⁷ This should be part of a wider strategy to educate the public about the reality of mental illness discussed in Chapter 9, and to enhance the ability of parents, teachers, and other key persons to identify and deal appropriately with children with, or at risk of, mental illness.

Age of Consent

The UN Committee on the Rights of the Child said in its 1998 report: “In relation to the definition of the child (article 1 of the Convention), the Committee is concerned at the various low age-limits set in the domestic legislation of the State party.” Where children over 16 years are classified as adults under the Mental Treatment Act, 1945, this has been rectified in the Mental Health Act, 2001, so that the age of consent for mental health treatment is 18 years. However, the latter continues to conflict with the lower age of consent in other pieces of Irish legislation: under the Non-fatal Offences Against the Person Act, 1997, a child of 16 years can consent to medical treatment without parental input. This is a matter which should be resolved by the Oireachtas.

Conclusion & Recommendations

Amnesty International urges the Irish Government to recognise the opportunity to redirect the lives of children with, or at risk of, mental illness, through the comprehensive provision of dedicated mental health care services, taking into account the interrelationship between mental illness and other life difficulties such as homelessness and poverty. The Chief Medical Officer’s second Annual Report cautioned:

“In the light of the high prevalence of emotional and psychiatric disorders, the higher than average prevalence of risky behaviours in Irish adolescents, and the deficits in the health system response to these matters, it is clear that the issue of child mental health and illness constitutes a major area of concern from a public health point of view. In Ireland, policy-makers, service providers, professionals and the public at large would do well to heed the warning of the US Surgeon General in relation to this matter as it affects the USA when he recently stated that ‘the burden of suffering by children with

²⁴⁵ Ibid.

²⁴⁶ Note 28 above.

²⁴⁷ Amnesty International welcomes a recent initiative by the non-governmental agency, Mental Health Ireland: the ‘Mental Health Matters Schools Project’. This is a resource pack for use in schools, comprised of a teacher’s/facilitator’s guide book and a video. A follow-up web based magazine, ‘Pro-Teen Matters’, was launched in October 2002 to educate secondary school children about the effects of certain mental disorders. For more information, see www.mentalhealthireland.ie/webmag.

*mental health needs and their families has created a health crisis in this country'. In that context, the policy priority which needs to be given to mental health in children is self-evident, if we are to pre-empt the occurrence of such a crisis in this country."*²⁴⁸

The CRC provides much guidance on how the rights of children should be interpreted and vindicated. An important step in ensuring national respect for this international instrument would be its incorporation into Irish law. Since the Irish courts have found themselves very active in reviewing the state's provision of mental health care and accommodation for children with mental illness, to have the CRC incorporated into Irish law would be of enormous benefit to all concerned. Furthermore, the rights within this Convention should be widely promulgated; the UN Committee, in its 1998 report, stated:

"The Committee is of the view that insufficient steps have been taken to promote widespread awareness of the Convention, and remains concerned at the lack of adequate and systematic training on the principles and provisions of the Convention for professional groups working with and for children, such as judges, lawyers, law enforcement personnel, including police officers, health professionals, teachers, social workers, community workers and personnel working in institutions for children."

Amnesty International encourages Ireland to seek the advice of international agencies such as UNICEF, UNHCR and WHO in taking effective and comprehensive measures to meet its international responsibilities towards its children. The Ombudsman for Children Act, 2002 provides for the appointment of an Ombudsman for Children, and it is to be hoped that this office will address the area of children's mental health as a matter of the utmost importance.

In particular, Amnesty International urges the Irish Government to:

- ▣ Adopt and implement all measures necessary to address deficiencies in child and adolescent psychiatric services, with a sufficient number of full specialist multi-disciplinary teams, with consideration given to the special needs of adolescents with learning disability, and to the provision of national forensic child and adolescent services, to bring them into line with best international practice, and extend all necessary resources to this end.²⁴⁹

²⁴⁸ Note 1 above.

²⁴⁹ In line with the UN Committee on the Rights of the Child's recommendation (note 16 above) that Ireland should "pursue further efforts to ensure the implementation of integrated mental health programmes and approaches and to make available the necessary resources and assistance for these activities".

- ❑ Regularly compile accurate data on the mental health needs of children and young people, particularly those in vulnerable communities, and in, and upon leaving, health board care.²⁵⁰
- ❑ Introduce positive measures to ensure that the particular needs of children in marginalised or disadvantaged communities are met, including children living in poverty, homeless children, asylum seeking and refugee children, and those living in, and leaving state residential care, to ensure that any discrimination against children in the provision of mental health care is addressed.²⁵¹
- ❑ End the practice of placing children in adult psychiatric institutions, except when it is considered in their best interests to be so placed; and establish the necessary complement of child and adolescent psychiatry in-patient units and residential places.
- ❑ Ensure that the practice of placing juvenile offenders in psychiatric institutions is discontinued, and that they are placed in more appropriate accommodation.
- ❑ Establish secure in-patient units for all children and adolescents who are in need of mental health care treatment in a secure setting in line with international standards.
- ❑ Incorporate effective and continuous mental health education into the curricula of all stages of the education system, with an emphasis on stigma reduction. This should be part of a wider strategy to educate the public about the reality of mental illness,²⁵² and to enhance the ability of parents, teachers, and other key persons to identify and deal appropriately with children with, or at risk of, mental illness.
- ❑ Commence Incorporate into Irish law the principles and provisions of the UN Convention on the Rights of the Child, and take steps to promulgate them amongst all stakeholders.

²⁵⁰ In line with the UN Committee's recommendation (ibid): "that the system of data collection and development of indicators be adjusted to include all children up to the age of 18, with a view to incorporating all the areas covered by the Convention ... with specific emphasis on vulnerable children and children in especially difficult circumstances. Adequate disaggregated data should be gathered and analysed in order to monitor and assess progress achieved in the realization of children's rights and to help define policies to be adopted to strengthen the implementation of the provisions of the Convention."

²⁵¹ In line with the UN Committee's recommendation (ibid) that Ireland "strengthen its efforts to ensure that children from vulnerable and disadvantaged groups, including children belonging to the Traveller community, children living in poverty and refugee children, benefit from positive measures aimed at facilitating access to ... health services".

²⁵² See Chapter 9.

Chapter 7

HOMELESSNESS

“The Simon Communities of Ireland are extremely concerned at the increase we have witnessed in the numbers of people who are homeless who are presenting with mental ill health. The lack of access to assessment and treatment services by people who are homeless further exacerbates the problem - leaving individuals very vulnerable, and homeless services struggling to ensure they meet service users needs.”

Simon Communities of Ireland²⁵³

Introduction

According to research in the United Kingdom,²⁵⁴ the average age of death of a homeless person sleeping rough is 42 years; the Simon Community, believes it to be the same here.²⁵⁵ Yet it has been observed that: “there has never been a structured, managed health care response to the needs of Ireland’s homeless. Despite the extreme poor health experienced by people homeless, a significant proportion of homeless people are neither registered with a GP or hold a medical card.”²⁵⁶

As will be outlined below, the data available on the mental health care needs of Ireland’s homeless is deficient, there are very few specialised mental health teams dedicated to this population, and there is little or no follow-up for them after discharge from in-patient care.

The problem of homelessness and mental illness is a very complex one, as noted by the European alliance of homeless organisations, FEANTSA:

“Housing and homelessness are inseparable. Becoming homeless is generally the upshot of a series of life events which push some people into exclusion. But housing is often not their only problem: they also have health (lifestyle, sickness, dependency, etc.), psychological and social problems (isolation, loss of self-confidence, depression, etc.) which mount up into a fast-track to homelessness. ... Unfortunately, few countries take account of the special needs of the homeless in these areas. Mostly they stop short at treating homeless people’s problems just as a housing issue.”²⁵⁷

²⁵³ Noeleen Hartigan, Social Policy and Research Coordinator, Simon Communities of Ireland commenting to Amnesty International on 18 Oct 2002.

²⁵⁴ Crisis Annual Report 1999-2000.

²⁵⁵ ‘Health Strategy 2001: Submission by the Simon Community of Ireland to the Department of Health on its review of the Health Service’, Simon Communities of Ireland.

²⁵⁶ Ibid.

²⁵⁷ ‘Analysis of the National Action Plans - Social Inclusion’ (2001), available at www.feantsa.org/key_docs/fea_docs/naps/NAPs_analysis_EN_june_02.pdf

The first principle in any discussion of homelessness, of course, is that housing is a fundamental human right.²⁵⁸ Everyone should have access to suitable accommodation, and homelessness, as the most fundamental violation of this principle, should be eliminated. Amnesty International pays tribute to Irish non-governmental homeless agencies like Focus Ireland, the Simon Community, St Vincent de Paul, and Threshold without whom the problems experienced by Ireland's homeless would be so much worse. Naturally, the housing needs of Ireland's homeless must be addressed if their mental health is to significantly improve. As a 1999 report stated: "It is surely taking de-institutionalisation to an unacceptable extreme to imply that people who are mentally ill can be cared for even if they have not been properly housed first".²⁵⁹ However, this chapter is concerned only with the mental health care needs of Ireland's homeless.

International Standards

The human rights outlined in Chapter 1 apply equally to homeless people, including the right to the highest attainable standard of health in Article 12 of the UN International Covenant on Economic Social and Cultural Rights (ICESCR), and the right to the best available mental health care in Principle 1 of the UN Principles for the Protection of Persons with Mental Illness.²⁶⁰ The UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities provide: "States are under an obligation to enable persons with disabilities to exercise their rights, including their human, civil and political rights, on an equal basis with other citizens."²⁶¹ Furthermore, in order for Ireland to comply fully with the ICESCR, the UN Committee on Economic Social and Cultural Rights says:

"The obligation of States parties to the Covenant to promote progressive realisation of the relevant rights to the maximum of their available resources clearly requires Governments to do much more than merely abstain from taking measures which might have a negative impact on persons with disabilities. The obligation in the case of such a vulnerable and disadvantaged group is to take positive action to reduce structural disadvantages and to give appropriate preferential treatment to people with disabilities in order to achieve the objectives of full participation and equality within society for all persons with disabilities. This almost invariably means that additional

²⁵⁸ Article 25(1) of the Universal Declaration of Human Rights provides: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including ... housing", and Article 11(1) of the International Covenant on Economic, Social and Cultural Rights: "The States Parties to the present Covenant recognise the right of everyone to an adequate standard of living for himself and his family, including adequate ... housing."

²⁵⁹ 'Mentally Ill and Homeless in Ireland: Facing the Reality, Finding the Solutions' (1999), McKeown K, Disability Federation of Ireland.

²⁶⁰ UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care adopted by General Assembly Resolution 46/119 of 17 December 1991.

²⁶¹ Rule 15. Adopted by General Assembly Resolution 48/96 in 1993.

resources will need to be made available for this purpose and that a wide range of specially tailored measures will be required.”²⁶²

Consequently, the significant occurrence of mental illness within this section of the population outlined below places a positive obligation on the Irish state to take active measures to address any gaps in their human rights protection, and, consequently, in any deficiencies in their mental health care. Failure to do so amounts to non-compliance with Ireland’s binding obligations under Article 12 of the ICESCR.

Background

The number of homeless in Ireland is climbing.²⁶³ The most recent official figures at the time of writing date from 1999, when 5234 people were assessed as homeless,²⁶⁴ the majority of whom were in the Dublin region.²⁶⁵ It must be emphasised that Ireland’s statutory definition of homelessness is much narrower than those operating in other jurisdictions; quantitative international comparison of homeless figures is therefore quite pointless. The definition of homelessness in the Irish Housing Act, 1988²⁶⁶ covers people sleeping rough and those accommodated in emergency shelters or Bed and Breakfast accommodation, but excludes those involuntarily sharing with family or friends, in insecure accommodation, or living in inadequate or sub-standard accommodation. It also excludes those currently housed but who are likely to become homeless due to economic difficulties, insecure tenure or health problems.

The United Kingdom’s definition, on the other hand, is much wider: it defines a person as homeless if there is nowhere where they, and anyone who is normally with them, can reasonably be expected to live, and includes those “threatened with

²⁶² General Comment No. 5, ‘Persons with Disabilities’; (Eleventh session, 1994), UN Doc E/C.12/1994/13 (1994), at para 9.

²⁶³ From 2,501 in 1996 to 5,234 in 1999, in ‘Local Authority Assessments of Social Housing Needs’, 31 March 1999, Department of the Environment and Local Government, (October 1999).

²⁶⁴ Ibid: 2,593 adult men, 1,399 adult women and 1,399 children.

²⁶⁵ ‘Counted In - The Report of the 1999 Assessment of Homelessness in Dublin Kildare and Wicklow’ (2000), Williams J & O’Connor M, ESRI/Homeless Initiative, Dublin. It covered the counties of Dublin, Wicklow and Kildare - over 50 per cent of those surveyed had been homeless for more than a year and 14 per cent had been homeless for the previous five years.

²⁶⁶ Section 2 states: “A person shall be regarded by a housing authority as being homeless for the purposes of this Act if - (a) there is no accommodation available which, in the opinion of the authority, he, together with any other person who normally resides with him or who might reasonably be expected to reside with him, can reasonably occupy or remain in occupation of, or (b) he is living in a hospital, county home, night shelter or other such institution, and is so living because he has no accommodation of the kind referred to in paragraph (a), and he is, in the opinion of the authority, unable to provide accommodation from his own resources.”

homelessness".²⁶⁷ One can look to Northern Ireland, which has a population a third of the size of Ireland's, to see the result: under its definition, there are about 12,694 households considered homeless there.²⁶⁸ Some comparison can be achieved through looking at the numbers of people sleeping rough on the streets. In November 2000, speaking on the results of its June 1999 count,²⁶⁹ Dublin Simon observed:

*"Compared to the number of rough sleepers in cities of comparable size in the UK, the number of rough sleepers in central Dublin is very high. According to figures from the UK Government's Department of the Environment, Transport and the Regions Rough Sleepers Count of June 1999, there are more rough sleepers in Dublin than in Oxford (52), Manchester (44), Birmingham (43), Nottingham (31) and Liverpool (30) combined. According to the UK's Homeless Network Street Monitor Count of January 1999, the number of rough sleepers in central Dublin is more than two-thirds of the number of rough sleepers in central London (302)."*²⁷⁰

²⁶⁷ Section 175 of The Housing Act, 1996 provides: "(1) A person is homeless if he has no accommodation available for his occupation, in the United Kingdom or elsewhere, which he - (a) is entitled to occupy by virtue of an interest in it or by virtue of an order of a court, (b) has an express or implied licence to occupy, or (c) occupies as a residence by virtue of any enactment or rule of law giving him the right to remain in occupation or restricting the right of another person to recover possession. (2) A person is also homeless if he has accommodation but - (a) he cannot secure entry to it, or (b) it consists of a moveable structure, vehicle or vessel designed or adapted for human habitation and there is no place where he is entitled or permitted both to place it and to reside in it. (3) A person shall not be treated as having accommodation unless it is accommodation which it would be reasonable for him to continue to occupy. (4) A person is threatened with homelessness if it is likely that he will become homeless within 28 days."

Section 176 provides: "Accommodation shall be regarded as available for a person's occupation only if it is available for occupation by him together with - (a) any other person who normally resides with him as a member of his family, or (b) any other person who might reasonably be expected to reside with him."

The UK's new Homelessness Act, 2002, widens this definition of homelessness again, so that people leaving state "institutions" - such as former members of the armed forces, teenagers leaving local authority care and young offenders released from prison, categories of homelessness that were removed by the Conservative government under the Housing Act 1996, are included.

Local authorities in the UK have a duty under these Acts to provide temporary accommodation to homeless households who have a 'priority need'; those who do have a 'priority need' are entitled only to the local authority's advice and assistance.

²⁶⁸ 'Northern Ireland Housing Statistics 2000-01' (2001), Statistics and Research Branch, Department for Social Development, Northern Ireland.

²⁶⁹ 'Sleeping Rough Report 2000', Bergin E, Dublin Simon, in association with Focus Ireland and Dublin Corporation (December 2000). It found that the main factors behind the increase in numbers of rough sleepers include: lack of move-on accommodation; lack of emergency accommodation; lack of adequate community care provision; lack of preventative strategies for those leaving prison, care, the army and other forms of institutional life; increase in drug misuse and inadequate number of drug treatment and rehabilitation centres; and growing wealth inequality and persistent absolute poverty.

²⁷⁰ Press statement on 29th November 2000, '[202 people sleeping rough in Central Dublin](http://www.dublinsimon.ie/newsroom/29th-nov-2000.htm)', available at www.dublinsimon.ie/newsroom/29th-nov-2000.htm. "This 1999 count of those sleeping rough in Central Dublin during the week of 15th-21st October 2000 represents an increase of 60% on the street count of 8th-14th December 1997 (which found 125 persons were sleeping rough) and a 36% increase on the street count of June 1998 (which found 149 persons were sleeping rough)."

There is a rising number of homeless families in Ireland: for instance, a recent study of those in Dublin stated:

"In 1984 there were 37 women with 93 children in hostels in Dublin and no family was homeless for more than six months (Kennedy 1985).²⁷¹ By 1999 there were 540 families with 990 children (530 under 5 years of age) assessed as being homeless in the ERHA region (Williams & O' Connor, 2000).²⁷² [...] The number of single-parent (usually mother-only) families with young children who find themselves in the vulnerable position of homelessness has increased at an alarming rate. The impact of this disruptive, unstable and often chaotic situation on young lives is becoming clear from research in various countries"²⁷³

Mental Illness Prevalence in the Homeless

Research and data on the prevalence of mental illness and mental health needs of Ireland's homeless, and appropriate effective responses for this community is under researched. "There is limited data available on the effects of homelessness on mental health in an Irish context and none that looks specifically at children and their families."²⁷⁴ The mental health status or needs of Ireland's homeless does not form part of the state's triennial homeless count, which also provides little information on characteristics such as the income source, special needs, ethnicity or general health status of Ireland's homeless.²⁷⁵

Policy makers and advocacy bodies must consequently operate on estimates, and various sources put the proportion of Ireland homeless suffering from a mental illness at between 30 and 50 per cent.²⁷⁶ A report commissioned by the then Eastern

²⁷¹ 'But Where Can I Go - Homeless Women In Dublin' (1985), Kennedy S, Arlen Press, Dublin.

²⁷² Note 13 above.

²⁷³ 'The Mental and Physical Health and Well-being of Homeless Families in Dublin: A Pilot Study', Focus Ireland, the Mater Hospital and the Northern Area Health Board. This pilot study came about as a result of concern within three agencies - the Department of Child and Family Psychiatry at the Mater Hospital in Dublin, the Housing Division of Focus Ireland and the Area Medical Services, Community Care Area 6, of the Northern Area Health Board - about the effects of homelessness on families and their children, the lack of adequate support services and how the mental health of parents impacts on children, especially in homeless families. This pilot study was carried out in Dublin through the collaboration of these three agencies.

²⁷⁴ Ibid. The Simon Community is endeavouring to address this gap, and has commissioned a major piece of work in this area of data collection, which will take place in 2003.

²⁷⁵ The Housing Act, 1988 conferred on Local Authorities the responsibility of conducting an assessment of their homeless populations at least once every three years. A national assessment was carried out in 2002, but the results are not available at the time of writing. The Simon Community recently observed in its September 2002 newsletter: "The data will tell us nothing about individual's housing need, family status or age, all of which should be pertinent to planning for housing provision. Additionally they tell us nothing about routes into homelessness and the types of services people wish to access. In the absence of this information, both the appropriateness of current service provision and the planning of new services will continue to occur in a chasm."

²⁷⁶ For instance, the Dublin Simon 'Annual Review' published on 30 May 2001 reported: "25% of the 813 people who used the Simon Community's emergency shelter in Dublin last year were diagnosed with a serious mental health problem. Dublin Simon staff estimate that the same proportion again suffered from a mental health difficulty that was left undiagnosed."

Health Board put the prevalence of homeless persons experiencing chronic mental illnesses at 32.5%.²⁷⁷ One report calculated that, based on the official homeless count,²⁷⁸ there were 1500 people homeless with mental illness in Ireland in 1999.²⁷⁹ Again, the narrow definition of homelessness in Ireland must be borne in mind when contemplating these figures.

The circumstances of homeless families are unfortunate.²⁸⁰ Studies in other jurisdictions have found very high levels of mental illness in homeless mothers.²⁸¹ The children of homeless families have also been found to have much higher likelihood of developing mental illness than the remainder of the population. For instance, Focus Ireland found that 12 of the 31 children profiled in its study “exhibited signs that they were likely to present with mental health problems of sufficient severity to merit referral for psychiatric assessment”.²⁸² It concluded that “the rate of psychiatric disorder is higher amongst homeless children than that of their housed counterparts”.

Mental Health Care & Ireland’s Homeless

The Simon Community of Ireland has noted:

“In the European context Ireland is exceptional in the undeveloped nature of its services to mentally ill people who are homeless. In particular supported housing is a neglected and under provided area in Ireland, with less than 200 units of supported accommodation provided for mentally ill and homeless people, the great majority of these through the voluntary sector. Health boards do provide some supported accommodation for people who are mentally ill in the community but this is mostly

‘The Health of Hostel-Dwelling Men in Dublin’, Feeley A et al, Royal College of Surgeons in Ireland and Eastern Health Board, (March 2000) found that 64 per cent of the survey population were suffering from some form of mental health condition.

²⁷⁷ ‘Health Status, Health Service Utilisation and Barriers to Health Service Utilisation among the Adult Homeless Population of Dublin’ (1997), Holohan.

²⁷⁸ Note 11 above.

²⁷⁹ ‘Mentally Ill and Homeless in Ireland: Facing the Reality, Finding the Solutions’, note 7 above, based on an estimated average incidence of mental illness among the population of between 25 and 30 per cent.

²⁸⁰ See Focus Ireland pilot study, note 21 above, which found only 28.6 per cent ‘psychiatric caseness’ in its sample. However, it noted: “The families involved had achieved some degree of accommodation stability in the family transition unit of Focus Ireland. This contrasted to some extent with the study by Vostanis (1997) [in England] where the families assessed were placed in short-term accommodation hostels. In that study they were assessed within two weeks of entering the hostels whereas in the Dublin pilot study the majority of the mothers interviewed had been in their accommodation for a number of months. ... [and they] reported a considerable improvement in their own mental health since obtaining some degree of stability of accommodation.”

²⁸¹ For example, in the UK, see ‘Psychopathology, Social Cognitive Functioning in a Hostel for Homeless Women’ (1996), Adams C, Pantelis C, Duke P & Barnes T, *Br J Psychiatry* 168:82-86, and in the US, ‘Characteristics of Sheltered Homeless Families’ (1986), Bassuk E L, Rubin L, and Lauriat A S *Am J Public Health* 76(9): 1097-1101.

²⁸² Note 21 above. It is worth noting that this study found: “One very positive and significant finding was that the score on which the parents as a group were within the average range was in the domain of attachment to their children (attachment sub-scale). This indicates that the mothers were strongly invested in caring for their children and strongly motivated to fulfil their parenting role.”

for compliant groups. Those who are homeless, who are generally seen and treated across the system as a non-compliant group, are not provided for.”²⁸³

Not all experts agree on many aspects of the causes for the high degree of mental illness in Ireland’s homeless population, or how best to address this problem. Nevertheless, it is widely acknowledged that the services for homeless people with mental illness are seriously underprovided. Because community-based care services for the homeless are deficient, with a particular shortage of community-based residential care accommodation, homeless people were discovered to make up one third of all persons inappropriately placed in acute psychiatric beds in the then Eastern Health Board area in a 1999 report.²⁸⁴ The scenario presents itself then, where the lack of mental health care and other services for homeless people with mental illness results in their inappropriate occupancy of much needed beds, impacting on the availability of such beds for acute patients. A non-governmental report concluded: “the rise in homelessness from the 1980s has often been linked to the de-institutionalisation of psychiatric patients into the community. In Ireland the evidence is less that discharged former long-stay patients became homeless but rather that the reduction of long-stay beds closed off what in effect was a residual social accommodation role performed by long-term psychiatric institutions.”²⁸⁵ The Inspector of Mental Hospitals has also remarked on this problem in his report for 2001:

“Time and again, the Inspectorate has been struck by the number of current psychiatric in-patients who are homeless and are accommodated in acute or long-stay hospital wards despite being suitable for community residential placement. There is hardly a service in Ireland where this is not a current issue.”²⁸⁶

In response to the Inspector’s observation, Schizophrenia Ireland commented:

“While we are aware that some service provision has been made there is a need to ensure that this problem is addressed urgently to ensure that people who are homeless do not end up in the prison population or are not receiving adequate mental health care supports”.²⁸⁷

There is a further difficulty for homeless people in accessing mental health care due to the sectorisation of psychiatric services into catchment areas, introduced on foot of the 1984 government strategy, ‘Psychiatric Services: Planning for the Future’. While unproblematic generally, this system is inappropriate to the needs of homeless

²⁸³ Note 3 above.

²⁸⁴ ‘We Have No Beds: An Enquiry into the Availability and Use of Acute Psychiatric Beds in the Eastern Health Board Region’ (1999), Keogh F, Roche A & Walsh W, Health Research Board, Department of Health and Children.

²⁸⁵ ‘Homelessness and Mental Health, policies and services in an Irish and European Context’, Harvey B, Homelessness and Mental Health Action Group.

²⁸⁶ Inspector of Mental Hospitals report for 2001.

²⁸⁷ ‘Schizophrenia Ireland’s Response to the Inspector of Mental Hospitals Report 2001’ (2002).

people. Whereas Amnesty International understands that individual service providers are often flexible about these arrangements, the fact remains that strictly speaking, homeless people in need of mental health care should return to their previous places of residence for such, effectively leaving many homeless people without a service, since the majority of homeless people live in Dublin and in other major cities but do not come from there originally. "Sectorisation has [also] led to staff generally not trained to meet and understand the needs and special requirements of some people homeless." ²⁸⁸

Government 'Guidelines on Good Practices and Quality Assurance in Mental Health Services' dictate: "A mechanism should be in place to review patients who have been lost to follow up and everything possible done to find out what has happened to the patient and to take appropriate action." Another consequence of this sectorisation - which does not operate in the wider medical service - is that follow-up for homeless people after discharge from in-patient psychiatric care is neglected:

"There is little or no follow-up of patients after discharge from in-patient care. In 'Planning for the Future', the 1984 report by the Department of Health's on the future of the psychiatric service, there is a commitment to "continuity of professional responsibility running through the different treatment services provided by the psychiatric team." The reality as experienced by the Simon Community is that there is no follow-up. If the person fails to turn up at the clinic, no follow-up action is taken." ²⁸⁹

Others are discharged directly into the care of homeless emergency shelters operated by voluntary agencies,²⁹⁰ which are not therapeutically appropriate for people with mental illness:

"The practice of directly discharging people who are without permanent accommodation from hospitals, including psychiatric hospitals, to emergency shelters

²⁸⁸ The Simon Community of Ireland, note 3 above.

²⁸⁹ Ibid. A government 'Homeless Prevention Strategy' was published in February 2002 (produced by the Cross Departmental Team that devised the original 'Integrated Strategy' mentioned below), Chapter 4 of which deals with people leaving mental health facilities.

²⁹⁰ In relation to discharge from psychiatric care, the Simon Communities note: "...homeless services claim that they are being used as a "dumping ground" by the mental health services, who send people presenting with mental illness to homeless hostels because the person and (it is claimed) the health service have no other option. However the Department of Health counters that from research they completed in 1992 tracing patients discharged from Mental Institutions, none of those discharged became homeless. The issue therefore may be that many people which the Psychiatric service classifies as having behavioural difficulties but not mental illness and therefore not part of their responsibility are finding their way into the 'homeless net' while previously they would have been housed in Mental Institutions." ('Policy Audit of Recent Developments in the area of Mental Health and Homelessness', Bergin E, Simon Communities of Ireland, 7 November 2002.)

for homeless people has been documented by the Simon Community as long ago as 1992. ²⁹¹ Today this modus operandi is more common and is causing greater problems than ever before.”²⁹²

In a recent survey of fourteen homeless families with thirty-one children in Dublin in Focus Ireland’s family transition units, “the women and children had been homeless for approximately 8.5 months on average prior to entering the ... family transition units and intermittently homeless for 26 months on average before living in the family transition units. Twenty-one per cent of the mothers reported they had experienced homelessness as a child ... [and] ... the behavioural and emotional problems of the children were at a much higher level and rate than the population norm”.²⁹³

The report revealed “predictably high levels of parental stress and high level of mental health needs for children”. It is of note that none of the parents profiled had ever accessed the psychiatric/psychology services or seen a community psychiatric nurse either before becoming or while homeless, but 52 per cent and 29 per cent respectively had done so upon entering the unit.

In 1999, the Chief Executive Officer of the then Eastern Health Board established a multidisciplinary group, to identify the gaps in service provision for the homeless in that region, which made a number of recommendations.²⁹⁴ One such recommendation was: “The in-patient treatment needs of the homeless mentally ill should ideally be provided by a centralised service, rather than devolved to catchment area services, to ensure that there is no fragmentation of service delivery.” This has not been acted upon almost four years later.

²⁹¹ ‘“Still Waiting for the Future”, Simon Community’s response to the Government’s Green Paper on Mental Health’ (1992).

²⁹² Simon Community, note 3 above. It continues: “For example, during 2000, in Dublin Simon’s shelter a total of 47 people or 7% of all people accommodated came directly from hospital.”

²⁹³ Note 21 above.

²⁹⁴ ‘Homelessness in the Eastern Health Board: Recommendations of a Multidisciplinary Group’ (1999), Eastern Health Board, Dublin.

Government Homelessness Action Plans

In May 2000, 'Homelessness - An Integrated Strategy' was launched by the government, and some of its key recommendations included:

- Local authorities and health boards, in full partnership with voluntary bodies, are to draw up action plans on a county-by-county basis to provide an integrated delivery of services to homeless people by all agencies dealing with homelessness.²⁹⁵
- Local authorities will be responsible for the provision of accommodation, including emergency hostel accommodation for homeless persons and health boards to be responsible for the provision of their in-house care and health needs.
- A Director for homeless services in the Dublin area will be appointed by Dublin City Council and a centre to be established for the delivery of these services in Dublin.
- Preventative strategies, targeting at-risk groups including procedures to be developed and implemented to prevent homelessness amongst those leaving custodial care or health related care.

Homeless Action Plans were subsequently developed and adopted by all local authorities throughout the country to provide an integrated delivery of services, including mental health services, to homeless people by all agencies dealing with homelessness. Presently they have no statutory basis and there is no overall reporting structure. A joint analysis by non-governmental homeless agencies of the Action Plans' provision for the development of health services, included mental health care, found the language of the plans "conditional and non-committal":

"The plans do achieve a relatively sophisticated understanding of the nature and complexity of the problem, but policies for dealing with the multiple social and health problems linked to homelessness, prevention and the transition to permanent accommodation are weakly stated or absent." ²⁹⁶

²⁹⁵ "Local homeless persons centres will be established jointly by local authorities and health boards, in consultation with the voluntary bodies, throughout the country. The service provided will be enlarged to involve a full assessment of homeless persons' needs and to refer persons to other health and welfare services." Arising out of this, some local authorities plan a dedicated service delivery system to people out of home - a one-stop-shop. Others see a mixed type of service delivery with the development of a dedicated centre or unit for advice and some direct service provision but with other services delivered through a number of different sources e.g. other statutory service providers, voluntary organisations and community groups.

²⁹⁶ 'Housing Access for All? An Analysis of Housing Strategies and Homeless Action Plans', Focus Ireland, Simon Community, St. Vincent de Paul, Threshold, Dublin, unpublished at the time of writing. It noted: "Of the completed plans available at the time of writing eleven of the twenty have made some commitment to provision/development in terms of health service access and use. The level of commitment and specificity varies with strong commitment from the urban local authorities such as Cork, Limerick, Waterford and Dublin. Clare County Council, Limerick County Council and Meath County Council for example, have all laid down specific objectives in relation to health care provision and/or access. ... The majority of plans recognise the importance of health care and the particular health needs of the homeless population, however, the language of the plans is conditional and non-committal...."

Meanwhile, mental health care provision to Ireland's homeless continues to be deficient, and Amnesty International is concerned that this may amount at the very least to a failure to comply with Article 12 of the ICESCR.

Recommendations

While Amnesty International endorses many of the more general recommendations made by the homeless agencies in relation to the root causes and consequences of homelessness, in relation to mental health it recommends that the Irish Government take the following actions:

- ▣ Adequately address the high level of mental illness in Ireland's homeless population, by ensuring the comprehensive and consistent provision of specialised community-based services, mental health teams and outreach services, learning from international best practice.
- ▣ Expand the data collection on homeless people and households, to provide a clearer picture of mental health, age, gender, and special needs; and improve systems of data recording, information gathering, and reporting by all service providers.
- ▣ Initiate an independent review of 'Homelessness - an Integrated Strategy' to address the weaknesses evident in the implementation of the homeless action plans in relation to mental health care.
- ▣ Implement all recommendations made by the Eastern Health Board's Multidisciplinary Group in 1999.

Chapter 8

PRISONERS & THE CRIMINAL JUSTICE SYSTEM

“It is important both for the rights of the prisoner and for the public health of all countries that time in custody is used positively for the prevention of disease and the promotion of health, and that negative effects of custody on health are reduced to a minimum”

World Health Organisation²⁹⁷

Introduction

There are approximately 3000 people in prison in Ireland,²⁹⁸ a figure that has been rising over the past few years, and will probably to continue to rise. The committal rate under sentence of imprisonment in Ireland is amongst the highest in Europe.²⁹⁹ There are no regularly compiled statistics on the mental health needs of prisoners,³⁰⁰ but it is accepted that these needs are much greater than the remainder of the population. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), in its 1998 report on Ireland, said: “In comparison with the general population, there is a high incidence of psychiatric symptoms among prisoners.”³⁰¹ A report commissioned by the Irish Government on the general health of the Irish prisoner population revealed that all the mental health indicators were much worse for prisoners than the general population.³⁰²

A study published in the British medical journal, *The Lancet*, in 2002, surveyed data on the mental health of 23,000 prisoners in 12 Western countries, including Ireland,

²⁹⁷ ‘Health in Prison’ Project, www.hipp-europe.org/background/0020.

²⁹⁸ ‘Irish Prison Service Report: 1999 and 2000’, the most recent available at the time of writing, gave an average daily number of 2948 prisoners for the year 2000.

²⁹⁹ According to a recent report: “Ireland already has one of the highest imprisonment rates in Europe, 281 per 100,000 ... Granted the relatively low level of crime in Ireland by international standards, the use of prison is extreme. By international comparison, the use of non-custodial penalties in Ireland is small compared to the use of custodial ones. However, Ireland presents a paradox, for it has one of the lowest numbers of people in prison per head of population, 62 per 100,000, the fourth lowest in EU. Prison in Ireland is used for short-term purposes, more so than other European countries. Ironically, the upward trend in the number of committals [in Ireland] has taken place at a time of decline in crime rates ...” (‘Rights and Justice Work in Ireland: A New Base Line’ (2002) Harvey B, The Joseph Rowntree Charitable Trust.)

³⁰⁰ The Irish Prisons Service is currently facilitating a research project being undertaken by a team based at the Central Mental Hospital which is examining the prevalence of mental illness among the prison population, the results of which are unavailable at the time of writing.

³⁰¹ Report to the Irish Government on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 31 August to 9 September 1998, CPT/Inf (99) 15 [EN], Publication Date: 17 December 1999.

³⁰² ‘General Healthcare Study of the Irish Prisoner Population’ (2000), report prepared for the Minister of Justice, Equality and Law Reform by the Centre for Health Promotion Studies, Department of Health Promotion, National University of Ireland, Galway.

over a period of three decades, and found that these prisoners "were several times more likely to have psychosis and major depression".³⁰³ It also found that one in seven inmates suffers from a mental illness that could be a risk factor for suicide.

This high incidence of mental illness in the prison population was recently acknowledged by the Minister for Justice, Equality and Law Reform: "As regards mentally ill prisoners, I should first of all say that an increasing number of vulnerable and mentally disordered people are being committed to prison"³⁰⁴ While not unique to Ireland,³⁰⁵ this scenario is partly attributable to the deficiencies in the wider mental health services pointed out in Chapter 3; many people needlessly end up in the prison system due to their behaviour while seriously ill, when this could have been avoided had they received the mental health care they needed at an early stage. Prisons have often, in effect, become a repository for people with mental illness, which, again, is an experience shared with many other jurisdictions.³⁰⁶ Clearly, an individual's time in prison should be used as an opportunity to ensure that s/he receives good health care, since, as a transient population who bring their mental health problems with them when they leave, they will impact on the wider mental health services upon release.

Despite the known characteristics of the prison population in relation to mental health, it is widely acknowledged that the treatment afforded to prisoners with mental illness within the Irish prison system is extremely unsatisfactory, and likely to breach international standards. While there has been a recent significant expansion in the provision of psychiatric consultations within prisons on an out-patient basis, in-patient services are extremely restricted. Special psychiatric units for prisoners do not exist within or outside prisons, and the only psychiatric hospital that accepts prisoners is Dublin's Central Mental Hospital, which does not have sufficient beds for the demand, while much of its infrastructure has been condemned in many reports due to insufficient capital funding.

³⁰³ 'Serious mental disorder in 23 000 prisoners: a systematic review of 62 surveys', Fazel S & Danesh J, *Lancet* 2002; 359: 545-50.

³⁰⁴ In a letter to the Irish Penal Reform Trust dated 11 December 2002.

³⁰⁵ See 'The organisation of health care services in prisons in European member states', a 1998 report by the European Health Committee of the Council of Europe report for an overview of mental health care for prisoners in member states, based on replies to a questionnaire as well as information obtained during visits to a number of member states. Ireland did not respond to the questionnaire, but was one of the states visited by the committee.

³⁰⁶ The above *Lancet* study, note 7 above, of 22 790 prisoners in 12 countries found that 3.7 per cent of male prisoners and 4 per cent of female prisoners had psychotic illnesses, comparing badly with the 0.1 - 0.4 per cent estimated prevalence in the general population. It also found that 10 per cent of male prisoners and 12 per cent of female prisoners had major depression.

International Standards

Principle 5 of the UN Basic Principles for the Treatment of Prisoners states:

“Except for those limitations that are demonstrably necessitated by the fact of incarceration, all prisoners shall retain the human rights and fundamental freedoms set out in the Universal Declaration of Human Rights, and ... the International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and Political Rights ... as well as such other rights as are set out in other United Nations covenants.”³⁰⁷

While the chief purpose of prison is punishment and rehabilitation, and the provision of primary health care in such a secure environment places difficulties and constraints on prison officers and health care staff, prisoners share the same basic human rights as the rest of the population, based on the right of all persons deprived of their liberty to be treated with humanity and with respect for the inherent dignity of the human person in Article 10 of the International Covenant on Civil and Political Rights (ICCPR).³⁰⁸ Prisoners, at the very least, are entitled to an equivalence of mental health care with the rest of the population, which is clear from the requirement of non-discrimination in Article 2(2) of the International Covenant on Economic, Social and Cultural Rights (ICESCR).³⁰⁹

Furthermore, due to the necessarily coercive and restrictive regime of prisons, international law dictates that additional, specific responsibilities are demanded of states in their treatment of prisoners to guard against ill-treatment and neglect while in custody such as the UN Standard Minimum Rules for the Treatment of Prisoners,³¹⁰ Rule 22(2) of which provides: “Sick prisoners who require specialist

³⁰⁷ Adopted by General Assembly Resolution 45/111, annex, 45 U.N. GAOR Supp. (No. 49A) at 200, U.N. Doc. A/45/49 (1990).

³⁰⁸ This is echoed in the UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, adopted by General Assembly resolution 43/173 of 9 December 1988, Principle 1 of which states: “All persons under any form of detention or imprisonment shall be treated in a humane manner and with respect for the inherent dignity of the human person”. Similarly, supplementing the rights in Article 7 of the ICCPR and Article 3 of the ECHR, Principle 6 provides: “No person under any form of detention or imprisonment shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. No circumstance whatever may be invoked as a justification for torture or other cruel, inhuman or degrading treatment or punishment.” Principle 7 elaborates: “The term “cruel, inhuman or degrading treatment or punishment” should be interpreted so as to extend the widest possible protection against abuses, whether physical or mental, including the holding of a detained or imprisoned person in conditions which deprive him, temporarily or permanently, of the use of any of his natural senses, such as sight or hearing, or of his awareness of place and the passing of time.”

³⁰⁹ “The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”

³¹⁰ Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolution 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977.

treatment shall be transferred to specialised institutions or to civil hospitals. Where hospital facilities are provided in an institution, their equipment, furnishings and pharmaceutical supplies shall be proper for the medical care and treatment of sick prisoners, and there shall be a staff of suitable trained officers." Also, Principle 9 of the Basic Principles for the Treatment of Prisoners stresses that "[p]risoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."

Finally, Principle 20(2) of the UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (the MI Principles)³¹¹ relates to criminal offenders³¹² and provides: "All such persons should receive the best available mental health care as provided in principle 1. The present Principles shall apply to them to the fullest extent possible..."

The World Health Organisation has recently begun a 'Health in Prison' Project to identify and foster good practice in prison health care,³¹³ believing that it "is important both for the rights of the prisoner and for the public health of all countries that time in custody is used positively for the prevention of disease and the promotion of health, and that negative effects of custody on health are reduced to a minimum".³¹⁴ To this end, it has begun to develop some practical examples of mental health promotion in prisons,³¹⁵ which it will continue to expand.

311 Adopted by General Assembly Resolution 46/119 of 17 December 1991.

312 Principle 20(1) states: "The present Principle applies to persons serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings or investigations against them, and who are determined to have a mental illness or who it is believed may have such an illness."

313 This project was initiated and is directed by the Regional Office for Europe of the World Health organization (WHO), in collaboration with the Directorate of Health Care of the Prison Service for England and Wales (DHC). The idea for the network was launched at a meeting of pilot members of the project in London in October 1995. Representatives of the Council of Europe and the European Commission attended. At this meeting, three priority areas were identified for action by the project, one of which was mental health. Ireland is one of the four countries invited to the business meetings of the project, which is being formulated at the pilot stage by eight European countries. For more information see www.hipp-europe.org.

314 www.hipp-europe.org/background/0020

315 It recommends, for example: 'listener' and 'befriending' schemes to help vulnerable prisoners; telephone helplines; counselling and therapy; psychiatric and psychological services; monitoring of those considered at risk of suicide and self-harm, and schemes to reduce their vulnerability; schemes to reduce bullying of vulnerable prisoners; and courses to improve prisoners' coping, social and parenting skills, including anger management therapy.

Situation in Ireland

The best available mental health care for prisoners, as in the community, should promote the mental health of prisoners by identifying those with mental health problems, assessing their needs and either delivering suitable treatment or referring them to specialist psychiatric services. It should also continue any mental health care already begun by a prisoner before entering prison, and facilitate aftercare on release, ensuring continuity of care. The social and economic benefits of such a system would appear indisputable. However, this is not the case in Irish prisons today, where the treatment of prisoners with mental illness would not seem to meet the requirements of international human rights law.

Amnesty International is aware of recent significant improvements in in-prison psychiatric care. For instance, the Inspector of Mental Hospitals notes in his report for 2001:

“Given the considerable increase in the prison population which has occurred in recent years, and because of the perception of a high prevalence of psychiatric disorder among prisoners, the Department of Health and Children has taken steps to expand considerably forensic psychiatric services. ... Together with the increase in consultant personnel, there is also an expansion and re-conceptualisation of the areas of function of the forensic psychiatric services.”³¹⁶

Notwithstanding these efforts, there remains much cause for concern. The European Committee for the Prevention of Torture (CPT) has, throughout the last decade, repeatedly raised concerns about the treatment of prisoners with mental illness in Ireland. In its report of its 1998 visit, it recommended “that the provision of prison psychiatric services be reorganised as matter of urgency”.³¹⁷

The report of a government-sponsored review of the prison health care services published in 2001 noted “many deficiencies and shortcomings”, and “long-term under resourcing of prison health care services ... [which] has led to increasing difficulties in both maintaining the existing levels of service and responding to the increasing expectations of prisoners and other interested parties in regard to the standards and provisions of prisons health care”.³¹⁸ A number of recommendations

³¹⁶ ‘Report of the Inspector of Mental Hospitals for the year ending 31st December 2001’, Department of Health and Children, Government Publications Sales Office, (2002).

³¹⁷ Note 5 above.

³¹⁸ ‘Report of the Group to Review the Structure and Organisation of Prison Health Care Services’ (2001). This multidisciplinary group was established in 1999 to review the structures and organisation of prison health care services in response to the 1998 Annual Report of the Director of Prison Medical Services, which noted a number of deficiencies in the prison health care services, and recommended a comprehensive review of their organisation. The review group is chaired by Mr. John Olden, second vice-president of the CPT, and its membership consists of representatives of the Department of Justice, Equality and Law Reform; Department of Health and Children; Department of Finance; director of prison medical services; a senior prison governor; a nominee of the Irish College of General Practitioners; a nominee of the Irish Division, the Royal College of Psychiatrists; a nominee of An Bord Altranais, representing professional nursing interests; a nominee of the Pharmaceutical Society, representing professional pharmacy interests; and a nominee of the Irish Dental Council,

were made in this report, but little action appears to have been taken on many of these. Schizophrenia Ireland, in its submission to the CPT in advance of the committee's 2002 visit to Ireland, stated:

*"Our concern is that this report now rests with the various Government Departments and to our knowledge no action has taken place as a result. Meanwhile prison services continue to provide a less than adequate mental health service to those people in need."*³¹⁹

Rule 9 of the European Prison Rules, reflecting Rule 10 of the UN Standard Minimum Rules for the Treatment of Prisoners, states: "The [prison] medical services should be organised in close relation with the health administration of the community or nation". This clearly implies that the provision of prison health services should be closely aligned with the Department of Health and Children. The provision of health care in the Irish prison system however, is the responsibility of the Department of Justice; the medical services are organised by the prison medical service unit within this department. While this model is followed in most European countries,³²⁰ the difficulty in Ireland is that "the present situation whereby prison health care is funded and organised entirely separately from general health care in the community has contributed to an inequitable situation".³²¹ While some have argued that the prison mental health care services should lie mainly within the sphere of responsibility of the Department of Health,³²² the abovementioned 2001 review report recommends that, "at very least there ought to be a formal arrangement between the relevant authorities with a view to ensuring a fully adequate health care service in the prisons".³²³

representing professional dental interests. Among other issues the group was asked to consider and make recommendations regarding the provision of psychiatric services to prisoners, taking into account changes in service provision generally and the potential ramification of possible new mental health legislation. This working group is currently exploring means of implementing the core recommendations of this report, including those referring to treatment structures relating to offenders with mental health problems.

³¹⁹ 'Submission to the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)' (2002).

³²⁰ The Ministry of Health is responsible for providing health care in a few countries, such as Norway, while, in some, such as France, measures have been taken to involve the Ministry of Health.

³²¹ Note 22 above.

³²² The non-governmental organisation, the Irish Penal Reform Trust, recommends that healthcare in prisons is delivered through a formal partnership between the health service and the prisons service; the prison service should remain financially and managerially responsible for the primary care delivered in prisons, and the health service should be responsible for secondary and tertiary care, even within prisons, and that an inter-ministerial agreement is needed. 'The Politics of Prison Medicine' (2002), Bresnihan Dr V, Irish Penal Reform Trust.

³²³ Note 22 above. This report observed: "The health boards are responsible for providing health care to the community and the Review Group endorses the view that prison is, in effect, an extension of the community." It also noted that "a joint report by the H.M. Prison Service and the National Health Service recommended that a substantial programme of change be initiated in prison health care in England and Wales on the basis of a formal partnership between the H.M. Prison Service and the National Health Service".

Schizophrenia Ireland has recently commented on this situation as follows:

“We are astonished at the lack of agreement between the Dept. of Health and Children and the Dept. of Justice about who is responsible for provision of mental health care service and how that should be provided. We demand as a matter of urgency that both Departments resolve this matter in the interest of providing acceptable levels of mental health care services for those people in the prison services who require it.”³²⁴

In-Patient Care

Where general medical services in prisons are widely regarded as deficient, this is even more pronounced in the case of the psychiatric services. Psychiatric services are currently provided to prisons and places of detention by visiting psychiatrists employed by the Health Boards. The psychiatric service of the Eastern Health Board at the Central Mental Hospital, Dundrum provide weekly counselling and treatment sessions at Dublin prisons, and in some prisons in the Midland Health Board area. There are now five consultant forensic psychiatrists in the Dublin region, and two in Cork and Limerick prisons. In its 1999 report on Ireland, the CPT commented:

“A mentally ill prisoner should be kept and cared for in a hospital facility which is adequately equipped and possesses appropriately trained staff. That facility could be a civil mental hospital or a specially equipped psychiatric facility within the prison system. Whichever course is chosen, the accommodation capacity of the psychiatric facility in question should be sufficient to avoid prolonged waiting periods before necessary transfers are effected.”³²⁵

Given the very high incidence of serious mental illness in the prison population when compared with wider society, in-patient psychiatric care is a vital part of prison health care. Offenders in Irish prisons who, in the opinion of their psychiatrist and the prison doctor, are in need of in-patient psychiatric treatment may, in theory, be transferred to either the Central Mental Hospital (CMH) or a District Mental Hospital. In practice, all such transfers occur to the CMH. The unacceptable physical conditions in the CMH have been pointed out in successive reports of the Inspector of Mental Hospitals, which refer, for instance to the lack of in-cell sanitation in many parts. The management of the CMH has requested 34m Euro from the government for its refurbishment, but there is concern that this may not be forthcoming given the recent downturn in exchequer revenue. International standards provide that prisoners are entitled to a therapeutic environment, and at least an equivalence of care with the remainder of the population, and Amnesty International urges that funding for such refurbishment be prioritised.

There is also a very long waiting list for admission to the CMH due its lack of beds, with many prisoners in need of in-patient care never receiving such a transfer. This too is a serious transgression of basic human rights principles, and makes the case for increased capital funding for the CMH even more pressing The UN Body of

³²⁴ ‘Schizophrenia Ireland’s Response to the Inspector of Mental Hospitals Report 2001’ (2002).

³²⁵ Note 5 above.

Principles for the Protection of All Persons under Any Form of Detention or Imprisonment stresses that “[p]risoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation”. The CPT, in its report on its 1998 visit, stated: “The transfer of a mentally ill prisoner to a psychiatric facility should be treated as a matter of the highest priority.” In the absence of available alternatives in civil mental health facilities, there is an urgent need for specialised psychiatric treatment units for prisoners.³²⁶

Regarding those transferred to the CMH, the CPT continued:

“The only in-patient psychiatric service available to prisoners is the Central Mental Hospital. In this connection, the Director of Prison Medical Services has informed the Committee that:

“The lack of adequate in-house facilities, both in terms of the availability of trained psychiatric nursing staff and adequate input by dedicated psychiatric staff, together with the lack of any observation or support type facilities has led to a situation where, not infrequently, mentally vulnerable or ill prisoners are incarcerated for significant lengths of time in padded or unfurnished cells while awaiting transfer to the Central Mental Hospital. These difficulties have been exacerbated by the apparent lack of sufficient beds in the Central Mental Hospital to enable a rapid response to be made to requests that a bed be made available.”

This was borne out by the delegation's own observations, both in the prisons visited, and at the Central Mental Hospital. A number of inmates being held in prison were

³²⁶ According to the 1998 report ‘The organisation of health care services in prisons in European member states’, note 9 above: “In some countries there are a number of special psychiatric institutions for mentally ill prisoners. In Portugal the prison service has a psychiatric and mental health clinic where mentally ill prisoners are detained; prisoners whose behaviour gives reason to suppose that they are mentally ill can also be kept in two psychiatric annexes for observation if their treatment does not last longer than six months. In France there are two central units where psychopathic prisoners are housed, in Metz-Barres and in Chateau-Thierry. In Austria treatment for prisoners who are not seriously ill is provided in a separate 45-bed unit situated just outside Vienna.. In Italy there are six psychiatric hospitals (HPJ) which are part of the prison system for mentally ill persons not sentenced to imprisonment but placed in custody as a security measure and for treatment.

It is important to highlight the fact that the special psychiatric institutions for prisoners function not just as detention centres but can also be seen as treatment centres. France and Italy are significant examples of the increasingly close co-operation of the detention system with local bodies and, through them, with the health system and in particular the psychiatric care system of the countries. In France some prisons, 18 in all, are served by regional psychological health departments which includes a full hospital team from a specialist hospital. This team works in the prison, making the diagnosis and following up mentally ill prisoners. If, during detention a prisoner shows signs of a mental condition which requires treatment, he is referred to the prison psychiatrist or to the team from the relevant prison psychiatric department. In Italy the prison administration can call on the relevant national services according to the agreements made with them. This is a two-way arrangement, in that personnel from the national health services can visit the prisons and, on the other hand, detainees can "leave" and go to external satellite sections of the HPJ such as the one established in Castiglione delle Stiviere. In Belgium follow-up treatment by a psychiatrist or by a psychologist may also be offered to prisoners released on parole.”

found to be suffering from conditions which required treatment in an in-patient psychiatric setting (e.g. serious post-traumatic cerebral sequellae). Further, apparently due to the shortage of beds at the Central Mental Hospital, a number of prisoners who had been placed there were found to have been returned to prison before their conditions had fully stabilised.”³²⁷

It is obvious therefore, that many prisoners are returned to prison from the CMH before they are well, a serious violation of the right to proper health care, and of MI Principle 20(2). The Minister for Justice, Equality and Law Reform has recently said: “... it is my intention that health care facilities for prisoners should broadly mirror public health facilities provided in the general community. The implementation of appropriate structures will, of course, require the active co-operation of a range of agencies.”³²⁸ Amnesty International urges that this promised reform take place as a matter of urgency.

Solitary Confinement

Mentally vulnerable prisoners and those with mental illness appear to be incarcerated for significant lengths of time in padded or unfurnished cells in prison, sometimes while awaiting transfer to the Central Mental Hospital, as adverted to by the CPT above. Amnesty International, in a letter to the Minister for Justice on 1st August 2001, raised concerns in relation to an Irish Penal Reform Trust (IPRT) document, ‘Report on the Treatment of Offenders who have Mental Illness’, regarding the use of solitary confinement in isolation cells in Irish Prisons.³²⁹ This letter spelt out three specific concerns:

Firstly, decisions regarding the detention of individuals in isolation cells do not appear to be based on explicitly set criteria. As a result, the purpose to be served by the imposition of solitary confinement seems often unclear, which makes it impossible to assess whether detention in solitary confinement is needed in all the cases in which it is imposed. The very high percentage of detention in isolation cells of people mentally disturbed indicates the use of solitary confinement appears to serve as a substitute for medical/psychological care. This is especially worrying because of the particular vulnerability – reportedly explicitly acknowledged by the governors and staff of the prisons examined in the report – of persons found to be more likely to be detained in an isolation cell. These prisoners, according to the IPRT report, are illiterate, cognitively impaired or have a mental illness. Failure to grant appropriate medical or psychological care to persons in prison custody, but to

³²⁷ Note 5 above.

³²⁸ Written Answer to Dáil question 17 October 2002. In the abovementioned letter of 11 December 2002 to the IPRT, the Minister said: “... I recognise the urgent need to tackle the underlying issue of delays in the provision of in-patient psychiatric care to mentally ill prisoners, and in this regard I have made arrangements for the Irish Prison Service and the East Coast Area Health Board to draw up a Service Level Agreement, to be concluded by the end of this year [2002], on the admission to the Central Mental Hospital of mentally ill prisoners and their treatment there.”

³²⁹ Bresnihan Dr V, IPRT, (2001).

instead place them in solitary confinement, is of grave concern to Amnesty International, and may constitute a violation of Article 10 of the International Covenant on Civil and Political Rights (ICCPR).

Secondly, the conditions in which prisoners are detained in isolation cells – as reported by the IPRT – is also of concern to Amnesty International, as they may amount to cruel, inhuman and degrading treatment and thus violate Article 7 of the ICCPR. For example, the report found that:

- ❖ Isolation cells are single cells furnished only with a thin mattress on the ground and a blanket.
- ❖ Some cells do not have a call-button (which results in some cases, in prisoners having to resort to shouting through a heating vent or hammering on the door of the cell to get the attention of the prison officers).
- ❖ Prisoners in isolation cells are locked up for 23 hours a day, and although they are entitled to one hour's exercise per day under the Prison Rules, this often does not happen.
- ❖ Windows are always sealed; many of the padded cells are dark and dank.
- ❖ In some cases prisoners have no access to toilets and have to use slopping out buckets kept inside the isolation cell, which, as a consequence, can be very fetid.
- ❖ Some prisoners are kept naked while in solitary confinement.
- ❖ Prisoners are not permitted to keep books, radios, or any personal belongings in isolation cells.

The period of time which prisoners held in solitary confinement are allowed to spend out of the isolation cells is reportedly only one hour a day, and this is not always granted. In this respect, attention is drawn to the CPT's recommendations on reports of Sweden "that prisoners spend a reasonable part of their day (i.e. 8 hours or more) outside their cells, engaged in purposeful activities of a varied nature (group association activities, education, sport, work with vocational value)".³³⁰

Thirdly, Amnesty International is very concerned about the reportedly very extensive periods which some prisoners spend in solitary confinement. According to Rule 78 of the Department of Justice's 1947 Rules for the Government of Prisons: "The Governor may order any refractory or violent prisoner or prisoner of suicidal tendencies to be temporarily confined in a special padded cell, but a prisoner shall not be confined in such a cell as punishment or for any longer period than is absolutely necessary." However, the IPRT examination of 224 entries on the use of isolation cells for stays of four days or more, dating from November 1999 to March 2001, reveals that some prisoners are repeatedly put into isolation cells (often at intervals of less than one week) and that the length of time spent in isolation can be worryingly long. In particular, one prisoner was reported to have spent 25 out of 30 days in isolation cells. Another prisoner was reported to have spent 21 out of 33 days

³³⁰ CPT/Inf (99) 4 [EN] (Part 1), 25 February 1999.

in solitary confinement, and was then transferred to the CMH. The longest recorded stay in an isolation cell at any one time was 18 days, while several other prisoners were detained in isolation cells for longer than 10 days at one time.

A fourth concern highlighted in the IPRT report is that records about placement in and exit from isolation cells are not accurately kept and were often missing. About 40 per cent of the 224 entries examined were missing the date on which a person was either placed in an isolation cell or released from an isolation cell. One prison (which is not named) had relatively few records of dates on which people were released from an isolation cell. This led the IPRT to believe that estimates about the length of time spent by some prisoners in isolation could be conservative. The IPRT also noted that the incomplete nature of records demonstrates that there is no proper procedure regarding the use of isolation cells.

Amnesty International is concerned, on the basis of the opinion of numerous medical experts, that prolonged isolation may have serious effects on the physical and mental health of fit prisoners, and is therefore likely to aggravate the condition of persons who are already suffering from mental illness and who should be receiving psychiatric treatment. Prolonged isolation may constitute cruel, inhuman or degrading treatment, contrary to Article 7 of the ICCPR. The UN Human Rights Committee in its General Comments No. 20 (44) has made clear that the prohibition of cruel, inhuman or degrading treatment includes “acts that cause mental suffering to the victim.”³³¹ and that “prolonged solitary confinement of the detained or imprisoned person may amount to acts prohibited by Article 7”.³³²

Amnesty International welcomes a commitment given by the Minister for Justice, Equality and Law Reform in a recent letter to the IPRT that this practice of solitary confinement will be ended:

“... while prisons must have suitable accommodation for prisoners at risk of self-harm, I regard the use of traditional padded cells ... as unacceptable. I have therefore directed the Director General of the Prison Service to replace as soon as possible all traditional padded cells with new safety observation cells which, while soft-surfaced so as to protect the prisoner from self-harm, will fully meet the needs and respect the dignity of the prisoner in every way consistent with his or her safety. ... I will also personally monitor the provision of the new safety observation cells.”³³³

Amnesty International urges that this instruction be complied with immediately, and that the alternative “suitable accommodation” to which reference is made, meet the requirements of international best practice and human rights standards. In tandem, vigilance in the operation, monitoring, and recording of use of the

³³¹ Para 5.

³³² Para 6.

³³³ Dated 11 December 2002.

observation cells must be ensured so as to avoid a repeat of the unfortunate practices documented by the IPRT.

Amnesty International also welcomes the Minister's statement that:

"...it is undoubtedly the case that there have been occasions when a mentally ill prisoner has been held in a padded cell, sometimes for a lengthy period, while awaiting transfer to the Central Mental Hospital. In response to that unacceptable state of affairs, and as an immediate measure pending the wider changes to padded cells which I have signalled, I have requested the Irish Prison Service to ensure that no mentally ill prisoner who is awaiting transfer to the Central Mental Hospital will be held in a padded cell, unless this is unavoidably necessary as an immediate and time-limited measure for the protection of the prisoner from harm."³³⁴

Amnesty International is nevertheless concerned that, while there remains an absence of suitable alternatives for prisoners with mental illness within the prisons, and given that the Minister's edict is similar to that contained in the Prison Rules mentioned above, this serious human rights abuse may continue. Consequently, mental health care for prisoners must be significantly enhanced; and special psychiatric facilities, whether in civil hospitals or special units, and improvement and expansion of the CMH, must be provided as a matter of the utmost urgency.

Aftercare

There is little for prisoners with mental illness upon release in the form of aftercare. This again amounts to a failure to comply with the requirements of the right to the best available mental health care. The government-appointed National Economic and Social Forum (NESF) published a report, 'Re-integration of Prisoners', in 2002, in which it made a number of observations and recommendations, in particular that:

*"Each prisoner should have an individually tailored Positive Sentence Management Plan, developed by a multi-disciplinary team in consultation with the prisoner, and their family where appropriate. The Plan should focus on addressing their needs (e.g. education, training, health, substance abuse, family supports, etc.) and preparing them for their successful re-integration back into society."*³³⁵

It recommended that continuity of treatment between prison and community should be ensured, that accommodation needs are a priority for many prisoners and a range

³³⁴ Ibid.

³³⁵The Government established the NESF in 1993 as an advisory body on major economic and social policy issues. It is the largest and most representative of the Social Partnership Institutions. The report was prepared on the basis of a wide series of consultations, visits to prisons and community-based projects, local hearings, written submissions from the public and commissioned research. Speaking at the launch of the report on 22 January 2002, Dr. Maureen Gaffney, Chairperson of the Forum said: "This Report, if implemented, will have far-reaching consequences. It brings one of Ireland's most marginalised groups to the centre of the social partnership process"

of options should be provided, and that a comprehensive leaflet on prisoners' options on leaving prison should be produced.

Travellers and other Ethnic Minorities.

There is a highly disproportionate number of members of the Travelling community in Irish prisons compared with the non-Traveller prison population.³³⁶ Consequently, the known effects of prison lifestyle and regime on an individual's mental health, when combined with this high experience of prison committal within the Travelling community, impacts negatively on this community in a more profound way than on the rest of the population. A recent study of admissions to the CMH from prisons found:

“There is a gross over-representation of Travellers in forensic psychiatry admissions. This reflects the excess of Travellers amongst prison committals. [...] These rates suggest that a very high proportion of all Travellers will be imprisoned at some time during their life. This ‘normalisation’ of the experience of imprisonment exposes a high proportion of all Travellers to the adverse health and lifestyle behaviours prevalent in prisons. Prison populations are at great risk of developing opiate and other drug dependence disorders, with associated problems. In a more general way, the normalisation of imprisonment is likely to have adverse effects on the expectations and aspirations of children and adults. It adds also to the stigma attached to Travellers as a group. [...] In any ethnic group or sub-population where imprisonment is so common, it is reasonable to hypothesise for future research that the ... impaired ... mental health, may to some extent be caused by imprisonment itself.”³³⁷

This study suggests that lessons can be learnt from other countries that have taken steps to address the situation of ethnic minorities in their prison populations:

“A practical consequence would be to use contact with the criminal justice system as a means of engaging individuals in culture-specific programmes for health promotion, examples of which can be found in other jurisdictions. In Canada, Australia and New Zealand, indigenous minorities are also over represented in prisons and forensic psychiatric institutions. Approaches to specific services and training have been described and should be considered in the Irish mental health services and also in the Irish Courts and prison service.”³³⁸

Amnesty International strongly recommends that the Irish authorities endeavour to address the mental health needs of Travellers and other ethnic minorities in Irish prisons in a culturally sensitive and specific way, including measures to address the negative impact of prison itself on mental health which affects the Travelling community to a disproportionate degree.

³³⁶ See Chapter 3 for a discussion on the mental health care needs of the Travelling community and other ethnic minorities more generally.

³³⁷ ‘Irish Travellers and forensic mental health’, Linehan S, Duffy D, O’Neill H, O’Neill C and Kennedy H G, *Ir. J. Psych. Med.* 2002; 19(3).

³³⁸ *Ibid.*

Intellectual Disability and Dual Conditions

In common with other jurisdictions, there is a very high level of intellectual disabilities in the Irish prisoner population. A 1999 government study, 'A Survey of the Level of Learning Disability (Mental Handicap) among the Prison Population in Ireland',³³⁹ of a randomly selected sample of 264 prisoners, representing about 10 per cent of the inmates in Irish prisons, 28.8 per cent of the sample scored so low on an intelligence test as to suggest a significant degree of learning disability or mental handicap. There is therefore, the strong possibility of dual conditions of mental illness and intellectual disability in this group. The Royal College of Psychiatrists has pointed to the consequences of this, and the need for a specialised approach:

“Given the dual disabilities of intellectual disability and the high prevalence of mental health needs in the population, increasingly their vulnerability within the Criminal Justice System is being identified. The treatment of people with intellectual disability within the criminal justice system depends on the extent to which their disability is recognised by those coming into contact with them as this is a factor which will often determine their course through the system. For those already with the Prison System access to appropriate multi-professional evaluation to assess the needs of this group, particularly those with a dual diagnosis and plan appropriate rehabilitative and therapeutic interventions.”³⁴⁰

Legislation Governing Prisons and Places of Detention

MI Principle 22 provides: “States shall ensure that appropriate mechanisms are in force to promote compliance with these Principles, for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient.” As above stated, the MI Principles apply equally to offenders with mental illness; consequently, there exists an imperative to ensure that an independent and effective inspection, monitoring and complaints system is available in respect of all prisoners with mental illness regarding all aspects of their mental health care.

Amnesty International’s concerns about the treatment of prisoners with mental illness, in particular with respect to the use of solitary confinement, are rendered even more serious by the ongoing lack of an effective prison system of complaints and inspection. While an Inspector of Prisons and Places of Detention was appointed in April 2002, at the time of writing, the office lacks statutory powers or independence. In relation to complaints regarding the arrangement and provision of medical care, the 1998 report of the European Health Committee of the Council of

³³⁹ Murphy M, Harrold Dr M, Carey Dr S, Mulrooney M, Department of Justice, Equality and Law Reform, 6 August 1999, unpublished.

³⁴⁰ ‘Response to The Prison Health Care Review Group’.

Europe asserts:

“...[P]risoners should have free and direct access to a judicial body, a specific committee for complaints, an ombudsman or any other sort of authority that has the legal competence to deal with such complaints and the power to make binding decisions.”³⁴¹

Amnesty International endorses the advice given by this committee that prisoners' rights are best protected when enshrined in legislation:

“The absence of legal provisions does not necessarily imply a neglect of the prisoner's rights: reality may be better than the law suggests. The contrary can also be the case: the written rule may look good without having any value in practice. Nevertheless, a number of fundamental rights, also regarding medical care, are easier to implement when they are laid down in statutory law.”³⁴²

This supports Ireland's obligation under Article 2(3) of the ICCPR to ensure an effective remedy for breaches of this Convention,³⁴³ by assisting prisoners to assert their rights through an independent and accessible monitoring, investigation and complaints machinery. Consequently, the promised Independent Prison Authority should be established on a statutory footing as a matter of the highest priority, and should be accorded all necessary assistance and resources. Amnesty International echoes the UN Human Right Committee's instruction that: “The Independent Prison Authority, whose establishment is envisaged in a current bill, should have power and resources to deal with complaints of abuse made by prisoners.”³⁴⁴ The CPT, too, has said in its report of its 1998 visit to Ireland that it would “welcome any measures which are designed to enhance the effectiveness and impartiality of current complaints and inspections procedures”.³⁴⁵ In its follow-up report to the CPT,³⁴⁶ the Irish Government stated that provisions in relation to a prison Inspectorate and Visiting Committees would be included in the Prison Service Bill, due to be published before the end of the year 2000. Amnesty International is disappointed that this Bill has not yet emerged, given its importance for this

³⁴¹ Note 9 above.

³⁴² Ibid.

³⁴³ “Each State Party to the present Covenant undertakes:

(a) To ensure that any person whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity;

(b) To ensure that any person claiming such a remedy shall have his right thereto determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy;

(c) To ensure that the competent authorities shall enforce such remedies when granted.”

³⁴⁴ Concluding observations of the Human Rights Committee: Ireland, 24/07/2000, A/55/40.

³⁴⁵ Note 5 above.

³⁴⁶ Follow-up report of the Irish Government in response to the report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on its visit to Ireland, CPT/Inf (2000) 8 [EN], Publication Date: 18 May 2000.

vulnerable group. In the interim, the current Inspector of Prisons should be afforded the fullest assistance and co-operation in fulfilling his functions.

Criminal Law and Diversion to Mental Health Services

Legislation allowing for the diversion of offenders with mental illness, where appropriate, to the psychiatric services rather than the prison system is contemplated by the MI Principles:

“Domestic law may authorise a court or other competent authority, acting on the basis of competent and independent medical advice, to order that such persons be admitted to a mental health facility.”³⁴⁷

Such a scheme was proposed in Chapter 7 of the White Paper published in advance of the Mental Health Bill, but was subsequently omitted from the Mental Health Act, 2001.³⁴⁸ Legislation to facilitate the diversion of persons with mental illness from the criminal justice system, including the courts and the prisons, to alternative treatment, supervision and care was advocated by the Report of the Group to Review the Structure and Organisation of Prison Health Care Services.³⁴⁹ Amnesty International believes that serious reconsideration should be given to this idea, looking at models developed in other states for guidance. Once again, the success of such a scheme would depend on the availability of quality community-based care, which is not currently provided on a comprehensive or consistent basis.³⁵⁰

The Gardaí and Mental Illness

In light of the fact that Ireland’s police force, An Garda Síochana, are at the interface between people with mental illness and the criminal justice system, and given their powers of coercion and detention under the existing Mental Treatment Act, 1945 and the new Mental Health Act, 2001, it is imperative that Gardaí receive adequate training in how to identify, and deal appropriately and sensitively with people with mental illness. Amnesty International believes that effective service-user-led training would assist Gardaí in the performance of their duties. The 2001 report of the Inspector of Mental Hospitals makes reference to his office’s discussions with the Garda Training Headquarters and senior Garda representatives about the

³⁴⁷ Principle 20(3).

³⁴⁸ Amongst other organisations, the Irish Division of the Royal College of Psychiatrists (now the Irish College of Psychiatrists) objected to this omission from the 2001 Act: “The absence of proposed legislation in relation to mentally disordered offenders would appear to breach both The European Prison Rules, Recommendation Number R (87) 3 of The Committee of Ministers, Council of Europe, 1987, and The United Nations Standard Minimum Rules for the Treatment of Prisoners, Resolution adopted 30 August 1955. The First UN Congress of the Prevention of Crime and the Treatment of Offenders. Department of Health 1997, which state that ‘The [prison] medical services should be organised in close relation with the health administration of the community or nation!’” (“Comments on An Bille Meabhair-Sláinte, 1999, Mental Health Bill, 1999’, available at www.irishpsychiatry.com.)

³⁴⁹ Note 22 above.

³⁵⁰ See Chapter 3.

establishment of a suitable training module on mental health for student Gardaí. In response, Schizophrenia Ireland said:

“Schizophrenia Ireland welcomes this development and is actively involved in discussions with Templemore to ensure that we can have a role and input into this. During 2002 discussions with Templemore have resulted in SI members making themselves available to the Garda training authorities to discuss issues to do with schizophrenia and mental health.”³⁵¹

The Mental Health Commission has informed Amnesty International of its intention to engage in discussion about such a course with the Garda Training Unit. Amnesty International welcomes any such endeavour, which would recognise and enhance the important role of the Gardaí in determining at the very outset how people with mental illness are dealt with by the criminal justice system.

In addition to providing general police training, the use of specially trained police officers to supply on-scene expertise, determine whether mental illness is a factor in a criminal incident, and ensure the safety of all involved parties, has been employed in a number of ways in different countries.³⁵² Such a scheme should be considered in Ireland.

³⁵¹ ‘Schizophrenia Ireland’s Response to the Inspector of Mental Hospitals Report 2001’ (2002).

³⁵² The following are some examples from the USA, which can be found at www.consensusproject.org/topics/flowchart/ps03-on-scene-assessment:

Crisis Intervention Team

Example: Memphis (TN) Police Department

In the Crisis Intervention Team (CIT) approach found in the Memphis Police Department, uniformed officers, specially trained in mental health issues, act as primary or secondary responders to every call involving people with mental illnesses. CIT officers are available on every shift and are also available to mental health clients (consumers) and their families. The Albuquerque, New Mexico, Police Department, The Roanoke, Virginia, Police Department and the Houston, Texas, Police Department are among numerous agencies across the country that have also adopted the CIT approach.

Comprehensive Advanced Approach

Example: Athens-Clarke County (GA) Police Department

In a comprehensive response, the Athens-Clarke County Police Department decided that its small size precluded the formation of a specialized team to respond to calls for service involving people with mental illness. Accordingly, the department decided that every officer would attend the advanced 40-hour crisis intervention training and thus be able to respond appropriately to these calls.

Mental health professionals who co-respond

Example: Birmingham (AL) Police Department

The Birmingham Police Department uses a Community Service Officer (CSO) Unit, which is attached to the Patrol Division. The unit is composed of social workers who respond directly to an incident location when requested by an officer. They serve a variety of populations, including people with mental illness. The CSOs are also certified law enforcement academy trainers and work closely with community groups and other components of the criminal justice system.

Amnesty International does not promote or endorse any of these models, either in theory or practice, but describes them merely as examples of practice elsewhere which could be explored by the Irish authorities.

Conclusion & Recommendations

At an absolute minimum, the prison health care service must be able to guarantee equivalence of care with that available to the rest of the population.³⁵³ Amnesty International urges the Irish Government to undertake the following measures as a matter of urgency to ensure that the human rights of this very vulnerable sector of the population are protected:

- ❑ Reorganise the mental health services provided to prisoners, in line with recommendations made in the CPT report, with the adoption of a multidisciplinary approach for their delivery,³⁵⁴ and incorporating culture-specific measures, particularly in the case of members of the Travelling community. Good practice in prison mental health care should be identified in line with the WHO 'Health in Prison' Project.
- ❑ Enshrine the rights of prisoners in Irish legislation, including the right to the best available mental health care; and make available to every prisoner a Charter of Prisoner Rights explaining these rights, and how to exercise them.
- ❑ In the absence of available alternatives in civil mental health facilities, establish high and medium secure units for the provision of psychiatric services to offenders, in line with the CPT report recommendation that, "in general, the development of prison psychiatric units and prison hospitals should be avoided",³⁵⁵ and provide the capital funding necessary to refurbish and expand the CMH.
- ❑ Immediately cease the practice of solitary confinement in padded cells of prisoners with mental illness, reduce the length of periods spent by other prisoners in isolation cells, and introduce observation units in line with international standards, ensuring that their use is carefully regulated, recorded and monitored.
- ❑ Establish a planned and integrated after-care system for prisoners on release, ensuring continuity of care.³⁵⁶
- ❑ Devise a formal arrangement between the Department of Justice, Equality and Law Reform, the Irish Prisons Service and the Department of Health and Children and/or the statutory health boards for relative responsibilities in relation to the delivery of timely and adequate mental health care to prisoners.

³⁵³ In line with CPT recommendation no. 1 in its 1998 report, note 5 above, that "there should be equivalence of care between the prison population and the general population".

On forensic psychiatric services, see 'The Role of Forensic Psychiatry in Prison Health Care' (2000), Smith Dr C, Consultant Forensic Psychiatrist, Central Mental Hospital, Dublin.

³⁵⁴ CPT recommendation no. 3.

³⁵⁵ CPT recommendation no. 31.

³⁵⁶ In line also with CPT recommendation no. 37 that "in relation to aftercare for prisoners, appropriate arrangements are put in place where possible with community health care resources".

- ❏ Establish a statutorily independent Inspectorate, with an effective inspection procedure, and, in the interim, accord the Inspector of Prisons full resources and assistance to allow him to perform this task.
- ❏ An effective complaints procedure should be provided to every person in detention, and an independent mechanism such as an Ombudsperson should be established to hear and adjudicate upon prisoners' complaints, including those in relation to the provision of mental health care.
- ❏ Mental health legislation should be introduced in a way that would facilitate diversion of mentally disordered individuals from the criminal justice system to an alternative treatment, supervision and care service.
- ❏ Training of an Garda Síochána should include a component on mental illness, and the use of specially trained police officers to supply on-scene expertise should be developed.

Chapter 9

ANALYSIS

"It is an out of date service requiring radical change"

Chair
Mental Health Commission³⁵⁷

Introduction

This report has so far outlined how the mental health care services in Ireland are, in many ways, inadequate, and have failed to live up to the requirements of best practice and international human rights standards. Several recent government and non-governmental reviews and reports, and comments by international treaty-based committees have also revealed worrying deficiencies in available services.

Significant expansion and improvement of Irish mental health services has indeed occurred over the years, but developments have been piecemeal and reactive, so that, in many places, they are insufficient and inconsistent in their application throughout the country.

This chapter deals with why this is so. Many reasons have been advanced for this current situation: poor revenue and capital funding, lack of inventiveness in service planning, industrial relations difficulties, etc. It is likely that each of these have had a substantial part to play and, in combination, have led to the picture we see today.

This is worldwide issue: in 2001, the World Health Assembly observed:

*"In contrast to the dramatic improvements in physical health in most countries over the course of the past century – in particular, unprecedented improvements in mortality rates – the mental component of health has in many places not improved. ... We know that one out of every four persons who turn to the health services for help is troubled by mental or behavioural disorders, which are not often correctly diagnosed and/or treated. And mental health care has simply not received until now the level of visibility, commitment and resources that is warranted by the magnitude of the mental health burden. Only a very small percentage of national health budgets in most countries go to mental health. One consequence of this inadequate attention is the "treatment gap" – the gulf between the huge numbers who need treatment and the small minority who actually receive it."*³⁵⁸

Amnesty International urges Ireland to be amongst those nations taking the lead to overcome this enduring injustice. The lack of political urgency so far afforded to this

³⁵⁷ Dr John Owens speaking at a conference on 17 September 2002 held by the Midland Health Board.

³⁵⁸ 'Mental Health: A Call for Action by World Health Ministers', Ministerial Roundtables 2001, 54th World Health Assembly, Geneva, WHO/NMH/MSD/WHA/01.1 (World Health Organisation 2001).

area has been allowed by the persistent reluctance of Irish society to respond to its obvious inequities because of the heavy stigma overshadowing mental illness. Until public apathy is significantly dispelled and vigorous debate on mental health emerges, the widespread injustice met by people with mental illness will endure.

*"In most countries, stigma and human rights violations of persons with mental illness are rampant. Few efforts are in place to address discrimination and stigmatisation both of which represent a substantial hidden burden of mental illness. WHO and Ministers of Health have concluded that this lack of investment in mental health is now unacceptable."*³⁵⁹

National Mental Health Policy

While advances in Ireland's mental health services has occurred in recent years, they remain insufficiently developed in many areas, and inconsistent in their application throughout the country.

The 1984 strategy, 'The Psychiatric Services: Planning for the Future', outlined the government's plans for the care of people with mental illness, but many of its targets remain underimplemented,³⁶⁰ and much of it is considered outdated.

'Guidelines on Good Practice and Quality Assurance in Mental Health Services' were published by the Department of Health and Children in 1998. They stated that they represent "a checklist in the form of a guide towards good practice and quality assurance [that] will form the basis for reflection and thought ... [and] must therefore be seen as a tentative and first attempt towards indicating how the principles of equity, quality of service and accountability can be reflected in daily clinical practice and administration in mental health services". Nevertheless, they too, in their emphasis on the patient as consumer, and the consequent necessity to

³⁵⁹ Ibid.

³⁶⁰ It is instructive to compare some of the recommendations of the 1984 Report with the current situation, as described most recently in the Report of the Inspector of Mental Hospitals for 2001. For instance, the 1984 document says: "One of the main tasks of the psychiatric team, initially, will be to build up a range of community services in its area. These include day facilities, outpatient clinics, community residential accommodation and rehabilitation services ..." Within Catchment Area 2 of the East Coast Area Health Board, the Inspector of Mental Hospitals, in 2001, noted, "there was no satisfactory community base or mental health centre in the entire service"; and in relation to Area 3 of the South Western Area Health Board: "There was no dedicated rehabilitation service in Area 3, but at least six patients in the sub-acute unit required community-based accommodation. In effect, the ground floor of the Beckett Ward in the Jonathan Swift Clinic functioned as a continuing-care residential centre. Clearly, this was undesirable and these beds should be used for acute purposes." The multidisciplinary team is one of the core elements of the service envisaged by the 1984 strategy document, with such a team headed by a consultant psychiatrist for each catchment area of about 25,000 people, yet there are still very few true such teams in existence today. For example, in relation to the three sectors of the Wicklow mental health service, the Inspector noted that "none of the sector teams was truly multidisciplinary as no occupational therapist and only one psychologist and two social workers were employed in the service."

provide, as a product, “the highest level of mental health care possible”, remain under-enforced throughout the service. For example, the Guidelines state: “It is essential that well planned discharge policies and procedures are in place”; while it is clear from a 1999 government report,³⁶¹ that, at least in the Eastern Area Health Authority region, this is largely unimplemented. The 1998 Guidelines emphasise the need to respect the privacy of the patient in in-patient facilities, yet the majority of patients interviewed by the Inspector of Mental Hospitals throughout the country complained of a lack of privacy. The Guidelines recommended that “all staff should be trained in the techniques of management of violence and aggression through participation in a recognised training course”; and yet the 2001 Inspector’s report noted: “Training programmes offered to staff on the management of aggression and violence within the mental health service varied widely in their extent and content. Some services had access to control and restraint instructors from within their own staffing resources, while others contracted instructors from the wider health services or from abroad. The Inspectorate had noted the diversity of providers and content of these courses and felt it important that a system of standardisation and monitoring to ensure the appropriateness of such courses be put in place.”

The 2001 national health strategy, ‘Quality and Fairness – A Health System for You’, promises the development of a new action programme on mental health, and programmes to promote positive attitudes to mental health. While it remains to be seen how this will operate in practice, in 2002, the UN Committee on Economic Social and Cultural Rights (CESCR) noted “with regret that a human rights framework encompassing, *inter alia*, the principles of non-discrimination and equal access to health facilities and services was not embodied in the ... National Health Strategy...”.³⁶² Individual Health Boards have devised regional planning documents based on this strategy.³⁶³ Amnesty International is concerned that, without more concrete resource commitments and binding standards, these plans will remain as difficult to implement as ‘Planning for the Future’.

The following factors have impeded Irish mental health care policy and services development, and it is hoped that each of these will be addressed in any future review.

³⁶¹ ‘We Have No Beds: an enquiry into the availability and use of psychiatric beds in the Eastern Health Board region’, Keogh F, Roche A, Walsh D, Health Research Board, 1999. See Chapter 4.

³⁶² Concluding observations on Ireland’s second periodic report, 17 May 2002, UN Doc No E/C.12/1/Add.77.

³⁶³ The Southern Health Board, for instance, developed what is considered by many professionals and service users to be a very fine plan, ‘Focussing minds: Developing Mental Health Services in Cork and Kerry’, Southern Health Board, launched in September 2002.

Financial Investment

Where Ireland's general health expenditure is relatively poor, it is markedly more so in the mental health sector. "The mental health services are the perennial Cinderella of the Health Services; first in line for cutbacks in times of financial stringency and the last to benefit in times of plenty."³⁶⁴ Funding of the mental health programme for 2002, while not insignificant, remained out of step with other medical programmes. This sector was already seriously and preferentially hit by cutbacks in the 1980s; in 1993, Dr Marcus T Webb wrote: "The share of gross expenditure provided in Ireland for the psychiatric services has been reduced by 20.7% since 1976. This slide must be halted and reversed if this country is to preserve a semblance of mature and civilised care for its mentally ill."³⁶⁵

Since then, revenue expenditure in mental health has remained disproportionately low. While overall growth in Irish non-capital health expenditure between 1990 and 2001 was over 300 per cent, that of the psychiatric programme was 131 per cent, by far the lowest.³⁶⁶ In 1994, mental health spending accounted for 9.4 per cent of total health non-capital expenditure; by 2001, it was just 7.2 per cent.³⁶⁷

The closure of psychiatric hospitals and a move to community-based care – considered by some to be more cost-efficient³⁶⁸ – is said to account for some of this drop, but Ireland still has a high level of dependence on expensive in-patient care, evidenced by the high rate of admissions annually.³⁶⁹ This indicates a need to consider the efficiency of investing in services delivered within institutions without simultaneously providing adequately for community-based alternatives. The 1999 government report, 'We have no beds', advocates that, instead of electing to invest in one or the other, a "system of double funding or 'pump priming' is needed for the overlap period between the establishment of community services and the closure of

³⁶⁴ Psychiatric Nursing, March 2001, Irish Psychiatric Nurses Association. The Irish Psychiatric Nurses Association has also said: "This union... is most disappointed with the lack of investment by consecutive governments. Indeed, might I add, it has been used in many circumstances as a cost-saving exercise." (Mr Gerry Coone, Chairman of the Psychiatric Nurses Association, at the association's annual conference in Ballyconnell, Co Cavan on 28/04/1998 as reported in the Irish Times on 29/04/1998.)

³⁶⁵ 'Closing Mental Hospital Beds: A Re-Appraisal', *Psychiatric Nursing*, March 1993, Irish Psychiatric Nursing Association.

³⁶⁶ Statistics issued by the Economic and Social Research Institute published in *Psychiatric Nursing*, March 2002, Irish Psychiatric Nursing Association. The highest, community protection spending, increased by 840%.

³⁶⁷ 'Equity of Access to Hospital Care', National Economic and Social Forum, Government Publications Sales Office, July 2002. See more recent statistics which reveal that the mental health share has again fallen to 7% in 2002, available at www.doh.ie/statistics/stats/section1.

³⁶⁸ 'We Have No Beds', note 5 above, assesses the evidence for this and notes that "community care is seen to cost at least as much if not more than existing [in-patient based] services".

³⁶⁹ See Chapter 3.

hospital beds”.³⁷⁰ The cost, while relevant, should not be the main consideration; rather, as that report concluded, the “motivation should be to provide the best quality psychiatric care within a comprehensive care structure which is based on the needs of patients”.³⁷¹

A core finding in a recent survey of service providers by the Irish Psychiatric Association is of marked regional discrepancies in service provision, and up to tenfold differences in funding between health board areas leading to staffing and resource disparities. It observes that well-resourced services are those commented favourably upon by the Inspector of Mental Hospitals, concluding that the money is well spent. Furthermore, it finds that, not only are there known discrepancies in funding and consequent service provision, but the areas of greatest underfunding are amongst the most economically deprived in the country, multiplying the disadvantage.³⁷²

Restricted capital funding is also an issue. Under-investment has led to many of the remaining older institutions falling into unacceptable states of disrepair, as described in the annual reports of the Inspector of Mental Hospitals. An example is the Central Mental Hospital, the physical infrastructure of which has also been condemned by the European Committee for the Prevention of Torture.³⁷³ There is poor provision too for capital development programmes for community residential centres.

Again, this situation is not unique to Ireland, but many states underinvest in their mental health care systems. Commenting on a 2002 survey of mental health expenditure, the WHO said:

*“One of the surprising findings is that wealthy countries are not always rich in the quantity and quality of mental health resources. These findings further reinforce the recommendations of the World Health Report 2001, that all countries, large and small, rich and poor, need to give a much higher priority to mental health and take urgent steps to enhance their mental health services.”*³⁷⁴

³⁷⁰ Note 5 above. It observed: “One of the difficulties in this change from a reliance on hospital care towards comprehensive community services has been the financing of the new services. [...] Where this situation exists, it can be difficult to break out of the vicious circle which ties up resources in providing costly inpatient care.”

³⁷¹ Ibid.

³⁷² By Keane Dr V, as yet unpublished. Results discussed in conversation between Amnesty International and Dr Justin Brophy, Chair, IPA, 22 January 2003.

³⁷³ See Chapter 8.

³⁷⁴ ‘Mental Health: New WHO Country Data Show Resources Fall Short of Needs’, Press Release WHO/30, 23 April 2002, www.who.int/inf/en/pr-2002-30.html

Ireland is now facing a downturn in its economy and exchequer revenue, and cutbacks in mental health care are again feared, for example:

“Schizophrenia Ireland is alarmed at the impending cuts in health expenditure demanded by the Department of Health of all regional Health Boards. Schizophrenia Ireland understands that all Boards have developed plans for major improvements in mental health care services. Cutbacks by the Dept. of Health can only lead to a reduction or delay in the development of any new mental health care service plans....”

Amnesty International is also concerned that many current national and regional health board plans for improvement in their community-based service may be seriously affected by downward revisions of projected government health care expenditure, particularly in light of the traditional disproportionate impact of cutbacks on mental health care spending outlined above. Amnesty International recommends a significant increase in revenue and capital funding in the mental health services, at the very least, to bring it into line with the other health sectors. The UN Committee on Economic, Social and Cultural Rights noted in 2002, “the favourable economic conditions prevailing in the State party and observe[d] no insurmountable factors or difficulties preventing the State party from effectively implementing the Covenant”.³⁷⁵

Poor Service Planning

Under-funding is only one strand of the difficulties at the root of the current mental health care problem. Poor service planning at national and regional levels is a significant factor: “It is clear that there has been a distinct lack of rational planning in the development of mental health care services in Ireland. There have been many obstacles to the development of high quality services. These include poor planning, lack of consistent funding across all Boards and local political and economic influences.”³⁷⁶

Ireland’s mental health services were devised in a system of sectors based more on geographic divisions than on patient needs. Funding for mental health care was initially concentrated in large psychiatric hospitals and remained incremental, so that health board regions with psychiatric hospitals have retained larger budgets irrespective of local need. As noted by the South Western Area Health Board: “In recent years, mental health services moved from an institutionalised service to a community-based service. Staff and other resources were redeployed as part of this transition, however, the South Western Area Health Board area has never had a

³⁷⁵ Note 6 above.

³⁷⁶ John Saunders, Director of Schizophrenia Ireland in joint press release with Amnesty International, 10 October 2002. www.amnesty.ie/news/2002/schizo.shtml

significant institutional base, therefore, we have resource problems in being able to develop services in line with current trends.”³⁷⁷

As noted above, service provision inconsistency throughout the country is significantly due to these varying levels of resources. “For example, well-developed services as commented on by the Inspector of Mental Hospitals such as the Cavan/Monaghan service³⁷⁸ spend £97 per capita, whereas the South Western Area Health Board spend £27.00 per capita.”³⁷⁹

Conversely, poor service provision can be due to an inability to respond to actual regional need. Where “some catchment areas are afforded enormous resources, and others far less, those in receipt of the lower levels are often better services”.³⁸⁰ This is attributed to a number of factors:

- *Research & Needs Assessment*

The report, ‘We have no beds’, observed that “services should be planned to meet the needs of a population, although this has largely not been the case in the psychiatric services”.³⁸¹ There is little research available on the prevalence of mental illness in Ireland (other than the level of in-patient service use), the needs of vulnerable groups, or the quality of service delivery. Consequently, mental health policy has often not been devised on an informed basis. While other indicators of mental health care need exist, such as socio-economic deprivation, unemployment, alcoholism, suicide and parasuicide, one of the principal recommendations in the WHO 2001 annual report is that states should conduct more research into biological and psychosocial aspects of mental health.³⁸² This should include epidemiological data collection and evaluation, considered by the WHO report “essential for setting priorities within ... mental health, and for designing and evaluating public health interventions”.³⁸³

³⁷⁷ ‘Board meeting – 4th December 2001 – A proposed Action Plan for Adult Mental Health Services in the South Western Area Health Board’, Report No. 16/2001, South Western Area Health Board.

³⁷⁸ A model often cited of good service planning in Ireland is that of the Cavan/Monaghan area. Services, particularly community-based services, in this area have been remarked on very favourably by the Inspector of Mental Hospitals in his report for 2001. It is notable that the funding for this area is far in excess of that of other areas. In its analysis of its service, *ibid*, the South Western Area Health Board listed “inadequate capital and revenue investment” as one of its four main weaknesses. It continued: “When the current level of resources for mental health services are compared with other areas and regions, it is clear that the Board is lagging behind in terms of beds per 1,000 population, hostels per 1,000 population and overall budget for mental health services.”

³⁷⁹ Note 21 above.

³⁸⁰ Dr Owens, note 1 above.

³⁸¹ Note 5 above.

³⁸² ‘Mental Health: New Understanding, New Hope’, The World Health Report 2001, WHO.

³⁸³ *Ibid*.

- ***Limited Role of Service Users***

Much service planning has proceeded without sufficient input from service users and their families. The UN Standard Rules on the Equalisation of Opportunities for People with Disabilities³⁸⁴ have enormous importance in this regard as they provide the fundamental principle that people with mental disabilities, including mental illness, have the right to fully participate in matters that affect them, and recognise the right of service users to be involved in mental health care planning. Rule 18 thereof further provides that:

“States should encourage and support economically and in other ways the formation and strengthening of persons with disabilities [including mental illness], family members and /or other advocates. States should recognise that those organizations have a role to play in the development of disability [including mental illness] policy”

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In the process of reviewing, formulating and implementing mental health care policy, whether locally or nationally, the state is therefore obliged to involve organisations of people with mental illness, and to assist and fund them to so do. In the event of a future revision of the 1984 strategy, 'Planning for the Future', the effective participation of service users should be ensured, and any emergent plan should take into account the perceived needs of service users themselves.

- ***Staffing Difficulties***

Deficiencies in professional training and development have resulted in few true multidisciplinary teams throughout the country. In the past few years the number of psychiatric nurses has fallen, and many nursing posts cannot be filled. Similar shortages of consultant psychiatrists and other professionals are hampering the development of services, and the Inspector of Mental Hospitals suggested in his report for 2001 that “the postgraduate training scheme in psychiatry needs serious scrutiny”. Staff shortages place even greater strain on those working in the service.

The impact of industrial disputes on services and staffing has, according to this Inspector’s report, “prevented services from initiating improvements and more effective and efficient methods of care”. The primary responsibility for mental health care lies with the Irish Government, and industrial relations difficulties should not be allowed to interfere with the rights of people with mental illness.

³⁸⁴ Adopted by Resolution of the UN General Assembly in 1993 (A/RES/48/96). See Chapter 2.

³⁸⁵ A welcome example of one such local consultation is described in a report ‘Unique Insight: a report on the consultation with users of the St Loman’s Mental Health Service’, Elliot I & Mason T, South Western Area Health Board, 2000. Its stated aim was “to ensure that the relocation and operation of the acute in-patient service from St. Loman’s hospital to the new psychiatric unit in Tallaght, would be informed by the experiences, opinions and ideas of the mental health services’ users”. Another is the Pathways project sponsored by the Western Health Board in conjunction with Schizophrenia Ireland: ‘Pathways: Experiences of Mental Health Services from a User-Led Perspective’ (2002), Brosnan L, Collins S, Dempsey H, Dermody F, Maguire L, Morrin N.

Recognising the Role of Carers

The burden of mental illness may fall on the family, and the cost to family carers, in terms of emotional stress, can be considerable. Failure to provide assistance to relatives of people with mental illness who live at home can impact negatively on the mental health of all concerned. A survey report on carers' views in five European countries, including Ireland found:

“The priority statements on all the 15 areas of care give clear guidance on all the issues which families really want to be addressed:

- * Advice on how to handle psychotic experiences;*
- * Help for patient and carer to recognise possibilities and limitations for future social functioning;*
- * Quiet and safe surroundings for the patient to regain structure and routine in his/her life;*
- * Detailed, accurate information on diagnosis and clinical outcome;*
- * Prompt assistance to the patient about housing in particular*
- * Continuity of care by the same agency;*
- * Consultations with professional staff to support patients and relatives;*
- * Short waiting period before admission to hospital;*
- * Compulsory admission to hospital if necessary;*
- * Professional staff taking seriously the signals reported by the patient's relatives and friends;*
- * Early start of medication with as few side-effects as possible;*
- * Professional staff who listen and are articulate;*
- * Mutual support and information through the patient's contact with other service users.”³⁸⁶*

Stigma

The stigma surrounding mental illness has been well documented, and the public's attitude stems from its lack of awareness, and misconceptions about the nature of mental illness. Relative to public perceptions about other forms of disability, a survey conducted by the National Disability Authority revealed the following:

“In general, attitudes to people with mental health disabilities were less positive than those expressed towards people with physical disabilities. Firstly, respondents were much less likely to mention mental health as a disability than they were to mention physical disability. Secondly, respondents report lower levels of comfort with people with mental health disabilities. And, thirdly, respondents seem less sure about the rights of people with mental health disabilities to work and to have families.”³⁸⁷

³⁸⁶ 'Breaking the Silence: Carers' views on the help given during the first episode of psychosis, A European perspective', European Federation of Associations of Families of People with a Mental Illness, Madrid, October 2001.

³⁸⁷ 'Attitudes to Disability: Preliminary Findings of a survey commissioned by the National Disability Authority', NDA Research Unit & Research and Evaluation Services, October 2001.

This can have many consequences: “Mental illness, despite centuries of learning is still perceived as an indulgence, a sign of weakness. This shame is often worse than the symptoms, with people making efforts to conceal the illness from others. Secrecy acts as an obstacle to the presentation and treatment of mental illness at all stages. The reality of discrimination supplies an incentive to keep mental health problems a secret.”³⁸⁸

Stigma may act as a barrier to the utilisation of available services by people with mental illness or their families. While stigma may never be eliminated, it can be reduced, and it is incumbent on the Irish state under human rights standards not alone to ensure that suitable services are provided, but that people are assisted and enabled to access these services.

The WHO 2001 report advises: “Tackling stigma requires a multilevel approach involving education of health professionals and workers, the closing down of psychiatric institutions which serve to maintain and reinforce stigma, the provision of mental health services in the community, and the implementation of legislation to protect the rights of the mentally ill.”³⁸⁹

The WHO report also recommends: “Well-planned public awareness and education campaigns can reduce stigma and discrimination, increase the use of mental health services, and bring mental and physical health care closer to each other.”³⁹⁰

Mental Health Legislation

As advised in Chapter 3, the right to the best available mental health care should be enshrined in legislation. The WHO report advises: “Mental health legislation should codify and consolidate the fundamental principles, values, goals, and objectives of mental health policy. Such legislation is essential to guarantee that the dignity of patients is preserved and that their fundamental rights are protected.”³⁹¹ While the Mental Health Act, 2001 is welcome, Irish legislation should reflect the full range of applicable international human rights standards.

³⁸⁸ Irish Psychiatry Online, the web page of the Irish College of Psychiatrists: www.irishpsychiatry.com/public.html#2.

³⁸⁹ Note 26 above.

³⁹⁰ Ibid.

³⁹¹ Note 26 above.

Recommendations

The current government's 2002 pre-election Programme for Government pledged that no patient will have to wait longer than three months for treatment once referred to a hospital consultant, promised "a world-class public health service" through investment and reform, and gave a commitment to "encourage the end of the two-tier health system" by ensuring that public patients will have access to "timely and quality" services. The 2001 Health Strategy says a new action programme for mental health will be developed, and set a target date of mid-2003 for the preparation of a national policy framework by the Department of Health and Children. Amnesty International urges the Irish Government, in devising this action programme, to:

- ❑ Increase revenue and capital funding in the mental health services to ensure full financial provision for all areas of mental health care.
- ❑ Conduct a comprehensive, needs-based, service-user-led review of the mental health care services, ensuring that they meet international human rights standards and best practice in line with the WHO 2001 annual report, with an emphasis on community-based care, and promptly and fully implement its outcome.
- ❑ Commission research in all areas of mental health care needs and service provision, an essential prerequisite for the development of a quality service.
- ❑ Introduce a public education and awareness programme to counter the stigma of mental illness, emphasising the rights of people with mental illness.
- ❑ Enact rights-based mental health legislation giving full effect to Ireland's international human rights obligations.

Conclusion & Key Recommendations

In Ireland, as throughout much of the world, “mental health care has simply not received until now the level of visibility, commitment and resources that is warranted by the magnitude of the mental health burden”.³⁹² A heightened impetus now exists at the international level to address the inequalities experienced by people with mental illness, and a drive for recognition of this issue as a human rights one.

While many strides have been made in Ireland in improving the mental health care services, developments to date have been piecemeal and reactive, with the result that, in both in-patient care and the community, they remain inadequate in many respects, and inconsistent in their application throughout the country. They are also severely under-resourced in staff, funding and available therapies, and service planning is hampered by a lack of resources and research.

There is an urgent need for a major review of Ireland’s mental health care services, to bring them finally into line with international best practice. Amnesty International is concerned that previous reviews, reports and strategies have not been adequately or comprehensively implemented, and urges the government to act promptly and effectively on all recommendations made in previous reports, and those that may emerge from a future review.

The Irish Government has also failed to take all the legislative measures necessary to give full effect to its international human rights obligations towards people with mental illness.

Amnesty International urges the Irish Government to provide as a matter of priority:

- ❑ A comprehensive, needs-based, service-user-led review of the mental health care services, promptly and fully implemented, ensuring that they meet international human rights standards and best practice in line with the World Health Organisation 2001 annual report, with an emphasis on community-based care.
- ❑ Regular quality research in all areas of mental health care needs and service provision, an essential prerequisite for the development of a quality service.
- ❑ Full financial provision for all areas of mental health care.
- ❑ All necessary resources and assistance for the Mental Health Commission in its securing adequate care and conditions for people with mental illness.

³⁹² ‘Mental Health: A Call for Action by World Health Ministers’, Ministerial Roundtables 2001, 54th World Health Assembly, Geneva, WHO/NMH/MSD/WHA/01.1.

- ❏ Effective action on all relevant recommendations made in the reports of international treaty-based committees, annual reports of the Inspector of Mental Hospitals, and government reviews and reports.
- ❏ A comprehensive system of personal advocacy and an effective complaints procedure, to ensure that people with mental illness are assisted in exercising the full range of their rights.
- ❏ Specialised mental health care for all who need it, including children, the homeless, prisoners, people with other forms of disability, Travellers, asylum seekers and refugees, and other minority or vulnerable groups.
- ❏ A public education and awareness campaign to counter the stigma of mental illness, emphasising the rights of people with mental illness.
- ❏ Rights-based disability and mental health legislation to give full effect to its international human rights obligations, with due regard to its obligation to enable persons with disabilities to exercise their rights on an equal basis with other citizens.

END