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Amnesty International



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Preface

Amnesty International's mental health campaign, launched in February 2003, has forged new and important directions for our human rights work. This is our final report in a series of four issued throughout the year on the right to mental health, and draws Government attention to the discrimination and exclusion experienced by a range of communities that must be addressed. The purpose of this report is to specifically highlight some of the most marginalised individuals and communities, directing Government to further explore the needs of these groups and to include them in the mental health agenda.

This report outlines various communities that are marginalised and invisible: people with physical disabilities, intellectual disabilities and sensory impairments, older people, lesbian, gay and bisexual people, people in minority ethnic groups, asylum seekers, refugees and prisoners. There are, of course, many other vulnerable groups in society, which too must be identified and responded to by Government if an equitable society is to be achieved. Each group has a unique experience of exclusion and discrimination both within mental health services and Irish society in general, and each has a message that must be listened to by Government policy shapers. Effective interventions to promote and protect the mental health of these groups are urgently required.

We have been heartened by the widespread endorsement that the campaign has received from individuals and a wide range of national organisations from the mental health sector: service users' advocacy organisations, professional bodies, unions, support groups, and other relevant NGOs. We look forward to joining with all these organisations in inputting into the work of the Mental Health Commission established in 2002 to promote reform in this sector, and into the development of a new mental health policy begun by the Department of Health and Children this year. It is timely that Amnesty is adding its voice and expertise in international human rights standards to the emerging national mental health movement.

Seán Love
Executive Director Amnesty International (Irish Section)

Introduction

Amnesty International (Irish Section) launched a campaign on the rights of people with mental illness in February 2003, with the publication of a report, 'Mental Illness: the Neglected Quarter'¹, outlining its concern that the Government of the Republic of Ireland (Ireland) does not fulfil its international human rights obligations in respect of mental health services. That report received the endorsement of almost 40 national support groups, service users' advocacy organisations, professional bodies and unions.

In May 2003, Amnesty International published 'Mental Illness: The Neglected Quarter – Homelessness', the first of its three follow-up reports. This highlights the significant interrelationship between the experiences of homelessness and mental ill health, and that the slow pace of reform in mental health is disproportionately affecting this vulnerable group. This was followed in September 2003 with the publication of 'Mental Illness: The Neglected Quarter – Children', which concludes that Irish policy and practice pertaining to children's mental health do not comply with the requirements of the UN Convention on the Rights of the Child, ratified by Ireland in 1992.

The purpose of this report on marginalised groups is to supplement the above reports, many recommendations in which apply equally here; and promote compliance in Irish legislation, policy and practice pertaining to the mental health of certain societal groups with the requirements of international human rights standards. In Ireland, like all societies, there are individuals or groups who have an isolated, marginalised or excluded existence within it, and whose experiences and needs are often overlooked by policy-makers and legislators.

The purpose of this report is to highlight the mental health needs and poor Government provision for a variety of vulnerable communities, in the context of a number of Government sponsored initiatives such as the Mental Health Act, 2001, and the development of a new national policy framework for mental health. In respect of the latter, the terms of reference of the Expert Group appointed, include specific reference to children and people experiencing homelessness, but many other groups have not, as yet, been specifically mentioned. These groups include people with disabilities, older people, members of minority ethnic groups, the poor, asylum-seekers and refugees and prisoners. It is important to note that these are not stand-alone categories, but overlap and cross cut – for instance, when assessing the needs of older people, the dual experience of being an older person with a disability, or an older member of a minority ethnic group must be considered. Marginality can be a consequence of economic

disadvantage, visible difference or disability, and all too frequently, economic deprivation, poverty and mental health problems are the experience of these disparate groups.

Amnesty International does not claim to be an expert in mental health policy or practice, and does not seek to duplicate or replace the work of the national organisations and individuals who are so expert. What it hopes to contribute is this: to raise awareness that not alone is mental ill health something that impacts on all our lives to some degree, but that the failure of successive Irish Governments to provide appropriate mental health responses for all is not just morally questionable but amounts to non-compliance with its international human rights obligations. A good, accessible, comprehensive and individually tailored mental health service is a human right.

Chapter 1 International Standards

Ireland, through the ratification of international human rights treaties, has assumed basic responsibilities towards everyone in its jurisdiction under international law. These exist in addition to those in Ireland's domestic law and Constitution and where there is a conflict, at the international level, international law is superior. Even if international treaties are not expressly reflected in domestic law, they are binding on states once ratified. Ultimate responsibility for compliance with international law lies with the Government, not with individual Government departments, health boards, voluntary agencies or service providers. Each general international human rights treaty protects the rights of persons with mental illness through the principle of non-discrimination.

The rights and freedoms that are guaranteed in the International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, Social and Cultural Rights (ICESCR), and the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR), extend to everyone without discrimination, including those with mental ill health. Article 12 of the ICESCR enshrines the right to the highest attainable standard of mental health for all.

The UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (the MI Principles) were adopted in 1991², and elaborate the basic rights and freedoms of people with mental illness that must be secured if states are to be in full compliance with the ICESCR³. The right to "the best available mental health care" is enshrined in MI Principle 1(1), which "includes analysis and diagnosis of a person's mental condition, and treatment, care and rehabilitation for a mental illness or suspected mental illness". MI Principle 1(2) lays down the basic foundation upon which states' obligations 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".

In complying with the ICESCR, Ireland is also obliged to secure for all its people "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"⁴. The entitlements under Article 12 "include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health"⁵.

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.”⁶ This means that services must not just be made available but that people are enabled to access them.

As the UN health agency, the World Health Organisation (WHO) reflects the former’s understanding of what is meant by “the best available mental health care”. In 2001, it ran a year-long campaign on mental health, when, for the first time, WHO’s annual report, World Health Day, and discussions at the World Health Assembly all focused on one topic, namely Mental Health, thereby revealing the urgency and importance attached at international level to this subject. The WHO 2001 annual report ‘Mental Health: New Understanding, New Hope’⁷ 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. In two years of relative prosperity, little action has been taken in Ireland on many of the core recommendations of this report.

Chapter 2 People with Disabilities

“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 2001⁸

Introduction

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.”⁹ 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 three different levels: body, person and society”.¹⁰

The UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (1993)¹¹ was a major outcome of the Decade of Disabled Persons, and is an instrument for national legislation and policy-making:¹²

*“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.”*¹³

The UN has recognised these Standard Rules as a guide to the requirements of the legally binding UN International Covenant on Economic, Social and Cultural Rights.¹⁴ The UN Committee on Economic, Social and Cultural Rights (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, especially in the fields of employment, social security benefits, education and health".¹⁵ It expressed its particular 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".

One Irish social policy analyst has said, "disability is a trigger for poverty and exclusion from health, education and employment".¹⁶ Furthermore, where they may experience additional inequalities, for example based on gender, ethnicity, or social status, people with disabilities in Ireland may be at risk of dual or even multiple discrimination. While mental illness is, of course, a disability, which can be experienced in combination with other forms of disability, the discrimination and social exclusion that is the experience of many people with disabilities can lead to mental health problems such as anxiety and depression.

The enactment of legislation securing the wider fundamental rights of, and addressing discrimination experience by, 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".¹⁷ The Bill was abandoned in 2002, and another is currently in preparation, with a new consultation process completed. What sort of legislative proposal will emerge from this process is quite uncertain in relation to its respect for human rights standards, but clearly, any revived Bill must not again seek to qualify equal rights for people with disabilities. Amnesty International made a submission to the Department of Justice, Equality and Law Reform in April 2003 urging that the emergent Disability Bill should adopt a rights-based, judicable approach as advocated by the CESCR in 2002. 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."*¹⁸

In furthering the advancement of the rights of persons with disabilities in Ireland, it is imperative that the full participation of people with disabilities and their representative organisations is involved in updating mental health policy, outlined in Chapter 7:

*"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."*¹⁹

Intellectual Disabilities

According to the Inspector of Mental Hospitals: "There is a strong feeling among those providing services for the intellectually disabled that this group is not receiving optimal treatment for co-morbid psychiatric illness which is particularly common among this group of persons, despite the number of consultants in post. The principal difficulty is that the services and consultants are not integrated with mental health services generally and, as a consequence, they and their patients do not have access to mental health facilities, such as acute units for the treatment of acute psychiatric illness."²⁰

The Mental Health Commission has also recognised the difficulties presented by the poor services for this group: "A special concern is the psychiatry of learning disability. There is inadequate provision of approved treatment units for the learning disabled with acute or long-term psychiatric illness."²¹

The Inspector also expresses the following concern in reference to people in in-patient mental health services: "We have...been told, and seen instances, where intellectually disabled, and sometimes others who have difficulties in feeding themselves, have been transferred to general hospitals and have been the subjects of percutaneous endoscopic gastrostomy or "peg feeding" (food being delivered directly through the stomach wall by tube) because general hospital staff have considered they have not had the time to spoon feed dependent and disabled patients. Some of these patients have returned to their psychiatric locations with the mechanism still in place."

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."²² 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. The Inspector of Mental Hospital's report for 2002 records 197 people with intellectual disabilities still residing in psychiatric facilities, and details a number of completed transfers, and plans in train in other services to provide alternative placements for this group. Notwithstanding these welcome advances, while people with intellectual disabilities remain inappropriately accommodated in psychiatric institutions, Ireland is failing to comply with 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".

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."

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 independent 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, 2001, 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. This has been recognised by the Mental Health Commission: "There is also a lack of informal inspections of psychiatric treatments and care within the learning disability service. The issue of incapacity in those with learning disabilities also needs to be addressed as a matter of urgency."²³

The procedures pertaining to admission to intellectual disability residential facilities has also been criticised by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment (CPT):

"The CPT is... concerned by the current absence of a clear legal or administrative framework for involuntary admission to establishments for mentally disabled persons. Despite often being severely mentally disabled, residents are generally regarded as voluntary admissions. Persons are apparently admitted to such facilities by decision of a

general practitioner or upon referral from another mental health establishment and it appears that there are no avenues to appeal against such placements. In the establishments visited, there was little or no trace of the decision-making process concerning each resident. Residents were examined by a psychiatrist shortly after admission, but there were no formal review procedures as to the need for placement to continue, nor any supervision by an independent (e.g. judicial) authority.”²⁴

It is intended to develop national standards for residential services for persons with disabilities. While welcoming this initiative, the 2003 CPT report recommended that the legal situation of persons placed in mental disability facilities be reviewed as a matter of urgency and that action be taken with a view to providing a comprehensive legal framework for such institutions, offering an adequate range of safeguards to persons placed in them.

The CPT further observed “a high prevalence of psychiatric illness in the establishments visited and the majority of residents were being treated with psychoactive medication”²⁵ and recommended that “certain residents would benefit from enhanced psychiatric services, on occasion extending to admission to an appropriate hospital/institution”. It recommended that an individualised assessment of residents in establishments for mentally disabled persons be carried out, with a view to ensuring that they receive the treatment they require or are transferred to a more appropriate establishment, and that a review of staffing level be carried out in the three facilities visited. Amnesty International urges that its recommendations be complied with as a matter of priority.

In addition, it is noted in Chapter 6 that there is a significant occurrence of intellectual disability within the prison population in Ireland, so the concerns and recommendations outlined in that Chapter are also relevant.

The Irish College of Psychiatrists has observed that the 2001 Health Strategy makes insufficient mention of mental health services for people with intellectual disabilities: “The area of psychiatry for those with learning disability is ignored in both the mental health and disability sections of the strategy. The only mention is to confirm the policy of providing appropriate accommodation for those individuals with severe learning disabilities currently placed in general psychiatric hospitals. Such omission is clearly evident in current provision of mental health services for those with learning disabilities.”²⁶

Deaf Community

People with sensory impairments have a distinct set of needs for their mental health promotion and treatment which are not being adequately met. It has been suggested: “Sensory impairment is often regarded from a medical/disability point of view and its effects on mental health can be poorly recognised. Communication is a key issue for deaf and deaf-blind people and difficulties here underlie developmental, psychological and emotional problems and delay or prevent appropriate assessment and treatment. . . . Those with and without sensory impairment need the same access to mental health services and this is particularly difficult to achieve for deaf and deaf-blind people.”²⁷

For individuals who are Deaf, or deaf-blind, oral English is often an ineffective means of communication, and Irish Sign Language (ISL) and other methods may be necessary to facilitate communication. Few health professionals are so equipped however, and quite how the communication barrier that this presents affects outcomes in mental health service delivery for deaf, and deaf-blind individuals has not been the subject of any formal analysis in Ireland.

A 2002 report of a survey of Deaf people commissioned by the Irish Deaf Society concluded: “Dealing with medical professionals on health issues can be a disastrous and traumatic experience for Deaf people. This is due to the barriers that the Deaf Community face when attempting to acquire information on health issues and the failure of doctors to understand deaf people’s needs to the lack of training on Deaf awareness.”²⁸ It suggests that most Deaf people have experienced poor communication with their doctors, and recommends: “measures to improve access to health services can be centred on a simple strategy where medical professionals and health officials, particularly those who are in regular contact with Deaf people, can be given an extensive Deaf awareness course”.

It also concludes that the limited availability of Registered ISL/English interpreters – there are just 22 for a population of approximately 5,300 deaf people in Ireland – is a significant problem. This is particularly the case, the report suggests, in view of the fact that a number of interpreters may have Deaf relatives or friends, and consequently mix socially within the Deaf Community, raising respondents’ concerns about privacy and confidentiality should they be involved in health-related consultations – this was the view of some respondents in spite of the confidentiality requirement in the Interpreters’ Code of Ethics. The report also pointed to the risks inherent in having a family member present instead, as some respondents preferred to do, in that the person acting as

communicator may not give full and accurate information to both doctor and deaf patient. The findings and recommendations in this report apply equally if not more so to allied mental health professionals, given the sensitive nature of mental health services and their emphasis on communication.

Two further concerns have been raised by the Irish Deaf Society that have relevance here.²⁹ The failure by the Irish Government to formally recognise ISL as an official national language it considers to have had a negative impact on awareness of Deaf communication needs. Secondly, it believes that the mainstream system of educating Deaf children results in lower levels of literacy and academic achievement, and negatively impacts on children's self esteem. It instead advocates a bilingual system for educating Deaf children, and first language acquisition and early childhood education, and the necessity for family and community support through ISL.

Chapter 3 Older People

"The active ageing approach is based on the recognition of the human rights of older people and the United Nations Principles of independence, participation, dignity, care and self-fulfilment. It shifts strategic planning away from a 'needs-based' approach (which assumes that older people are passive targets) to a 'rights-based' approach that recognises the rights of people to equality of opportunity and treatment in all aspects of life as they grow older. It supports their responsibility to exercise their participation in the political process and other aspects of community life."

World Health Organisation³⁰

Introduction

In Ireland, there are approximately 436,000 people over the age of 65 years, representing 11.1 per cent of the population, 67.8 per cent of whom are female.³¹ It is projected that, within 30 years, this figure will double to 858,800 people or 18 percent of the population.³² While Ireland has the lowest percentage of older people within the European Union, the life expectancy of older people in Ireland also is the lowest in Europe. Given this anticipated 'ageing' of the population, hailed as "one of humanity's greatest triumphs", it is essential that the increased economic and social demands that this presents are met.

At the outset, it must be noted that the traditional association of old age with ill health, retirement and dependency has changed. According to WHO: "It is time for a new paradigm, one that views older people as active participants in an age-integrated society and as active contributors as well as beneficiaries of development. This includes recognition of the contributions of older people who are ill, frail and vulnerable and championing their rights to care and security."³³ Active ageing according to WHO is "the process of optimizing opportunities for health, participation and security in order to embrace quality of life as people age". It explains: "The word 'active' refers to continuing participation in social, economic, cultural, spiritual and civic affairs, not

just the ability to be physically active or to participate in the labour force.” It is in this context that Government promotion of the mental health of older people must be viewed. A broad view of mental wellbeing for older and ageing people encompasses factors such as material living standards and deprivation, physical health and social interaction. While many in this age group may be ill or otherwise vulnerable for whom medical interventions are needed, other positive measures are required in respect of all older people to ensure that their mental health is not compromised in the course of ageing.

It is also important to note that older people are not a homogenous group – rather their experiences and needs vary over crosscutting determinants, such as their social, economic or cultural circumstances. In addition, WHO observes that “[o]lder age often exacerbates other pre-existing inequalities based on race, ethnicity or gender”.³⁴

The independence of older people, and their ability to remain in their community is a paramount entitlement: “The care of elderly persons should go beyond disease orientation and should involve their total well-being, taking into account the interdependence of the physical, mental, social, spiritual and environmental factors... Health efforts, in particular primary health care as a strategy, should be directed at enabling the elderly to lead independent lives in their own family and community for as long as possible instead of being excluded and cut off from all activities of society.”³⁵

The Vienna International Plan of Action on Ageing adopted by the World Assembly on Ageing is the first international instrument on ageing, guiding thinking and the formulation of policies and programmes. It was endorsed by the UN General Assembly in 1982,³⁶ and contains 62 Recommendations for Action. The Plan suggests: “Policies to meet the challenge of a growing, healthier and more active elderly population – based on the view of the ageing of society as an opportunity to be utilized – automatically benefit the individual ageing person, materially and otherwise. Similarly, any effort to ameliorate the quality of life for the elderly, and to meet their diverse social and cultural needs, enhances their capacity to continue interacting with society. In this sense, the developmental and the humanitarian aspects of the question of ageing are closely intertwined.”

In 1991, following its endorsement of the Plan, the UN General Assembly adopted the United Nations Principles for Older Persons³⁷ recognising the special needs and protection of rights for older persons, the 18 Principles of which fall into five categories

relating to the status of older persons: independence, participation, care, self-fulfilment and dignity. With the UN’s designation of 1999 as the International Year of Older Persons, based on the Plan and the Principles, a further call was made to Governments to direct attention specifically to the rights and needs of older adults.

Prevalence of mental ill health

WHO advises: “A high prevalence of disorders is... seen in old age... Overall, the prevalence of some disorders tends to rise with age. Predominant among these is depression... Depressive disorders among elderly people go undetected even more often than among younger adults because they are often mistakenly considered a part of the ageing process.”³⁸

A 1996 study, ‘Mental Disorder in Older Irish People: Incidence, Prevalence and Treatment’, estimated that 20–25 per cent of Irish people over 65 years have a mental health problem of some severity at any one time.³⁹ While approximately 5 per cent of older people suffer from some form of dementia, 15–20 per cent experience other mental health problems such as depression and anxiety – 13.1 per cent of older people living in the community experience from some form of depression at any one time. It suggested that these problems are normally of a mild severity but that a significant proportion require specialist intervention. Research has found higher levels of psychological distress in women than men, and a definite age progression in distress levels. Similarly, a 2001 study of older people living at home recorded 20 per cent of women reporting clinical or borderline scores for anxiety or depression compared with 15 per cent of men.⁴⁰

In 2001, 92.8 per 100,000 population in the 65-74 age group and 40.1 per 100,000 population in the 75+ age group were admitted to psychiatric in-patient units due to alcohol abuse.⁴¹ With regard to drug abuse, it has been suggested: “Little evidence for drug abuse and dependence in older people exists nationally or internationally. However, it is widely believed that the problem is underdiagnosed because most abuse occurs with prescription drugs. Both clinicians and patients may refuse to accept that abuse or dependence is occurring because the drugs being taken are considered ‘legitimate’.”⁴² An increase in the level of suicide in older males has been observed in Ireland as throughout the world. It has been advised: “The factors associated with suicide by older people include declining physical health, chronic pain, loss of independence, bereavement, alcohol and drug abuse, and loneliness.”⁴³

Poverty

The UN has expressed concern that “the living conditions of the elderly in most countries have by and large lagged behind those enjoyed by the economically active population”.⁴⁴ A 1999 Irish study, ‘Income, Deprivation and Well-being Among Older Irish’, examined data from the 1997 ‘Living In Ireland’ Survey on income deprivation, basic material deprivation and marginalisation from “normal activities”.⁴⁵ It found: “the incomes of the elderly fall deep into the lower half of the national household income distribution and that this translates into poverty rates at the 50 and 60% levels which are higher than non-elderly households... These findings tend to suggest that the lifestyles of the elderly are falling far behind those of the general population and that that their quality of life will be damaged because of this.”

It found that over a quarter of older households fell under the 50 per cent poverty line and over half fell below the 60 per cent line, figures described as “extremely high and worrying” by the National Council on Ageing and Older People (NCAOP)⁴⁶. 10 per cent were found to experience income poverty and basic deprivation (an enforced lack of food and clothing), which, according to NCAOP, is “unacceptably high and shows much needs to be achieved”. It found that one in ten older persons were at risk of combined income poverty and basic deprivation. It noted a high reliance of older people on social welfare pensions – around 82% living alone were reliant on this form of income at double the risk of combined income poverty and basic deprivation. The particular vulnerability of older women to poverty and deprivation was highlighted, due to their higher dependency on the non-contributory or the widow’s pension since many had no option but to leave the workforce upon marriage and motherhood.

There is an indubitable link between poverty and mental ill health. The 1999 NCAOP study found that older people with incomes below the 60% relative poverty line had almost 1.5 times the risk of experiencing psychological distress, and those in basic deprivation had twice the risk of suffering psychological distress. Rural older people, especially women, were found to be at greatest risk of housing and secondary deprivation (access to transport, leisure activities), with rural older people over the age of 75 at greatest risk of basic deprivation. It further found that 25 per cent of older people have a chronic physical illness in combination with income poverty, which leads to 4.5 times the risk of developing a mental health problem compared to an older person who has neither of these characteristics. It also revealed that an older person experiencing both basic deprivation and chronic physical illness has almost

eight times the risk of psychiatric disturbance compared to an older person with neither of these characteristics.

NCAOP concluded that, “in our current buoyant economic situation, it is unacceptable that so many of our older people are living in these circumstances”.⁴⁷ It advised that “future research in this field should be more closely targeted on those whom the report has shown to be most vulnerable, i.e., females and the rural elderly but also those in the private rented sector and those whom the report did not cover at all, i.e., the homeless, those in long-stay care and elderly Travellers”.

The National Anti-Poverty Strategy is criticised in the 1999 NCAOP report, in that “many of [its] poverty reduction targets... are not relevant to the older population, being too heavily focused on labour market and early educational measures”. The Equality Authority has expressed its concern that: “At present, older people and their organisations have only a peripheral involvement in the forum where the major social and economic decisions are made i.e. the social partnership arena which produced the Programme for Prosperity and Fairness.”⁴⁸

Community health and social services

Principle 11 of the above UN Principles provides: “Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.” Principle 12 states: “Older persons should have access to social and legal services to enhance their autonomy, protection and care”. A 2001 survey of older people living at home, ‘Health and Social Services for Older People’, noted barriers to accessing community supports for older people. It found “a markedly low level of utilisation of other home and community-based health and social services (other than Public Health Nurses) with only five per cent or less of older people living in the community having used any one of these services in the past year.”⁴⁹ A significant number of people (37 per cent) deemed to be ‘severely impaired’ in carrying out activities of daily living had not received any home services in the previous year. The home help service was used by five per cent of respondents, meals-on-wheels by one per cent and personal care attendants by less than one per cent. Less than two per cent had used respite services either as carers themselves or to give respite to their usual carer. One per cent of older people living in the community had seen a social worker in the previous 12 months,

with fewer using counselling or psychological services – in both cases, twice as many people would have liked to have used the service than actually received it.

Other than access concerns, such as transport, waiting time or cost, the primary reported barriers to accessing services revealed in this study were the lack of information about the availability of a service or the suitability of a service for particular health conditions, and the stigma surrounding the utilisation of such services. In this context, the NCAOP has also recommended that information on the mental health problems encountered by older people should be more widely disseminated: “Public education programmes, directed at older people and their carers and focusing on the nature of mental disorders in old age, would enable older people to detect mental problems at an early stage. It would also reassure older people that mental disorders are not a negative reflection on their character and encourage them to seek help as early as possible.”⁵⁰

When asked about their wishes should they need long-term care in the future in ‘Health and Social Services for Older People’, older people expressed a clear preference for being cared for in their own homes with minimal health service involvement. Almost half of those living in the community received some help on a regular basis. A challenge identified in the report “is to develop ways in which family caregivers can be facilitated, encouraged and supported to continue in their role of caring for older people at home”.

According to NCAOP, this report confirms that: “Older people have expressed clearly that they want to remain living in their own homes, that they wish their family or friends to be their principal caregivers and that the role of health and social services should be to provide support to help them and their families realise this aspiration.”⁵¹ It further comments: “The low level of use of home and community care services evidenced in this study is indicative of their limited availability.”

NCAOP has elsewhere expressed “a particular long-standing concern that community care services be further developed to meet the needs of older people. These services enable older people remain at home in dignity and independence, one of the stated objectives of ‘The Years Ahead’⁵². . . access to these services is limited and variable within and among regional health board areas.”⁵³

To support the role of carers, NCAOP recommends the provision of a “range of respite options, including day care places, short-term relief care (for instance through

community residential services), night-sitting (freeing the carer for a number of hours in the late evening) and, most importantly, domiciliary relief provided by home helps during the day”.⁵⁴

The Equality Authority (see below) advises: “community care should be underpinned by clear legislative entitlement and dedicated funding provided to ensure that this legislative entitlement is delivered. Amongst the community care services to be covered by this entitlement are home help, night sitting services, respite care inside and outside the home, day care and social activity centres, social work services for older people, community and domiciliary paramedical services. . .”⁵⁵

WHO is giving special emphasis to activities that enhance the capacity of the primary health care sector to promote health, prevent or manage disease at older ages. These include efforts to prevent abuse and neglect of older people, survey medical students attitudes towards ageing, and setting standards to make primary health care services more “age-friendly”. These activities are pursued within the context of the general policy recommendations contained in the Active Ageing Policy Framework and the recommendations of the International Plan of Action on Ageing.

The General Practitioner and Public Health Nurse are key health providers for older people; older people are more likely to see their GP than any other health professional. NCAOP recommends: “health professionals should build an awareness of the individual patient into their care practices and try to involve people in their own care by informing them, listening to their point of view and involving them in decisions about their own care. This may entail health boards implementing a programme of awareness building among staff.”⁵⁶ It recommends: “(education) programmes for care professionals (e.g. GPs and public health nurses) are needed to ensure problems are detected at an early stage. Such a programme would also educate healthcare providers on the effects of physical problems (e.g. chronic pain) on mental health.”⁵⁷

Mental health services

The International Plan of Action on Ageing advises: “Early diagnosis and treatment are of prime importance in the prevention of mental illness in older people. Special efforts need to be taken to assist older persons who have mental health problems or who are at high risk in this respect.” WHO advises that mental health services play a crucial role in active aging and should be an integral part of long-term care, and cautions:

“Particular attention should be paid to the under-diagnosis of mental illness (especially depression) and to suicide rates among older people.”⁵⁸

The International Plan also advises that “mental disorders could often be prevented or modified by means that do not require placement of the affected in institutions”. It recommends: “Health and health-allied services should be developed to the fullest extent possible in the community. These services should include a broad range of ambulatory services such as: day-care centres, out-patient clinics, day hospitals, medical and nursing care and domestic services. Emergency services should be always available... Health screening and counselling should be offered through geriatric clinics, neighbourhood health centres or community sites where older persons congregate... Special support must be given to home care services, by providing them with sufficient medical, paramedical, nursing and technical facilities of the required standard to limit the need for hospitalization.”

NCAOP further recommends the development of psychological counselling services for older people by the health boards. It observes: “There are many psychological problems arising from the changes associated with late life (e.g. bereavement, retirement, ill-health, cognitive disorders and abusive family situations) which would benefit from some form of counselling. At present there are few or no psychological services available to older people, and few psychologists trained to deal with the problems of old age. The postgraduate courses in clinical and counselling psychology should incorporate modules on old age to ensure trained professionals are available in future.”⁵⁹

With regard to specialist mental health services, 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.” Since the appointment of the first consultant psychiatrist in this new speciality in 1989, there are now over 20. The Inspector 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.” This has also been remarked on by the Mental Health Commission: “there can be difficulty in accessing services because provision is still somewhat uneven. In addition, full multidisciplinary teams are not available in all areas.”⁶⁰

In-patient mental health care

For some older people, admission to in-patient mental health facilities will of course be necessary. In 2001, there was a total of 3,274 admissions of persons aged 65 and over to psychiatric facilities in Ireland.⁶¹ This rate has declined significantly over the last few decades. Concern has been expressed in relation to older long-stay inpatients, many of whom were admitted at a younger age and have ‘grown old’ in institutions. On the number of older people in in-patient care, the Inspector of Mental Hospitals has observed in his report for 2002: “The majority – fifty-five per cent – of patients in hospital at the end of 2002 were longstay being continuously hospitalised for over one year, over one third of them for over five years and the majority of the long-stay were over sixty-five.”⁶² In his previous report for 2001, he commented:

“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.”

The UN advises: “Institutional care should always be appropriate to the needs of the elderly. Inappropriate use of beds in health care facilities should be avoided. In particular, those not mentally ill should not be placed in mental hospitals.”⁶³

There are two varieties of long-stay mental health care facility in Ireland: long-stay wards of psychiatric hospitals and units, and mental health hostels (community residential accommodation). Concern has been raised that mental health hostels “are not specifically located or designed for older people as they cater for all those with a mental illness who require supported accommodation. This can present problems for older residents with mobility impairments.”⁶⁴

Other older long-stay people and those with intellectual disabilities reside in former psychiatric facilities that have been de-designated, that is, rather than being transferred to other residential facilities, their units have been formally separated from the psychiatric hospital and the residents are no longer considered to be psychiatric patients. There are concerns in relation to these de-designated facilities in that the remit of the Inspectorate of Mental Hospitals and the newly appointed Inspector of Mental Health Services does not cover these. There are consequently without any formal, statutory review of the living conditions or quality of care they offer.

Other long-term care

Principle 13 of the above UN Principles states: "Older persons should be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment". Approximately 5 per cent of people in Ireland aged over 65 reside in long-term care settings other than hospital care. A 1988 Government policy, 'The Years Ahead', noted: "The quality of [residents'] lives is dependent upon the nature and quality of the care provided by those who work in institutions catering for the elderly."⁶⁵

The NCAOP advises: "long-term residential care is a critical part of the continuum of care services; it should be provided to such a standard to those older people who can no longer be maintained in dignity and independence at home that they experience both health gain and social gain from the service. Attention must focus unequivocally on the quality and effectiveness of long-term care services, rather than on the provision of such services to a minimum standard... standards should be raised uniformly throughout the long-term residential care sector, including in public facilities."⁶⁶

Long-term care facilities in Ireland comprise health board geriatric homes/hospitals, health board welfare homes, health board district/community hospitals, voluntary geriatric homes/hospitals and private nursing homes. The Department of Health Survey of Long-Stay Units recorded that on December 31st 2002 there were 20,959 older people resident in such long-stay units.⁶⁷ Chronic mental illness was the primary medical/social status in 6.4 per cent of cases,⁶⁸ but, again, these facilities remain outside the remit of the Inspector of Mental Health Services or other statutorily independent body.

In a recent survey of residents of three long-term residential facilities, a number of participants said they had taken no part in the decision to enter the facility or were resistant to it, and "many were distressed and continued to be unsettled and angry as a result".⁶⁹ The study noted: "Although some of the interviewees were very clear that they had had no involvement in the decision to move to long-term residential care, there was a general reluctance to talk about how the decision had been made. It was not always possible to make a clear distinction between those individuals in their lives who had offered advice and those who had actually made the decision. The older persons were unclear, or unwilling, to share 'why' that particular centre had been chosen." It concluded: "Residents who had been involved in the decision to move to the care centre tended to have a far more positive evaluation of their new life in residential care than those who had not been involved."

Beyond the short-term measure that older people should be more involved in the decision to enter long-term residential care, the study recommended: "The matter of quality of life within long-term residential care would seem to be the responsibility of a broader group than simply the individual institutions themselves. If we are to ensure that residents in long-term care experience a good quality of life, we may need, as a society, to establish a level of expectation in terms of what these institutions can do. This standard should draw on the views of older people both within and outside residential care, but would also need to draw on the views of outside professionals, and indeed society itself..." Suggesting that "there is enormous potential to improve the lives of many older people in the long-term care setting, if the concept of social gain and quality of life can be integrated with the concept of health gain", it advised that further research into quality of life in long-term residential care should be undertaken. Another 2001 survey of older people's attitudes similarly recommends: "different perceptions of the acceptability of public and private residential care illustrate the need to explore further what constitutes a quality service from older people's perspectives".

There are also anecdotal reports from the public and concerned practitioners that older people in residential homes are sometimes sedated, but without an independent monitoring body reviewing prescribing practices. Medication should, of course, be administered only where medically necessary or therapeutic. A recently published general review of medications prescribed in long-term care settings has recommended "that standards for prescribing in Long Term Care should be derived, and that prescribing practices would be one indicator of quality of Long Term Care."⁷⁰

There is currently no independent inspection system for long-term residential facilities. The Social Services Inspectorate, which investigates children's residential facilities at present, is expected to be placed on a statutory basis, and its remit extended to include residential care for people with disabilities and older people. This should occur as a matter of urgency. Principle 14 of the above-mentioned UN Principles states: "Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives." It is essential that clear guidelines and independent monitoring of their implementation be established in respect of these facilities.

The NCAOP has also observed: "the need for a standardisation of the inspection system for public and private institutional care settings, and across health board regions. Central to this will be a standard, national training programme for inspection staff, and the development of national procedures and guidelines to cover both inspection and intervention in cases of abuse. The Council believes that the proposed Working Party on elder abuse should advise the Department of Health and Children on these issues. The implementation of recommendations should then pass to the new Social Services Inspectorate at the Department of Health and Children."⁷¹

Government policy and implementation

The 2001 national health strategy⁷² noted that submissions made from the public and organisations centred on improving the quality of life for older people. Proposed measures included: supporting carers, improving assessment, community support services and rehabilitation in order to allow older people to remain in their homes; measure to address the availability, cost and quality of long-term residential care; advocacy services for vulnerable groups; greater education for health care workers and the public about the needs of older people with disabilities and mental illness; and the development of specialised services. The health strategy made several recommendations specific to older people, the first point of action of which was that a coordinated action plan to meet the needs of ageing and older people would be developed by mid-2002, but this has not yet been delivered. The health strategy also proposes a system of regional advisory panels comprised of older people, their carers and services providers, which is to be welcomed and should afford an opportunity for older people to be central to the development and improvement of services. The Equality Authority has observed: "The present generation of older people

and their organisations are not sufficiently represented in the policy making processes. The concerns of older people are addressed in some of these processes but often without the direct input of those affected."⁷³ It is crucial that the development and delivery of the envisaged national action plan, and the new national mental health policy framework outlined in Chapter 7, should also involve meaningful participation of older people and their representative organisations. This is also the counsel of the UN: "Participation of the aged in the development of health care and the functioning of health services should be encouraged."⁷⁴ The International Plan warns: "All too often, old age is an age of no consent. Decisions affecting ageing citizens are frequently made without the participation of the citizens themselves. This applies particularly to those who are very old, frail or disabled. Such people should be served by flexible systems of care that give them a choice as to the type of amenities and the kind of care they receive."

Of course, Government policies in respect of older people's mental wellbeing should extend beyond health care; the International Plan advises: "The recognition that all aspects of ageing are interrelated implies the need for a coordinated approach to policies and research on the subject." In 1988, the Government published its cornerstone strategy, 'The Years Ahead – A Policy for the Elderly'⁷⁵, which identified the need for comprehensive, coordinated and accessible community based services with the capacity to respond flexibly to current and emerging needs, and high quality hospital and residential care for those who cannot remain in the community.

The National Council on Ageing and Older People (NCAOP) was established in 1997⁷⁶, and is the advisory body to the Minister for Health and Children on all aspects of ageing and the welfare of older people. In its 1997 review of 'The Years Ahead', NCAOP identified difficulties in that policy and issued the following conclusions:

"First, have recommendations been universally implemented in the manner envisaged by the Working Party? The answer here is almost always no. Second, is it likely that the recommendations will, in the near future, be fully implemented in the manner envisaged? Again the answer is almost always no. Third, are there regional variations in the implementation status of recommendations? Where relevant, the answer is almost always yes. Fourth, are the implementing bodies satisfied with

the recommendations of the report? Here the study findings are mixed, but real questions have been raised about the value of certain recommendations.”⁷⁷

It also noted the absence of involvement of older people in devising the 1988 policy. NCAOP has since published extensive reports covering the many and diverse barriers and discriminatory policies faced by older people, and issued many recommendations for change.

The Equality Authority is the statutory body charged with the elimination of discrimination and the promotion of equality of opportunity, and observes: “The age ground (of equality legislation⁷⁸), while not confined to older people, lays valuable foundations for change for older people using an individual rights based approach as a point of departure.” In 2002, it published ‘Implementing Equality for Older People in Ireland’⁷⁹, a wide-ranging strategy for change drawing extensively on NCAOP recommendations designed to achieve greater equality. Its range and direction very much correspond with WHO’s advice that: “If governments are to cope with a rapidly ageing population they need to have policy-driven initiatives based on a clear identification of personal, social, and cultural factors that contribute to healthy ageing. The question of ageing needs to be addressed through initiatives that encourage active ageing and not solely through increased service provision.”⁸⁰ ‘Implementing Equality’ describes the obstacle of ageism facing older people:

“Ageism involves an interlinked combination of institutional practices, individual attitudes and relationships. Institutional practices in this context can be characterised by:

- *the use of upper age limits to determine provision or participation;*
- *segregation where older people are not afforded real choices to remain within their communities;*
- *a failure to take account of the situation, experience or aspirations of older people when making decisions, and a failure to seek to ensure benefit to them as a result of an over emphasis on youth and youth culture; and*
- *inadequate provision casting older people as burdens or dependants.”*

It sets out extensive proposals for change in policy, law and legal status⁸¹ which Amnesty International urges the Government to implement as a matter of priority. The National Economic and Social Forum subsequently established a Project Team to identify barriers to the implementation of ‘Implementing Equality’, which, in 2003, published ‘Equality Policies for Older People Implementation Issues’⁸². This notes that “in relation to policy for older people a lack of consistency is evident between official policy, which is to support older people to live at home for as long as possible, and the reality, which is insufficient supports for many older people to exercise the choice of doing so”. It also noted: “some concern was expressed in relation to day-to-day compliance with equality obligations at the level of the individual organisation. It was not clear to the Team from its discussion with Government Departments that arrangements existed within those Departments to monitor the extent to which their practices are compliant with their obligations under the Equality Legislation.” It stressed the “importance of a strong monitoring mechanism to track the conversion of policy statements of intent into practical results on the ground – and the extent to which this is done”, and recommended that the Department of Justice, Equality and Law Reform should undertake this overall monitoring role.

Chapter 4 Lesbian, Gay and Bisexual People

The Employment Equality Act, 1998 and the Equal Status Act, 2000 were designed to promote equality and to prohibit discrimination on nine grounds, including sexual orientation, in relation to employment, training, and promotion and in the provision of goods, services, facilities, accommodation and education. It has been cautioned that “legislation can only create the conditions to facilitate equality of participation and cannot of itself guarantee equality of outcome”⁸³. It is worth noting that there is no explicit mention of the needs of this group in the 2001 National Health Strategy.

A 2002 Equality Authority report marks a positive move forward on this equality agenda. It contains 88 recommendations across a wide spectrum of Government policies, the five key themes of which are:

- the need to mainstream LGB people’s circumstances and needs into the design, delivery and implementation of economic and social policies and services;
- strategic development of the LGB community;
- training to enhance decision-makers’ understanding of the LGB community;
- participation by LGB people and their organisations in decision-making that impacts on them; and
- the recognition of same-sex partnerships with regard to parenting, inheritance, property, healthcare, pensions and immigration.

It concludes 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, appropriate and accessible health service”.⁴⁸ 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.”

It cites US research that “indicates that up to 30 per cent of suicide attempts and completed suicides are made by young people struggling with their sexual orientation.” In Ireland, however, research into the relevant mental health needs and service provision is currently lacking. 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.”

The report was reviewed for potential barriers to its implementation by a Project Team established by the National Economic and Social Forum (NESF), which published ‘Equality Policies for Lesbian, Gay and Bisexual People: Implementation Issues’⁸⁵. While noting that all public service providers have an obligation to be aware of the need to provide accessible and appropriate services to the LGB community, the report identified the following as significant barriers to its implementation:

- the tendency for sexual orientation to be either glossed over or overlooked in the proofing process, particularly with regard to poverty/equality proofing;
- the lack of profile data and research which acts as a major barrier to effective monitoring; however, this should not be a barrier to progress; action needs to be taken first by official bodies and the data will then follow; and
- the lack of examples or models of how to successfully operationalise equality proofing is a serious drawback.

To address these barriers, the report recommended that:

- LGBs should be specifically addressed in all equality proofing exercises;
- examples of sexual orientation in equality proofing processes should be documented and disseminated; and
- all data regarding social inclusion and equality should include LGB as a target group.

It recommended that “all Departments and State Agencies should take the necessary steps to ensure that they are aware of the needs of their LGB clients or service users, the extent to which their needs are currently met and how these needs are included in the planning and review of services, programmes and schemes”. It noted however:

“the lack of an effective and adequately-resourced infrastructure to help LGB people better inform and input their views into the policy-making process was highlighted as a barrier on a number of occasions during the Team’s consultations. Even bodies well versed in other equality issues may not appreciate the specific concerns and issues arising for other groups such as LGBs. The lack of visibility of LGB groups in policy design and review and the tendency for LGB issues often not to be specifically addressed in policy and practice were main contributory factors in this regard. The Team concluded that addressing representation and funding is a key requirement to reducing the barriers that exist to policy improvements and effective implementation in this area.”

Significant negative attitudes still abound in Ireland in relation to this community. The NESF report cites a recent European values survey: “It found that over a quarter (26.9 per cent) of people surveyed in Ireland said that they would not like to have a homosexual as a neighbour. This did not compare favourably with the results from our European Union neighbours – only Greece, Northern Ireland and Italy scored higher”.⁸⁶

The Department of Health and Children was commended by the NESF Team on its commitment to and development of an innovative model to tackle the inequality in health for gay men, particularly around HIV prevention and capacity-building in the gay community. The Team felt that increasing the visibility of LGB needs in the healthcare system was important and their inclusion in the Department’s Business Plans and the Health Boards’ Service Plans would be beneficial. The Department indicated that it had already written to the Health Boards on this matter, drawing their attention to the recommendations in the Equality Authority’s report and asking them to include relevant aspects in their Plans.

The Department of Health and Children advised the Team “that a global request for LGB involvement in all health policy development was less effective than targeting specific areas of particular interest, where the community can demonstrate its contribution more clearly”. The Team indicated to the Department five areas of particular interest, one of which is mental health. The Team recommended that it be reconvened by the Forum within a year to review progress. Amnesty International suggests that the Team include an assessment of the progress of the consultative process of updating national mental health policy outlined in Chapter 7 in this review, particularly in view of the Team’s highlighting mental health to the Department, and the express recommendation in the Equality Authority report that a national mental health strategy should take account of the needs of lesbian, gay and bisexual people and the marginalisation attached to homosexuality.

Chapter 5 **Minority Ethnic Groups, Asylum Seekers & Refugees**

Minority Ethnic Groups

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.⁸⁷ [...] 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."⁸⁸

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.

The needs of older members of minority communities will also have to be considered in the context of concerns and recommendations outlined in Chapter 3: "At present, there are relatively few older members of any other minority ethnic groups living in Ireland. This will change over the coming years so a strategy for equality has to address their particular needs."⁸⁹

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

Traveller Community

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.⁹⁰ 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."⁹¹

In addition, 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.⁹² Yet, while it is estimated that there are 4790 Traveller families in Ireland, comprised of 21158 individuals,⁹³ 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."⁹⁴

There is anecdotal concern that health services are illequipped to fully address the needs of this significant minority group, leading to their poor uptake of these services. Many Travellers only experience of mental health services may be from care situations or institutional settings such as prisons or psychiatric services, and so they may have a negative association with the services.⁹⁵ It is estimated that 90 per cent of adult Travellers are pre/illiterate so information regarding services are often missed as the information is not accessible to non readers.

There is a strong stigma attached to having mental health problems within the community, so many Travellers would not normally seek or avail of any form of service because of the perceptions of their community. The extended family and especially older Travellers in the extended family traditionally have provided informal counselling in the form of

listen and advice (wisdom) to the “troubled” person and this intervention has been accepted by the community as an appropriate way of dealing with issues. It also guarantees confidentiality as the information remains within the family.

As the Traveller population is very young, there will be implications for the future in the provision of culturally appropriate mental health services, if younger Travellers needs are to be addressed. There is anecdotal evidence that there is a much higher rate of suicide in young male Travellers compared to the majority population of the same age group. Any service that is to be provided therefore must bear these facts in mind and offer a culturally acceptable as well as a culturally appropriate service to the Traveller community. This means that there must be a level of flexibility within the service to facilitate this.

Traveller women are probably most affected by the appalling conditions that they are forced to live in. There are approximately 1,200 families still living on the roadside and the lack of facilities, caring for children etc. can be extremely difficult for women. The potential for accidents for children where trailers are parked too close to the roadside, and constant illness due to bad living conditions, poverty and marginalisation all impact on the Traveller women’s health. The fear of eviction for families on the road side is a real and constant pressure. Traveller men with little employment opportunity are often under pressure to provide for their families. They have to deal with the prejudice of their settled peers and this again impacts on their well being. The lack of acknowledgement of racism and discrimination adds to the burden of Travellers in that the normal social interactions enjoyed by the majority population are not afforded to Travellers.

In relation to the impact of ageing on mental health, it has been noted: “Relatively few members of the Traveller community live to reach retirement age as they have a much lower life expectancy than the rest of the population. This is an indictment of society’s treatment of Travellers of all ages.”⁹⁶

Recommendations made by the Pavee Point Travellers Centre Health Team include:

- The recommendations for mental health services providers in the Government’s National Traveller Health Strategy 2002-2005 need to be implemented.
- In service training should be offered to GPs and psychiatric service providers to raise awareness of barriers facing Travellers in accessing these services, to ensure a more flexible and culturally appropriate service can be offered.

- While mainstream service provision should be made more flexible to accommodate different needs, a targeted approach should also be adopted if appropriate in consultation with Traveller organisations and especially where PHC for Traveller Projects are active.
- Information should be prepared in a culturally appropriate way (again in consultation with Traveller community) to encourage Travellers to use a service which has not been seen by them as for them.
- Traveller organisations should work with the Traveller community to de-stigmatise “mental health” to help the community uptake services.⁹⁷

Asylum Seekers & Refugees

In Amnesty International’s September report, ‘Mental Illness: The Neglected Quarter – Children’, concerns and recommendations were issued regarding the mental health of asylum seeking and refugee children, and in particular unaccompanied minors. In respect of asylum seeking adults, 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.”⁹⁸

In Ireland, while local needs assessments have been conducted in several health board areas,⁹⁹ asylum seekers and refugees are not routinely provided with specialised psychological or psychiatric services.¹⁰⁰ 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.”¹⁰¹

Chapter 6

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 Organisation¹⁰²

Introduction

There are over 3000 people in prison on any average day in Ireland,¹⁰³ 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.¹⁰⁴ There are no regularly compiled statistics on the mental health needs of prisoners,¹⁰⁵ 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.”¹⁰⁶ 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.¹⁰⁷

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, over a period of three decades, and found that these prisoners “were several times more likely to have psychosis and major depression”.¹⁰⁸ 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. . . .”¹⁰⁹ While not unique to Ireland,¹¹⁰ this scenario is partly attributable to the deficiencies in the wider mental

health services pointed out in Amnesty International's February report, 'Mental Illness: The Neglected Quarter'; many people 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. According to the first report of the recently appointed Inspector of Prisons and Places of Detention, "[t]he prison has become a dumping ground for many of the psychiatrically ill amongst us. This issue has been raised in (the Prison Chaplains') annual report for years."¹¹¹ This, again, is an experience shared with many other jurisdictions.¹¹² 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 available to prisoners 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.

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."¹¹³

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).¹¹⁴ 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).¹¹⁵

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,¹¹⁶ Rule 22(2) of which provides: "Sick prisoners who require specialist treatment shall be transferred to specialized 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)¹¹⁷ relates to criminal offenders¹¹⁸ 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, 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."¹²⁰ To this end, it has begun to develop some practical examples of mental health promotion in prisons, which it will continue to expand.¹²¹

Prison Mental Health Services

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.

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”.¹²² A number of recommendations 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.”¹²³

There have been 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.”¹²⁴

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 2002 visit, it noted an increase in psychiatrists’ input at Mountjoy Prison for Men in line with its previous recommendation.¹²⁵ It observed: “At the time of the 2002 visit, the establishment was visited daily by psychiatrists from the Central Mental Hospital. A similar arrangement provided sufficient in-house psychiatric care at the Dóchas Centre and at Cloverhill Prison (which were visited by a psychiatrist two and three times per week, respectively).” It recommended that the psychiatric services in Cork Prison be strengthened. It noted however: “in all of the establishments visited, psychological support was very limited, and at Cloverhill non-existent. Such a situation will inevitably strain the prison’s in-house psychiatric services. The CPT recommends that the psychological services of the prisons visited be developed.”

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,¹²⁶ 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”.¹²⁷ While some have argued that the prison mental health care services should lie mainly within the sphere of responsibility of the Department of Health,¹²⁸ 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”.¹²⁹

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.”¹³⁰

In-Patient Care

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.”¹³¹

Given the known 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. Regarding the older buildings in the CMH, the CPT commented: “the rooms had only limited access to natural light (e.g., windows were covered on the inside by shutters, apparently to prevent self-harm) and the furniture (bed, locker, television) did not include chairs. Further, they had not been equipped with integral sanitation and, at night, patients were required to use disposable chamber pots. The sanitary facilities used by patients during the day were very run down and offered little privacy. More generally, at the time of the visit, the hospital as a whole was poorly heated.”¹³²

There are plans being developed for its refurbishment, but there is concern that this may not progress expeditiously 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 planning and 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 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.¹³³

It is acknowledged that many prisoners are returned to prison from the CMH before they are well, a serious failure to respect 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.”¹³⁴ Amnesty International urges that this promised reform take place as a matter of urgency.

Solitary Confinement

Mentally vulnerable or ill prisoners may be placed in isolation cells in prison, often for significant lengths of time, and sometimes while awaiting transfer to the CMH. Amnesty International, in a letter to the Minister for Justice in August 2001 in relation to an Irish Penal Reform Trust report,¹³⁵ expressed its concern at this practice as a substitute for medical/psychological care, which may constitute a violation of international standards for humane detention. The conditions in which prisoners are detained in these isolation cells may also amount to cruel, inhuman and degrading treatment. The prolonged periods of some instances of solitary confinement may

have serious effects on the physical and mental health of prisoners, and are likely to aggravate the condition of persons already suffering from mental illness. Such prolonged isolation may also constitute cruel, inhuman or degrading treatment, contrary to Article 7 of the ICCPR.

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.”¹³⁶

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 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.”¹³⁷

In 2003 the IPRT issued a follow-up report on padded cells.¹³⁸ It reported that plans for certain improvements from the former padded/strip cells have been suggested by the relevant Government authorities, including: the new cells will have fixed beds on plinths (normal bed height); all walls will be soft surfaced so as to protect the prisoner from self-harm; there will be a call button in every cell; toilets will exist in or adjacent to each observation cell; a gown will be provided (patients will no longer be naked); three cells of varying types are to be built for demonstration purposes in Cloverhill prison by September 2003. It reported from its conversations with these authorities that further consultation is to then take place.

Amnesty International remains concerned that, while there remains an absence of suitable alternatives for prisoners with mental illness within the prisons, and given that the Minister’s interim 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. The 2003 IPRT also suggested: “If standards of good practice are to be applied then it is essential that resources are put into the prison medical system in order to prevent undue detainment of mentally ill patients in observation cells. More medical and para-medical staff, as well as observation rooms and wards, are needed.”

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.”

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

Homelessness & the Prison System

In its May report, 'Mental Illness: The Neglected Quarter – Homelessness', the profound interrelationship between homelessness and mental ill health, and the poor Government responses to this group, were pointed out. A 2002 study, 'Crime and Homelessness', concluded that “periods of imprisonment can...lead to homelessness, [and] homelessness can also lead to imprisonment”.¹³⁹ It observed: “There has been little research in Ireland on the complex relationship between homelessness and crime or on the difficulties and problems faced by offenders on leaving prison.” It noted that Irish prison statistics yield little information on the number of prisoners who are homeless.¹⁴⁰ Without this sort of information, it would seem difficult to devise individual sentence and release plans as is the duty of the prison authorities. The report noted however:

“Recent profiles of male prisoners in Mountjoy prison in Dublin by O’Mahoney (1993, 1997)¹⁴¹ indicate that 3 per cent and 7 per cent respectively of the sample populations were homeless. These figures are considerably lower than those found in comparative studies from the UK. A recent snapshot survey of the incidence of homelessness among male and female prisoners in Mountjoy Prison and the Dochas Centre respectively conducted by PACE in 2002 shows the incidence of homelessness to be closer to Taylor and Parrot’s (UK) estimate than

O’Mahoney’s. The PACE survey¹⁴² found that 33 per cent of all Irish female prisoners in the Dochas Centre will be homeless on release from prison and 35 per cent of men reported that they will not have accommodation upon their release....”

It nevertheless found that significant numbers of homeless people with mental illness end up in prison because of public order or nuisance offences, often related to their homelessness and mental health or addiction problems.¹⁴³

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.¹⁴⁴ 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.”¹⁴⁵

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.”¹⁴⁶

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.

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’,¹⁴⁷ 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 Irish 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.”¹⁴⁸

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 sufficient resources. In relation to complaints regarding the arrangement and provision of medical care, the 1998 report of the European Health Committee of the Council of Europe advises:

“...[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.”¹⁴⁹

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.”¹⁵⁰

This supports Ireland’s obligation under Article 2(3) of the ICCPR to ensure an effective remedy for breaches of this Convention,¹⁵¹ 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.”¹⁵² 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”. In its 2003 report, the CPT stated: “The complaints procedures described in previous visit reports...remain basically unchanged... prisoners appeared to have very little confidence in the complaints system; the CPT has made clear in this connection that complaints procedures should offer appropriate guarantees of independence and impartiality.”¹⁵³ In its follow-up report to the CPT in 1998,¹⁵⁴ the Irish Government stated that provisions in relation to a prison Inspectorate and Visiting Committees would be included in the Prison Service Bill, which would be published by the end of 2000. Amnesty International is disappointed that this Bill has not yet emerged, given its importance for this vulnerable group. In the interim, the current Inspector of Prisons should be afforded the fullest assistance and cooperation 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.”¹⁵⁵

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, 2001.¹⁵⁶ 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.¹⁵⁷ Amnesty International believes that serious consideration 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.

An apparent lack of integration between government departments is evident in the Criminal Law (Insanity) Bill, 2002, currently before the Oireachtas. While the welcome ambition behind this Bill is to resolve the law in relation to the verdict of ‘not guilty by reason of insanity’, and to introduce the plea of ‘diminished responsibility’ where mental illness is a factor in the commission of a crime, the Bill speaks of referring defendants to ‘designated centres’ for their assessment or detention. Where exactly these centres are to be however, does not seem to have been considered. As mentioned earlier, civil psychiatric hospitals and units do not currently accept patients from the criminal justice system. Even if they are forced to change this policy, the majority of in-patient facilities are already overburdened. There are no specialist forensic units other than the Central Mental Hospital, which is under impossible strain at all times, and its physical conditions are widely condemned. There are no in-patient psychiatric facilities within the prison system. There are no stated plans in the Bill to create new specialist units for these referrals, nor to increase the number of places in the mainstream services. Neither is there provision in the Bill for increased resources for this new regime.

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 2002 report of the Inspector of Mental Hospitals observes that up to now, "Gardaí had no formal training in principles of mental health or on service availability or contactability". It notes however that: "following discussions between the Department of Health and Children and An Garda Síochana, a mental health module will be introduced into the student Garda training programme in 2003. Thereafter, it is to be hoped that there will be improved communication and mutuality between the mental health services and the Gardaí to replace the former distrust between the two. This is all the more important in the light of the proposed further development of forensic psychiatric services."

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.¹⁵⁸ Such a scheme should be considered in Ireland.

Chapter 7 Government Responses & Plans

Research & Needs Assessment

It has been 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".¹⁵⁹ There is little centralised data available on the prevalence of mental illness in Ireland (other than the Psychiatric In-patient Reporting System, which does not compile information on a variety of areas such as ethnic group or physical disability), the needs of vulnerable groups, or the quality of service delivery. In earlier reports, Amnesty International has pointed to the needs for enhanced data collection on the needs of and provision for children and the homeless population. In the present context, greater knowledge of the situation of marginalised groups is required.

It has been suggested: "there is, in general, a dearth of information on disability identity".¹⁶⁰ The situation of minority groups is even more problematic: according to this 2003 Equality Authority report "very little is known about the incidence of disability among minority ethnic communities in Ireland". One of the factors behind this is the lack of data on the minority ethnic communities in Ireland. While, for the first time, a question designed to determine the level of membership of the Travelling community was included in the 2002 national census, this was not the case in respect of other ethnic communities, which many believe to have been a missed opportunity to better map service needs. The report concludes, "the invisibility of minority ethnic people with disabilities in Ireland is exacerbated by the lack of data making it difficult to statistically identify this multiple identity group and measure inequalities related to this group". The Equality Authority report advises: "the availability of data on the nine grounds covered by equality legislation is considered essential to the analysis and monitoring of progress towards greater equality in Irish society". The Government's Traveller Health Strategy has acknowledged the lack of data on the experience of disability within the Traveller population.

It has also been pointed out in Chapter 2 that the needs of the Deaf community are underexplored, and in Chapter 3, that greater evaluation of the provision for older people, particularly those at risk of poverty or social isolation, is required. With regard to the criminal justice system, the National Disability Authority suggests: "The lack of prevalence and process research in Ireland inhibits our understanding of the numbers and categories of people with mental health and intellectual disability in the criminal

justice system and the decisional processes, which move them through its different stages.”¹⁶²

The Mental Health Commission has noted: “The use of Information Technology (IT) and the collection and use of data have been poor in the health services in general, but the mental health services have lagged behind other services. Mental health services are probably the most diffuse specialist health services in the country, being delivered in a huge number of locations and a variety of care settings. This practical difficulty has hindered the development and implementation of an information system... An integrated IT system is a long overdue requirement for mental health services.”¹⁶³ 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, one of WHO’s principal recommendations is that states should conduct more research into biological and psychosocial aspects of mental health, including epidemiological data collection and evaluation considered “essential for setting priorities within... mental health, and for designing and evaluating public health interventions”.¹⁶⁴

Funding

Amnesty International highlighted the inequitable funding allocated to mental health services in its previous reports: while there have been considerable increases in health budgets in recent years, revenue funding of the mental health programme has not proceeded in step with other medical programmes and now accounts for just 6.8 per cent of total revenue health expenditure. It is worth adding that a recent public survey commissioned by Mental Health Ireland found widespread public support for increased investment in services for those with mental illness.¹⁶⁵ Again, Amnesty International would like to remind the Government that, while the ICESCR does not require full realisation of the standards therein immediately upon ratification, it does require progressive realisation to the maximum of available resources. In 2002, the CESCR, noted “the favourable economic conditions prevailing in the State party and observes no insurmountable factors or difficulties preventing the State party from effectively implementing the (ICESCR)”.¹⁶⁶

A further inequity is that, in Ireland’s mental health sector there is “a five-fold difference in funding between health board areas;”¹⁶⁷ and a 2003 study found that areas of greatest socio-economic deprivation receive fewest resources.¹⁶⁸ It has also been observed that regional budgets allocated to mental health services have been eroded

in times of competing needs from other health sectors. The Government’s recently announced plans to reform the health services recognises that “significant demographic and social changes over the ... are not reflected in the way in which resources have been allocated in the system” and promises that “funding will be determined in a manner that captures these changes in society”.¹⁶⁹ Amnesty International urges that this reform ensures equity for mental health services, and that ring-fencing and other measures to protect mental health budgets at central and regional levels will be introduced.

WHO also advises that funding allocation should form part of mental health policy: “Mental health financing is a powerful tool with which policy-makers can develop and shape quality mental health systems. Without adequate financing, mental health policies and plans remain in the realm of rhetoric and good intentions.”¹⁷⁰

Mental Health Act & Commission

The Mental Health Commission was established in April 2002 as an independent statutory agency under the Mental Health Act, 2001.¹⁷¹ Its statutory functions are to: appoint an Inspector of Mental Health Services; put in place arrangements for an independent review by a Mental Health Tribunal of decisions to admit or detain a patient on an involuntary basis and decisions to extend the duration of such detentions; and prepare codes of practice and guidelines for those working in the mental health services. The Commission will also be the registration authority for ‘approved centres’ – all in-patient facilities where people may legally be involuntarily admitted or detained. The Chair of the Commission has mentioned the particular concern of the Commission about inadequate services, and “recognises that it has a major responsibility in the role of advocacy”.¹⁷² The Act will also require substantial funding: “There is an urgent need to provide the resources and structures needed to implement the new Act... Certainly, there is little point in having an elegant legislative framework if the resources are not in place to provide high quality mental health care to all.”¹⁷³

Mental Health Policy

It has been suggested that the “absence of an up-to-date mental health national strategy” is seen as a “significant cause of the current inequities in clinical resource distribution, and limited availability of specialist services”.¹⁷⁴ Work is to begin this year on a new national policy framework, promised under the 2001 National Health Strategy,

to update current policy,¹⁷⁵ *Planning for the Future* (1984). Together with several national organisations, Amnesty International submitted to the Department of Health and Children a joint position statement seeking an informed review of the existing services, with the full participation of stakeholder organisations in an open, transparent and accountable process, as a necessary part of this policy update. In August, announcement was made by the Department of the establishment of an Expert Group on Mental Health Policy to prepare this new national policy framework. Amnesty International welcomes the commitment that the process will involve wide consultation with interested parties, and will take account of “innovative developments in the care and treatment of mental illness and the views of those who use the services, as well as those who work within them”.¹⁷⁶ Of particular relevance to children are the commitments to explore measures to reduce stigma, and specialised mental health services for children and the homeless. However the needs of the other groups mentioned in this report should also be addressed.

After almost two decades in existence, ‘*Planning for the Future*’ has not led to an adequate, comprehensive or equitably resourced service. Mental health service users and providers are still struggling with an outdated, fragmented, and severely under-resourced system. It is clear that when this new policy emerges, detailed programmes of action for its implementation must follow from Government, with clear timeframes and dedicated resources.

Amnesty International recommends that the values and principles of mental health policy should reflect the civil, political, economic, social and cultural human rights obligations binding on the Irish Government under international law. WHO will shortly publish its ‘*Mental Health Policy and Service Guidance Package*’, at the heart of which is a human rights focus, and which Amnesty International has promoted to the Irish Government as a solid basis for Ireland’s policy update.¹⁷⁷ Interdepartmental responsibility should be reflected in mental health policy according to this WHO Package, and it advises: “it is necessary for (the) ministry of health to convince other policy-makers and planners, e.g. the executive branch of government, the ministry of finance and other ministries, the judiciary, the legislature and political parties, to focus on and invest in mental health”.

Wider Government Policy

One of the stated visions of the 2001 National Health Strategy is a “health system that is there when you need it, that is fair, and that you can trust”, and the commitment to reviewing mental health policy has been noted. However, employment and antipoverty strategies also have enormous significance for the mental wellbeing of people with mental illness and other vulnerable groups. Schizophrenia Ireland advises: “It is imperative that persons with severe mental illness are able to attain a reasonable standard of living, which allows them to become central participants of the wider community rather than residing at the margin.”¹⁷⁸ It points to, for instance, “an urgent need to review the level of disability allowance and benefit”. Its 2000 report, ‘*Social Inclusion & Mental Illness*’, indicated that the majority of its service users felt their income was inadequate for their needs.¹⁷⁹ This organisation also recommends: “There is an ongoing need to ensure that people with severe mental illness have equal access to and opportunities in further education, training and employment. . . . Additionally, the funding basis for rehabilitative programmes needs to be addressed to allow for the provision of appropriate rehabilitation and support services.”¹⁸⁰

Interdepartmental responsibility should be reflected in mental health policy according to the WHO Guidance Package - it advises, “it is necessary for (the) ministry of health to convince other policy-makers and planners, e.g. the executive branch of government, the ministry of finance and other ministries, the judiciary, the legislature and political parties, to focus on and invest in mental health”.¹⁸¹

Personal Advocacy

Many marginalised 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. “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”.¹⁸² Consequently, Ireland is obliged to assist all people with mental illness in doing so, not alone by making services available, but their use accessible. Language barriers for minority ethnic groups, asylum seekers, refugees and the Deaf community should also be addressed.

Mental Health Legislation

According to international standards, mental-health-related human rights principles should be placed in national law. While the Mental Health Act, 2001 is welcome in updating the law in relation to involuntary in-patient admission and detention, legislation should reflect the full range of applicable international human rights standards. WHO is currently developing a 'Manual on Mental Health Legislation', which will compile information on international norms and standards in the area of mental health and human rights, and information on the operation of mental health law in other countries. When the manual is published, Amnesty International will seek its implementation in Ireland

A planned action in the 2001 Health Strategy is the introduction by the Department of Health and children of new legislation "to provide for clear statutory provisions on entitlement to health and personal social services". A Bill was to have been published in 2002, but has not yet been. Whether this Bill, the Mental Health Act, or a separate piece of legislation should deliver on the relevant rights is a matter for the legislature. WHO advises that ensuring legislative provision is also an essential component of a mental health policy: "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."¹⁸³

Most recent Irish debate about the proper place for economic, social and cultural (ESC) rights in national law has taken place in the context of the soon to be published Disability Bill. The current Minister for Justice, Equality and Law Reform, whose Department has responsibility for this and other equality legislation (and which, as noted in Chapter 4, the NESF has recommended should take overall responsibility for the promotion and protection of equality measures) has conceded that "what are now called 'economic and social rights', with the notable exception of the right to free primary education, cannot be enforced in the (Irish) Courts".¹⁸⁴ He also stated: "In distinguishing between basic human rights and social and economic rights, however, I would say this. Civil and political rights form a corpus of rights that are undoubtedly suitable for protection in a system based on adversarial trial before an independent arbitral judiciary which is the cornerstone of the Common Law state. The same cannot be said of social and economic rights. Whether the State should expend its resources on doctors, police, soldiers or social workers (and in what proportions) as opposed to whether available resources should be spent on hospitals,

roads, schools, or art galleries (and in what proportion) are matters of democratic political judgement - not arbitral legal judgement."

While the Minister issued this comment with reference to fundamental human rights as enshrined in the Constitution, it is important to clarify that, in international human rights law, there is no inherent hierarchy of rights that in any way implies that ESC rights are inferior to the civil and political variety. The UN has made this perfectly clear. Furthermore, with respect to their justiciability, the Irish Human Rights Commission has pronounced that there is a "strong presumption in favour of legal remedies under the CESCR".¹⁸⁵ It also concluded that domestic constitutional impediments are not a defence at the level of international law with respect to the non-performance of a State's treaty obligations.

Article 2(1) of the ICESCR instructs States to take steps "to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the (ICESCR) by all appropriate means, including particularly the adoption of legislative measures ..."¹⁸⁶ This does not mean that rights must always be legally enforceable, so long as they are otherwise protected. The UN instructs: "A State party seeking to justify its failure to provide any domestic legal remedies for violations of economic, social and cultural rights would need to show either that such remedies are not 'appropriate means' within the terms of article 2, paragraph 1, of the (ICESCR) or that, in view of the other means used, they are unnecessary".¹⁸⁷ It cautions however: "It will be difficult to show this and the Committee considers that, in many cases, the other means used could be rendered ineffective if they are not reinforced or complemented by judicial remedies." This has evidently not been the case in Ireland in relation to the right to the highest attainable standard of mental health enshrined in Article 12 of the ICESCR, making the case for comprehensive mental health legislation a solid one.

Stigma

Stigma may act as a barrier to the utilisation of available services by people with mental illness. WHO has said: "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."¹⁸⁸ 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. The abovementioned public survey found that current attitudes towards mental illness in Ireland are generally very positive, but "sizeable minorities still retain some negative views about a range of issues affecting those who have had a mental illness. This suggests that public awareness programmes should be stepped up and be targeted toward these sectors of the population."¹⁸⁹

WHO 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."¹⁹⁰ It also 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."¹⁹¹ This is all the more vital in the case of societal groups that may already experience discrimination and negative attitudes.

Conclusion & Recommendations

There is an inextricable link between respect for international human rights standards and a national mental health system. Firstly, failure to respect the wide range of rights of individuals - to physical health, non-discrimination, housing, education or respect for one's culture for example - can have a profound impact on mental health. Secondly, the services available for people with or at risk of mental illness may not live up to the standards demanded in international human rights instruments and thus fail to comply with human rights law. Also, the processes through which planning and decision-making are conducted around mental health may not comply with the right to self-determination and participation, particularly in the case of those less visible or well-represented communities.

WHO advises States to take serious and meaningful action on mental health. It has laid down 'Three Scenarios for Action' according to States' needs and resources in its 2001 annual report.¹⁹² 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 education and awareness campaigns to educate the public about mental illness. In two years of relative prosperity, insufficient action has been taken by the Irish Government on its key recommendations.

Amnesty International does not hold service providers, medical professionals or civil servants accountable - governments alone are bound by international human rights treaties. Service providers are also under strain: while, despite resource constraints, "services have continued to develop and innovate, due in no small part to the dedication of the people who work in the mental health services", as the Mental Health Commission has noted, "the decrease (in mental health funding)... coupled with continued demands to provide high quality services, can demoralise staff".¹⁹³

Amnesty International strives to protect the rights of the marginalised throughout the world. The message of this report and campaign is that human rights apply to Ireland too. Amnesty International hopes that the rights-based approach, based on the principle that people with mental illness have a right to an appropriate and equitable service,

and that the Government has a duty to provide it, will further empower service users and providers in demanding that their individual needs be met. It is heartening to see that, in a recent public survey, 98 per cent of those polled believed that society has a responsibility to provide the best possible care for people with mental illness.

Recommendations

- The mental health policy update begun by the Department of Health and Children must address the needs, and ensure that its consultative process allows for the full participation of marginalised communities and their representative organisations, as should other areas of mainstream policy-making where they have not traditionally been involved.
- Disaggregated data collection and research is required to support policy on the mental health of marginalised groups and to measure the effectiveness of responses.
- Awareness-raising, training and staff supports are required regarding the needs of marginalised or vulnerable groups, and should be incorporated into all relevant public and mental health services.
- Effective action should be taken on all relevant recommendations made in the reports of the Equality Authority, the NESF, the National Council on Ageing and Older People, and other reports endorsed in this report.
- A comprehensive system of personal advocacy and an effective complaints procedure are required, to ensure that marginalised people with or at risk of mental illness are assisted in exercising the full range of their rights.
- A public education and awareness campaign to counter the stigma of mental illness, emphasising the rights of people in marginalised communities.
- Rights-based disability and mental health legislation should be enacted to give full effect to Ireland's international human rights obligations, with due regard to its obligation to enable persons in marginalised communities to exercise their rights on an equal basis with other citizens.

Endnotes

¹ 'Mental Illness: the Neglected Quarter', Amnesty International (Irish Section), Dublin (2003). Reports and information on the campaign are also available at www.amnesty.ie

² Adopted by General Assembly Resolution 46/119, 46 U.N. GAOR Supp. (No. 49) Annex at 188-192, U.N. Doc.A/46/49 (1991). 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. In this report, Amnesty International refers to the MI Principles while recognising that they do not enjoy universal support. It has been suggested 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, by endorsing medical explanations and treatments for 'mental illness'; by referring to the medical term 'patient' throughout, and because medication is the only type of treatment specified. The latter has the whole of Principle 10 dedicated to it. These Principles have however, been utilised by international nongovernmental organisations in their assessment of the mental health systems of a number of countries.

³ Although the MI Principles are a General Assembly Resolution and therefore not legally binding, General Comment No. 5, 'Persons with Disabilities', was adopted by the UN CESCR on 9 December 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.

⁴ CESCR, General Comment No 14 'The right to the highest attainable standard of health', UN ESCOR, 2000, UN Doc No E/C, 12/2000/4.

⁵ Ibid.

⁶ Rule 15. Adopted by General Assembly Resolution 48/96 in 1993.

⁷ 'Mental Health: New Understanding, New Hope', WHO, Geneva (2001).

⁸ Report of the UN High Commissioner for Human Rights to the Economic and Social Council, UN Doc. No. E/2001/64 at para 48.

¹⁰ (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). 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.)

- ¹¹ Adopted by General Assembly Resolution 48/96 in 1993.
- ¹² 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).
- ¹³ Rule 15 of the UN Standard Rules, note 8 above.
- ¹⁴ 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).
- ¹⁵ 17 May 2002, UN Doc No E/C.12/1/Add.77.
- ¹⁶ 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.
- ¹⁷ Note 15 above.
- ¹⁸ ‘The Role of Disability Legislation’, www.un.org/esa/socdev/enable/disovlf.htm.
- ¹⁹ Report of the United Nations Consultative Expert Group Meeting on International Norms and Standards relating to Disability, note 5 above.
- ²⁰ Note 62 below.
- ²¹ Keogh Dr F, ‘Developments and Challenges in Mental Health Services in Ireland’,

‘Mental Health Commission Annual Report: 2002’, Mental Health Commission, Dublin (2003).

- ²² Concluding Observations on Ireland’s periodic report, E/C.12/1/Add.77, 17 May 2002.
- ²³ Note 21 above.
- ²⁴ 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 20 to 28 May 2002, CPT/Inf (2003) 36, Publication Date: 18 September 2003.
- ²⁵ In all three establishments visited, the CPT found no signs of overmedication, medical records were detailed, precise and easily readable, and medical confidentiality was being respected.
- ²⁶ ‘Quality and Fairness: A Health System for You, Health Strategy 2002 – A Year On, The lack of implementation of the Health Strategy on Mental Health’, Irish College of Psychiatrists (2003).
- ²⁷ du Feu M & Fergusson K, ‘Sensory impairment and mental health’, *Advan Psychiatr Treat*, March 1, 2003; 9(2): 95 - 103.
- ²⁸ Conama JB & Grehan C, ‘Is There Poverty in the Deaf Community’, *Irish Deaf Society* (2002).
- ²⁹ Personal communication to Amnesty International, November 2003.
- ³⁰ ‘Active Ageing, A Policy Framework’, WHO/NMH/NPH/02.8, World Health Organization, Geneva (2002).
- ³¹ ‘Census of Population 2002 - Principal Demographic Results’, Central Statistics Office (2003).
- ³² ‘Population and Labour Force Projections, 2001-2031’, Central Statistics Office (1999).
- ³³ Note 30 above.
- ³⁴ Ibid.
- ³⁵ International Plan of Action on Ageing, adopted by General Assembly Res. No. 37/51.
- ³⁶ By General Assembly Res. No. 37/51.
- ³⁷ By General Assembly Res. No. 46/91.
- ³⁸ Note 7 above.
- ³⁹ Keogh F & Roche A, ‘Mental Disorders in Older Irish People: Incidence, Prevalence and Treatment’, National Council for the Elderly, Dublin (1996).
- ⁴⁰ Note 48 below.
- ⁴¹ Daly A & Walsh D, *Activities of Irish Psychiatric Services 2001*, Health Research Board (2003).
- ⁴² ‘Mental Disorders, Ageing In Ireland Fact File No. 8’, National Council on Ageing and Older People (2001).
- ⁴³ Ibid.
- ⁴⁴ Note 35 above.
- ⁴⁵ Layte R, Fahey T & Whelan C, ‘Income, Deprivation and Well-Being Among Older Irish People’, National Council on Ageing and Older People, Dublin (1999).
- ⁴⁶ ‘Council Comments and Recommendations’, Ibid.
- ⁴⁷ Ibid.
- ⁴⁸ Note 79 below.
- ⁴⁹ Garavan R, McGee H & Winder R, “Health and Social Services for Older People”, National Council on Ageing and Older People (2001).
- ⁵⁰ Note 42 above.
- ⁵¹ Note 46 above.
- ⁵² ‘The Years Ahead: A Policy for the Elderly’, Working Party on Services for the Elderly (1988).
- ⁵³ Note 45 above.
- ⁵⁴ Note 46 above.
- ⁵⁵ Note 79 below.
- ⁵⁶ Note 46 above.
- ⁵⁷ Note 42 above.
- ⁵⁸ Note 30 above.
- ⁵⁹ ‘Comments and Recommendations’, appended to ‘Abuse, Neglect and Mistreatment of Older People’, O’Loughlin A & Duggan J, National Council on Ageing and Older People (1998).
- ⁶⁰ Note 21 above.
- ⁶¹ Daly A & Walsh D, ‘Activities of Irish Psychiatric Services 2001’, Health Research Board (2003).

⁶² ‘Report of the Inspector of Mental Hospitals for the year ending 31st December 2002’, Department of Health and Children (2003).

- ⁶³ Note 35 above.
- ⁶⁴ ‘Long-stay Care, Ageing In Ireland Fact File No. 7’, National Council on Ageing and Older People (2001).
- ⁶⁵ Note 35 above.
- ⁶⁶ ‘A Framework for Quality in Long-Term Residential Care for Older People in Ireland’, National Council on Ageing and Older People (2000).
- ⁶⁷ ‘Long-Stay Activity Statistics 2002’, Department of Health and Children.
- ⁶⁸ This varied between health boards areas from 4.4 per cent in the Southern Health Board and 8.6 per cent in the North-Western.
- ⁶⁹ ‘Home From Home? The Views of Residents on Social Gain and Quality of Life. A Study in Three Care Centres for Older People’, Age & Opportunity (2003).
- ⁷⁰ Clarke B & McCormack P, ‘Prescribing Practices in an Irish Long Term Care Setting’, *Ir Med J*, 2003 Jul-Aug. 96(7):203-7.
- ⁷¹ Note 59 above.
- ⁷² Note 175 below.
- ⁷³ Note 79 below.
- ⁷⁴ Note 35 above.
- ⁷⁵ Note 52 above.
- ⁷⁶ In succession to the National Council for the Elderly (January 1990 to March 1997) and the National Council for the Aged (June 1981 to January 1990)
- ⁷⁷ Ruddle H, Donohue F & Mulvihill R, ‘The Years Ahead Report: A Review of the Implementation of its Recommendations’, National Council on Ageing and Older People (1997).
- ⁷⁸ Discrimination on the ground of age is prohibited under the Employment Equality Act, 1998, in relation to access to and conditions of employment, and the Equal Status Act, 2000, in relation to the provision of goods, services and facilities.

- ⁷⁹ 'Implementing Equality for Older People in Ireland', Equality Authority (2002). The strategy pertains to the wider age-group of people aged 50 and over "because it is the age at which positive action may be taken under the provisions of the Employment Equality Act, 1998".
- ⁸⁰ 'Quality of Life', World Health Organisation Regional Office for Europe, at www.who.dk/ageing/Quality/20020710_1
- ⁸¹ For a more extensive critique of the legal status and capacity of older people in Ireland's Constitution and legislation, see 'Consultation Paper on Law and the Elderly' (LRC CP – 2003), The Law Reform Commission (2003).
- ⁸² 'Equality Policies for Older People: Implementation Issues', National Economic and Social Forum (2003).
- ⁸³ Note 85 above.
- ⁸⁴ 'Implementing Equality for Lesbian, Gays and Bisexuals' (2002).
- ⁸⁵ 'Equality Policies for Lesbian, Gay and Bisexual People: Implementation Issues', National Economic and Social Forum (2003).
- ⁸⁶ Halman L, 'The European Values Study: A Third Wave', Source book of the 1999/2000 European Values Study Survey. The Netherlands: WORC Tilburg University (2001).
- ⁸⁷ 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."
- ⁸⁸ 'Submission from The Irish Psychiatric Association to The National Action Plan against Racism Consultation', 27th September 2002.
- ⁸⁹ 'Implementing Equality for Older People in Ireland', note 79 above.
- ⁹⁰ 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 Heron et al, 'The Psychosocial Health of Irish Traveller Mothers', MacLachlan M, O'Connell M (eds), Cultivating pluralism: Psychological, Social and Cultural perspectives on a changing Ireland, Oak Tree Press, (2000).
- ⁹¹ Linehan S, Duffy D, O'Neill H, O'Neill C & Kennedy H G, Irish Travellers and forensic mental health', *Ir. J. Psych. Med.* 2002; 19(3).
- ⁹² See Chapter 6.
- ⁹³ Traveller Accommodation Unit, Department of Environment and Local Government, Dublin (1999).
- ⁹⁴ 'Irish Travellers and forensic mental health', note 91 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."
- ⁹⁵ "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.*
- ⁹⁶ 'Implementing Equality for Older People in Ireland', note 79 above.
- ⁹⁷ Personal communication to Amnesty International, November 2003.
- ⁹⁸ Kelly B D, 'Mental health and human rights: challenges for a new millennium', *Editorial, Ir J Psych Med* 2001; 18(4): 114 – 115 at 114.
- ⁹⁹ 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.)
- ¹⁰⁰ 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.
- ¹⁰¹ Collins A, 'The Needs of Asylum Seekers in Cork', NASC, The Irish Immigrant Support Centre (2002).
- ¹⁰² 'Health in Prison' Project, www.hipp-europe.org/background/0020.
- ¹⁰³ 'Irish Prison Service: Annual Report 2002', published in 2003, gave an average daily number of 3165 prisoners for the year 2002.
- ¹⁰⁴ 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.)
- ¹⁰⁵ 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.
- ¹⁰⁶ 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.
- ¹⁰⁷ '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.
- ¹⁰⁸ 'Serious mental disorder in 23 000 prisoners: a systematic review of 62 surveys', Fazel S & Danesh J, *Lancet* 2002; 359: 545-50.
- ¹⁰⁹ In a letter to the Irish Penal Reform Trust dated 11 December 2002.
- ¹¹⁰ 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.
- ¹¹¹ 'First Annual Report of the Inspector of Prisons and Places of Detention', Department of Justice, Equality and Law Reform (2003).
- ¹¹² The above *Lancet* study, note 108 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.
- ¹¹³ Adopted by General Assembly Resolution 45/111, annex, 45 U.N. GAOR Supp. (No. 49A) at 200, U.N. Doc. A/45/49 (1990).

- ¹¹⁴ 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."
- ¹¹⁵ "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."
- ¹¹⁶ 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.
- ¹¹⁷ Adopted by General Assembly Resolution 46/119 of 17 December 1991.
- ¹¹⁸ 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."

- ¹¹⁹ 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.
- ¹²⁰ www.hipp-europe.org/background/0020
- ¹²¹ 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.
- ¹²² 'Report of the Group to Review the Structure and Organisation of Prison Health Care Services' (2001). 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.
- ¹²³ 'Submission to the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)' (2002).

¹²⁴ 'Report of the Inspector of Mental Hospitals for the year ending 31st December 2001', Department of Health and Children, Government Publications Sales Office, (2002).

- ¹²⁵ Note 24 above.
- ¹²⁶ 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.
- ¹²⁷ Note 122 above.
- ¹²⁸ The nongovernmental 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. Bresnihan Dr V, 'The Politics of Prison Medicine', Irish Penal Reform Trust (2002).
- ¹²⁹ Note 122 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".
- ¹³⁰ 'Schizophrenia Ireland's Response to the Inspector of Mental Hospitals Report 2001' (2002).
- ¹³¹ Note 106 above.
- ¹³² Note 5 above.
- ¹³³ 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."

- ¹³⁴ 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."
- ¹³⁵ 'Out of Sight, Out of Mind: Solitary Confinement of Mentally Ill Prisoners', Bresnihan Dr V, IPRT (2001).
- ¹³⁶ Dated 11 December 2002.
- ¹³⁷ Ibid.
- ¹³⁸ Bresnihan Dr V, 'To be or not to be, in observation cells? A discussion paper on the introduction of observation cells for mentally ill and suicidal prisoners', IPRT (2003).
- ¹³⁹ Hickey C, 'Crime and Homelessness', Focus Ireland & PACE, Dublin (2002).
- ¹⁴⁰ The report suggests: "Inclusion of prisoners who are homeless in homeless statistics is essential so as to provide a clearer picture of both the homeless and prisoner populations for planning purposes."
- ¹⁴¹ O'Mahoney P, 'Crime and Punishment in Ireland', Roundhall, Dublin, (1993) and O'Mahoney P, 'Mountjoy Prison: A Sociological and Criminological Profile', Stationery Office, Dublin (1997).
- ¹⁴² Prisoners and Homelessness, PACE, Dublin, (2002), unpublished and conducted for internal information purposes.
- ¹⁴³ "The criminal behaviour of those who are homeless is often characterised by the survivalist nature of the crimes they commit e.g. begging, shop lifting and other types of larceny and by crime carried out to escape the physical reality of homelessness e.g. drug and alcohol related offences."

International literature identified in this report indicates a very high level of arrest and imprisonment of homeless people. It is not known if homeless offenders are more likely to be sent to prison than offenders with homes for the commission of the same crime, but the report's author suggests that this might merit further study.

- ¹⁴⁴ See Chapter 5 for a discussion on the mental health care needs of the Travelling community and other ethnic minorities more generally.
- ¹⁴⁵ '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).
- ¹⁴⁶ Ibid.
- ¹⁴⁷ Murphy M, Harrold Dr M, Carey Dr S, Mulrooney M, Department of Justice, Equality and Law Reform, 6 August 1999.
- ¹⁴⁸ 'Response to The Prison Health Care Review Group'.
- ¹⁴⁹ Note 110 above.
- ¹⁵⁰ Ibid.
- ¹⁵¹ "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."

¹⁵² Concluding observations of the Human Rights Committee: Ireland, 24/07/2000, A/55/40.

¹⁵³ Note 24 above.

- ¹⁵⁴ 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.
- ¹⁵⁵ Principle 20(3).
- ¹⁵⁶ 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.)
- ¹⁵⁷ Note 122 above.
- ¹⁵⁸ 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.

- ¹⁵⁹ Keogh F, Roche A & Walsh W, 'We Have No Beds: An Enquiry into the Availability and Use of Acute Psychiatric Beds in the Eastern Health Board Region', Health Research Board, Department of Health and Children (1999).
- ¹⁶⁰ Pierce M, 'Minority Ethnic People in Ireland', Equality Authority (2003).
- ¹⁶¹ 'National Traveller Health Strategy', Department of Health and Children (2002).
- ¹⁶² 'Submission to the Department of Justice, Equality and Law Reform on the Criminal Law (Insanity) Bill 2002', National Disability Authority (2003).

- ¹⁶³ Note 21 above.
- ¹⁶⁴ Note 7 above.
- ¹⁶⁵ 'Attitudes to Mental Illness', Millward Brown IMS, on behalf of Mental Health Ireland (2003).
- ¹⁶⁶ Note 22 above.
- ¹⁶⁷ Chairman's Statement, 'Mental Health Commission Annual Report: 2002', Mental Health Commission (2003).
- ¹⁶⁸ 'The Stark Facts: The Need for a National Mental Health Strategy, as well as Resources', Irish Psychiatric Association (2003).
- ¹⁶⁹ 'Health Service Reform Programme', Department of Health and Children (2003).
- ¹⁷⁰ 'Mental Health Financing', in 'Mental Health Policy and Service Guidance Package', WHO (unpublished at the time of writing).
- ¹⁷¹ While the Act is not yet in force, the Minister for Health and Children signed a commencement order enacting from 5 April 2002 sections of the Act establishing the Commission, and providing for the appointment of the Inspector of Mental Health Services. Further information on the Commission and the Act is available at www.mhcirl.ie
- ¹⁷² Note 167 above.
- ¹⁷³ Kelly Dr B, 'The Mental Health Act 2001', Irish Medical Journal, May 2002, Volume 95 No 5.
- ¹⁷⁴ Note 168 above.
- ¹⁷⁵ 'Quality and Fairness: A Health System for You', Department of Health and Children (2001).
- ¹⁷⁶ Press Release: 'Minister announces formation of Expert Group on Mental Health Policy', 4 August 2003, Government Press Office.
- ¹⁷⁷ 'Submission to the Department of Health and Children and the Expert Group on the Proposed Mental Health Policy Update', July 2003.
- ¹⁷⁸ 'Investing in Recovery: Pre-Budget 2004 Submission' (2003).
- ¹⁷⁹ Bruce A, 'Social Inclusion & Mental Illness', Schizophrenia Ireland (2000).
- ¹⁸⁰ Note 178 above.
- ¹⁸¹ 'Advocacy for Mental Health'.
- ¹⁸² Rule 15 of the UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities.
- ¹⁸³ Note 7 above.
- ¹⁸⁴ In 'Confronting the rhetoric of rights', Insight June 2003 (Rehab publication).
- ¹⁸⁵ 'Observations on the proposals Paper of the Disability Legislation Consultation Group (DLGC), From the Perspective of the International Covenant on Economic, Social and Cultural Rights', Irish Human Rights Commission (2003).
- ¹⁸⁶ Emphasis added.
- ¹⁸⁷ CESCR General comment 9, 'The domestic application of the Covenant', E/C.12/1998/24, 3 December 1998.
- ¹⁸⁸ 'The World Health Report 2001: Mental Disorders Affect One In Four People, Treatment available but not being used', WHO Press Release, WHO/42.
- ¹⁸⁹ Note 165 above.
- ¹⁹⁰ Note 7 above.
- ¹⁹¹ Ibid.
- ¹⁹² Note 7 above.
- ¹⁹³ Note 167 above.
- ¹⁹⁴ Note 21 above.





mental illness

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THE NEGLECTED QUARTER