



mental illness THE NEGLECTED QUARTER

Amnesty International

mental illness  
**THE NEGLECTED QUARTER**

promoting the rights of the one in four  
Irish people affected by mental illness



Amnesty International

S U M M A R Y   R E P O R T

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This is a summary of a report entitled  
'Mental Illness: The Neglected Quarter'.  
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## Preface

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

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

Here in Ireland we have known about the problems in the mental health care area for many years. What is most striking is the extent to which reviews, reports and strategies have never been adequately or comprehensively implemented. That is why Amnesty International is adding our campaigning voice to all those who have been fighting this cause for so long.

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

I recall what Gabor Gombos, the Hungarian mental health rights activist, says: *"I remind myself that many of the mistakes in mental health care come from a helping attitude. But they want to help you without asking you, without understanding you, without involving you, 'in your best interest.'"*

Seán Love

Director, Amnesty International (Irish Section)

# Introduction

*“One in four people in the world will be affected by mental or neurological disorders at some point in their lives. Around 450 million people currently suffer from such conditions, placing mental disorders among the leading causes of ill-health and disability worldwide. Treatments are available, but nearly two-thirds of people with a known mental disorder never seek help from a health professional. Stigma discrimination and neglect prevent care and treatment from reaching people with mental disorders. . . . Where there is neglect, there is little or no understanding. Where there is no understanding, there is neglect.”*

World Health Organisation Press Release, 28 September 2001<sup>1</sup>

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

Much progress has, of course, been achieved in the Irish mental health services in recent years. For centuries, in Ireland as throughout much of the world, people with mental illness were separated from the rest of society and placed for long periods in large institutions with little or no treatment, or worse, with radical and dangerous therapies applied to them. Today, the situation in Ireland has improved with a shift towards community-based care, and greater protection for those in institutions.

Despite significant efforts, Irish mental health care policy and service provision remain out of step with international best practice and, as such, fail to fully comply with international human rights law. In this report, Amnesty International will outline some criticisms of the treatment in Ireland of people with mental illness, and measure them against international human rights standards. Ultimate responsibility for compliance with international law lies with the government, not with individual government departments, health boards, civil servants or service providers. In most countries of the world, the level of care still falls far short of full respect for the human rights of people

with mental illness. It is no answer to these shortcomings, however, to say that all countries appear to be failing equally in their duty towards people with mental illness. Fundamental human rights are inalienable and must be respected no matter what the international state of play.

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

In any discussion on the Irish mental health care system, the first thing to note must be the dedication of the many thousands of people caring for people with mental illness throughout the country: psychiatrists, psychiatric nurses, care workers, social workers, psychologists and other specialists, hospital administrators, health board workers, and civil servants in the Department of Health and Children, who are serious in their desire to ensure the best possible service is provided. This can be a difficult and thankless task. Amnesty International hopes to highlight difficulties they are faced with every day, and thereby contribute to the development of a better working environment.

Amnesty International also acknowledges the work of other countless thousands who, in different ways, must cope with the effects of any deficiencies in the mental health care system: members of families, carers, GPs, members of voluntary organisations, and many others. Above all, Amnesty International pays tribute to people with mental illness themselves: many service users have driven the agenda for change, and many improvements that have taken place have been achieved by the work of groups such as the Irish Advocacy Network. Many voluntary groups such as GROW and Aware provide much needed support and assistance to their fellow service users and others have stepped into the breach to fill needs that the government has failed to do, such as the provision of sheltered housing.

## Methodology

From May to October 2002, Amnesty International conducted a wide-ranging review of how the rights of people with mental illness are respected in Ireland: the legal

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

## Mental Health Act, 2001

In 2001, the new Mental Health Act was passed, but, to the disappointment of many, in a form far short of what the original White and Green Papers promised, in that it obliges the Irish authorities only to ensure that the involuntary detention of psychiatric in-patients in 'approved centres' is reviewed for legality after a certain period, and take specified action in the event of illegal detention; it does not lay down minimum standards of treatment or care, nor any procedures for their monitoring, for example. At the time of writing, the Act is not yet in force, so it is difficult to predict how it will operate in practice. Meanwhile, Ireland's treatment of the involuntarily detained continues to be governed by an antiquated set of laws which, the government has conceded, fail to meet the requirements of international law. When the Act comes into force, there are concerns that it may not prove as effective as it should be with regard to this function, particularly given the traditional under-resourcing in this sector.

However, of major significance in the Mental Health Act is the establishment, with effect from 5 April 2002, of a statutorily independent Mental Health Commission, which, in addition to establishing tribunals to review the legality of involuntary psychiatric admissions and detentions, has the statutory duty to promote, encourage and foster

the establishment and maintenance of high standards and good practices in the delivery of mental health services in Ireland. Amnesty International is heartened by recent public statements by its Chair, Dr John Owens,<sup>2</sup> indicating that the Commission will make full use of this power to ensure, insofar as it can, that best practice is respected and the best available mental health care afforded to people with mental illness in Ireland.

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

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MI Principle 1

## Introduction

Ireland has responsibilities towards everyone in its jurisdiction under international law. These international obligations exist in addition to those in Ireland’s domestic law and 1937 Constitution, and where there is a conflict, at the international level, international law is superior. Even if international standards are not expressly reflected in domestic law, they are binding on states once ratified. Each general international human rights instrument protects the rights of persons with mental illness through the principles of equality and non-discrimination, and more specific standards exist in relation to people with mental illness.

## The United Nations and Mental Illness

The primary source of international human rights under the United Nations (UN) system is the Universal Declaration of Human Rights (UDHR), which encompasses civil, political, economic, social and cultural rights. Civil and political rights, such as the right to liberty, to a fair trial, and to vote, were subsequently laid down in an internationally binding treaty, the International Covenant on Civil and Political Rights (ICCPR), and a committee of experts established to oversee its implementation in national jurisdictions, the UN Human Rights Committee (HRC). Economic, social and cultural rights, such as the rights to an adequate standard of living, the highest attainable standard of physical and mental health, and to education, were laid down in a second binding treaty, the International Covenant on Economic, Social and Cultural Rights (ICESCR), with a similar supervisory committee established, the UN Committee on Economic, Social and Cultural Rights (CESCR). These UN committees are supported by the UN High Commissioner for Human Rights (UNHCHR), which also issues comments that are instructive.

Other treaties are of relevance; the UN Convention on the Rights of the Child (CRC), for example, carries certain additional obligations in respect of children.

Ireland has ratified both the ICCPR and the ICESCR, and is consequently obliged under international law to guarantee to every person on its territory, without discrimination, all the rights enshrined in both.<sup>3</sup> Regarding what is required of states in implementing the ICESCR, the CESCR says:

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*“The obligation of States parties to the Covenant to promote progressive realisation of the relevant rights to the maximum of their available resources clearly requires Governments to do much more than merely abstain from taking measures which might have a negative impact on persons with disabilities. The obligation in the case of such a vulnerable and disadvantaged group is to take positive action to reduce structural disadvantages and to give appropriate preferential treatment to people with disabilities in order to achieve the objectives of full participation and equality within society for all persons with disabilities. This almost invariably means that additional resources will need to be made available for this purpose and that a wide range of specially tailored measures will be required.”<sup>4</sup>*

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The UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (the MI Principles)<sup>5</sup> were adopted in 1991, 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 ICESCR. Many of the rights in both the ICCPR and the ICESCR are further explained in other secondary UN instruments, such as:

- Standard Rules on the Equalisation of Opportunities for Persons with Disabilities<sup>6</sup>
- Declaration on the Rights of Mentally Retarded Persons<sup>7</sup>
- Declaration on the Rights of Disabled Persons<sup>8</sup>
- UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment<sup>9</sup>

## The Right to Mental Health

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

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

## Council of Europe

In addition to the UN mechanisms outlined above, Ireland is bound by certain human rights principles laid down by the Council of Europe, a regional system of international human rights law comprising 43 Member States throughout Europe. Chief amongst the Council of Europe’s treaties is the 1950 European Convention on Human Rights and Fundamental Freedoms (ECHR). Another is the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, which pertains specifically to places of detention. It has an expert committee, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), which visits States Parties to the Convention on both periodic and ad hoc bases to review their compliance with Article 3 of the ECHR in relation to those held under any form of detention.<sup>10</sup>

## WHO

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

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*“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.”*

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UN High Commissioner for Human Rights<sup>11</sup>

## Introduction

Ireland’s treatment of people with mental illness is part of a wider pattern of discrimination against people with disabilities. Amnesty International uses the term *‘persons with disabilities’* in accordance with contemporary UN usage, which 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”*.<sup>12</sup>

Ireland’s treatment in general of people with disabilities is often at variance with international standards. The UN Committee on Economic, Social and Cultural Rights (CESCR), in its 2002 Concluding Observations on Ireland’s second periodic report,<sup>13</sup> was very critical of Ireland’s treatment of people with disabilities; it remarked on the *“persistence of discrimination against persons with physical and mental disabilities, especially in the fields of employment, social security benefits, education and health”*, and expressed concern that *“the principles of non-discrimination and equal access to health facilities and services was not embodied in the recently published National Health Strategy”*. The UN Human Rights Committee (HRC) recommended *“that further action be taken [by Ireland] to ensure full implementation of the [ICCPR] in... [e]nsuring the full and equal enjoyment of Covenant rights by disabled persons, without discrimination, in accordance with article 26”*.<sup>14</sup>

## International Standards

A number of international disability instruments elaborate what is expected of states in their treatment of people with mental illness. Article 3 of the UN Declaration on the Rights of Disabled Persons<sup>15</sup> states:

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

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The UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (1993)<sup>16</sup> offers guidance on national legislation and policy-making:

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*“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.”<sup>17</sup>*

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Work on a new UN convention on the rights of people with disabilities is currently in progress, which, when complete, offers new hope for the advancement of the rights of people with mental illness in Ireland. Amnesty International hopes that the Irish government will ensure that this convention, which Ireland has been championing at the UN, is quickly adopted, and will ratify and incorporate it into Irish law as soon as possible thereafter.

## Irish Legislation

Enhanced protection for people with mental illness is offered in recent Irish equality legislation,<sup>18</sup> which prohibits discrimination in employment, and access to goods and services, on certain grounds including the ground of disability, the definition of which encompasses mental illness. While this equality legislation is welcome, it does not fully implement the non-discrimination requirements of international human rights law.<sup>19</sup> More legislation is needed to afford full protection to all the rights of people with disabilities, including mental illness. For instance, the CESCR, in its 2002 Concluding Comments on Ireland's second report, has advised the Irish government to *"enact legislation that extends the constitutional right to free primary education to all adults with special educational needs"*. Amnesty International urges Ireland to take immediate action on this recommendation, and to provide a full range of statutory disability rights, with due regard to the rights of *"[d]isabled persons ... to have their special needs taken into consideration at all stages of economic and social planning"*.<sup>20</sup>

The Department of Justice, Equality and Law Reform published a Disability Bill in 2001,<sup>21</sup> 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"*. The Irish Department of Finance had successfully prevailed on the government to introduce this clause stating:

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*"The Department of Finance cannot accept these recommendations which imply the underpinning by law of access to and provision of services for people with disabilities as a right. This right, if given a statutory basis, would be prohibitively expensive for the Exchequer and could lead to requests from other persons seeking access to health and other services without regard to the eventual cost of providing these services."*<sup>22</sup>

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

The Bill was abandoned in 2002, and another is currently in preparation, with a new consultation process begun. What sort of legislative proposal will emerge from this process is quite uncertain in relation to its respect for human rights standards, but clearly, any revived Bill must not again seek to qualify equal rights for people with disabilities.

## Conclusions & Recommendations

2003 has been designated European Year of People with Disabilities by the European Union, and it is hoped that the Irish government will take this opportunity to address the many deficiencies in its national system for the protection of disability rights.

The challenge for Ireland is to shape its policies and laws around evolving international standards, norms and best practice, not to formulate them by reference to past behaviour. In furthering the advancement of the rights of persons with disabilities in Ireland, it is imperative that full participation of people with disabilities is involved.

Amnesty International particularly urges the Irish Government to:

- *Immediately begin the process of adopting new disability legislation in line with UN recommendations, taking an expansive, rights-based approach, and refraining from inserting a similar clause as that in the Disability Bill, 2001, purporting to deny people with disabilities the right to judicial redress.*
- *Take immediate and effective action on each of the CESCR's 2002 recommendations.*

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

World Health Organisation<sup>23</sup>

## International Standards

Principle 1 of the MI Principles, outlined in Chapter 1, lays down the overarching standard expected of all nations to be in full compliance with the International Covenant on Economic Social and Cultural Rights (ICESCR): *"All persons have the right to the best available mental health care..."*. MI Principle 7(1) provides: *"Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives."* MI Principle 9(1) states: *"Every patient shall have the right to be treated in the least restrictive environment..."*.

Ireland is also obliged to secure *"the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country"*.<sup>24</sup>

## Situation in Ireland

There have been significant Irish advances in the provision of community psychiatry nursing services, community residences, day hospitals and daycare centres, voluntary

nursing associations and other rehabilitation facilities. Particularly since the publication of the government strategy, 'Planning for the Future',<sup>25</sup> in 1984, there has been continued growth of community-based facilities, alongside the provision of acute psychiatric units attached to or associated with general hospitals, to replace services previously provided in large psychiatric hospitals throughout the country. Patients are increasingly being cared for in settings other than in-patient care. Funding has also been made available to support groups and organisations such as Schizophrenia Ireland, Mental Health Ireland, GROW and AWARE to heighten awareness and develop services such as carers' support groups.

Yet, it must be acknowledged that there remain many serious deficiencies in Ireland's mental health care system. The consequences can impact severely on the quality of life for people with mental illness, ultimately amounting to a lack of respect for basic human rights.

### De-institutionalisation

The number of people in psychiatric hospitals in Ireland at any one time has plummeted over the decades: in 1958, there were 21,075 in-patients in public psychiatric hospitals compared with about 4,500 at present. *"This reduction in in-patient psychiatric beds was largely due to the death of long-stay patients, and to a lesser extent to the community resettlement of long-stay patients..."*<sup>26</sup> In the 1980s, de-institutionalisation occurred, with a move from placing people in large psychiatric hospitals towards a more community-based model of service provision. However, this process has met with some difficulties, with sufficient resources not made available to ease the transition to community care. A press release announcing the 2001 Health Research Board (HRB) psychiatric hospitals and units census<sup>27</sup> noted:

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*"The number of admissions to psychiatric hospitals and units has changed little over the last twenty years according to HRB databases. In all there were 24,282 admissions in the year 2000 ... and 70% of these were re-admission. This exemplifies both the enduring or recurrent nature of much major mental illness and the need for a greater expansion of community based alternatives to long stay hospital care. . . ."*<sup>28</sup>

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The fact therefore that the number currently in in-patient care in Ireland has fallen so dramatically does not mean that mental health care is being adequately provided elsewhere.

The 2001 annual WHO report says, *“a sound deinstitutionalisation process has three essential components:*

- *Prevention of inappropriate mental hospital admissions through the provision of community facilities;*
- *Discharge to the community of long-term institutional patients who have received adequate preparation;*
- *Establishment and maintenance of community support systems for non-institutionalised patients.”<sup>29</sup>*

De-institutionalisation in Ireland has failed to live up to this standard. Ireland still has excessively high admission rates to psychiatric hospitals, both voluntary and involuntary, due in large part to a lack of community-based alternatives. Conversely, there is a shortage of acute hospital beds for those in need of emergency admission due to inappropriate non-acute admissions – i.e. where people who do not require emergency in-patient care are nevertheless admitted to hospital – because of a lack of appropriate services for a range of needs. Rather than being well-coordinated and methodical, Ireland’s de-institutionalisation policy and practice has been uncoordinated, piecemeal and ad hoc.

## Community care

The WHO 2001 annual report provides a detailed account of international best practice in the planning and delivery of mental health care, and lays down a comprehensive package of recommendations for states to implement. It promotes community-based care as a first recourse, and only where admission to hospital is therapeutically necessary should community care be bypassed. Various studies have shown that, while for some, acute in-patient care is essential, a comprehensive community psychiatric service has better results for many people with mental illness than acute hospitalisation. For those not in need of hospitalisation, a community-based service is the *“best available mental health care”*, and an entitlement under international human rights law. This is also a requirement of MI Principles 7 and 9(1). The very high rate of psychiatric in-patient admission in Ireland – currently 75 per 100,000 of total population, compared to a rate of 49 per 100,000 for England and Wales and 26 per 100,000 for Italy – suggests a failure to respect the rights of many. There are also wide divergences in the admission rates between the health board regions, which, the 2001 HRB Census said, *“point to*

*the uneven pace of development between Health Boards, and indicate the necessity of continuing scrutiny of the extent and quality of community placed alternatives to what was formally an extensive system of institutional care”.*

The 1984 strategy, ‘Planning for the Future’, lists seven essential components of community care,<sup>30</sup> which are broadly similar to the WHO specifications:

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

None of these have been adequately provided in Ireland today.

The psychiatric crisis intervention service has never been put into place, despite plans to do so in the 1984 strategy, to deal with local emergencies. One of the findings of a government report ‘We have no beds’ was: *“Community-based, emergency out-reach, 24 hour, seven-day-week, crisis intervention services were generally unavailable.”*<sup>31</sup> While this report refers to the then Eastern Health Board area, the same is true of much of the rest of the service. The result is that at weekends and at night many people are inappropriately admitted instead to acute psychiatric units.

There is a shortage of suitable community-based residential facilities and hostels right throughout the mental health service. The Report of the Inspector of Mental Hospitals for 2001<sup>31</sup> also observes that the development of community-based accommodation is somewhat uneven throughout the country.

The severe lack of rehabilitation and occupational therapy for people with mental illness both in in-patient care and in the community risks irreparably compromising their recovery, and is inconsistent with many of the rights in the ICESCR. The Inspector of Mental Hospitals referred to the distinct lack of rehabilitation services in his report for 2000, an assertion that remains valid today.

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

- Drug and Alcohol Services
- Psychiatry for Older Persons
- Asylum Seekers and Refugees
- Travellers and other Ethnic Minorities
- People with Hearing Impairments

## Conclusions

Amnesty International is concerned that the widespread inadequate provision of community-based mental health services breaches MI Principles 3 and 7(1), and thus is inconsistent with Ireland’s obligations under the ICESCR. It will be outlined in Chapter 9 how many of the deficiencies are due to insufficient funding, while others are due to poor service planning – often it is a combination of both. Unfortunately, many people with mental illness are not 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”*.<sup>33</sup> Consequently, Ireland is obliged to assist all people with mental illness in doing so, not alone by making services available, but their use accessible. A comprehensive system of personal advocacy for all who need it should be considered to allow this to happen.<sup>34</sup>

## Recommendations

Amnesty International urges the Irish government, as a matter of priority, to:

- Commence a thorough and comprehensive review of mental health care services to ensure that they meet international human rights standards and standards of professional best practice;<sup>35</sup> with due regard to cultural needs, implementing the promises made in the 2001 Health Strategy;<sup>36</sup> and with an emphasis on community-based care, incorporating the recommendations made in the 1999 'We Have No Beds' report and meeting the requirements laid down in Appendix 4 thereof; and, when complete, implement all recommendations promptly and thoroughly.
- Immediately act upon all criticisms and recommendations laid out in the report of the Inspector of Mental Hospitals for 2001, and those in earlier reports still pertinent.
- Take immediate action to provide, until such time as the above review is complete, the complete range of individualised community-based services promised in the 1984 strategy, 'Planning for the Future', finally ensuring that all seven of its target components are met in full.
- Introduce a comprehensive and adequately-resourced system of personal advocacy, to assist people with mental illness to assert their rights in a manner consistent with MI Principles 12(1) and (2).
- Provide a legislative mechanism for people with mental illness to vindicate their right to the best available community mental health care.<sup>37</sup>

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

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European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment<sup>38</sup>

## International Standards

In addition to the right to the highest attainable standard of mental health and to the best available mental health care, people in in-patient psychiatric care have specific rights. Principle 13(2) of the MI Principles<sup>39</sup> states: *“The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age...”*

Additional obligations apply in relation to people involuntarily admitted to, and detained in, psychiatric facilities, such as MI Principles 16 and 17, outlined below; and the UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment,<sup>40</sup> 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.”*

The UN Declaration on the Rights of Mentally Retarded Persons<sup>41</sup> provides additional protection for people with intellectual disabilities in psychiatric in-patient care.

## Situation in Ireland

Many of the issues raised throughout this report relate to both in-patient and out-patient care. In this chapter, Amnesty International highlights concerns and recommendations relating specifically to Irish psychiatric hospitals and units. The primary source of

information on standards and practices in Ireland's psychiatric facilities is the annual report of the Inspector of Mental Hospitals (the Inspector),<sup>42</sup> described by the government as "*an objective account of standards of care and accommodation in the mental health services*".<sup>43</sup>

## In-patient Care

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

For example, the 1999 study of the situation in the then Eastern Health Board (EHB) area, 'We have no beds', found that the lack of community alternatives led directly to the inappropriate occupancy of almost half of the available acute beds by patients not requiring acute hospitalisation.<sup>44</sup> Two-thirds of the patients inappropriately occupying acute beds in the psychiatric service could have been placed elsewhere, had community-based residential facilities been available, the report found. One consequence was "*an increasing number of reports of EHB psychiatric services which had no beds for patients who were acutely ill and who needed hospitalisation*". Another was the emergence of "*a system of borrowing beds for short term purposes from one service by another*", an arrangement described as "*unsatisfactory for patients, representing poor quality of service delivery to acutely ill persons*". It concluded that there was probably a sufficient number of beds for those actually in need of them, but only if more community-based services were provided; if not, more beds were required. In a subsequent government commitment to create 850 new hospital beds,<sup>45</sup> none were in fact allocated to the mental health services; meanwhile only little has advanced in the way of community alternatives to hospitalisation.

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

## Physical conditions

The report of the Inspector for 2001, while noting a number of welcome advances that had been made in addressing many of the more extreme instances observed in previous reports, details a catalogue of substandard hospitals and units, overcrowding and poor living conditions, a failure to comply with MI Principle 13(2). MI Principle 13(1) provides the right to privacy in in-patient care, but the majority of patients interviewed by the Inspectorate complained of a lack of privacy.

## Safety & Quality of Life

The Inspector's report for 2001 highlights the following grave concerns:

- The physical health examination of in-patients, as documented in patients' records, was often infrequent, desultory and superficial in nature. Given that psychiatric patients are known to enjoy poorer health and have higher mortality than the general population, it is particularly important that this be addressed, particularly for long-stay patients in psychiatric hospitals or community residences.
- The occurrence of sudden deaths in psychiatric in-patients due to asphyxia from the inhalation of food or other material, mainly in older patients, reveals a need for *"training of staff in the appropriate procedures in cases of foreign body airway obstruction and the care necessary in feeding many older, feeble patients with poor swallowing capacity"*.
- Suicides among psychiatric patients at a local level are not the subject of any formal audit, and there is a need for *"local services carefully to audit cases of suicide so that lessons may be learned to make risk assessment and management more potent and effective in the future"*.

Amnesty International urges that these matters be immediately addressed.

## Admission and Assessment Policies and Practices

'We Have No Beds' found: *"Not all hospitals [in the EHB area] had written admission and discharge policies. Those that were available were of varying quality. There was little evidence of audit or other monitoring procedures to ensure the effective implementation of these policies."* It also discovered:

- The decision to admit to acute beds was often taken by inexperienced staff, with less than one third made by consultants.

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

Amnesty International urges that action be taken on each of its recommendations that written admission policies be developed, not just for in-patient services, but for all residential and acute services; special attention is paid to pre-admission assessments, preferably in community-based settings<sup>46</sup>, and discharge policies be drawn up, and their implementation monitored.

## Involuntary Admission and Detention

In Ireland, in addition to an excessively high rate of admission to in-patient care generally, the rate of involuntary admission and detention amongst these the report of the Inspector of Mental Hospitals for 2001 deems *“unnecessarily high”*. The Mental Health Act, 2001, will require that all involuntary detentions be automatically and periodically reviewed by mental health tribunals. Because of the workload this will impose on the tribunals, during 2001, the Inspectorate of Mental Hospitals again circulated to all clinical directors of psychiatric facilities a request that their consultants review all patients currently involuntarily detained, particularly long-stay patients, with a view to changing their status from non-voluntary to voluntary where this was appropriate. Amnesty International would like to see this process happen as speedily as possible, particularly given the human rights implications of unnecessarily detaining people against their will. Amnesty International would like to remind the Irish authorities that MI Principle 15(1) provides: *“Where a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission.”*

The 2001 Act was designed to amend the current situation where people with mental illness are detained involuntarily in psychiatric facilities under procedures that fail to safeguard against arbitrary detention, contrary to the requirements of international law. When brought into force, it will ensure that the detention of all people involuntarily admitted to psychiatric facilities will be reviewed after 21 days. Amnesty International

remains concerned that this period may be too long under international standards in relation to the deprivation of liberty.

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

When the Act comes into force, there are concerns that it may not prove as effective as it should be with regard to this function, particularly given the traditional under-resourcing in this sector.<sup>47</sup> For this reason, Amnesty International urges that the fullest assistance and cooperation be extended by the Irish government to the Mental Health Commission.

## Exercise of rights

MI Principle 12(1) provides:

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

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MI Principle 21 states:

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

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Psychiatric patients have a right under Irish legislation to write letters of complaint to the Minister for Health and Children, the President of the High Court, or the Inspector of Mental Hospitals, but there is no statutory procedure for their investigation. Furthermore, the Inspector’s report for 2001 records: *“In many of our interviews with selected patients,*

the majority informed us that they were not fully aware of their rights under the Mental Treatment Act 1945 or amending legislation, or of how to make a complaint if they felt aggrieved.” This amounts to a fundamental failure to fully secure to these patients the rights in the above MI Principles; and indicates the need for a statutory complaints system, for example through the appointment of a Mental Health Ombudsperson.

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

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

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

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

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A comprehensive system of personal advocacy based on patients’ best interests should be provided to all those admitted to in-patient psychiatric care, and especially to those involuntarily detained.

## Juveniles in Psychiatric Institutions

Amnesty International is seriously concerned that Ireland is in breach of Article 20 of the UN Convention on the Rights of the Child by placing children and juvenile offenders in adult psychiatric facilities.<sup>48</sup> All those inappropriately detained in such psychiatric institutions should be removed, and placed in more appropriate accommodation.

## Intellectual Disabilities

In 2002, the UN 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”*. While people with intellectual disabilities remain inappropriately accommodated in psychiatric institutions, Ireland is in violation of human rights law. Amnesty International urges Ireland to promptly comply with the CESCR’s recommendation *“that the State party speed up the process of transferring persons with mental disabilities who are not suffering from serious psychiatric illness and who are still living in psychiatric hospitals, to more appropriate care settings”*.

Many people with intellectual disabilities with a diagnosed mental illness are not accommodated in psychiatric hospitals, but in de-designated former psychiatric units and hospitals, or in privately owned facilities run by voluntary bodies and religious organisations. Even though their admission and detention cannot be said to be voluntary given their lack of capacity, they will not be covered by Mental Health Act when it comes into force, and their places of accommodation will not be subject to monitoring as ‘approved centres’ within its remit, a situation which should be rectified.

## Conclusion & Recommendations

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

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

- Address all deficiencies alluded to in the reports of the Inspector.
- Take immediate action to address the lack of acute psychiatric beds, primarily by providing a complete range of community-based services.

- Amend the 2001 Act 21-day review period in line with international standards.
- Introduce an effective and well-publicised system of complaints in line with international law.
- Establish a comprehensive and adequately resourced system of personal advocacy for psychiatric in-patients to assist them in vindicating their rights.
- End the inappropriate placing of children and juvenile offenders in adult psychiatric facilities.
- Ensure the prompt transfer of persons with intellectual disabilities who are not suffering from serious psychiatric illness and who are still living in psychiatric hospitals, to more appropriate care settings.
- Ensure that the physical health care and treatment of psychiatric in-patients is adequate and that regular monitoring and assessment by medical and other specialists is a standard practice.

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

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MI Principle 9(2)<sup>49</sup>

## International Standards

In addition to MI Principle 9, MI Principle 11 stipulates that no treatment shall be given to a patient without his or her informed consent,<sup>50</sup> and provides exacting standards in relation to the provision of information by the service provider:

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

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

Failure to ensure that proper guidelines are in place in relation to the provision of psychiatric treatment, and are being adhered to, amounts to a failure to comply with these principles.

## Treatment Plans

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

Patient participation in treatment plans is limited: many complain that they rarely have their treatment discussed with them or are provided with written information, which prejudices the right to informed consent to treatment in MI Principle 11.

The 2001 WHO report<sup>51</sup> lists factors that improve medication and treatment compliance, particularly essential in serious mental illness, and that should be observed:

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

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

Patients who attend out-patient clinics are likely to see registrars-in-training, who change every six months, producing a lack of continuity in the doctor-patient relationship, a matter on which Amnesty International has received many complaints. The training plans of the Health Boards should not be allowed to take priority over the wellbeing of patients.

## Range of Therapies

Both within and outside psychiatric facilities, there appears to be an over-reliance on medication alone as therapy, rather than, as the WHO recommends, “*a full range of therapies considered essential to modern psychiatric care: psychotherapy, psychosocial rehabilitation, and vocational rehabilitation and employment*”. While medication is considered essential in the treatment of many serious mental illnesses, the lack of a range of additional treatments is inconsistent with many of the MI Principles, in particular the right to the “*least restrictive or intrusive treatment*” in 9(1).

## Medication

Notwithstanding the efficacy of medication in the treatment of many mental illnesses, it is essential that vigilance is exercised in their use. The report of the Inspector of Mental Hospitals for 2001 urged *“caution in relation to drug prescribing, the frequent review of the necessity for prescribed medication and of any side effects deriving from it, and avoidance of poly-pharmacy”*. The Inspector has observed: *“A wide range and diversity of drug prescribing in psychiatric illness was noted. Junior doctors, in particular, were subject to considerable pressures to prescribe newer products and appeared to lack guidance for appropriate and effective prescribing in certain circumstances.”*<sup>52</sup>

Prescription of medication should last only for the time required by the nature and severity of the condition, and be discontinued as soon as possible. All mental health service users should receive an independent review of their prescribed medication on at least an annual basis in line with MI Principle 9(2). While it is likely that the majority of people are on correct doses of the most appropriate drug, even for them there is much benefit in such reviews to allay any concerns they, or their families, may have.

A 2002 Schizophrenia Ireland survey found that polypharmacy – the concurrent prescription of more than one drug – remains widespread, and cited serious problems associated with this practice, including confusion between therapeutic efficacy and side effects, and a heightened risk of a drug interaction developing.<sup>53</sup> The report of the Inspector for 2001 concluded that three sudden deaths in in-patient care that year *“were possibly the consequence of drug interaction”*.

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

## Intellectual Disability Facilities

*“The vast majority of the adult population with Intellectual Disability/Mental Handicap are legally incompetent, are neither voluntarily or compulsorily detained within their residential centres and have no capacity to give informed consent to any type of medical or psychiatric intervention and between thirty to fifty per cent are on psychotropic medication without consenting to same...”*<sup>54</sup> They are outside the remit of the Mental Health Act, the Inspector of Mental Health Services and the Mental Health Commission,

whose mandate should be widened to monitor all residential health centres where patients with mental illness are receiving medical treatment without informed consent; and their rights in relation to consent to treatment should be placed on a statutory footing.

## Recommendations

Amnesty International particularly urges the Irish Government to:

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

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

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Annual Report of the Chief Medical Officer<sup>55</sup>

## International standards

International law requires states to provide a specialised regime to identify, treat and protect children with or at risk of mental illness, and to detain children only as an exceptional measure of last resort.

The general standards outlined in Chapter 1 apply to children. Additional specific rights and obligations are contained in the UN Convention on the Rights of the Child (the CRC), with the overriding criterion that, in all actions concerning children under 18 years of age, *“the best interests of the child shall be a primary consideration”*.<sup>56</sup> The CRC provides *“the right of the disabled child to special care and ... the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance ... which is appropriate to the child’s condition ...”*.<sup>57</sup> In relation to children in state care, the CRC provides that *“a child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State”*.<sup>58</sup> It contains further rights for children in detention, as does the UN Rules for the Protection of Juveniles Deprived of their Liberty.<sup>59</sup>

## Situation in Ireland

Amnesty International is concerned that Ireland does not comply with its international obligations in its treatment of children with, or at risk of, mental illness. The UN Committee said in its last report on Ireland in 1998 (the UN Committee report):<sup>60</sup>

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*“The Committee is concerned about the lack of a national policy to ensure the rights of children with disabilities and the lack of adequate programmes and services addressing the mental health of children and their families.”*

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Research into the mental health needs of children is very poor: *“The absence of epidemiological information relating to children’s mental health on a national basis is a significant limitation in our current system. [...] A highly developed information system is required, in order to underpin approaches to quality assurance and evaluation of mental health prevention and treatment services, to monitor trends in incidence, and to identify risk factors and risk groups.”*<sup>61</sup>

The UN Committee report stated particular concern about the incidence of child homelessness in Ireland – there is a particularly high rate of homelessness of children upon leaving state residential care – which is of concern given the overlap between homelessness and mental illness.<sup>62</sup>

- **Children Aged 16 or Under**

Mental illness in this age group is not uncommon – *“... as many as 18 per cent of the child population under the age of 16 years will experience significant mental health problems at some period of their development”*<sup>63</sup> – yet, services in Ireland for them are very few, difficult to access, and long waiting lists are the norm in many areas. A position paper by the Irish College of Psychiatrists (ICP) noted that the lack of dedicated adolescent services reduces the children’s services ability to treat younger children so that *“waiting lists for Child Psychiatry services are lengthened further by the need to respond urgently to adolescents”*.<sup>64</sup>

It is *“internationally acknowledged [that] best practice for the provision of child and adolescent psychiatric services is through the multi-disciplinary team”*, but *“many of the child psychiatric teams currently in place throughout the country do not have the full complement of team members”*.<sup>65</sup> There is also a large discrepancy between the existing and required numbers of appropriate acute psychiatric beds for children.<sup>66</sup> This does not comply with Ireland’s obligations under the CRC.<sup>67</sup>

- **Adolescents**

The needs of this age group are considerable: *“Psychiatric disorders increase in incidence and prevalence during adolescent years. The incidence and prevalence of deliberate self-harm and attempted suicide also increase with increasing age throughout the adolescent phase. Epidemiological studies show that psychological disturbances of varying intensity exist in up to 20% of adolescents.”*<sup>68</sup> Yet, there is a lack of dedicated adolescent psychiatric services, inconsistent with Article 24(1) of the Convention. Most areas are seriously short of adolescent psychiatric facilities, and in some there are none at all.

The ICP position paper states that existing child psychiatry, which provides services for children up to the age of 16 years, is not equipped to deal with the older adolescent age group. For children over the age of 16 years, services are provided by the adult psychiatric services, which, according to this paper, *“are not resourced to deal with adolescents because of the lack of developmental perspective and the serious lack of appropriate multidisciplinary input which would centre around family, school and social interventions”*. Adolescents with a learning disability and mental illness are a distinct group considered by the ICP to have special needs that are not being dealt with in an adequate or consistent fashion.<sup>69</sup>

- **Juveniles in Adult Psychiatric Institutions**

Under Article 37(c) of the CRC, children under the age of 18 years, when detained, should be treated in a manner which takes into account the needs of persons of their age; and should generally not be detained in adult facilities. That children with mental health needs are in fact placed in adult psychiatric facilities is a matter of considerable concern to Amnesty International. Furthermore, the Inspector of Mental Hospitals commented in his report for the year 2000 on the practice of placing children who do *not* have mental illness, but behavioural problems, in adult psychiatric units. This is a serious cause for concern amounting to a violation of Articles 20 and 37(c) of the CRC, and Amnesty International hopes this practice has been discontinued.

The ICP position paper also observed that the shortage of childcare residential services for children with very severe behavioural difficulties has resulted in inappropriate referrals to the psychiatric services; and that a distinct lack of forensic psychiatric services exists for children and adolescents. In addition, adolescents with mild learning disability are considered by the ICP paper to be a distinct subset of juveniles who offend, and it recommends that a dedicated forensic adolescent service should be developed for this group.

- **Asylum Seekers & Refugees**

The rights enshrined in the CRC apply also to asylum seeking and refugee children, *“without discrimination of any kind, irrespective of the child’s or his or her parent’s or legal guardian’s ... status”*.<sup>70</sup> The unique situation of juvenile asylum seekers and refugees, which may include experiences of war, persecution, death, sexual assault, violence, fear, and displacement, is such that rigorous attention must be paid to their mental health care, to comply with international human rights law.<sup>71</sup>

The United Nations High Commissioner for Refugees instructs that asylum seeking or refugee children who suffer *“emotional distress or mental disorders [should] benefit from culturally appropriate mental health services and treatment”*.<sup>72</sup> Ireland appears to fall far short of this requirement, not alone because of the deficiencies in general child mental health care pointed out above, but because of the absence of a comprehensive programme of counselling and mental health care for this vulnerable group.

- **Preventive Mental Health Care & Early Intervention**

Preventive mental health care for children and adolescents is of major importance. Ireland as a State Party to the CRC and to related international instruments<sup>73</sup> is required to *“develop preventive health care”*,<sup>74</sup> that is, detecting and treating physical and mental illness in children, in addition to providing education and guidance to parents on children’s health. Irish mental health preventive services for children and adolescents at risk of mental illness are inadequate, however.

Early intervention also requires wider awareness-raising regarding the effects of mental illness *“to remove barriers to early identification and help-seeking”*.<sup>75</sup> The education system is a useful focal point for preventive mental health care, as this is more likely to be accepted as a normal part of the child’s life if integrated into curricula from an early age. Schools are also ideally placed to promote and protect children’s mental health: *“Children showing behavioural problems in school or at home can benefit from school-based interventions and parent training programmes.”*<sup>76</sup>

A government Working Group observed in 2001, *“there does not appear to be any formal liaison or agreed protocols between the child and adolescent psychiatric services and the education system”*.<sup>77</sup> Amnesty International urges the Irish Government to incorporate effective and continuous mental health care and education into the curricula of all stages of the education system, with an emphasis

on stigma reduction. This should be part of a wider strategy to educate the public about the reality of mental illness,<sup>78</sup> and to enhance the ability of parents, teachers, and other key persons to identify and deal appropriately with children with, or at risk of, mental illness.

## Conclusion & Recommendations

Amnesty International urges the Irish Government to recognise the opportunity to redirect the lives of children with, or at risk of, mental illness, through the comprehensive provision of dedicated mental health care services, particularly given the interrelationship between mental illness and other life difficulties such as homelessness and poverty.

The Convention on the Rights of the Child provides much guidance on how the rights of children should be interpreted and vindicated. An important step in ensuring national respect for this international instrument would be its incorporation into Irish law, and that its provisions be widely promulgated

The Ombudsman for Children Act, 2002 provides for the appointment of an Ombudsman for Children, and it is to be hoped that this office will address the area of children's mental health as a matter of the utmost importance. In particular, Amnesty International urges the Irish Government to:

- Regularly compile accurate data on the mental health needs of children, particularly those in vulnerable communities, and in, and upon leaving, health board care.
- Adopt and implement all necessary measures to address deficiencies in child psychiatry services to bring them into line with best international practice, expand the number of child and adolescent multidisciplinary teams nationally, provide national forensic child and adolescent services, and establish a sufficient number of additional children's acute beds.
- Put in place a comprehensive system of adolescent psychiatric services, with consideration given to the special needs of adolescents with learning disability.
- Introduce positive measures to ensure that the particular needs of children in vulnerable or disadvantaged communities are met, including children from the Travelling community, children living in poverty, and asylum seeking and refugee children.
- Introduce positive measures to meet the mental health needs of the high numbers of homeless children, and those living in, and leaving, state residential care.

- End the practice of placing children with mental illness in adult psychiatric institutions, except when it is considered in their best interests to do so, by establishing the necessary complement of child and adolescent psychiatry in-patient units and residential places.
- Ensure that the practice of placing juvenile offenders in psychiatric institutions is discontinued, and that they are placed in more appropriate accommodation.
- Establish secure in-patient units for all children and adolescents who are in need of mental health care treatment in a secure setting in line with international standards.
- Incorporate effective and continuous mental health care and education into the curricula of all stages of the education system, with an emphasis on stigma reduction. This should be part of a wider strategy to educate the public about the reality of mental illness, and to enhance the ability of parents, teachers, and other key persons to identify and deal appropriately with children with, or at risk of, mental illness.
- Incorporate into Irish law the principles and provisions of the CRC, and promulgate them amongst all stakeholders.

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

Simon Communities of Ireland<sup>79</sup>

### International Standards

The human rights outlined in Chapter 1 apply to homeless people, including the right to the highest attainable standard of mental health in Article 12 of the ICESCR, and the right to the best available mental health care in MI Principle 1. 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.”*<sup>80</sup>

The significant occurrence of mental illness within this section of the population outlined below places a positive obligation on the Irish state to take active measures to address any gaps in their mental health care. Failure to do so amounts to a breach of Ireland’s obligations under the ICESCR.

### Situation in Ireland

The first principle in any discussion of homelessness is that housing is a fundamental human right.<sup>81</sup> Everyone should have access to suitable accommodation, and homelessness, as the most fundamental violation of this principle, should be eliminated.

The number of homeless people in Ireland is climbing.<sup>82</sup> The most recent official figures at the time of writing date from 1999, when 5,234 people were assessed as homeless,

the majority of whom were in the Dublin region.<sup>83</sup> Ireland's statutory definition of homelessness<sup>84</sup> is much narrower than those operating in other jurisdictions, so quantitative international comparison of homeless figures is quite pointless.

Data on the prevalence of mental illness, and the mental health care needs of Ireland's homeless, and research into appropriate effective responses are very limited. Policy makers and advocacy bodies must consequently operate on estimates, and various sources put the proportion of Ireland homeless suffering from a mental illness at between 30 per cent and 50 per cent. The circumstances of homeless families are also unfortunate: studies in other jurisdictions have found very high levels of mental illness in homeless mothers, and children of homeless families have also been found to have much higher likelihood of developing mental illness than the remainder of the population.<sup>85</sup>

General primary health care provision for homeless people is inadequate, and there are very few specialised mental health teams and outreach services dedicated to this population. Because community care services for the homeless are so deficient, with a particular shortage of community-based residential care accommodation, high numbers of people with mental health problems are becoming homeless. *"In the European context Ireland is exceptional in the undeveloped nature of its services to mentally ill people who are homeless. In particular supported housing is a neglected and under provided area in Ireland, with less than 200 units of supported accommodation provided for mentally ill and homeless people, the great majority of these through the voluntary sector."*<sup>86</sup> The result of the shortage of community-based services is that homeless people make up one third of all persons inappropriately placed in acute psychiatric beds in the Eastern Regional Health Authority area.<sup>87</sup>

The scenario presents itself then, where the lack of mental health care and other services for homeless people with mental illness results in their inappropriate occupancy of much needed beds, impacting on the availability of such beds for acute patients. A nongovernmental report stated: *"the rise in homelessness from the 1980s has often been linked to the de-institutionalisation of psychiatric patients into the community. In Ireland the evidence is less that discharged former long-stay patients became homeless but rather that the reduction of long-stay beds closed off what in effect was a residual social accommodation role performed by long-term psychiatric*

*institutions.*<sup>88</sup> The Inspector of Mental Hospitals has also remarked on this problem in his report for 2001.

Additional difficulties exist for homeless people in accessing mental health care due to the sectorisation of psychiatric services into catchment areas, introduced on foot of the 1984 government strategy, 'Planning for the Future', which is inappropriate to the needs of homeless people. Whereas Amnesty International understands that individual service providers are often flexible about these arrangements, the fact remains that, strictly speaking, homeless people in need of mental health care should return to their previous places of residence, effectively leaving many homeless people without a service. *"Sectorisation has [also] led to staff generally not trained to meet and understand the needs and special requirements of some people homeless."*<sup>89</sup>

Government 'Guidelines on Good Practices and Quality Assurance in Mental Health Services' dictate: *"A mechanism should be in place to review patients who have been lost to follow up and everything possible done to find out what has happened to the patient and to take appropriate action."* Another consequence of this sectorisation – which does not operate in the wider medical service – is that there is little or no follow-up for homeless people after discharge from in-patient psychiatric care. Others are discharged directly into the care of homeless emergency shelters operated by voluntary agencies, which are not therapeutically appropriate for people with mental illness.

The homeless problem has also been referred to in a report by the Irish College of Psychiatrists: *"A major source of discontent in the Eastern region is the problem posed by homeless individuals who repeatedly cross or are pushed across catchment area boundaries to St. Brendan's Hospital, or to direct-access hostels and night shelters in this hospital's catchment area, leaving the services there over-stretched and under-resourced."*<sup>90</sup>

In 1999, the Chief Executive Officer of the then Eastern Health Board established a Multidisciplinary Group to identify gaps in service provision for the homeless in that region.<sup>90</sup> One of its recommendations was: *"The in-patient treatment needs of the homeless mentally ill should ideally be provided by a centralised service, rather than devolved to catchment area services, to ensure that there is no fragmentation of service delivery."* This has still not been acted upon.

## Government Homelessness Action Plans

In May 2000, 'Homelessness – An Integrated Strategy' was launched by the government, and Homeless Action Plans were subsequently developed and adopted by all local authorities throughout the country to provide an integrated delivery of services, including mental health services, to homeless people by all agencies dealing with homelessness. Presently they have no statutory basis and there is no overall reporting structure. A joint analysis by nongovernmental homeless agencies of the Action Plans' provision for the development of health services, included mental health care, found the language of the plans "conditional and non-committal":

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*"The plans do achieve a relatively sophisticated understanding of the nature and complexity of the problem, but policies for dealing with the multiple social and health problems linked to homelessness, prevention and the transition to permanent accommodation are weakly stated or absent."*<sup>91</sup>

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

## Recommendations

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

- Adequately address the high level of mental illness in Ireland's homeless population, by ensuring the comprehensive and consistent provision of specialised community-based services, mental health teams and outreach services, learning from international best practice.
- Expand the data collection on homeless people and households, to provide a clearer picture of mental health, age, gender, and special needs; and improve systems of data recording, information gathering, and reporting by all service providers.

- Initiate an independent review of 'Homelessness – an Integrated Strategy' to address the weaknesses evident in the implementation of the homeless action plans in relation to mental health care.
- Implement all recommendations made by the Eastern Health Board's Multidisciplinary Group in 1999.

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*“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”*

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World Health Organisation<sup>93</sup>

## International Standards

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 have the right to be treated with humanity and with respect for the inherent dignity of the human person in Article 10 of the ICCPR. They have the right to the best available mental health care,<sup>94</sup> and at the very least an equivalence of mental health care with the rest of the population under Article 2(2) of the ICESCR.

Due to the necessarily coercive and restrictive regime of prisons, specific responsibilities are demanded, such as Rule 22(2) of the Standard Minimum Rules for the Treatment of Prisoners: *“Sick prisoners who require specialist treatment shall be transferred to specialised institutions or to civil hospitals.”*<sup>95</sup>

## Situation in Ireland

Approximately 3,000 people are currently detained in Irish prisons, and the committal rate under sentence of imprisonment is amongst the highest in Europe. The CPT<sup>96</sup> report on Ireland in 1998<sup>97</sup> (the CPT report) observed: *“In comparison with the general population, there is a high incidence of psychiatric symptoms among prisoners.”* A 2000 report commissioned by the government also revealed that the mental health indicators were much worse for prisoners than the general population.<sup>98</sup> A 2002 international study found that these prisoners *“were several times more likely to have psychosis and major depression”* and that one in seven inmates suffers from a mental illness that

could be a risk factor for suicide.<sup>99</sup> This high incidence of mental illness is partly attributable to the deficiencies in the wider mental health services,<sup>100</sup> so that many people end up in the prison system due to their behaviour while seriously ill.

## Situation in Ireland

The treatment of prisoners with mental illness is widely acknowledged as extremely unsatisfactory, and would not seem to meet the requirements of international human rights law. The CPT report recommended *“that the provision of prison psychiatric services be reorganised as a matter of urgency”*. The report of a government-sponsored review in 2001 also noted *“many deficiencies and shortcomings”*, and *“long-term under resourcing of prison health care services”*.<sup>101</sup> It noted that the provision of health care in the Irish prison system is the responsibility of the Department of Justice, and *“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”*. Little action appears to have been taken on the recommendations made in this report.

A highly disproportionate number of members of the Travelling community are in Irish prisons. The known effects of prison on mental health, when combined with this high experience of prison committal, impacts negatively on this community in a more profound way than on the rest of the Irish population.<sup>102</sup>

## In-Patient Care

The CPT report recommended: *“A mentally ill prisoner should be kept and cared for in a hospital facility which is adequately equipped and possesses appropriately trained staff.”*

While there has been a recent significant expansion in the provision of prison psychiatric consultations on an out-patient basis, in-patient services are extremely restricted. Special psychiatric units for prisoners do not exist within or outside prisons, and the only psychiatric hospital that accepts prisoners is Dublin’s Central Mental Hospital (CMH). The CMH does not have sufficient beds for the demand, and much of its infrastructure is unsatisfactory due to insufficient capital funding. The CPT report stated: *“The transfer of a mentally ill prisoner to a psychiatric facility should be treated as a matter of the highest priority.”* Very long waiting lists for admission to the CMH mean that many prisoners in need of in-patient care never receive a transfer. Other prisoners are returned to prison from the CMH before they are well. Both of these

scenarios represent a serious lack of respect for the right to proper health care in MI Principle 20(2). In the absence of available alternatives in civil mental health facilities, there is an urgent need for specialised psychiatric treatment units for prisoners.

## 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,<sup>103</sup> 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 letter to the IPRT that padded cells will be replaced by safety observation cells that will fully meet the needs and respect the dignity of the prisoner.<sup>104</sup> Amnesty International urges that this instruction be complied with immediately, and that the alternative meet the requirements of international best practice and human rights standards. In tandem, vigilance in the operation, monitoring, and recording of use of observation cells must be ensured so as to avoid a repeat of the practices documented by the IPRT.

Amnesty International also welcomes the Minister's statement in this letter 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"*. Amnesty International is nevertheless concerned that, given the continuing absence of suitable alternatives for prisoners with mental illness within the prisons, and as the Minister's edict is similar to that contained in the Prison Rules<sup>105</sup> under which the current practice operates, this grave situation may continue. Consequently, special psychiatric facilities and treatment for prisoners must be provided as a matter of the utmost urgency.

## Intellectual disability and dual conditions

In common with other jurisdictions, there is a 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',<sup>106</sup> of a sample of about ten per cent of the inmates in Irish prisons, 28.8 per cent exhibited a significant degree of learning disability. Therefore, a strong possibility exists in this group of dual conditions of mental illness and intellectual disability. The Irish College of Psychiatrists has pointed to the increasing vulnerability of those with dual disabilities in the prison system and the need for a specialised multi-professional approach to their care.<sup>107</sup>

## Legislation Governing Prisons and Places of Detention

MI Principle 22 requires that an effective inspection, monitoring and complaints system is available in respect of all prisoners with mental illness regarding all aspects of their mental health care, yet there is an ongoing lack of an effective prison system of complaints and inspection in Ireland. While an Inspector of Prisons and Places of Detention was appointed in April 2002, this office lacks statutory powers or independence, and at the time of writing, still does not have a secretariat. 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 asserts:

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*"...prisoners 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."*<sup>108</sup>

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Amnesty International notes the advice given by this committee that prisoners' rights are best protected when enshrined in legislation. Amnesty International echoes the UN Human Right Committee's request 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."*<sup>109</sup> The CPT report stated that it would *"welcome any measures which are designed to enhance the effectiveness and impartiality of current complaints and inspections procedures"*. In the interim, the 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 should be introduced, as contemplated by MI Principle 20(3): *“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.”*

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.<sup>110</sup>

## The Garda and Mental Illness

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

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

## Recommendations

Amnesty International urges the Irish Government to undertake the following measures as a matter of urgency to ensure that the human rights of this very vulnerable sector of the population are protected:

Reorganise the mental health services provided to prisoners, in line with recommendations made in the CPT report, with the adoption of a multidisciplinary approach for their delivery, and incorporating culture-specific measures, particularly in the case of members of the Travelling community. Good practice in prison mental health care should be identified in line with the WHO 'Health in Prison' Project.

Enshrine the rights of prisoners in Irish legislation, including the right to the best available mental health care; and make available to every prisoner a Charter of Prisoner Rights explaining these rights, and how to exercise them.

In the absence of available alternatives in civil mental health facilities, establish high and medium secure units for the provision of psychiatric services to offenders, in line with the CPT report recommendation that, *"in general, the development of prison psychiatric units and prison hospitals should be avoided"*, and provide the capital funding necessary to refurbish the CMH.

Immediately cease the practice of solitary confinement in padded cells of prisoners with mental illness, reduce the length of periods spent by other prisoners in isolation cells, and introduce observation units in line with international standards, ensuring that their use is carefully regulated, recorded and monitored.

Establish a planned and integrated after-care system for prisoners on release, ensuring continuity of care.

Devise a formal arrangement between the Department of Justice, Equality and Law Reform, the Irish Prisons Service and the Department of Health and Children and/or the statutory health boards for relative responsibilities in relation to the delivery of timely and adequate mental health care to prisoners.

Establish a statutorily independent Inspectorate, with an effective inspection procedure, and, in the interim, accord the Inspector of Prisons full resources and assistance to allow him to perform this task.

An effective complaints procedure should be provided to every person in detention, and an independent mechanism such as an Ombudsperson should be established to hear and adjudicate upon prisoners' complaints, including those in relation to the provision of mental health care.

Mental health legislation should be introduced in a way that would facilitate diversion of mentally disordered individuals from the criminal justice system to an alternative treatment, supervision and care service.

Training of an Garda Síochána should include a component on mental illness, and the use of specially trained police officers to supply on-scene expertise should be developed.

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*“It is an out of date service requiring radical change”*

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Chair, Mental Health Commission<sup>111</sup>

### National Mental Health Policy

While significant expansion and improvement of Ireland’s mental health services has occurred in recent years, they remain insufficiently developed in many areas, and inconsistent in their application throughout the country.

The 1984 strategy, ‘The Psychiatric Services: Planning for the Future’, outlined the government’s plans for the care of people with mental illness, but many of its targets remain under implemented, and much of it is considered outdated. ‘Guidelines on Good Practice and Quality Assurance in Mental Health Services’ were published by the Department of Health and Children in 1998, and in their emphasis on the patient as consumer, and the duty to provide *“the highest level of mental health care possible”*, remain under-observed.

The 2001 national health strategy, ‘Quality and Fairness – A Health System for You’, promises the development of a new action programme on mental health, and programmes to promote positive attitudes to mental health. While it remains to be seen how this will operate in practice, in 2002, the UN Committee on Economic Social and Cultural Rights (CESCR) noted *“with regret that a human rights framework encompassing, inter alia, the principles of non-discrimination and equal access to health facilities and services was not embodied in the ... National Health Strategy...”*.<sup>112</sup> Individual health boards have devised regional planning documents based on this strategy. Amnesty International is concerned that, without more concrete resource commitments, and binding standards, these plans will remain as difficult to implement as ‘Planning for the Future’.

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

## Financial Investment

Where Ireland's general health expenditure is relatively poor, it is markedly more so in the mental health sector. Revenue funding of the mental health programme for 2002, while not insignificant, remained out of step with other medical programmes.

This sector was already seriously and preferentially hit by cutbacks in the 1980s; in 1993, Dr Marcus T Webb wrote:

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*"The share of gross expenditure provided in Ireland for the psychiatric services has been reduced by 20.7% since 1976. This slide must be halted and reversed if this country is to preserve a semblance of mature and civilised care for its mentally ill."*<sup>113</sup>

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

The closure of psychiatric hospitals and a move to community-based care – considered by some to be more cost-efficient<sup>114</sup> – is said to account for some of this drop, but Ireland still has a high level of dependence on expensive in-patient care, evidenced by the high rate of admissions annually.<sup>115</sup> This indicates a need to consider the efficiency of investing in services delivered within institutions without adequately providing for community-based alternatives. The 1999 government report, 'We have no beds', advocates that, instead of electing to invest in one or the other, a "system of double funding or 'pump priming' is needed for the overlap period between the establishment of community services and the closure of hospital beds". The cost, while relevant, should not be the main consideration; rather, as that report concluded, the "motivation should be to provide the best quality psychiatric care within a comprehensive care structure which is based on the needs of patients".

Restricted capital funding is also an issue. Under-investment has led to many of the remaining older institutions falling into unacceptable states of disrepair, as described in the annual reports of the Inspector of Mental Hospitals. An example is the Central Mental Hospital, the physical infrastructure of which has also been condemned by the

European Committee for the Prevention of Torture. There is poor provision too for capital development programmes for community residential centres.

The CESCR, in 2002, noted *“the favourable economic conditions prevailing in the State party and observe[d] no insurmountable factors or difficulties preventing the State party from effectively implementing the Covenant”*.

## Poor Service Planning

Ireland’s mental health services were devised in a system of sectors based more on geographic divisions than on patient needs. Funding for mental health care was initially concentrated in large psychiatric hospitals and remained incremental, so that health board regions with psychiatric hospitals have retained larger budgets irrespective of local need. Service provision inconsistency throughout the country is significantly due to these varying levels of resources. *“For example, well-developed services as commented on by the Inspector of Mental Hospitals such as the Cavan/Monaghan service spend £97 per capita, whereas the South Western Area Health Board spend £27.00 per capita.”*<sup>116</sup>

Conversely, poor service provision can be due to an inability to respond to actual regional need. Where *“some catchment areas are afforded enormous resources, and others far less, those in receipt of the lower levels are often better services”*.<sup>117</sup> This is attributed to a number of factors:

- **Research & Needs Assessment**

The report, ‘We have no beds’, observed that *“services should be planned to meet the needs of a population, although this has largely not been the case in the psychiatric services”*. There is little research available on the prevalence of mental illness in Ireland (other than the level of in-patient service use), the needs of vulnerable groups, or the quality of service delivery. Consequently, mental health policy has often not been devised on an informed basis. While other indicators of mental health care need exist, such as socio-economic deprivation, unemployment, alcoholism, suicide and parasuicide, one of the principal recommendations in the WHO 2001 annual report is that states should conduct more research into biological and psychosocial aspects of mental health.<sup>118</sup> This should include epidemiological data collection and evaluation, considered by the WHO report *“essential for setting priorities within ... mental health, and for designing and evaluating public health interventions”*.

- **Limited Role of Service Users**

Much service planning has proceeded without sufficient input from service users and their families. The UN Standard Rules on the Equalisation of Opportunities for People with Disabilities<sup>119</sup> provide that people with mental illness have the right to be involved in mental health care planning, and that in the process of reviewing, formulating and implementing mental health care policy, the state is obliged to involve organisations of people with mental illness, and to assist and fund them to do so. In a review, the effective participation of service users should be ensured, and emergent planning should take into account the perceived needs of service users.

- **Staffing Difficulties**

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

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

## **Recognising the Role of Carers**

The burden of mental illness may fall on the family, and the cost to family carers, in terms of emotional stress, can be considerable. Failure to provide assistance to relatives of people with mental illness who live at home can impact negatively on the mental health of all concerned. A survey report on carers’ views in five European countries, including Ireland, gives *“clear guidance on all the issues which families really want to be addressed”*.<sup>120</sup>

## Stigma

The stigma surrounding mental illness has been well documented, and the public's attitude stems from its lack of awareness, and misconceptions about the nature of mental illness. This can have many consequences: *"Mental illness, despite centuries of learning is still perceived as an indulgence, a sign of weakness. This shame is often worse than the symptoms, with people making efforts to conceal the illness from others. Secrecy acts as an obstacle to the presentation and treatment of mental illness at all stages. The reality of discrimination supplies an incentive to keep mental health problems a secret."*<sup>21</sup>

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

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

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

## Mental Health Legislation

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

## Recommendations

Amnesty International urges the Irish government to:

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

# Conclusion & Key Recommendations

In Ireland, as throughout much of the world, *“mental health care has simply not received until now the level of visibility, commitment and resources that is warranted by the magnitude of the mental health burden”*.<sup>122</sup> A heightened impetus now exists at the international level to address the inequalities experienced by people with mental illness, and a drive for recognition of this issue as a human rights one.

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

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

The Irish government has also failed to take all the legislative measures necessary to give full effect to its international human rights obligations towards people with mental illness.

Amnesty International urges the Irish government to provide:

- A comprehensive, needs-based, service-user-led review of the mental health care services, promptly and fully implemented, ensuring that they meet international human rights standards and best practice in line with the World Health Organisation 2001 annual report, with an emphasis on community-based care.
- Regular quality research in all areas of mental health care needs and service provision, an essential prerequisite for the development of a quality service.
- Full financial provision for all areas of mental health care.

- All necessary resources and assistance for the Mental Health Commission in its securing adequate care and conditions for people with mental illness.
- Effective action on all relevant recommendations made in the reports of international treaty-based committees, annual reports of the Inspector of Mental Hospitals, and government reviews and reports.
- A comprehensive system of personal advocacy and an effective complaints procedure, to ensure that people with mental illness are assisted in exercising the full range of their rights.
- Specialised mental health care for all who need it, including children, the homeless, prisoners, people with other forms of disability, Travellers, asylum seekers and refugees, and other minority or vulnerable groups.
- A public education and awareness campaign to counter the stigma of mental illness, emphasising the rights of people with mental illness.
- Rights-based disability and mental health legislation to give full effect to its international human rights obligations, with due regard to its obligation to enable persons with disabilities to exercise their rights on an equal basis with other citizens.

# Endnotes

- <sup>1</sup> 'The World Health Report 2001: Mental Disorders Affect One In Four People, Treatment available but not being used' WHO/42 (<http://www.who.int/inf-pr-2001/en/pr2001-42.html>)
- <sup>2</sup> For example, at a conference on 17 September 2002 in Tullamore held by the Midland Health Board on the new Act, Dr Owens elaborated on this role.
- <sup>3</sup> Article 2(1) of the ICCPR and Article 2(2) of the ICESCR. As noted in Chapter 2, the CESCR, in its Concluding Observations on Ireland's second periodic report was very critical of Ireland's discrimination against people with disabilities.
- <sup>4</sup> 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).
- <sup>5</sup> Adopted by UN General Assembly Resolution 46/119 of 18 February 1992.
- <sup>6</sup> Adopted by Resolution of the UN General Assembly in 1993 (A/RES/48/96). See Chapter 2.
- <sup>7</sup> G.A. Res. 2856 (XXVI), 26 U.N. GAOR Supp. No. 29 at 99, U.N. Doc. A/8429 (1971). While still relevant to people with learning difficulties and mental illness, this Declaration is considered to be quite dated, for example, in that the term "mental retardation" is widely regarded as derogatory, where "intellectual disability" is generally favoured today.
- <sup>8</sup> Adopted by General Assembly Resolution No. 3447 (XXX), 30 U.N. GAOR Supp. (No. 34) at 88, U.N. Doc. A/10034 (1975). See Chapter 2.
- <sup>9</sup> Adopted by General Assembly resolution 43/173 of 9 December 1988. This instrument reflects the fact that special standards govern detention of all forms, including involuntary committal to psychiatric facilities, and will be discussed in Chapters 4 and 8.
- <sup>10</sup> After country visits, the CPT issues reports which are made public with the permission of the national government; two such reports on Ireland have been published to date, the second in 1998, and a third is due pursuant to a periodic visit to Ireland by the CPT in 2002.
- <sup>11</sup> Report of the UN High Commissioner for Human Rights to the Economic and Social Council, UN DOC. NO. E/2001/64, at para. 48.
- <sup>12</sup> In 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 the 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).
- <sup>13</sup> 17 May 2002, UN Doc No. E/C.12/1/Add.77.
- <sup>14</sup> Concluding observations of the Human Rights Committee: Ireland, 24/07/2000, A/55/40.
- <sup>15</sup> General Assembly Resolution 3447 (XXX) of 9 December 1975.
- <sup>16</sup> Adopted by Resolution of the UN General Assembly in 1993 (A/RES/48/96).
- <sup>17</sup> *Ibid*, Rule 15.
- <sup>18</sup> Employment Equality Act, 1998 & Equal Status Act, 2000, Government Publications Sales Office.
- <sup>19</sup> Such as Article 2 of the ICESCR or Article 2 of the ICCPR. See Chapter 3.
- <sup>20</sup> Article 8 of the abovementioned UN Declaration on the Rights of Disabled Persons.
- <sup>21</sup> The result 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.

- <sup>22</sup> "Toward Equal Citizenship" progress report, December 1999, in reply to recommendations nos. 31, 41, 43, 44 and 45 thereof.
- <sup>23</sup> 'Mental Health: New WHO Country Data Show Resources Fall Short of Needs', Press Release WHO/30, 23 April 2002, [www.who.int/inf/en/pr-2002-30.html](http://www.who.int/inf/en/pr-2002-30.html)
- <sup>24</sup> CESCR, General Comment 14, para 36.
- <sup>25</sup> 'The Psychiatric Services: Planning for the Future', Department of Health and Children (1984).
- <sup>26</sup> 'We Have No Beds: An Enquiry into the Availability and Use of Acute Psychiatric Beds in the Eastern Health Board Region', Keogh F, Roche A & Walsh W, Health Research Board, Department of Health and Children, 1999.
- <sup>27</sup> 'Irish Psychiatric Hospitals and Units Census 2001', Daly A & Walsh D, Health Research Board, Dublin, May 2002.
- <sup>28</sup> HRB Press Release, Irish Psychiatric Hospitals and Units Census 2001, 12 May 2002.
- <sup>29</sup> 'Mental Health: New Understanding, New Hope', World Health Organisation, 2001.
- <sup>30</sup> See also 'We Have No Beds' no. 26 supra, Appendix 4: Components of a Comprehensive Psychiatric Service.
- <sup>31</sup> No. 26 supra.
- <sup>32</sup> 'Report of the Inspector of Mental Hospitals for the year ending 31st December 2001', Department of Health and Children, Government Publications Sales Office, (2002).
- <sup>33</sup> Rule 15 of the UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities. See Chapter 1.
- <sup>34</sup> For an analysis of personal advocacy, its various models, and how it operates in different countries, see 'Advocacy: A Rights issue' (2001), Forum of People with Disabilities.
- <sup>35</sup> See Chapter 9 for a more comprehensive outline.
- <sup>36</sup> 'Quality & Fairness: A Health System for You', Department of Health and Children.
- <sup>37</sup> See Chapter 9.
- <sup>38</sup> 8th General Report on the CPT's activities covering the period 1 January to 31 December 1997, Ref: CPT/Inf (98) 12[EN], published on 31 August 1998.
- <sup>39</sup> See Chapter 1.
- <sup>40</sup> See Chapter 1.
- <sup>41</sup> See Chapter 1.
- <sup>42</sup> The most recent report of the Inspectorate covers the period up to December 2001, and was published on 13 September 2002.
- <sup>43</sup> Department of Health and Children website at: [www.doh.ie/aboutus/sections/mehe](http://www.doh.ie/aboutus/sections/mehe).
- <sup>44</sup> No. 26 Supra. "*This accumulation of patients in acute beds was largely due to difficulties in moving patients on to more appropriate services. In 41% of cases the service required had no vacancies and in 42% of cases the service did not exist.*" At p5.
- <sup>45</sup> 'Minister announces 850 beds under Public Private Partnership in the Health Sector', Department of Health and Children press release, 29 July 2002.
- <sup>46</sup> Naturally, this will hinge on the provision of a greater number of these centres.
- <sup>47</sup> See Chapter 9.
- <sup>48</sup> See Chapter 6.
- <sup>49</sup> See Chapter 1.
- <sup>50</sup> Except as provided for in paragraphs 6, 7, 8, 13 and 15 thereof.
- <sup>51</sup> No. 29 Supra.
- <sup>52</sup> Report for 2000, but this comment is still valid.
- <sup>53</sup> 'A Question of Choice – Ireland: Service Users' Experience of Medication and Treatment' (2002).
- <sup>54</sup> 'Comments on the Mental Health Act 2001', Irish College of Psychiatrists (2001).
- <sup>55</sup> 'The Health of our Children', Second Annual Report of the Chief Medical Officer of the Department of Health and Children, published on 19 September 2001.
- <sup>56</sup> Article 3(1).

- <sup>57</sup> Article 23(2).
- <sup>58</sup> Article 20(1).
- <sup>59</sup> Adopted by General Assembly Resolution 45/113 of 14 December 1990.
- <sup>60</sup> Concluding observations of the Committee on the Rights of the Child: Ireland, 04/02/98, (CRC/C/15/Add.85).
- <sup>61</sup> 'The Health of our Children' no. 55 supra. The UN Committee report observed "*certain lacunae in the statistical and other information collected by the State party, including with respect to the selection and development of indicators to monitor the implementation of the principles and provisions of the Convention*".
- <sup>62</sup> See Chapter 7.
- <sup>63</sup> 'The Health of our Children' no. 55 supra.
- <sup>64</sup> 'Position Statement on Psychiatric Services for Adolescents'.
- <sup>65</sup> 'First report of the Working Group on Child and Adolescent Psychiatric Services', Department of Health and Children (February 2001). It also estimated that an additional 25 such teams are required nationally.
- <sup>66</sup> Ibid.
- <sup>67</sup> It also fails to meet the requirement to provide "*a sufficient number of hospitals, clinics and other health-related facilities*" in UN CESCR, General Comment 14, para 36.
- <sup>68</sup> No. 64 supra.
- <sup>69</sup> Ibid.
- <sup>70</sup> Article 2(1).
- <sup>71</sup> Children from the Travelling community and other ethnic minorities are also entitled to specialised, culturally sensitive services and treatment.
- <sup>72</sup> UNHCR Refugee Children: Guidelines on Protection and Care (1994), Geneva, Chapter 4.
- <sup>73</sup> See too Principle 4(1), MI Principles.
- <sup>74</sup> Article 24(2)(f).
- <sup>75</sup> 'The Health of our Children' no. 55 supra.
- <sup>76</sup> Ibid.
- <sup>77</sup> No. 65 supra.
- <sup>78</sup> See Chapter 9.
- <sup>79</sup> Noeleen Hartigan, Social Policy and Research Coordinator, Simon Communities of Ireland, commenting to Amnesty International on 18 October 2002.
- <sup>80</sup> Rule 15. Adopted by Resolution of the UN General Assembly in 1993 (A/RES/48/96).
- <sup>81</sup> Article 25(1) of the UDHR and Article 11(1) of the ICESCR.
- <sup>82</sup> From 2,501 in 1996 to 5,234 in 1999, in 'Local Authority Assessments of Social Housing Needs', 31 March 1999, Department of the Environment and Local Government, October 1999.
- <sup>83</sup> 'Counted In – The Report of the 1999 Assessment of Homelessness in Dublin Kildare and Wicklow' (2000), Williams J & O'Connor M ESRI/Homeless Initiative, Dublin.
- <sup>84</sup> Irish Housing Act, 1988.
- <sup>85</sup> See 'The Mental and Physical Health and Well-being of Homeless Families in Dublin: A Pilot Study', Focus Ireland (2000).
- <sup>86</sup> 'Health Strategy 2001: Submission by the Simon Community of Ireland to the Department of Health on its review of the Health Service'.
- <sup>87</sup> A finding in 'We have no beds' no. 26 supra.
- <sup>88</sup> 'Homelessness and Mental Health, policies and services in an Irish and European Context', Harvey B, Homelessness and Mental Health Action Group.
- <sup>89</sup> The Simon Community of Ireland, no. 86 supra.
- <sup>90</sup> 1998, Appendix XIII.
- <sup>91</sup> 'Homelessness in the Eastern Health Board: Recommendations of a Multidisciplinary Group' (1999), Eastern Health Board, Dublin.
- <sup>92</sup> 'Housing Access for All? An Analysis of Housing Strategies and Homeless Action Plans', Focus Ireland, Simon Community, St. Vincent de Paul, Threshold, Dublin, unpublished at the time of writing.

- <sup>93</sup> 'Health in Prison' Project, [www.hipp-europe.org/background/0020](http://www.hipp-europe.org/background/0020).
- <sup>94</sup> MI Principle 20(2).
- <sup>95</sup> 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.
- <sup>96</sup> See Chapter 1.
- <sup>97</sup> 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.
- <sup>98</sup> General Healthcare Study of the Irish Prisoner Population, Centre for Health Promotion Studies, Department of Health Promotion, NUI Galway, (2000).
- <sup>99</sup> 'Serious mental disorder in 23,000 prisoners: a systematic review of 62 surveys', Fazel S & Danesh J, *Lancet* 2002; 359: 545-50.
- <sup>100</sup> See Chapter 3.
- <sup>101</sup> 'Report of the Group to Review the Structure and Organisation of Prison Health Care Services'. (2001)
- <sup>102</sup> See 'Irish Travellers and forensic mental health', Linehan S, Duffy D, O'Neill H, O'Neill C & Kennedy H G, *Ir. J. Psych. Med.* 2002; 19(3).
- <sup>103</sup> 'Report on the Treatment of Offenders who have Mental Illness', Bresnihan Dr V, IPRT (2001).
- <sup>104</sup> Dated 11 December 2002.
- <sup>105</sup> Rules for Government of Prisons, 1947 (S.I. number 320 of 1947)
- <sup>106</sup> Murphy M, Harrold Dr. M, Carey Dr S, Mulrooney M, Department of Justice, Equality and Law Reform, 6 August 1999, unpublished.
- <sup>107</sup> 'Response to The Prison Health Care Review Group'.
- <sup>108</sup> 'The organisation of health care services in prisons in European member states' (1998).
- <sup>109</sup> Concluding observations of the Human Rights Committee: Ireland. 24/07/2000, A/55/40.
- <sup>110</sup> See Chapter 3.
- <sup>111</sup> Dr John Owens speaking at a conference on 17 September 2002 held by the Midland Health Board.
- <sup>112</sup> Concluding observations on Ireland's second report, no. 13 supra.
- <sup>113</sup> 'Closing Mental Hospital Beds: A Re-Appraisal', Psychiatric Nursing, March 1993, Irish Psychiatric Nursing Association.
- <sup>114</sup> 'We Have No Beds' no. 26 supra assesses the evidence for this and observes that "community care is seen to cost at least as much if not more than existing [in-patient based] services".
- <sup>115</sup> See Chapter 4.
- <sup>116</sup> 'Board meeting – 4th December 2001 – A proposed Action Plan for Adult Mental Health Services in the South Western Area Health Board', Report No. 16/2001, South Western Area Health Board.
- <sup>117</sup> Dr Owens, supra.
- <sup>118</sup> 'Mental Health: New Understanding, New Hope'.
- <sup>119</sup> No. 6 supra. See Chapter 1.
- <sup>120</sup> 'Breaking the Silence: Carers' views on the help given during the first episode of psychosis, A European perspective', European Federation of Associations of Families of People with a Mental Illness, Madrid, October 2001.
- <sup>121</sup> Irish Psychiatry Online, the web page of the Irish College of Psychiatrists: [www.irishpsychiatry.com/public.html#2](http://www.irishpsychiatry.com/public.html#2).
- <sup>122</sup> 'Mental Health: A Call for Action by World Health Ministers', Ministerial Roundtables 2001, 54th World Health Assembly, Geneva, WHO/NMH/MSD/WHA/01.1.