Submission to the Inter-Departmental Group on Persons with Mental Illness and Interactions with the Criminal Justice System

May 2012

IHRC

AN COIMISIÚN UM CHEARTA AN DUINE
IRISH HUMAN RIGHTS COMMISSION

0. Introduction

The Irish Human Rights Commission (IHRC) has a statutory remit under the Human Rights Commission Act, 2000, to endeavour to ensure that the human rights of all persons in the State are fully realised and protected in the law and practice of the State. The IHRC seeks to ensure that Irish law and practice reflects best international practice in the area of human rights. To this end, its functions include keeping under review the adequacy and effectiveness of law and practice in the State relating to the protection of human rights, and making such recommendations to the Government as it deems appropriate in relation to the measures the IHRC considers should be taken to strengthen, protect and uphold human rights in the State.

The IHRC welcomes the opportunity to make the present submission to the Interdepartmental Group. While it is noted that the terms of reference of the Interdepartmental Group do not expressly refer to human rights standards, nonetheless, the necessity to include reference to such standards appears to be implicit in the terms of reference of the group. All good practice in the area must be informed by the human rights standards that apply. Adopting a human rights framework, it is submitted, will be of considerable assistance in addressing the question of treatment of persons with mental illness in the criminal justice system. Human rights standards are ultimately directed to preserving the dignity and autonomy of the individual, preventing exposure to inhuman or degrading treatment and, in the present, context ensuring that persons with a mental illness are not discriminated against in the justice system. These core principles must be the underlying basis on which the Group considers the issues before it. The present submission considers the human rights standards that apply where persons with a mental illness or disability may come into contact with the criminal justice system and proposes recommendations in this regard.

1. Preliminary Observations

The significance of the issue the Interdepartmental Group is considering cannot be underestimated. The UN Special Rapporteur on the right to Health, in considering the human rights of persons with mental disabilities, highlighted some of the principal concerns in this regard, specifically referring to the over-representation of such persons in the prison population:

> *Also alarming is the high rate of persons with mental disabilities, as well as the high rate of suicides, in prisons. In many cases, persons with severe mental disabilities who have not committed a crime, or who have committed only a minor offence, are misdirected towards prison rather than appropriate mental health care or support services. Prison conditions - such as overcrowding, lack of privacy, enforced isolation and violence - tend to exacerbate mental disabilities. However, there is often little access to even rudimentary mental health care and support services. Recent jurisprudence testifies to the vulnerabilities of persons with mental disabilities in detention to the violation of a range of their human rights.*[1]

[1] *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Paul Hunt, Economic and Social Council, E/CN.4/2005/51.

There is a striking resemblance between the concern expressed by the Special Rapporteur and that of the Report of the Thornton Hall Project Review Group, which states that "*imprisonment can aggravate mental health problems, heighten vulnerability and increase the risk of self-harm and suicide*".[2] The Project Review Group also expressed the view that there are people in prison who should be treated in a therapeutic environment.[3]

In *A Vision for Change (2006),*[4] a number of recommendations are made in relation to forensic mental health care. It appears, however, based on the Report of the Thornton Hall Project Review Group, that only some of those recommendations, for whatever reason, have been fully realised. The relevant recommendations for the purpose of the Interdepartmental Group's work are as follows:

- Every person with serious mental health problems encountering the forensic system should be accorded the right of mental health care in the non-forensic mental health services unless there are cogent legal reasons why this should not be done. Where mental health services are delivered in the context of prison, they should be person-centred, recovery oriented and based on evolved and integrated care plans.

- Forensic Mental Health Services (FMSH) should be expanded and reconfigured to provide court diversion services and legislation should be devised to allow this to take place.

- Four additional multidisciplinary, community-based forensic mental health teams should be provided nationally on the basis of one per HSE region.

- The Central Mental Hospital (CMH) should be replaced or remodelled to allow it to provide care and treatment in a modern, up-to-date humane setting, and the capacity of the CMH should be maximised.

- Prison health services should be integrated and coordinated with social work, psychology and addiction services to ensure provision of integrated and effective care. Efforts should be made to improve relationships and liaison between FMHS and other specialist community mental health services.

While it is noted that the Criminal Justice (Insanity) Act, 2006 (as amended),[5] has addressed one of the recommendations above and there is now a diversion programme in place in Cloverhill Prison, it is also important that the other recommendations would also be acted upon. In particular, the diversion programme operating in Cloverhill should operate in relation to *all* remand prisoners and be put on a full statutory footing, to ensure that all prisoners with a significant mental health problem, who are charged with a relatively minor offence, are directed away from being dealt with by the Courts at the earliest stage.

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[2] *Report of the Thornton Hall Project Review Group*, July 2011, at p.56
[3] *Ibid.*, at p.72
[4] *A Vision for Change*, *Report of the Expert Group on mental health Policy*, Department of Health, 2006.
[5] Criminal Justice (Insanity) Act 2010.

In considering the rights of persons with a mental illness in detention, be that Garda custody or in prison, it is an accepted norm that prisoners and others lawfully in detention enjoy the same rights as others in the community. Such rights may only be curtailed to the extent that is absolutely necessitated by the detention.[6] In this regard, the standard of medical care in and out of a detention setting should essentially be the same.

The IHRC has recently made observations on the review of the Criminal Justice (Insanity) Act 2006. Those Observations are appended to this Submission as they are also relevant to the work of this Interdepartmental Group. It is recommended that the report of this Interdepartmental Group be integrated with the ongoing review of the Criminal Justice (Insanity) Acts, 2006 and 2010, to ensure a coherent approach to persons with a mental illness in the criminal justice system.[7] It is also noted that the Irish Prison Service has recently published a three year strategic plan, which also refers to addressing mental illness in prisons.[8]

The Inspector of Prisons has issued *Guidance on Physical Healthcare in a Prison Context.*[9] This guidance document sets out many of the human rights standards that apply to healthcare in a custodial context. These standards apply with equal force to mental health care. It is noted, however, that the Inspector did not address this matter directly in light of the forthcoming report on the death of Gary Douche. While the human rights standards may be the same, it is clear that persons with a mental illness in a custodial setting are particularly vulnerable, which inevitably places a heightened burden on the State to address their welfare while in State custody.[10]

Finally, it is noted that the Interdepartmental Group is considering the issue of those with mental illness in the criminal justice system. The IHRC submits that similar issues arise for persons with an intellectual disability interfacing with the criminal justice system. While the present Submission confines itself to consideration of those with a mental illness; mental illness and an intellectual disability may co-exist. Many of the standards referred to below may have applicability to those with an intellectual disability. The IHRC recommends that this aspect of mental disability should not be neglected when the Group comes to report to the relevant Ministers. [11] In particular the IHRC draws attention

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[6] This is stated in the *Report of the Thornton Hall Project Review Group* at p. 48. See also *Hirst v The United Kingdom*, Grand Chamber, [2005] ECHR 681, at para 69.

[7] In this regard it is important that judges have the power to ensure that a person, who has a mental illness, but is not mentally incapable may order that the person be treated for their mental illness outside the prison service if appropriate. Obviously, this may depend on an assessment of the security risk involved.

[8] Irish Prison Service, *Three Year Strategic Plan*, April 2012, at p. 45.

[9] *Guidance on Physical Healthcare in a Prison Context, Inspector of Prisons, 2011.*

[10] Specific issues arise in relation to the risk of suicide that will be addressed further in this Submission.

[11] The UN Special Rapporteur on the right to health, in considering the appropriate terminology to use states as follows: "*Having taken extensive advice, the Special Rapporteur has decided to adopt the generic term "mental disability". In this report the umbrella term "mental disability" includes major mental illness and psychiatric disorders, e.g. schizophrenia and bipolar disorder; more minor mental ill health and disorders, often called psychosocial problems, e.g. mild anxiety disorders; and intellectual disabilities, e.g. limitations caused by, among others, Down's syndrome and other chromosomal abnormalities, brain damage before, during or after birth, and malnutrition during early childhood. "Disability" refers to a range of impairments, activity limitations, and participation restrictions, whether permanent or transitory".* Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, E/CN.4/2005.51, at para 19.

to the fact that there are a number of persons with an intellectual disability, but not suffering from a mental illness, currently being detained in the Central Mental Hospital having been transferred there under Court Order, and it is apparent that there is a need for a separate facility to meet the need of such individuals in a secure setting.

2. Where interaction occurs

Persons with a mental illness may come into contact with the criminal justice system in a number of respects. In this regard, a number of actors or organs of the State are relevant. The first point of contact is most likely An Garda Síochána, possibly followed by prosecution services, the Courts, the Prison Service, secure mental health facilities, and the Probation Service. Each will have specific duties and obligations depending on their functions. In addition to these specific actors in the justice system, there is inevitably an overlap with other actors such as mental health services (either in the community or the National Forensic Mental Health Service) and services for the homeless. This Submission outlines the applicable human rights standards as they apply to a particular organ of the State.

3. UN Convention on the Rights of Persons with Disabilities ("CRPD")

There are aspects of the CRPD which, the IHRC submits, must be taken into account by the Interdepartmental Group in making its recommendations. Although the State has not, as yet, ratified the Convention, a number of public commitments to do so have been made by the Government and ratification is expected to happen in the short term. In any event, the rights contained in the CRPD are largely a reconfiguring of the rights already contained in other human rights instruments, but realigned to address the particular circumstances of persons with disabilities. They are therefore relevant even prior to ratification.

It is noted that the CRPD does not define the term disability, but refers to "*any impairment*" and, in this regard, it is that clear it includes persons with a mental illness.

Article 4 of the Convention requires States to bring all its systems (including legislation, policies and practice) into line with the Convention. Of particular note in the present context is the requirement regarding training:

> *To promote the training of professionals and staff working with persons with disabilities in the rights recognized in this Convention so as to better provide the assistance and services guaranteed by those rights.*[12]

This provision has relevance across the criminal justice system and requires specific training for Gardaí, Prison officers, Probation officers, the legal profession, particularly prosecutors and the Judiciary.[13] In order to roll out comprehensive and effective diversion

[12] Article 4.1(i).

[13] It being noted that there are specific obligations on Judges under the Criminal Justice (Insanity) Act 2006 to refer defendants for psychiatric care or assessment, if there is concern as to whether they are fit to be tried or fit to plead. This obligation to ensure that a defendant is fit to be tried also arises from the Constitutional right to a fair trial pursuant to Article 38.

programmes, it is important that those in the criminal justice system learn to recognise the existence of mental illness and identify where medical intervention is required.[14] A person's medical care should never be compromised by the fact that they have come into contact with the criminal justice system.

The IHRC submits that it is particularly important for Gardaí who first deal with persons coming into custody, to be trained in the area (typically Station House Officers in Dublin, and Members-in-charge in the rest of the country). It is also essential that a medical practitioner with some basic forensic medical training is available in each Garda area, although this need not be a psychiatrist, unless there is an urgent need for such an intervention. Ensuring that Gardaí can identify signs of a mental illness when a person is taken into custody, and that an appropriate medical practitioner is available to assess their condition, may indicate a need to divert them from the criminal justice system, and if not, should at least prevent their being inappropriately questioned by the Gardai, and will ensure the condition is identified for other services dealing with the person in the criminal justice system further down the line.

In relation to access to justice, the CRPD recognises that persons with disabilities may come into contact with the justice system, either as direct or indirect participants. In the present context, it is the direct participation of persons with a mental illness that is of significance. Article 13 of the Convention requires that procedural accommodations be made to ensure the person's full engagement in any legal proceedings in which they are a defendant.[15] The requirement to provide procedural accommodation begins at the pre-trial stage and continues through to the final determination of the case. This obligation, therefore, falls on the Gardaí, the Courts and judiciary, the prosecution and the Probation Service, if involved. None of these actors can take a passive roll and must ensure that their involvement fully respects the rights of the individual.

Article 14 of the Convention guarantees the right to liberty and security of the person, and provides that:

> 1. *States Parties shall ensure that persons with disabilities, on an equal basis with others:*
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>   a. *Enjoy the right to liberty and security of person;*
>   b. *Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.*
>
> 2. *States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance*

[14] It is noted that in fact contact with the criminal justice system, may be the first opportunity for a person to receive adequate health care. See *A WHO guide to the essentials in prison health*. 2007, at p.25.
[15] Article 13 states: "*States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages*."

with the objectives and principles of this Convention, including by provision of reasonable accommodation.

While Article 14 has a particular relevance to civil detention in relation to a person with a mental disorder under the Mental Health Act 2001, it is also significant in the context of the criminal justice system. Again, it is recalled that the Special Rapporteur on Health and the Report of the Thornton Hall Project Review Group both commented on the inappropriate presence of persons with a mental illness in prisons. Such detention may be inappropriate either because the person needs therapeutic care in a non-prison or therapeutic environment or, alternatively, the person should never have been committed to prison in the first place.

As noted in *A Vision for Change*;

> *…where offending behaviour is clearly related to mental illness, a diversion scheme can allow offenders to be diverted to the care of the mental health services rather than into the prison service where there may be a delay in identifying and responding to their mental health needs.*[16]

The fact that individuals with mental illness are being inappropriately confined to prisons may raise an issue under Article 14 of the CRPD. In order for the State to be in a position to demonstrate compliance with Article 14, the risk of arbitrary deprivation of liberty may be avoided through the operation of robust, consistent and properly resourced diversion programmes.

4. Right to Health

The right to health is one of the most universally recognised and fundamental of human rights.[17] The right to health applies to everyone, irrespective of whether they are in State custody or living in the community. The UN Committee on Economic, Social and Cultural Rights has issued authoritative guidance on the realisation of the right to health, and has stated:

> *Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable.*[18]

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[16] At p.139.

[17] The right to health is enshrined in the Universal Declaration of Human Rights, and is further set out in Article 12 of the International Covenant on Economic, Social and Cultural Rights ("ICESCR") which states: "*The States Parties to the present Convention recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*

[18] Committee on Economic, Cultural and Social Rights, General Comment 14 (2000), *The right to the highest attainable standard of health*, E/C.12/2000/4, at para 1.

The Committee clearly views the right to health as an essential requirement for the realisation of other human rights. The Committee goes on to state that the right to health is not just the right to 'health care' but also refers to other determinants of health. According to the Committee:

> *… the reference in article 12.1 of the Covenant to "the highest attainable standard of physical and mental health" is not confined to the right to health care. On the contrary, the drafting history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.*[19]

Where a person is detained in a prison or other custodial setting the right to health requires that their living environment is healthy. Therefore, the prison environment must be conducive to proper mental health or, where a person already has a mental illness on entering a prison, the environment should not lead to a further diminution in their condition. Similar considerations apply to Garda custody but the obligation may be less onerous where the period of detention is brief.

The Inspector of Prisons, in his *Guidelines,* sets out the essential elements of the right to health, as formulated by the UN Committee. In brief, the elements are **Availability, Accessibility, Acceptability, and Good Quality**, ("the AAAQs"). All mental health services, along with other medical services provided within prisons should meet the AAAQs. In addition, the Special Rapporteur on the right to health points to the obligations of States under international law to respect, protect and fulfil the right to health.[20] Again, it must be ensured that in relation to mental health services in prisons, they meet these obligations on behalf of the State.[21] While it is not possible to address in detail in the present submission what the AAAQs would imply in a prison setting, it is submitted that mental health care in a custodial setting should not differ unnecessarily from care in the community. In this regard, the World Health Organisation (WHO) has stated:

> *Reducing mental harm and promoting mental health requires that prison authorities, health authorities and prison staff acknowledge that the preventive treatment and health care*

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[19] *Ibid*., at para 4.

[20] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, E/CN.4/2005.51, at paras 47-50.

[21] The Committee on Economic, Social and Cultural Rights has stated "*The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to respect, protect and fulfil. In turn, the obligation to fulfil contains obligations to facilitate, provide and promote. The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health." Ibid*, at para 33. The Committee on Economic, Social and Cultural Rights has also stated: *"In particular, States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants…*" (at para 34).

provided to prisoners should be equivalent to those provided to the community in general.[22]

The IHRC considers that if all health care within prisons came within the remit of the HSE, rather than the Prison Service, (noting that the CMH itself is the responsibility of the HSE) this could, at least to some extent, address the current deficits in care in prisons. It could also ensure continuity of care from the community, into the prison and into the community again on release.

5. Hospital Psychiatric Services

One of the most significant criticisms levelled at the current mental health service within prisons is the unavailability of beds within community mental health services (or approved centres under the Mental Health Act 2001) for prisoners that do not necessarily require care in a high security setting, and the inability of the Central Mental Hospital (CMH) to meet the demand for its bed spaces.[23]

In his "*Guidance on Physical Healthcare in a Prison Context",* the Inspector of Prisons refers to a variety of sources including the evidence of mental health experts and his own observations that there are many prisoners suffering from mental illness who should not be accommodated within the prison system.[24] The Inspector also noted that a number of prisoners who were identified by medical professionals as requiring treatment in the CMH were unable to access same due to lack of beds and resources.[25] A case history of one such prisoner is presented and highlights the inhuman and undignified environment in which mentally ill prisoners may be forced to live, due to a basic lack of appropriate facilities.[26] This is indicative of discrimination in the provision of health care to prisoners, which may breach the State's obligations under, *inter alia*, Article 12 of the Convention on Economic Social and Cultural Rights.

The most recent Committee on the Prevention of Torture ("CPT") report on Ireland noted some of the positive developments in relation to psychiatric care in prisons, particularly the screening and diversion programme in Cloverhill, and the fact that the CMH operates an "In Reach Service" in the Midlands, Mountjoy, Portlaoise and Wheatfield Prisons and

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[22] *A WHO guide to the essentials in prison health*. 2007. This guidance document sets out a list of 10 positive contributions to prisoner's mental health, and it is clear from same that issues regarding sanitation and overcrowding in Irish prisons are not conducive to good mental health for prisoners. See http://www.euro.who.int/__data/assets/pdf_file/0009/99018/E90174.pdf

[23] This concern was expressed in *A Vision for Change* at p. 138. This deficit has also been identified by the Inspector of Prisons, see *Guidelines on physical Health care in a Prison Context*, at p 7.

[24] "*Guidance on Physical Healthcare in a Prison Context*" 18th April 20122, Inspector of Prisons at para 1.9.

[25] *Ibid* at para 1.13.

[26] *Ibid* at para 4.1-4.16. In this case the prisoner in a safety observation cell was naked, crawling on all fours on the floor, covered in their own excrement and completely incoherent. However, the Inspector of Prisons emphasised that he did not wish to criticise prison staff as they were doing all they could to help the prisoner and were not trained to deal with such situations. Maintaining a prisoner in such conditions over an unnecessarily prolonged period of time might also raise issues under the convention Against Torture.

St Patrick's Institution.[27] However, the CPT also recorded concerns about the detention of persons with severe psychiatric disorders:

> *"More specifically, the CPT's delegation observed that Irish prisons continued to detain persons with psychiatric disorders too severe to be properly cared for in a prison setting; many of these prisoners are accommodated in special observation cells for considerable periods of time. For instance, at the Central Mental Hospital, the CPT's delegation met with a young man who had been placed in a special observation cell at Mountjoy Prison between 3 August and 11 September 2009. In another case, a prisoner had on several occasions spent considerable time in a special observation cell at Wheatfield prison. Moreover, this prisoner's medical records show that his mental health condition deteriorated significantly during his stay in prison."* [28]

The CPT recommended that all necessary steps be taken to further enhance the level of care available to prisoners suffering from a psychiatric disorder. The Committee went on to note that in more severe cases, a person cannot be treated in a prison setting and it further recommended that the availability of beds in psychiatric care facilities for acutely mentally ill prisoners be enhanced.

Particular concerns arise in relation to the use of Special Observation Cells in prisons. It is clear from the CPT report and the report of the Inspector of Prisons *Guidance* document that special observation cells are used in prisons to deal with concerns for the mental health of prisoners. However, it is not difficult to imagine that the isolation of an observation cell and inability to participate in the daily routine of the prison may in itself inhibit prisoners from alerting prison authorities, or indeed medical staff, to a deterioration in their mental health, if the response to such concerns has all the appearances of a punishment regime.

It is of further concern to the IHRC that, while the use of seclusion in an approved centre under the Mental Health Act 2001 is heavily regulated by the Mental Health Commission, and engages the oversight of the Mental Health Inspector, this is not the case with special observation cells in prisons.[29] Again, those receiving in-patient treatment for mental illness in the community appear to enjoy an enhanced level of safeguards for their human rights than prisoners suffering from mental illness in a custodial setting.

5.1 European Prison Rules

The European Prison Rules[30] set out a number of detailed principles in relation to health care in prisons which are worthy of note by this Interdepartmental Group, but are too extensive to set out here in full. Of particular relevant, in the present context, is the

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[27] Report *to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman and Degrading Treatment of Punishment*, at paras. 84-85.
[28] *Ibid.*, at para 87. The report also referred to particular problems arising in Cork Prison as it does not have an "In Reach Service", and there appeared to be an over reliance on pharmacotherapy.
[29] The Mental Health Commission, *Rules Governing the Use of Seclusion and Mechanical means of Bodily Restraint*, October 2009.
[30] Recommendation Rec (2006) of the Committee of Ministers to member states on the European Prison Rules.

requirement that health care in prisons be commensurate with health care available in the community:

> *40.1 Medical services in prison shall be organised in close relation with the general health administration of the community or nation.*
>
> *40.2 Health policy in prisons shall be integrated into, and compatible with, national health policy.*
>
> *40.3 Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.*
>
> *40.4 Medical services in prison shall seek to detect and treat physical or mental illnesses or defects from which prisoners may suffer.*
>
> *40.5 All necessary medical, surgical and psychiatric services including those available in the community shall be provided to the prisoner for that purpose.*
>
> *…….*
>
> *43.1 The medical practitioner shall have the care of the physical and mental health of the prisoners and shall see, under the conditions and with a frequency consistent with health care standards in the community, all sick prisoners, all who report illness or injury and any prisoner to whom attention is specially directed*

In relation to the appropriate setting for the delivery of health care, the Rules require that specialist treatment should be delivered in dedicated facilities, rather than the prison[31]:

> *46.1 Sick prisoners who require specialist treatment shall be transferred to specialised institutions or to civil hospitals, when such treatment is not available in prison.*

In relation to mental health, the Rules require that psychiatric treatment be available in prisons and that facilities under medical control would be available for the treatment and observation of prisoners if need be:

> *47.1 Specialised prisons or sections under medical control shall be available for the observation and treatment of prisoners suffering from mental disorder or abnormality who do not necessarily fall under the provisions of Rule 12.*
>
> *47.2 The prison medical service shall provide for the psychiatric treatment of all prisoners who are in need of such treatment and pay special attention to suicide prevention.*

This is quite distinct from special observations cells that are under the supervision of non-medical staff in prisons.

[31] Rule 22(2) of the UN Standard Minimum Rules for the Treatment of Prisoners, states: "*Sick Prisoners who require specialist treatment shall be transferred to specialised institutions or to civil hospitals.*"

6. European Convention on Human Rights ("ECHR")

While the ECHR does not include an express right to health, a number of its Articles are relevant to health care in a prison setting.

6.1 Article 2

Keenan v UK, is of considerable significance in the present context, as it addresses one of the most serious aspects of mental health in a prison setting, the identification of suicide risk and its prevention. The particular analysis in the case focused on Article 2 ECHR (the right to life) as Mr Keenan had died of suicide while in prison.

In *Keenan*, the European Court of Human Rights ("ECtHR") noted that the relevant prison authorities had, *inter alia*, placed Mr Keenan on the hospital wing of the prison and checked him every fifteen minutes during periods when his behaviour was a cause for concern. Such precautions satisfied the ECtHR that the prison authorities had acted reasonably to protect the person from his actions in that case, albeit unsuccessfully. While ultimately the ECtHR found no violation of the Applicant's right to life, the Court defined the nature and scope of the obligations on States, under Article 2, to protect the right to life of a person who may attempt suicide in prison.

According to the ECtHR, the relevant domestic authorities **must establish effectively whether the person poses a real and immediate risk of suicide and, if so, take all actions reasonably expected of them to prevent that risk.**[32] The Court affirmed that Article 2 requires States not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction. The Court noted, in this regard, that persons in custody are in a vulnerable position and the authorities are under a duty to protect them. While this obligation does not impose a disproportionate burden on the State, a positive obligation does arise where the authorities knew, or ought to have known, of the existence of a real and immediate risk to the life of an identified individual and failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk.

It is worth noting that the World Health Organization ("WHO") has issued guidance in relation to suicide prevention in prisons. WHO indicates that a starting point for States should be the development of a comprehensive Suicide Prevention Plan, implemented through Suicide Prevention Programmes.[33]

WHO acknowledges the difficulty faced by prison authorities in accurately predicting whether an inmate will attempt or commit suicide. However, WHO states its view that prison officials and correctional, health care, and mental health personnel are in the best position to identify, assess, and treat potentially suicidal behaviour. According to WHO, even though not all inmate suicides are preventable, many are, and a systematic

[32] It is important to note that this applies from the first point of contact with the criminal justice system, which is most likely the Gardaí.
[33] WHO; '*Preventing Suicide in Jails And Prisons*': Department of Mental Health and Substance Abuse, 2007, pg 21.

reduction of these deaths can occur if comprehensive suicide prevention programmes are implemented in correctional facilities throughout the world.

The IHRC recommends that WHO guidance be taken into consideration by the Interdepartmental Group and that an assessment be made as to whether current practice in prisons is in line with same.

6.3 Article 3

Article 3 contains a prohibition on inhuman and degrading treatment. In *Price v UK,*[34] which concerned a severely physically disabled prisoner, a breach of Article 3 was found as the conditions of the Applicant's detention were completely unsuited to her particular disabilities. The ECtHR noted in *Price* that the trial judge, when sentencing Ms Price, did not ascertain whether there were conditions of detention suitable to her needs, suggesting that he might have had a responsibility to do so. While this case addresses the position of a person with a physical disability, the principle also applies in relation to a person with mental health concerns.

The case of *Slawomir Musial v Poland (2009)* specifically addressed the issue of mental health services in a custodial setting. This case concerned the detention and treatment of a person suffering from mental illness in a remand centre and then prison. The Applicant had periodically been moved to a psychiatric hospital for examination before being returned to the remand centre and later to prison. The Applicant was originally remanded in custody in April 2005 and remained in detention at the time the judgment was delivered.

In assessing the Applicant's claim that his detention and treatment amounted to a violation of Article 3 ECHR, the ECtHR reiterated its general principles in this area in stating that:

> *85 …[I]ll-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3. The assessment of this minimum level is, in the nature of things, relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim… Although the purpose of such treatment is a factor to be taken into account, in particular whether it was intended to humiliate or debase the victim, the absence of any such purpose does not inevitably lead to a finding that there has been no violation of Article 3…*
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> *86. Article 3 of the Convention cannot be interpreted as laying down a general obligation to release a detainee on health grounds or to transfer him to a civil hospital, even if he is suffering from an illness that is particularly difficult to treat... However, this provision does require the State to ensure that prisoners are detained in conditions which are compatible with respect for human dignity, that the manner and method of the execution of the measure do not subject them to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, their health and well-being are adequately secured by, among other things, providing them with the requisite medical assistance…*

[34] *Price v UK, 10 Judgment, July 2001.*

> *87. The Court has held on many occasions that the detention of a person who is ill may raise issues under Article 3 of the Convention … and that the lack of appropriate medical care may amount to treatment contrary to that provision... In particular, the assessment of whether the particular conditions of detention are incompatible with the standards of Article 3 has, in the case of mentally ill persons, to take into consideration their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by any particular treatment...*
>
> *88. The Court observes that there are three particular elements to be considered in relation to the compatibility of an applicant's health with his stay in detention: (a) the medical condition of the prisoner, (b) the adequacy of the medical assistance and care provided in detention, and (c) the advisability of maintaining the detention measure in view of the state of health of an applicant...*

The ECtHR found that the failure of the Polish authorities to hold the Applicant during his detention in a suitable psychiatric hospital or detention facility with a specialised psychiatric ward had unnecessarily exposed him to a risk to his health and caused him stress and anxiety. In addition, the Court expressed the view that as the Applicant has received, for the most part, the same attention as other inmates, notwithstanding his particular state of health, this displayed a failure in the authorities' commitment to improving the conditions of detention in compliance with the relevant recommendations of the Council of Europe.[35]

Ultimately, the Court held that the nature, duration and severity of the ill-treatment to which the applicant had been subjected amounted to inhuman and degrading treatment and found a violation of Article 3 of the Convention. The ancillary issue of the conditions of the prison regime (including overcrowding; poor hygiene levels; limited access to outdoor spaces and recreation time), was held to be an exacerbating factor in the case. The Court also offered guidance as to the steps to be taken by the Respondent State to remedy the breach of Article 3 ECHR.[36]

In the case of *Stanev v Bulgaria*, it was found that the Applicant had been deprived of his liberty when he was placed against his will in a social care home for persons with psychiatric problems. In finding that the Applicant's rights under Article 5 of the ECHR had been violated, the Court held that it followed that Article 3 was also applicable to the Applicant's situation. The obligations of the State under Article 3 of the ECHR are to:

> "*ensure that a person is detained in conditions which are compatible with respect for his human dignity, that the manner and method of the execution of the measure do not subject him to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, his health and*

[35] Recommendation Rec (2006) 2 of the Committee of Ministers to Member States on the European Prison Rules and, Recommendation No R(98) 7 of the Committee of Ministers of the Council of Europe to Member States Concerning the Ethical and organisational Aspects of Health Care in Prisons.

[36] The European Court of Human Rights stated that the respondent State must secure, at the earliest possible date, adequate conditions for the Applicant's detention in an establishment capable of providing him with the necessary psychiatric treatment and constant medical supervision (see paragraph 108).

well-being are adequately secured by, among other things, providing him with the requisite medical assistance."[37]

Although there has not been extensive case law in the Irish Courts on the issue of mental health in prisons, it is worth noting the Judgment of Hogan J. in *Kinsella v Governor of Mountjoy Prison*,[38] where it was found that a person's detention in a padded cell in prison for a period of 11 days, objectively amounted to a breach of the State's obligation under Article 40.3.2 of the Constitution to protect the person; which obligation includes the "*integrity of the human mind and personality*."[39]

In relation to Garda custody the recent case of *M.S. V The United Kingdom* is of note. In this case, the applicant, following a violent assault on a relative, had been detained at a police station for over 72 hours following his arrest. The ECtHR found that the Applicant's prolonged detention, without appropriate psychiatric treatment, had diminished his human dignity, although there had been no intentional neglect on the part of the police.[40] Specifically, the Court stated that "*the mentally ill are in a position of particular vulnerability, and clear issues of respect for their fundamental human dignity arise whenever such persons are detained by the authorities*"[41] The Court also identified the lack of coordination between the police and relevant health services as being a contributory factor to the Applicant's prolonged detention without access to psychiatric care. The submission of the government that this had been remedied since was noted by the Court.

6.4 Article 8

Article 8 guarantees respect for private and family life and has both a negative aspect, (preventing the State from interfering with private and family life) and a positive aspect (requiring the State to take measures to ensure respect for private and family life). In *Bensaid v The United Kingdom,*[42] the ECtHR specifically addressed whether mental health was encompassed within Article 8 and stated that *"mental health must also be regarded as a crucial part of private life associated with the aspect of moral integrity*". This is significant insofar as the threshold for a breach of Article 8 ECHR is lower than would apply in relation to Article 3.

6.5 Article 14

Article 14 prohibits discrimination in the enjoyment of rights protected under the Convention on the basis of a one's status. While in general Article 14 has not played a prominent part in the jurisprudence dealing with prisons and health care, it may be that in light of the evolving standards under the CRPD and indeed under Article 3 (such as in the *MS* case above), this situation may change. In fact, the ECtHR often considers it

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[37] *Stanev v Bulgaria* [2012] ECHR 46 at para 204. See also *Kudla v Poland* [2000] 35 EHRR 198 at para 94

[38] *Kinsella v Governor of Mountjoy Prison*, [2011] IEHC 235.

[39] *Ibid.*, at para 16.

[40] *M.S. v the United Kingdom*, Judgment of 3 May 2012, at paras 44-45.

[41] *Ibid.,* at para 39.

[42] *Bensaid v the United Kingdom* [2001] 33 EHRR 10 at para 47.

sufficient, where it finds a breach of the substantive article, not to proceed to consider Article 14. Subject to this, issues concerning the treatment of persons with disabilities *qua* their disability have been considered under the substantive provisions of the Convention such as Article 3 (*Price v UK*[43]) or Article 8 (*Pretty v UK*[44]), rather than being considered under Article 14.

More recently, however, it has been established, in *Glor v Switzerland,* that a difference of treatment on the ground of disability comes within the ambit of Article 14 of the ECHR.[45] As stated, this area of the case law of the Court is evolving and is referred to here for completeness.

7. Conclusion

The IHRC has serious concerns regarding the ability of the present systems to appropriately deal with persons with a mental illness who come in contact with the justice machinery. The identification and appropriate treatment of people with mental illness is of paramount importance both in terms of the rights of the person and of public safety. The general sub-standard conditions in Irish prisons, including in the CMH, places an additional obligation on the State as regards persons with a mental illness within the justice system. In addition to ensuring that there is appropriate recognition of persons with mental illness, and proper provision for their care, the heightened risk posed by poor prison conditions to a person in a vulnerable mental state cannot be ignored.

The IHRC submits the following conclusions and recommendations:

- People with a mental illness in a custodial setting are particularly vulnerable which inevitably places a heightened burden on the State to address their welfare while in State care, whatever that may be.
- A person's medical care should not be compromised by the fact that they have come into contact with the criminal justice system and the standard of medical care in Ireland, in and out of a detention setting, should essentially be the same.
- Intellectual disability must not be neglected when the Group comes to report to the relevant Ministers.
- All actors in the justice system who come into contact with a person with a mental illness must actively ensure that their involvement fully respects the rights of the individual.

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[43] *Price v UK*, [2002] 34 EHRR 1285.
[44] *Pretty v UK* [2002] 35 EHRR 1.
[45] In *Glor*, the Court stated: "*La Cour estime que l'on se trouve, à un double titre, en présence d'une différence de traitement entre personnes placées dans des situations analogues. La liste des motifs de distinction énumérés à l'article 14 n'étant pas exhaustive (« ou toute autre situation » ; voir Stec et autres, précitée, § 50), il n'est pas douteux que le champ d'application de cette disposition englobe l'interdiction de la discrimination fondée sur un handicap*"; at para 80. In *Botta v Italy*, although the Court did not consider that Article 14 arose to be considered in detail as Article 8, the substantive right relied on, was not engaged, the Court appeared to accept "disability", in that case a physical disability as a status under the Article.

- In order for the State to be in a position to demonstrate compliance with Article 14 of the CRPD, the risk of inappropriate deprivation of liberty must be addressed through the operation of robust, consistent and properly resourced diversion programmes.
- The prison environment must be conducive to proper mental health, and where a person already has a mental illness on entering a prison, the environment should not lead to a further diminution in their condition.
- If all health care within prisons came within the remit of the HSE rather than the Prison Service this could address some of the current deficits in care in prisons, while also ensuring continuity of care from the community, into the prison and into the community again on release.
- It is recommended that the report of this interdepartmental Group is integrated with the ongoing review of the Criminal Justice (Insanity) Acts 2006 and 2010.

Irish Human Rights Commission
14 May 2012