LEGISLATING FOR CHANGE: ACCOUNTABILITY AND REFORM OF OUR MENTAL HEALTH SERVICES

A DISCUSSION PAPER

AMNESTY INTERNATIONAL

FEEDBACK

—

We welcome your views.
Should you have any feedback on the contents of this discussion paper we would be delighted to hear from you.

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FOREWORD

The Human Right to Mental Health in Ireland: Towards a Global Standard of Excellence

Professor Lawrence O. Gostin

"Every person has the right to the highest attainable standard of … mental health."

International Covenant on Economic, Social and Cultural Rights (Article 12)

For the majority of people, the words "mental health and human rights" bring to mind issues around liberty, privacy, bodily integrity and non-discrimination. The right to an adequate mental health service is often overlooked, but it is an essential component of the human right to health. So too do human rights require governments to provide mental health services in ways that are transparent, cost effective, and accountable. By providing supports and services in the community, States can enable people to realise their right to live and participate in the community and avoid the social exclusion and discrimination that destroys so many lives.

Respect for human rights in the context of mental health demands accountability from governments and state bodies for mental health service funding and delivery. Human rights demand the efficient and effective use of resources, especially in times when resources are limited.

Major reform of the Irish mental health services was first promised in Government policy in 1984. The Government reiterated this commitment in 2006. However, as this document explains, while there have been important developments, overall the pace of reform has been disappointingly slow and incomplete. It is clear that policy alone has not delivered what persons with mental health problems need.

Surely the time has come to try a new approach?

Ireland ratified the International Covenant on Economic, Social and Cultural Rights in 1989. It thereby made an international commitment to defend and promote the right to the highest attainable standard of mental health. International human rights law is clear that mental health services must continually improve and that states and responsible bodies should be held accountable to ensure this is happening. If this is not happening then legislation can be a powerful tool to drive progress.

The World Health Organisation has also identified law as a valuable means to ensure objectives of mental health policy are achieved. Yet, Irish mental health legislation is mainly focused on involuntary admission and treatment, while ignoring the duty to provide essential mental health services.

Legislation could act as a catalyst for the reform of the mental health system for which successive governments have been striving for more than 25 years. If Government were to do this, Ireland could act as a model for other countries to learn from and follow.

In this discussion paper, Amnesty International Ireland has put forward a compelling case for this new approach. It explains the 'why?': the approach to date simply has not worked. But more importantly, it has also set out the 'how?': practical and insightful recommendations for how law could be used as a vital tool to improve the mental health of the population.

There is nothing to be lost and everything to gain by putting on the statute books the State's duty to progressively achieve a mental health service that respects people's dignity, and be accountable for that task.

I strongly endorse these recommendations and I urge you, the reader, to give them the careful consideration they deserve. It could dramatically improve the lives of people with mental health problems in Ireland. But it could do more than that by becoming a model for the world to follow.

Professor Lawrence O. Gostin*
July 2010

*Linda D. and Timothy J. O'Neill Professor of Global Health Law, Georgetown University; Faculty Director, O'Neill Institute for National and Global Health Law; Editorial committee for Mental Health, Human Rights and Legislation: stop exclusion, dare to care (World Health Organisation 2005); WHO Expert Committee on Mental Health; and Director, WHO Collaborating Center on Law and Human Rights.

GLOSSARY OF TERMS

AI	Amnesty International Ireland
CMHT	Community mental health team
CRPD	Convention on the Rights of Persons with Disabilities
ECHR	European Convention on Human Rights
Green Paper	Green Paper on Mental Health (Department of Health June 1992)
HSE	Health Service Executive
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
2009 Indecon Report	Indecon International Economic Consultants *Review of Government Spending on Mental Health and Assessment of Progress of Implementation of A Vision for Change* (2009).
2010 Indecon Report	Indecon International Economic Consultants *Accountability in the Delivery of A Vision for Change – A Performance Assessment Framework for Mental Health Services* (2010)
MI Principles	United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care
White Paper	White Paper: A New Mental Health Act (Department of Health July 1995)
WHO	World Health Organisation

EXECUTIVE SUMMARY

For more than 25 years Ireland has been striving to reform its mental health services. However, change has been slow and accountability has been inadequate. Law to date has focused on involuntary treatment and detention and has not been used as a means of driving policy and improving accountability for how mental health services are delivered.

The ultimate goal is the creation of a system of comprehensive and community-based mental health services which offers the range of services and supports required to cater for each individual's needs, and thereby effectively promotes and supports the right of each individual to live in the community and participate in community life. This paper examines the role that legislation could play in making Ireland's shared vision of a modern and progressive mental health service a reality.

THE VISION

Successive Government policies on mental health have called for fundamental reform of our mental health system (*Planning for the Future* (1984) and *A Vision for Change* (2006)).[1] *A Vision for Change* set out a policy framework for the mental health of the whole population. In addition to recognising the importance of mental health promotion and primary care, it called for a person-centred, recovery-oriented and holistic approach to mental health services. It called for a shift from the existing system, which involves an over-reliance on institutional care, to a system centred on community-based care to be provided by multi-disciplinary mental health teams. Community-based mental health services are intended to ensure that people with mental health problems can access the services and supports they need while continuing to live and participate in their community.

A Vision for Change set out a framework for mental health service delivery that encompasses general adult mental health and rehabilitation and recovery teams as well as specialist teams for older people, children and people with intellectual disability and liaison, homeless, substance abuse and forensic services. According to *A Vision for Change* multi-disciplinary community mental health teams (CMHTs) should be based in, and operate from, community mental health centres and should include social workers, occupational therapists, family therapists and clinical psychologists in addition to medical staff. Unsuitable institutional facilities should be closed and replaced with day centres, community residential units, high support intensive care residences, crisis houses, rehabilitation units, acute in-patient units within general hospitals and other specialist in-patient units.

THE REALITY

Some modest progress has been made in improving mental health services in recent years and the €50 million capital programme announced by John Moloney TD, Minister for Equality, Disability and Mental Health at the Department of Health and Children on 1 March 2010 is to be welcomed. The efforts of many dedicated individuals within the HSE, the Department of Health and Children and the Office for Disability and Mental Health to drive reform of the services must also be acknowledged. In addition, the introduction of the Quality Framework for Mental Health Services by the Mental Health Commission is a positive step.[2] However, on the whole, implementation of the recommendations of *A Vision for Change* has been inadequate. This is evidenced all too clearly in successive reports of the

Inspector of Mental Health Services and the Independent Monitoring Group for *A Vision for Change*. A report by Indecon International Economic Consultants published by AI in 2009, found that there continues to be an imbalance between the level of resources allocated to in-patient services as against that spent on community-based services.[3] The economic downturn has led to cuts in mental health services, and while there have been some exemptions from the moratorium on recruitment, mental health service staffing has suffered and it appears that valuable progress has been undone. In the most recent annual report of the Mental Health Commission the Inspector for Mental Health Services stated "unfortunately and ironically, when cuts are made, it is the progressive community services which are culled, thus causing reversion to a more custodial form of mental health service".

There has been widespread criticism of the existing HSE Implementation Plan for *A Vision for Change*. And neither the HSE Service Plan, nor the HSE Corporate Plan required to be prepared under the Health Act 2004 incorporate a detailed, time-lined and resourced plan for implementation of mental health reform policy. Furthermore, there is no published detailed multi-annual capital programme for mental health services infrastructure. The 2009 Indecon report also found significant failures in accountability for expenditure in mental health services since *A Vision for Change* was published and the 2010 Indecon Report confirmed that there continues to be gaps in the availability of detailed information to support ongoing monitoring of the funding and delivery of mental health services. These shortcomings in planning and accountability highlight the urgent need for more robust and transparent planning and reporting obligations to ensure accountability and value for money in the implementation of *A Vision for Change*.

MENTAL HEALTH AND HUMAN RIGHTS

Every person has the human right to the highest attainable standard of mental health.[5] This right is set out in Article 12 of the International Covenant on Economic, Social and Cultural Rights, which was ratified by Ireland in 1989. This means that under international human rights law the State must ensure the availability of, at the very least, core minimum essential levels of mental health services. Year on year, the State must demonstrate that it is using its available resources in an efficient manner so as to improve mental health service provision over time, thereby progressively realising the right to the highest attainable standard of mental health. Failure to make appropriate mental health services available can have consequences, not only for people's right to health, but for a whole

range of other rights such as the rights to liberty, privacy and bodily integrity and freedom from inhuman or degrading treatment. Inadequate community based services and supports also have serious implications for the right to live and participate in the community and can lead to social exclusion.[6]

Accountability is a key human rights principle which gives individuals and organisations the opportunity to understand what steps the State has taken to reform mental health services and why.[7] As a process, it also helps to identify what works to improve the system and what does not.[8] In order to measure whether or not the State is using its resources efficiently and improving its mental health system over time, effective and transparent monitoring and accountability mechanisms must be in place.

IRELAND'S MENTAL HEALTH LAWS

To date, Ireland's approach to legislation in the area of mental health has been limited and there continues to be a disproportionate emphasis on involuntary admission and treatment and in-patient services in our laws. Both the *Green Paper on Mental Health* (Department of Health June 1992) and the *White Paper: A New Mental Health Act* (Department of Health July 1995), which preceded the Mental Health Act 2001, called for the new Act to address the obligations of Health Boards (since replaced by the HSE) to provide access to comprehensive community-based services. However, the new law mainly focused on the issues of involuntary detention and treatment.[9] While it also established the Mental Health Commission and the Inspectorate of Mental Health Services, the 2001 Act did not contain a framework for the delivery of mental health services needed to reflect a community-based, comprehensive and integrated service as recommended in successive mental health policy documents and as contemplated by the Green and White Papers. Although the 2001 Act was a welcome improvement on the Mental Treatment Acts 1945-61,[10] the omission of provisions for community-based services was criticised by all the main political parties during the Dáil and Seanad debates.[11]

THE KEY ROLE OF LAW IN DRIVING MENTAL HEALTH POLICY

The World Health Organisation (WHO) has stated that legislation can play a major role in promoting community-based care for people with mental health problems and reducing involuntary admissions, thereby putting into practice the principle of "least restrictive alternative".[12] In its Mental Health Policy and Service Guidance Package (2003), the WHO recognises that mental health legislation is "essential for complementing and reinforcing mental health policy and providing a legal framework for meeting its goals".[13] The WHO also points out that the role of mental health legislation is not limited to the provision of institution-based health services.[14] Legislation can also play a part in ensuring that people with mental health problems can live in and participate in the community by providing access to the appropriate supports and services in the community.[15] Mental health laws can help to achieve the goals set out in mental health policy by providing a legal framework for implementation and enforcement.[16]

A Vision for Change acknowledges that mental health legislation is essential to underpin the right to respect for the dignity of individuals and the protection of their human rights.[17] In its Third Annual Report (2008) on Implementation of *A Vision for Change*, the Independent Monitoring Group recommended that "[t]he Office for Disability and Mental Health should consider the role legislation might play in accelerating implementation of *A Vision for Change*".[18] In January 2010, Minister Moloney stated in response to a parliamentary question that the forthcoming review of the Mental Health Act "will also consider whether further provisions are required in relation to community-based mental health services".[19]

HOW TO ADDRESS THE IMPLEMENTATION GAP

Legislation in itself is not a panacea. A review of expert commentary makes clear that there are many components required for successful implementation of policy. In the context of mental health services in Ireland, these include the need for a clear, detailed implementation plan, the need for accountable, effective leadership, accountability in the provision and use of resources and the closure of old psychiatric hospitals. Effective public administration also has a key role to play. Legislation that underpins accountability can support these mechanisms and play a significant part in driving implementation of *A Vision for Change*.

A Vision for Change also demands a radical cultural shift within services that would see the service user at the heart of the service with a clear focus on recovery. This can only truly happen when the full range of supports and services that promote recovery are available.

AI believes that the Government needs to use legislation to effectively promote and drive the provision of comprehensive community-based mental health care and support services and improve accountability for how money is spent in the area of mental health. This approach is called for by human rights law, which requires States to "use all appropriate means, including particularly the adoption of legislative measures",[20] to realise the right to health. It is hoped that this discussion paper will stimulate meaningful discourse among all relevant stakeholders in the mental health sector in Ireland on how legislation could improve accountability and, as a key enabler of existing policy and standards, serve as a driver for reform of our mental health services.

THE KEY OVERALL CONCLUSIONS FROM THIS REPORT ARE:

- **For more than 25 years, successive Government policies have called for a shift in the way mental health services are delivered. This calls for a move from an over-reliance on inpatient care to comprehensive and community-based multi-disciplinary services. A progressive framework for mental health services is set out in *A Vision for Change* and this was widely endorsed and welcomed by stakeholders and people with mental health problems.**

- **Implementation of policy-based reform of the mental health services has been slow and uneven to date. Accountability for expenditure on mental health and transparent information on how such expenditure is used to reform the services in line with policy has been lacking. The need for a new approach to accountability for implementation of *A Vision for Change* is clear.**

- **International human rights law demands that mental health services be continuously improved in line with best practice in order to fulfil the right to the highest attainable standard of mental health and avoid social exclusion. For so long as Ireland fails to implement the policy of reform, it will continue to fail to meet international human rights standards. The human cost of this is huge for people who experience mental health problems and their families.**

- **Ireland's laws in the area of mental health mainly focus on inpatient care and treatment and do not provide a framework for the delivery of mental health services as envisaged in *A Vision for Change*. In addition, they do not demand the level of planning and accountability necessary to track progress towards reform.**

- **To date Ireland has relied to a large extent on policy and standards to make the transition from a mental health service that is dominated by institutionalised care to a modern, comprehensive mental health service that has specialist community-based services at its core. However, progress towards achieving this reform has been unacceptably slow and uneven. Legislation, together with effective public administration, strong leadership and resources, can drive reform by complementing existing policy and standards and underpinning their implementation.**

- **Legislation could establish a framework for sustained improvement of mental health services and increased transparency and accountability in mental health expenditure by clarifying the obligations of the HSE and the principles that should guide its fulfilment of those obligations. Amendments to the provisions of existing law on the inspection, approval and registration of mental health services could also drive reform.**

AI'S RECOMMENDATIONS FOR USING LEGISLATION TO DRIVE REFORM AND ACCOUNTABILITY ARE THAT GOVERNMENT SHOULD:

→ **place a statutory obligation on the HSE:**

- to prepare and publish a detailed, time-bound plan for the closure of unsuitable facilities and the development and ongoing provision of comprehensive and community-based mental health services in line with *A Vision for Change*. This statutory obligation (or accompanying regulations) should stipulate the level of detail to be included in such a plan including measurable targets, milestones, outcomes and indicators as well as clear timeframes and details of funding, human resources and infrastructure needed for implementation. The plan should also include details of management structures and responsibilities and it should be subject to the approval of the Minister for Health and Children and possibly also any independent monitoring group established by the Minister from time to time (i.e. the Independent Monitoring Group in the current context);
- to provide comprehensive and community-based mental health services including the specialist services identified in *A Vision for Change* in line with the detailed plan and to the maximum of available resources; and
- to report annually by catchment area and service area to the Oireachtas and any independent monitoring group established by the Minister from time to time (i.e. the Independent Monitoring Group in the current context) on progress towards the implementation of its plan and expenditure of allocated funding and to publish this report. This reporting requirement could point to key performance indicators (both transformation indicators[21] and ongoing performance indicators[22]) relating to financial accountability, mental health services infrastructure, staffing/human resources (by speciality/skill mix), scope and quality of services and outcomes such as those recommended in the 2010 Indecon Report.

➔ **enshrine principles in law to guide the planning and delivery of mental health services. These could include:**

- the principle that services and supports should be designed in such a way as to enable people to enjoy their right to live in the community and participate in community life and to prevent social exclusion and isolation;
- that persons be able to access the appropriate range of treatments and supports suited to their needs in the least restrictive environment appropriate;
- that the mental health services be designed in a way that promotes and underpins the recovery ethos; and
- that service user participation be a core element of service planning and delivery.[23]

➔ **extend the scope of Part 5 of the Mental Health Act 2001 so that the system of registration and approval of mental health services by the Mental Health Commission also applies to community-based services; and**

➔ **place equal emphasis on the periodic inspection of inpatient and community-based mental health services by amending section 51 of the 2001 Act (functions of the Inspector).**

THE KEY DRIVERS OF MENTAL HEALTH REFORM

REFORM AND ACCOUNTABILITY

EFFECTIVE PUBLIC ADMINISTRATION, ADEQUATE IMPLEMENTATION PLAN, ACCOUNTABLE AND EFFECTIVE LEADERSHIP AND CLOSURE OF OLD PSYCHIATRIC HOSPITALS

POLICY, STANDARDS AND LEGISLATION

PUBLIC SUPPORT AND POLITICAL WILL.

INTRODUCTION

Amnesty International Ireland (AI) has as a long-term goal of ensuring that the right of all people in Ireland to the highest attainable standard of mental health is fully realised.[24] AI is campaigning for changes in law, policy and practice to bring this about.

A key priority of AI's campaign is to explore how legislative reform could provide greater accountability and underpin meaningful progress towards achieving the comprehensive model of mental health service provision foreseen in *A Vision for Change*.

The process of reforming mental health services in Ireland began over 25 years ago. This process has involved a variety of different approaches, including policy, standards, planning and budgetary measures. However, in Ireland today we are still failing to fulfil the rights of people who experience mental health problems. While there have been some improvements and the efforts of many committed individuals within the HSE and Department of Health and Children cannot go unacknowledged, these combined actions have so far failed to deliver a mental health system that provides comprehensive and community-based services on an equal basis throughout the country. What is more, monitoring and accountability mechanisms to track expenditure, progress and value for money in the reform of our mental health services have been weak.

Legislation has not been used to date to improve accountability and expedite reform of the mental health services. AI believes that, since other approaches have not yielded results, legislation must now be considered.

OVERVIEW

Section 1 of this paper sets out the vision of comprehensive and community-based mental health services, which Ireland is striving to achieve. **Section 2** then gives an overview of the mental health system in Ireland today. In particular it outlines the slow rate of implementation of *A Vision for Change* since its publication in 2006 and Government and HSE failures in accountability for such implementation. **Section 3** looks at the key components of successful implementation of policy as highlighted by other reports on this subject. It also focuses on existing structures for implementation of *A Vision for Change*. **Section 4** explains the nature of the State's legal obligations under international human rights law. It provides an overview of what the international human rights framework requires of mental health services, as well as referring to the right to live independently and be included in the community. It also discusses the human rights principles of progressive realisation and accountability as well as touching on the other human rights that may be adversely affected by a lack of appropriate mental health services. **Section 5** outlines the mental health related issues currently addressed in Irish law and the gaps that exist, including those highlighted by the Green and White Papers on Mental Health during the 1990s. This section also highlights the limitations of the existing statutory accountability mechanisms in the context of mental health services. **Section 6** then goes on to discuss the role legislation can play as a driver for the implementation of policy and standards and as a means of protecting human rights. Finally, **Section 7** sets out how legislation would strengthen accountability for mental health services in Ireland while at the same time underpinning continuous improvement of mental health service provision in line with policy.

FOOTNOTES

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1 Department of Health T*he Psychiatric Services: Planning for the Future Stationary Office*, Dublin 1984 and Report of the Expert Group on Mental Health Policy *A Vision for Change* Stationary Office, Dublin 2006.

2 Mental Health Commission *Quality Framework: Mental Health Services in Ireland* Mental Health Commission, Dublin (2007).

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3 Indecon International Economic Consultants *Review of Government Spending on Mental Health and Assessment of Progress on Implementation of A Vision for Change* (2009).

4 *Mental Health Commission Annual Report 2009 including the Report of the Inspector of Mental Health Services 2009*, p. 82. Exemptions from the moratorium on recruitment obtained for 2010 that will enable recruitment of 100 psychiatric nurses as well as some other Health and Social Care staff should result in the filling of some vacant posts.

5 The "right to the highest attainable standard of health" and the "right to health" will be used throughout this document as abbreviations for the "right to the highest attainable standard of physical and mental health", which is protected *inter alia* under Article 12 of the International Covenant on Economic, Social and Cultural Rights and discussed in detail in Section 4 of this paper. The focus of this paper will be on mental health.

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6 The right to live in the community with choices equal to others is set out in Article 19 of the Convention on the Rights of Persons with Disabilities (CRPD), which Ireland has signed but not yet ratified. For further details see Section 4 of this paper.

7 Potts, Helen *Accountability and the Right to the Highest Attainable Standard of Health* University of Essex Human Rights Centre (undated) p. 7.

8 ibid.

9 The Mental Health Act 2001 was eventually introduced in response to the threat of a finding against the State by the European Court of Human Rights (*Croke v Smith* (unreported) High Court 31 July 1995; *Croke v Smith* (No. 2) [1998] IR 101; *Croke v Ireland* European Court of Human Rights Application no. 33267/96 (struck out 21 December 2000)). This case was resolved by way of 'friendly settlement' between the parties. It was on foot of this settlement that the Mental Health Bill 1999 was introduced.

10 There have been a number of developments in the international human rights framework since the introduction of the Mental Health Act 2001, including recent case law of the European Court of Human Rights and the entry into force of the CRPD, which Ireland has signed but not yet ratified. The Mental Health Act is out of step with these developments and needs to be comprehensively reviewed so that its provisions can be amended as appropriate. AI is calling on the Government to ensure that its next review of the Act is completed by November 2011 as planned and that it is a substantive review of the Act carried out in consultation with service users, their representative organisations and all relevant stakeholders, using human rights law as its basis.

11 See, for example, Dáil Eireann Volume 517 (6 April 2000) Mental Health Bill 1999, Second Stage, Deputy Alan Shatter, 1008 and Deputy Liz McManus, 1016-1018 (available at: http://www.oireachtas.ie/viewdoc.asp?fn=/documents/bills28/bills/1999/7099/default.htm).

FOOTNOTES

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12 World Health Organisation (WHO) *Resource Book on Mental Health, Human Rights and Legislation: Stop exclusion, dare to care* WHO Geneva (2005) p. 30. The WHO defines the principle of "least restrictive alternative" as "providing treatment in settings and in a manner which is the least intrusive while meeting treatment needs".

13 WHO *Mental Health Policy and Service Guidance Package: Mental Health, Legislation and Human Rights WHO* Geneva (2003) p. 3.

14 ibid, p. 2.

15 Note 12 above, p. 6

16 Note 12 above p. 2.

17 First core value/principle of A Vision for Change (note 1 above), Annex 1.2.

18 *A Vision for Change* Independent Monitoring Group *Third Annual Report on Implementation 2008* (April 2009) available at www.dohc.ie, p. 22.

19 Response to Parliamentary Questions 3669/10 and 3670/10 Dail Debate, Vol. 700 No. 1, Tuesday 26 January 2010.

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20 Article 2 ICESCR.

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21 That is, indicators designed to facilitate monitoring of progress towards mental health service reform as recommended by *A Vision for Change*, see Indecon International Economic Consultants Accountability in the Delivery of *A Vision for Change – A Performance Assessment Framework for Mental Health Services* (2010) (2010 Indecon Report) p. 47.

22 That is, indicators designed to facilitate the ongoing monitoring of performance and financial accountability of the mental health service, ibid, p. 47.

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23 This is covered to some extent in Part 4 of the Health Act 2004. Moreover, the establishment of the National Service User Executive (NSUE) is a welcome step in ensuring the involvement of service users in service planning and delivery.

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24 The right to the highest attainable standard of physical and mental health is set out in Article 12 of the International Covenant on Economic, Social and Cultural Rights, ratified by Ireland in 1989, and reiterated in a number of other international human rights treaties including the Convention on the Rights of the Child (article 24) and the newly adopted Convention on the Rights of Persons with Disabilities (article 25), which Ireland has not yet ratified.

SECTION 1

The vision of comprehensive and community based mental health services

THE IMPORTANCE OF COMMUNITY-BASED SERVICES

"The core of *A Vision for Change* is the move from institutional care to community care. Such a change is international best practice but it is given added urgency because of the poor condition of some of Ireland's Approved Centres, a point made clearly and repeatedly in the reports of the Inspectorate of Mental Health Services."

Dr Edmond O'Dea. Chairman,
Mental Health Commission
Foreword to the Mental Health
Commission Annual Report 2009

While the majority of people who experience a mental health problem can receive care through their GP, those with severe or ongoing mental health problems require specialist support. While *A Vision for Change* acknowledges that specialist community mental health services "deal with the smallest part of the population affected by mental health problems", such services provide supports to "people with the greatest need for mental health treatment and care".[25] Community mental health services can provide this specialised support so that individuals with severe or ongoing mental health problems can recover while living in their community. Community mental health services also provide a wider range of supports than would have been the case in traditional psychiatric hospitals. Therefore, they are able to support a person to recover and reintegrate into their community, to retain or obtain employment and education and sustain family life. Thus, community mental health services and supports can enable people to exercise their right to live and participate in the community and can help to prevent social exclusion or isolation.[26] Specialist community mental health services also play an important role in the provision of mental health supports in primary care by providing consultation and liaison services to General Practitioners.[27] Community mental health teams (CMHTs) should also support mental health promotion in the local community as recommended in *A Vision for Change*.[28]

The development of comprehensive, community-based services is essential in order to achieve de-institutionalisation. Without appropriate community-based supports, people who are in crisis but who could be treated at home will end up being hospitalised unnecessarily. Furthermore, if a person in hospital requires supports in order to be discharged, their stay will be unnecessarily lengthened if the supports they need are not available in the community. And for individuals who have resided in psychiatric hospitals for many years, they will require intensive community-based support and rehabilitation in order to transfer to the community and enable the old hospitals to close. Community based mental health services are also necessary to successfully challenge the stigma and discrimination faced by people with mental health problems since they integrate service users into their communities rather than keeping them isolated.

The WHO has stated that a sound de-institutionalisation process has three essential components:

- prevention of inappropriate mental hospital admissions through the provision of community facilities;
- discharge to the community of long-term institutional patients who have received adequate preparation; and
- establishment and maintenance of community support systems for non-institutionalised patients.[29]

THE APPROACH ADVOCATED IN *A VISION FOR CHANGE*

A Vision for Change set out a policy framework for the mental health of the whole population. In addition to recognising the importance of mental health promotion and primary care, it called for a person-centred, recovery-oriented and holistic approach to mental health services.[30] It called for a shift from the existing system, which involves an over-reliance on institutional care, to a system centred on community-based care to be provided by multi-disciplinary mental health teams. The policy set out a framework for mental health service delivery that encompasses general adult multi-disciplinary mental health and rehabilitation and recovery teams as well as specialist multi-disciplinary teams for older people, children and people with intellectual disability and liaison, homeless, substance abuse and forensic services.[31] While this multi-disciplinary, community-based approach was first recommended in 1984 in the Government's policy paper *Planning for the Future*, the 2006 policy developed this approach further, incorporating a set of principles that includes the recovery approach and respect for human rights. A recent report by the Health Research Board on personal experiences of recovery from mental health problems in Ireland reinforces the need for the development of multi-disciplinary teams and community services, as recommended by *A Vision for Change*, in order to provide recovery-oriented services.[32]

WHAT DO COMMUNITY MENTAL HEALTH TEAMS DO?

The WHO describes the community-based mental health service approach as comprising:

- "services which are close to home, including general hospital care for acute admissions, and long-term residential facilities in the community;
- interventions related to disabilities as well as symptoms;
- treatment and care specific to the diagnosis and needs of each individual;
- a wide range of services which address the needs of people with mental and behavioural disorders;
- services which are coordinated between mental health professionals and community agencies;
- ambulatory rather than static services, including those which can offer home treatment;
- partnership with carers and meeting their needs; and
- legislation to support the above aspects of care".[33]

Community mental health services provide multi-disciplinary assessment, home-based treatment and support, crisis houses for crisis care in the community, day hospitals for community-based day treatment, and early intervention services. While CMHTs can provide acute interventions such as home-based treatment, crisis care and support intensive care rehabilitation units and high support intensive care residences, *A Vision for Change* also recognises the ongoing need for hospital-based acute care for some individuals. In keeping with WHO guidance, *A Vision for Change* recommends that hospital-based treatment be carried out in general hospitals.[34]

The benefits of CMHTs are that they result in greater user and carer satisfaction and fewer people leaving treatment early. They may also reduce suicides.[35]

A Vision for Change states that the central structure within the adult mental health service should be a specialised CMHT to serve everybody aged 18-64 in a community of 50,000.[36] It also states that home-based treatment should be the main method of treatment delivery for all elements of the adult mental health services. This requires fully-resourced CMHTs.

WHAT KIND OF STAFF ARE IN A COMMUNITY MENTAL HEALTH TEAM?

In order to provide a mental health service that will enable individuals to recover, *A Vision for Change* recommends that a CMHT include the following personnel:

- psychiatry;
- nursing;
- social work;
- clinical psychology;
- occupational therapy;
- mental health support workers (people with health and social care skills to support practical needs of service users); and
- other expertise for particular teams, such as addiction counsellors, psycho-therapists, creative/recreational therapists, speech and language therapists, etc.

In addition to the general adult CMHTs, *A Vision for Change* also identifies the need for a range of specialist CMHTs accessible to each community. These are:

- Child and adolescent CMHTs;
- Recovery and rehabilitation teams;
- Mental health services for older people CMHTs;
- CMHTs for adults with intellectual disability (26 nationally based on two per 300,000 population);
- CMHTs for children and adolescents with intellectual disability (13 nationally based on one per 300,000 population);
- Forensic CMHTs (one for each of the four HSE regions);
- Homeless CMHTs (Dublin);
- CMHTs for mental health co-morbid with substance abuse services (26 nationally based on two per 300,000 population);
- Eating Disorder CMHTs (one for each of the four HSE regions);
- Liaison multi-disciplinary teams to liase with each regional hospital (13 nationally); and
- Two neuro-psychiatry teams.

A Vision for Change sets out that almost all of these teams would operate from community mental health centres. These centres allow staff to communicate with each other and coordinate care for each service user. Without a dedicated base from which to operate, there is a strong risk that care for each individual will be fragmented and ad hoc.

HOW MUCH DO THEY COST?

Community based services have been found to be a cost-effective way to provide care that is preferred by service users. An Irish study commissioned by the Mental Health Commission found that a balanced approach between hospital-based and community care is recommended. Community care is not necessarily cheaper, but it is likely to yield better outcomes for users and their families.[37] The evidence is not clear on the relative costs of CMHTs compared to standard, hospital-based care. A range of studies have found that the average total cost of care is less for patients treated by CMHTs than with standard care, although other evidence suggests that CMHTs do not result in real cost savings.[38] While CMHTs are not necessarily more expensive, and may be cheaper than traditional care, they require extra initial investment in order to set them up.

Community-based mental health services for people with mental health problems are clearly crucial. A progressive framework for mental health services, as outlined above, is set out in *A Vision for Change*. AI believes that legislation is key to making this vision a reality.

FOOTNOTES

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25 *A Vision for Change* (note 1 above) p. 23.

26 Article 19 of the Convention on the Rights of Persons with Disabilities (CRPD) (which Ireland has signed but not yet ratified) expressly recognises the right to live independently and be included in the community. It requires that states parties to the CRPD take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community including by ensuring access to a range of in-, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community.

27 See *A Vision for Change*, (note 1 above) p. 65.

28 ibid, p. 49.

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29 World Health Organisation (WHO) *The World Health Report 2001: Mental Health: New Understanding, New Hope,* WHO Geneva (2001), p. 52

30 A holistic approach to mental health services is one that covers all aspects of mental health including biological, psychological and social.

31 *A Vision for Change* (note 1 above), Chapter 8.

32 Kartalova-O'Doherty Y and Tedstone Doherty T *Reconnecting with life: personal experiences of recovering from mental health problems in Ireland*. HRB Research Series 8. Dublin: Health Research Board (2010), p. 46.

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33 Note 29 above, p. 50.

34 *A Vision for Change* (note 1 above), p. 77.

35 O'Shea E and Kennelly B *The Economics of Mental Health Care in Ireland* Mental Health Commission Dublin (2008), p. 70.

36 *A Vision for Change* (note 1 above), p. 73.

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37 Note 35 above, p.83

38 ibid, p. 70.

SECTION 2

The mental health system in Ireland today

The publication of *A Vision for Change* in 2006 was widely welcomed and marked a positive step towards respecting the human rights of people experiencing or at risk of mental health problems.[39] At its launch, the Government committed that the policy would guide the future development of "modern, high-quality mental health services". It put in place a monitoring group and promised €25 million for implementation in the first year, with the then Tánaiste saying that this level of investment was expected to follow in future years[40].

IMPLEMENTATION OF *A VISION FOR CHANGE* TO DATE

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Some positive developments must be acknowledged since the adoption of *A Vision for Change*. These include the establishment of the Office for Disability and Mental Health, the appointment of a single Assistant National Director for Mental Health within the HSE, the increase in service user involvement with the HSE through the establishment of the National Service User Executive (NSUE), the development of some innovative and progressive services throughout the country and some modest increases in staffing, together with initiation of additional child and adolescent mental health teams, and the roll-out of new in-patient facilities for children and young people in Cork, Galway and Dublin.

These changes have signalled an increased priority for mental health both within the Department of Health and Children and in the HSE and herald a new approach to planning with significantly greater input from service users. The establishment of the Office for Disability and Mental Health has also provided a focal point for cross-departmental action on mental health. The Government's announcement of a €50 million capital development programme in 2010 that includes the development of new acute and long-stay units as well as some community residences is welcome. This designated funding stream is providing a new impetus for the development of mental health facilities. The obvious commitment of many individuals within the Department of Health and Children and the HSE to reforming the mental health service, particularly in the current economic climate, must not be overlooked or understated.

"The person is at the centre of the mental health system. The human rights of individuals with mental health problems must be respected at all times..."

A Vision for Change "citizenship" principle, p.15

However, for many people who experience mental health problems, access to the type of mental health care system envisaged by *A Vision for Change* is far from reality. Successive reports of the Independent Monitoring Group for *A Vision for Change* and the Mental Health Commission have shown the substantial failure to implement policy. Mental health services continue to be dominated by a one-dimensional response that over-emphasises medication at the expense of other supports. The Mental Health Commission's 2008 report describes community-based mental health services with sufficient staffing and appropriate skill mix as "woefully inadequate" in many parts of the country and 2009 has seen no improvement in this regard.[41] In his 2008 report, the Inspector of Mental Health Services raised concerns about over-prescribing of benzodiazepines, stating that their use in Ireland appears to be high.[42] Furthermore, most service users reported to the Inspector that psychological therapies and other alternatives to medication were not available, or where available were not sufficient.[43]

The lack of appropriate holistic supports in in-patient services is also evident from the Inspector's finding that many people under the care of rehabilitation services are "left to live out cold, empty, colourless lives in old institutions, forgotten and neglected", while the lack of quality community services means that people with long-term mental health problems are being re-institutionalised, a practice the Inspector has described as "neo-warehousing" in the community where "little in the way of gainful, productive day-time activities" is provided.[44] The HSE's own review of long-stay services found that the majority of activities provided to clients were of a social nature, with fewer engaged in therapeutic activities. Less than a quarter of those in high support community residences, and only 6.7 per cent of those on identified rehabilitative units, were participating in rehabilitative training.[45] That report also shows that long-stay admissions are arising in acute treatment units in general hospitals, which are inappropriate for long-stay support.[46] The "dangerous" practice of placing frail, elderly patients with dementia in the same adult wards as younger patients was widespread in 2008.[47] And during that year, 263 children[48] were admitted to adult wards in contravention of the Convention on the Rights of Children, an increase of 14 per cent on the previous year.[49] Some 200 children and young people were admitted to adult services during 2009.[50]

A report by Indecon International Economic Consultants commissioned by AI in 2009, found significant shortages in staffing of CMHTs that is limiting choice in services and supports available.[51] Their analysis showed that across the years 2006 to 2008, human resources development continued to be biased towards medical staff, while health and social care staffing including psychologists, occupational therapists and social workers persistently lagged far behind.[52] According to the report, health and social care staff were least well resourced at the end of 2008, with just 645 out of 2,835 Whole Time Equivalents (WTEs)[53] (staff) in place.[54] In contrast, there was a surplus over required levels of nursing staff, although many of these are assigned to acute and long-stay residential services and there continues to be shortages of nursing staff in some CMHTs.[55] The report also showed that there is a persistent over-reliance on in-patient treatment instead of the shift to community services that *A Vision for Change* and its predecessor *Planning for the Future*, were intended to bring about.[56] CMHTs accounted for a reported total of 1,982 WTEs as at December 2008, equivalent to just 18.9 per cent of overall mental health service staffing.[57] The report concluded that at the current rate of progress, the HSE will not be able to achieve its own target date of implementation by 2013, even for the general, adult mental health service.[58] Approximately 10 per cent of nursing staff are reported to have left the mental health services in 2009[59] and according to the HSE, this has had the effect of limiting the reconfiguration of services from inpatient units to the community.[60] The Inspector of Mental Health Services in his most recent report has confirmed that "unfortunately and ironically, when cuts are made, it is the progressive community services which are culled, thus causing a reversion to a more custodial form of mental health service".[61] And in its most recent report, the Independent Monitoring Group for *A Vision for Change* pointed out that the replacement of just 65 of the 700 staff who left the mental health services is "unsustainable and greatly comprises existing services and strategic objectives".[62]

Also of concern from a human rights perspective is the apparent under-prioritisation of specialist mental health services. Human rights principles place an obligation on the State to prioritise vulnerable groups.[63] However, since 2006 the services for the most vulnerable people with mental health problems have undergone the least development, a fact which has once again been highlighted by the most recent report of the Independent Monitoring Group for *A Vision for Change*.[64] For example, although a court diversion system has been put in place in the Dublin remand prison, Cloverhill, there have been no developments of specialist forensic care units outside Dublin, nor are there firm plans to improve the manifestly inadequate facilities at the Central Mental Hospital. And there is reason for concern about the extent of mental health problems among

individuals on remand, mostly for non-violent offences,[65] a situation that may indicate that the lack of effective follow up care in the community is leading individuals in need of such support into the criminal justice system inappropriately. Furthermore there has been little development of specialist eating disorder services and mental health services for persons with intellectual disability remain the most severely under-resourced, with just 23 out of the 424 recommended staff in place at the end of 2008.[66] Worryingly, in 2009 the Independent Monitoring Group found no evidence of progress on any of the recommendations of *A Vision for Change* relating to mental health services for people with intellectual disabilities or a National Eating Disorder Service.[67]

CURRENT MONITORING MECHANISMS FOR *A VISION FOR CHANGE*

In addition to the broader accountability framework of the HSE generally (discussed in more detail in Section 5), the current arrangements for monitoring the implementation of *A Vision for Change* consist of three components:

- Oversight by the Minister for Disability and Mental Health;
- Oversight by the Office for Disability and Mental Health;
- Annual monitoring report by the Independent Monitoring Group

Successive Ministers for Disability and Mental Health have committed to greater oversight in expenditure of mental health funding. However, Ministerial oversight has been hampered by the fact that the statutory reporting obligations on the HSE do not demand detailed reporting on mental health expenditure. These statutory reporting obligations are discussed in more detail in section 5 below.

The Office for Disability and Mental Health is responsible for driving implementation of *A Vision for Change*. Its stated remit includes "monitoring and evaluating HSE performance in relation to mental health services" and it engages with the HSE on a regular basis with regard to implementation.

The Independent Monitoring Group was established in 2006 by the then Minister of State at the Department of Health and Children in order to monitor progress on the implementation of *A Vision for Change*. The group consists of a range of independent stakeholders including a representative from the Department of Health and Children, the HSE and the Inspector of Mental Health Services. Its terms of reference are:

- To monitor and assess progress on the implementation of all the recommendations in A Vision for Change;
- To make recommendations in relation to the manner in which the recommendations are implemented; and
- To report to the Minister annually on progress made towards implementing the recommendations of the report and to publish the report.

Clearly, the Independent Monitoring Group has a very important role to play in monitoring implementation of *A Vision for Change*. However, AI believes that its work has been hindered by a number of factors discussed in more detail below, including the poor quality implementation plan for *A Vision for Change* and the lack of available information to track mental health funding and expenditure and evaluate service provision. In its most recent report the Independent Monitoring Group criticised the quality of communications received from the HSE and concluded that "the HSE is either unwilling or unable to provide the information required".[68]

It is clear that four years later, not enough of the vision set out in policy has been achieved. Accountability for expenditure on mental health and transparent information on how such expenditure is used to reform the services in line with policy has been lacking and this in turn has impeded the effectiveness of existing monitoring mechanisms. The following section will discuss the key factors in addressing the gap between policy development and implementation.

FOOTNOTES

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39 It is also worth noting that Ireland was at that time one of 52 States in the WHO European Region who endorsed the Helsinki Mental Health Declaration and Action Plan for Europe. The objective of the Helsinki Action Plan (2005-2010) was to drive mental health policy, one of its priority areas being the design and implementation of comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery. See: Amnesty International Irish Section *Action Briefing: Mental Health Policy* (2006), p. 4.

40 Department of Health and Children Tánaiste and Minister O'Malley launch the Report of the Expert Group on Mental Health Policy (press release 24 January 2006)

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41 Mental Health Commission Annual Report 2008 including the Report of the Inspector of Mental Health Services 2008, p. 67. See also *Mental Health Commission Annual Report* 2009 (note 4 above), p. 82 – "Multidisciplinary community mental health teams are still deficient in numbers and where they exist, in staffing".

42 ibid, p. 88. It was reported that 63% of in-patients were on benzodiazepines and 32% of these prescribed more than one benzodiazepine at the same time.

43 ibid, p. 84.

44 ibid, p. 64.

45 Health Service Executive *The Efficiency and Effectiveness of Long-Stay Residential Care for Adults within the Mental Health Services: Evaluation report prepared under the Value for Money and Policy Review Initiative* Health Service Executive (2009), pp vii-viii.

46 ibid, p. 21. In addition to the many long-stay patients residing in old psychiatric hospitals, over the five-year period 2002-2006 1.76 per cent of long-stay admissions were to acute treatment units in general hospitals.

47 *Mental Health Commission Annual Report 2008* (note 40 above) pp 63-64.

48 *National Psychiatric In-Patient Reporting System (NPIRS) Preliminary National Bulletin Ireland* 2008 Health Research Board 2009, p. 2; The Mental Health Commission reported in its annual report that there were 247 admissions of children to adult units during 2008 because data had not been returned from all Approved Centres when the Annual Report went to print.

49 ibid, p. 94.

50 See *Mental Health Commission Annual Report 2009* (note 4 above), p. 42.

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51 Note 3 above, p. 78.

52 ibid, p. 24.

53 The Whole Time Equivalent is the standard way of measuring an individual post in the health service.

54 Note 3 above, pp. 19-20.

55 ibid, p. 43.

56 ibid, p. 79.

57 ibid, p. 23.

58 ibid,p. 81.

59 *Mental Health Commission Annual Report 2009* (note 4 above) p. 82.

60 *A Vision for Change* Independent Monitoring Group Fourth *Annual Report on Implementation 2009* p.13.

61 *Mental Health Commission Annual Report 2009* (note [ ] above) p. 82.

62 Note 60 above p. 42.

63 Article 2 ICESCR and Article 2 ICCPR.

64 Note 60 above pp. 45-48. The only exception being Child and Adolescent Mental Health Services, which saw "significant development" in 2009.

FOOTNOTES

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65 See 'Criminal justice system fails men with mental illness' Irish Examiner 22 December 2009.

66 2009 Indecon Report (note 3 above), p. 31

67 Note 60 above pp.46-47.

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68 Note 60 above p. 39.

SECTION 3

Key factors in addressing the gap between policy development and implementation

The gap between policy development and implementation in Ireland is widely accepted and the need for greater accountability for delivery of policy objectives is a consistent theme in expert commentary. A number of other reports in the Irish context have sought to advise on how to address the implementation gap.[69] For example, in making its recommendations for delivering quality public services, the National Economic and Social Forum (NESF) has advised that there is a need for greater clarity on accountability for delivery of public policy in order to ensure effective implementation.[70]

EFFECTIVE PUBLIC ADMINISTRATION

Two reports by the National Economic and Social Council (NESC) describe effective, modern public administration for the Irish context in broad terms. The NESC recommended a new approach to governance that adopts an "accountable autonomy" framework in which "those delivering services are given more autonomy in return for information and a willingness to embrace continuous improvement".[71] The NESC described this framework in the following way:

> "In these approaches to public administration, local actors are given freedom to set goals for improvement and the means to achieve them. In return, they must propose measures for assessing their progress and provide rich information on their own performance. The centre pools the information and ranks local actors by reference to periodically revised performance measures."[72]

According to the NESC, this approach increases innovation and local transparency. In its view, the central Government body's role (in the case of mental health, the Office for Disability and Mental Health) is to support the capacity of local actors to act autonomously and to hold them accountable through monitoring, sanctioning and intervening.[73] In order for such 'accountable autonomy' to work as an effective way of delivering Government policy, there must be adequate financial and performance management systems in place to enable monitoring.

The NESC's recommendations must be read in combination with those of the NESF in its report *Improving the Delivery of Quality Public Services*. There, the NESF proposed a 'public value approach' that involves:

- providing quality, cost-effective services for users;
- ensuring equity and fairness in service provision;
- improving service outcomes and use of resources; and
- building up trust/legitimacy in the value of public services.[74]

The NESF stated that "overarching principles of equality, fairness, transparency, cost-effectiveness, accountability and evaluation must form the ethos and way of working for all public service providers", and highlighted the need for consistent performance indicators to measure the impact of public spending on meeting policy objectives.[75] Taken together, these two reports reflect a consensus around the need to improve accountability for public expenditure and develop systems to transparently monitor the effectiveness of public services.

So too, a recent analysis of implementation of the Government's home care scheme recommended that:

> "the integrity of any system of implementation and the prospects of success depend on clarity of accountability more than on any other single element of the implementation infrastructure … .The structure of accountability from the front line up through the managerial hierarchy, to the CEO, the Board, the Government Department, the relevant Minister and ultimately the Cabinet is the essential 'spinal cord' that enables good governance."[76]

KEY ISSUES FOR SUCCESSFUL IMPLEMENTATION OF *A VISION FOR CHANGE*

In a recent report on implementation of *A Vision for Change* the Mental Health Commission highlighted the following four major themes of concern around lack of implementation:

- the need for a clear, detailed implementation plan;
- the need for accountable, effective leadership;
- the provision and use of resources; and
- the closure of hospitals.[77]

THE NEED FOR AN ADEQUATE IMPLEMENTATION PLAN

The Independent Monitoring Group has repeatedly criticised the HSE for failing to produce an adequate implementation plan. In its 2008 monitoring report, the Independent Monitoring Group expressed concern about the lack of detail within the HSE's second draft Implementation Plan, commenting "…almost three years following the publication of *A Vision for Change*, the Group expected to see a plan of more substance".[78] In its 2009 report, the Independent Monitoring Group called on the HSE to develop and publish detailed, time-lined and costed plans as a matter of urgency.[79] The inadequacy of the HSE's Implementation Plan has also been commented upon in a recent cross-border review of mental health policy implementation which found that in the HSE's plan, "the key deliverables are couched in the language of uncertainty…".[80]

The Mental Health Commission commented that the HSE's Implementation Plan "provides no sense of the overall HSE vision for mental health services" [81]. Furthermore, the Commission found that "the emphasis throughout the plan is on the *process* with little evidence of focus on *outcome*" and the plan "provides some but by no means all the detail required for effective implementation".[82] The Mental Health Commission has called for publication of an implementation plan with clear actions, outcomes, costs, timelines and assigned responsibilities without delay.[83]

According to the WHO:

> "a mental health plan needs to specify what activities will be taking place; who the people are who will take responsibility for each activity; how long each activity will take; when it will take place and which activities can be done simultaneously and which can only follow the completion of another. It is also necessary to specify what the expected outputs of each activity are as well as the potential obstacles and delays which could inhibit the realisation of the activity".[84]

So, in short, AI believes that an effective implementation plan requires:

- Specific, measurable targets with annual milestones - wherever possible targets and milestones should be attached to estimated costings in terms of human and financial resources;
- Key performance indicators - to show how services are developing towards the model of service delivery enshrined in policy. Reporting on key performance indicators must be shown at local, national and regional levels;[85]
- Clear lines of accountability for all recommendations - the implementation plan should identify the individual responsible for delivering on each policy recommendation; and
- Monitoring and reporting on progress – at local, regional and national level.[86]

The accountability framework recommended by the 2010 Indecon Report provides an appropriate, human rights based set of indicators that could be incorporated into an implementation plan.

ACCOUNTABILITY IN THE PROVISION AND USE OF RESOURCES

Failures in accountability for the implementation of *A Vision for Change* are evident, not only in terms of service deliverables, but also in the transparent allocation and usage of financial resources.

A Vision for Change recognised the steady decline in the percentage of total health spend being allocated to mental health between 1984 (13 per cent) and 2004 (7.3 per cent).[87] The 2009 Indecon report found that expenditure on mental health has averaged 6.9 per cent of total health expenditure since 2006.[88] This is significantly lower that the target of 10 per cent that the Mental Health Commission Report, *The Economics of Mental Health Care in Ireland* recommended be realised over a five-year period or even the target of 8.24 per cent recommended in *A Vision for Change*.[89] And this trend seems set to continue. The 2010 Service Plan allocation of €734 million to mental health services amounts to just 5.4 per cent of the HSE's anticipated expenditure for 2010.[90]

THE FIGURES

Inconsistency in the figures presented in the HSE Service Plans for 2009 and 2010 make analysis of budgeted expenditure for mental health services in recent years difficult. The Service Plan for 2009 showed a budget for mental health in 2009 of €1.02 billion.[91] However, the Service Plan for 2010 showed a budget for 2009 of €787 million.[92] According to the HSE, a combination of public sector pay cuts, savings due to the moratorium on public sector recruitment, Value for Money savings, acceleration of cash collection and administrative efficiencies have together accounted for the difference between these figures.[93] The Service Plan for 2010 shows a budget for mental health in 2010 of €734 million, significantly lower than the original amount of €1.02 billion budgeted for 2009 and also lower than the revised amount of €787 million for 2009.[94] The 2010 Indecon Report calls for improved transparency in the HSE's National Service Plan including a breakdown of actual and budgeted annual mental health service expenditure by service area and mental health catchment area.[95] This continuing decrease in expenditure is a cause for concern according to the Independent Monitoring Group for *A Vision for Change* which commented "there is a concern that expenditure and staffing within the mental health services is reducing at a rate disproportionate to overall expenditure and numbers employed in the health service".[96]

As pointed out in *A Vision for Change*, an increase in the proportion of funding given to mental health services is only one of the steps needed to facilitate reform. Funding will not lead to change unless it is used efficiently and in a way that ensures equity and priority in service developments.[97] The 2009 Indecon Report found that the overall level of resources allocated to CMHTs remains very low in proportion to the overall level of human resources in Ireland's mental health services; CMHTs accounted for just 18.9 per cent of overall mental health service staffing.[98] Funding needs to be reconfigured in line with policy goals.

Since publication of *A Vision for Change*, there has been a lack of adequate accountability for mental health expenditure. From 2006 to 2007, Government invested an additional €51.2 million of development funding that was intended to support implementation of *A Vision for Change*. However, almost half of this money was diverted to meet deficits in other areas of health spending.[99] With regard to the additional investment the Independent Monitoring Group stated, "it is not apparent … that improvements in services to patients are commensurate with this level of investment".[100] It was ostensibly for this reason that the Minister for Health and Children stated in September 2008:

> "Before any additional funding is provided it is essential that the HSE is in a position to demonstrate that money allocated for mental health services is efficiently used and that the substantial changes in the organisation and delivery of mental health services envisaged in *A Vision for Change* are progressed".[101]

According to the Inspector's Report for 2009, that year saw "many examples of 'raiding of the monasteries' with respect to leakage of mental health resources to other services".[102]

The 2009 Indecon Report also found weaknesses in accountability for expenditure in mental health services since *A Vision for Change* was published.[103] In summary, Indecon found a lack of information that could provide a robust basis for ongoing monitoring of funding, expenditure and human resource allocation across Ireland's mental health services, both at national and sub-national levels.[104] Commenting on the 2009 Indecon Report, the Inspector of Mental Health Services described funding for mental health services as "Byzantine, opaque and almost incomprehensible" and has called for the establishment of a coherent and transparent system for the funding of mental health services.[105] This lack of information prevents groups and individuals from being able to determine whether inequity in expenditure in the mental health services is continuing.

The 2010 Indecon Report specifies the financial accountability and

performance measurement components for delivery of *A Vision for Change*. Indecon has developed a monitoring framework of key performance indicators that can evidence implementation of *A Vision for Change* and fulfilment of human rights. In their view, effective performance indicators will help prioritise resources and increase value for money. However, measuring performance requires appropriate budgeting and information systems so that information can be collected and collated. Indecon also recommendS clearer allocation of responsibilities for mental health budgets to the Assistant National Director for Mental Health and the Executive Clinical Directors, and publication of both the HSE's Implementation Plan and the funding model for delivering *A Vision for Change*.[106]

THE NEED FOR ACCOUNTABLE, EFFECTIVE LEADERSHIP

The establishment of the Office for Disability and Mental Health and its role in monitoring and evaluating implementation of policy and improvement of the mental health services is welcome. This enables greater oversight by the Department of Health and Children of the HSE and how it is transforming the mental health services.

The recent appointment of an Assistant National Director for Mental Health is also a welcome development. However, as the Mental Health Commission's recent analysis clearly states "a single leader alone is not sufficient to ensure effective implementation".[107] Instead the evidence base "points to the need for an accountable leader with supporting team, and the necessary resources and authority to ensure implementation".[108] The evidence also points to the need for investment in capacity building of staff to provide them with the skills, knowledge and experience to deliver effective implementation.[109] The new Assistant National Director does not have direct responsibility for the mental health budget. This is required to provide effective leadership to deliver on implementation.[110]

Another welcome development is the appointment of 14 Executive Clinical Directors to provide leadership for service delivery in each catchment area, which was completed in 2009 in an effort to drive implementation of *A Vision for Change*. While this is a welcome development, it is just one element of the governance and management structures needed to ensure effective local implementation of *A Vision for Change*.[111] Ensuring financial accountability and effective implementation of service development plans will also require appropriate management and associated responsibilities at local/ regional level within the mental health service. Despite the recent appointment of the Assistant National Director and the 14 Executive Clinical Directors, the Independent Monitoring Group continued to be critical of the lack of leadership for implementation of *A Vision for Change* within the HSE in its 2009 report and emphasised that "leadership needs to permeate all levels of service including national, regional and local".[112]

HOSPITAL CLOSURES

The closure of old psychiatric hospitals is a key step in the implementation of *A Vision for Change* for two main reasons. Firstly, the sale of old land and buildings is hoped to be a source of funds for the capital infrastructure needed to implement the policy. Secondly, the planned closures would release staff to be re-deployed to community-based services. John Moloney TD, Minister for Equality, Disability and Mental Health at the Department of Health and Children announced a €50 million capital programme on 1 March 2010 that will enable the following changes in 2010:

- transferring acute admissions from St Brendan's Hospital to Connolly Memorial Hospital, Blanchardstown;
- a new acute unit at Beaumont Hospital which will remove all acute admissions from St Ita's Hospital, Portrane;
- a new acute unit in Letterkenny; and
- a Community Nursing Unit in Clonmel to enable St Lukes's Hospital to close this year.[113]

These commitments, if realised, could mark a significant improvement on the capital developments that have occurred since *A Vision for Change* was launched particularly if they are successful in realising the closure of some of the old psychiatric hospitals. However, it is not certain that funding will be available to continue such developments, and thereby the closure of other old hospitals, in future years. There is no published detailed multi-annual capital programme for mental health services infrastructure. Instead projects are approved on an ad hoc basis depending on service requirements, specific policy decisions and the overall funding context.[114]

A Vision for Change also demands a radical cultural shift within services that would see the service user at the heart of the service with clear focus on recovery. This can only truly happen when the full range of supports and services that promote recovery are available.

The need for a new approach to accountability for implementation of *A Vision for Change* is clear. Despite concerted attempts by successive Junior Ministers and notwithstanding the current accountability framework between the Department of Health and Children and the HSE, Government has not been able to ensure delivery of *A Vision for Change* by the HSE, nor to ensure that monies allocated for mental health were spent for that purpose. Irish society cannot afford to allow *A Vision for Change* to suffer the same fate as its predecessor *Planning for the Future* (1984) which was never fully implemented. Legislation could drive reform and provide a stronger accountability framework for implementation of *A Vision for Change*.

FOOTNOTES

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69 See Mental Health Commission From Vision to Action?: Analysis of Implementation of *A Vision for Change,* MHC Dublin (2009) and National Economic and Social Forum *Improving the Delivery of Quality Public Services*, Report No.34 NESF Dublin (2007).
70 National Economic and Social Forum *Improving the Delivery of Quality Public Services*, Report No.34 (2007), pp. 80-82.
71 National Economic and Social Council *NESC Strategy 2006: People, Productivity and Purpose*. Report No.114 NESC Dublin (2005), p. 300.
72 National Economic and Social Council *The Developmental Welfare State*. Report No.113 NESC Dublin (2005), p. 167.
73 ibid.
74 National Economic and Social Forum *Improving the Delivery of Quality Public Services Report* No.34 NESF Dublin (2007), p. 10.

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75 ibid. See also 2010 Indecon Report recommendations (note 21 above).
76 Molloy, E. "Analysis of 'best practice' in policy implementation and implementation of the Home Care Package Scheme" (unpublished 2009), p. 11.
77 Note 69 above, p. 7.
78 Note 18 above, p. 8.
79 Note 60 above p. 51.
80 Clarke P. Mental Health: *The case for a cross-jurisdictional approach combining policy and research efforts on the island of Ireland. Centre for Cross Border Studies, Armagh (2009), cited in Mental Health Commission From Vision to Action? An Analysis of the Implementation of A Vision for Change*, (note 69 above) p.6

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81 Note 69 above, p. 27.
82 ibid, pp 27 and 34.
83 ibid, p. 34.
84 World Health Organization Mental Health Policy, Plans and Programmes WHO (updated version 2 2005), p. 5.
85 See the 2010 Indecon Report (note 21 above), which recommends that a range of new key performance indicators be implemented and published to facilitate the ongoing monitoring of funding, progress on implementation of *A Vision for Change* and outcomes of mental health service delivery. That report also proposes a suite of key performance indicators for the mental health services in Ireland.
86 Amnesty International Ireland Minimum Requirement for *A Vision for Change* Implementation Plan unpublished submission to John Moloney TD, Minister for Equality, Disability and Mental Health.

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87 *A Vision for Change* (note 1 above), p. 178.
88 See note 3 above, p. 10.
89 See note 35 above, p. 90 and *A Vision for Change* (note 1 above), p. 178, respectively.
90 *HSE National Service Plan 2010* p.4 See also 2010 Indecon Report (note 21 above) p. 57.
91 *HSE National Service Plan* 2009, p. 5.
92 Note 90 above, p. 4.
93 HSE response to AI request under the Freedom of Information Acts 1997 and 2003 received by AI on 26 April 2010.
94 Note 90 above, p. 4.
95 2010 Indecon Report (note 21 above) p. 136
96 Note 60 above p. 41.

FOOTNOTES

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97 *A Vision for Change* (note 1 above), chapter 17.
98 Note 3 above, p. 23.
99 HSE response to request by the Irish Mental Health Coalition under the Freedom of Information Acts 1997 and 2003 dated 9 January 2008.
100 Note 18 above, p. 19.
101 Response from the then Minister for Health and Children to the Irish Mental Health Coalition, quoted in *Transparency & Accountability in Budget 2009: A Call to Government on World Mental Health Day IMHC* (10 October 2008), available at http://www.imhc.ie/publications.
102 See *Mental Health Commission Annual Report 2009* (note 4 above), p. 81.
103 Note 3 above .
104 ibid, p. 79.
105 See *Mental Health Commission Annual Report 2009* (note 4 above), pp. 84 and 87.

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106 Note 21 above.
107 Note 69 above, p. 19.
108 ibid.
109 ibid.
110 ibid, pp 19-20.
111 Note 60 above p. 40
112 ibid, p. 21.

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113 *A Vision for Change Independent Monitoring Group Fourth Annual Report on Implementation 2009* (note 54 above) p. 40.

114 Speaking Notes for Minister Moloney at a press briefing on achievements to date in the Mental Health Services, Farmleigh, 1 March 2010 available at: http://www.dohc.ie/press/speeches/2010/20100301.html.
115 2009 Indecon Report (note 3 above), p. 8.

SECTION 4

Mental Health and Human Rights

International human rights law and standards provide a valuable framework of minimum standards against which Government policy and practice in the area of mental health service provision can be assessed.

THE RIGHT TO HEALTH AND MENTAL HEALTH SERVICES

Article 12 of the International Covenant on Economic, Social and Cultural Rights has been interpreted by the UN Committee on Economic, Social and Cultural Rights to require that mental health services be:

- **available - there must be enough mental health-related facilities and services as well as sufficient trained medical and other professionals;**
- **accessible - appropriate facilities, goods and services must be affordable, geographically accessible and available without discrimination. Information about services must also be available and accessible;**
- **acceptable - facilities, goods and services must respect different cultures and medical ethics; and**
- **of good quality - facilities, goods and services must meet medical and scientific standards of quality.**[116]

Human rights law and standards do not demand that the State be overburdened financially. Instead the right to health imposes an obligation on States to ensure the satisfaction of, at the very least, core minimum essential levels of services required under the right to health.[117] This is an immediate obligation; failure to comply constitutes a breach of the State's international law obligations. It then requires that such core minimum services be improved and expanded over time in accordance with the **principle of progressive realisation**.[118]

This principle recognises the economic realities of individual states. Thus the human rights framework accepts that certain elements of the right to health will not become reality overnight, but will take some time to realise, depending on the resources available to the state in question. This should not be misinterpreted as rendering the right to health meaningless.[119] Progressive realisation requires the State to take steps (which must be deliberate, concrete and targeted)[120] to the maximum of its available resources with a view to progressively realising the right to health over time. It thereby imposes an immediate obligation on states to move as expeditiously and effectively as possible towards that goal by using all appropriate means.[121] If policy alone is not effective in progressively realising the right to health, the State is obliged to consider other steps that might be more effective, such as legislation.[122] The UN Committee on Economic, Social and Cultural Rights has recognised that in many instances, including in particular in the health context, legislation is highly desirable and may even be indispensable.[123]

Effective planning is also a key component of the right to health. The former UN Special Rapporteur on the Right to Health, Professor Paul Hunt, has identified the key features of effective planning as follows: "Clear objectives and how they are to be achieved, time frames, indicators and benchmarks to measure achievement, effective coordination mechanisms, reporting procedures, a detailed budget that is attached to the plan, financing arrangements … evaluation arrangements, and one or more accountability devices." [124] In order to measure whether or not the State is improving its health system over time and thereby progressively realising the right to health, it is essential that there be effective and transparent **monitoring and accountability mechanisms** in place.[125] In human rights terms, accountability goes beyond ensuring that funds are spent as intended; effective systems of accountability should also ensure that health systems are improving and the right to health is being progressively realised over time.[126]

COMMUNITY-BASED SERVICES AND HUMAN RIGHTS

The importance of providing a broad range of community-based mental health care and support services is recognised by the human rights framework. Thus, for example, Professor Paul Hunt has stated that:

> "States should take steps to ensure a full package of community-based mental health care and support services conducive to health, dignity, and inclusion, including medication, psychotherapy, ambulatory services, hospital care for acute admissions, residential facilities, rehabilitation for persons with psychiatric disabilities ...". [127]

In this way, unnecessary institutionalisation can be avoided.[128] The importance of community-based treatment, care and support is also stressed in the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles), which encompass the right "to be treated and cared for, as far as possible, in the community in which the person lives", and the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate (MI Principles 7(1) and 9(1) respectively). Article 10 of Council of Europe Recommendation 2004(10) provides that member states should (taking into account available resources) take measures to provide a range of services "of appropriate quality to meet the mental health needs of persons with mental health problems, taking into account the differing needs of different groups of such persons, and to ensure equitable access to such services".[129]

The WHO, which has taken a human rights based approach to mental health in recent years,[130] recommends that mental health services, including support services, be based in the community and integrated as far as possible into general health services, including primary health care, in accordance with the principle of the least restrictive environment.[131] The WHO has called for well-organised community based care to bring an end to "the days of locking up people with mental health or behavioural disorders in grim prison-like psychiatric institutions".[132]

The Council of Europe Committee on the Prevention of Torture and Inhuman and Degrading Treatment and Punishment (CPT) has also described as a "favourable development" the tendency in a number of countries to reduce the number of beds in large psychiatric establishments and to develop community-based mental health units, on condition that such units provide a satisfactory quality of care.[133] The UN Committee on the Rights of the Child also expressed concern at the lack of a comprehensive legal framework for children's health services and recommended that Ireland adopt an all-inclusive legislation that addresses the health needs of children in its Concluding Observations on Ireland published in 2006.[134]

THE RIGHT TO LIVE IN THE COMMUNITY, WITH CHOICES EQUAL TO OTHERS

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While Ireland has not yet ratified the Convention on the Rights of Persons with Disabilities (CRPD), it has indicated its intention to do so by signing the Convention in March 2007. Article 19 of the CRPD has significant implications for institutionalised care of persons with mental health problems. Its recognition and expression of the right of persons with disabilities to independent living and community inclusion demands a shift in government policies away from institutions towards in-home, residential and other community support services.[135] Policies and practices which isolate or segregate persons with mental health problems, including through unnecessary institutionalisation, are inherently discriminatory and represent a violation of Article 19 CRPD. They also conflict with the right to community integration, which derives from the right to health.[136] Thus states are required to plan and develop community-based services and supports as alternatives to institutionalisation.[137]

Article 19, like the right to the highest attainable standard of mental health, is subject to the principle of progressive realisation. So while the State will not be expected to realise all aspects of Article 19 overnight, it will be required to take concrete measures, using the maximum of its available resources, in order to realise this right over time.[138] A lack of resources is not a justification for inaction.[139]

ARTICLE 19 CRPD (LIVING INDEPENDENTLY AND BEING INCLUDED IN THE COMMUNITY)

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States Parties to this Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

A Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;

B Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;

C Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

OTHER RIGHTS

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The provision of adequate community-based services and supports are critical for the enjoyment of a number of other human rights, such as the right to work and the right to education. Such rights cannot be enjoyed if people with mental health problems are not offered the services and supports they need to live in the community.[140]

As long as there continues to be an over-reliance on in-patient care for the treatment of persons with mental health problems, people will be deprived of their right to liberty unnecessarily.[141] The connection between deprivations of liberty and the availability of alternative community-based treatments and supports was alluded to by the European Court of Human Rights when it stated that individuals should not be detained save where other less severe measures are considered insufficient.[142] The explanatory memorandum to Council of Europe Recommendation 2004(10) also emphasises the importance of providing services to preclude the need to invoke compulsory powers of admission and detention:

> Involuntary placement and involuntary treatment are measures that involve a significant restriction of the rights of the individual concerned. They should be a last resort ... Article 10 emphasizes the need to develop alternatives to involuntary treatment, in accordance with the principle of least restriction.[143]

The Council of Europe Committee on the Prevention of Torture has expressed concern at situations where people are deprived of their liberty due to a lack of adequate care/accommodation in the outside community.[144]

CASE STUDY

The facts leading to the 2009 case of SM v the Mental Health Commission and others[145] illustrated that the lack of alternative community services and supports in Ireland can lead to unnecessary deprivations of liberty. This case concerned a young person who, between the age of 19 and 36, had been admitted to the mental health facility in question on 23 occasions, 15 of which were involuntary. The intervals between admissions were becoming shorter and there had been "a constant and sustained pattern of relapse upon discharge from hospital".[146] In summing up the facts, Mr Justice McMahon referred to a statement from the individual's treating psychiatrist that "ideally, the more suitable regime for the applicant's care [would be] by way of supported accommodation rather than involuntary admission" in the hospital, "where necessary supports would ensure that her significant medication regime is adhered to".[147] However, because such supports were not available, the individual in question was involuntarily detained under the Mental Health Acts.

A lack of well-resourced, effective, comprehensive and community-based services can result in the so-called 'revolving door scenario'.[148]
An effective system of comprehensive and community-based services and supports would reduce the need for recourse to the involuntary detention and treatment provisions of the Mental Health Act, a development which would surely be welcomed by all.

The right to privacy, including the right to autonomy and bodily integrity[149] can also be adversely affected by the lack of appropriate community-based facilities. A number of provisions of the MI Principles and Council of Europe Recommendation 2004(10) provide further guidance and principles that should be adhered to in order to ensure that treatment is provided to persons with mental health problems in a way that respects these fundamental human rights. So, for example, the MI Principles state that "every patient shall have the right to be treated in the least restrictive environment and with the least intrusive treatment appropriate" (Principle 9(1)). The CRPD also emphasises the need for respect for inherent dignity and individual autonomy including the freedom to make one's own choices.[150] Article 17 of that Convention recognises that every person who experiences a mental health difficulty ***"has a right to respect for his or her physical and mental integrity on an equal basis with others".*** Moreover, article 25(d) obliges states to require health professionals "to provide care of the same quality to persons with [mental health problems] as to others, including on the basis of free and informed consent". There is necessarily an overlap between the lack of availability of a broad range of mental health treatments and supports and the right to make choices around treatments and refuse treatment.[151] The reality of the mental health system in Ireland where there are uneven levels of services available means that these rights may not be fully enjoyed by all persons.

For so long as Ireland fails to implement the policy of reform, it will continue to fail to meet international human rights standards. The human cost of this is huge for people who experience mental health problems and their families. International human rights law requires states to take all necessary steps, including the adoption of legislation, to make the right to the highest attainable standard of mental health real over time. The Government must now consider how it can use legislation to fulfil this obligation.

FOOTNOTES

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116 UN Committee on Economic, Social and Cultural Rights, General Comment No. 14 (right to health) (2000) UN Doc E/C.12/2000/4.
117 Committee on Economic, Social and Cultural Rights General Comment 3 on the nature of States parties obligations under article 2(1) of the Covenant UN Doc E/1991/23(14/12/90), para 10.
118 ibid, para 9.

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119 ibid, para 9.
120 ibid, para 2.
121 ibid, para 9.
122 ibid, para 3. See also CESCR General Comment 9 on the domestic application of the Covenant UN Doc E/C.12/1998/24 (03/12/98) para 5.
123 ibid, para 3.
124 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 UN Doc.A/HRC/711 (31 January 2008) para 96.
125 ibid, paras 48 and 99-106.
126 ibid, para 101.

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127 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 UN Doc.E/CN.4/2005/51 (11 February 2005) para 42 (emphasis added)
128 ibid.
129 Council of Europe Recommendation 2004 (10) of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with "mental disorder", adopted by the Committee of Ministers of the Council of Europe on 22 September 2004 at the 896th meeting of the Ministers' Deputies.
130 See, for example WHO Resource Book on Mental Health, Human Rights and Legislation (note 12 above); see also WHO Mental Health Care Law: Ten Basic Principles.
131 WHO The World Health Report 2001: Mental Health: New Understanding, New Hope (note 29 above), pp 89-91, cited in Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Physical and Mental Health UN Doc E/CN.4/2005/51, para 14.
132 ibid, p. 4.
133 European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment The CPT Standards: Substantive sections of the CPT's General Reports (Council of Europe CPT/Inf/E (2002) 1 - Rev. 2006) p. 61.
134 Committee on the Rights of the Child Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Concluding Observations Ireland UN Doc. CRC/C/IRL/CO/2 (29 September 2006) paras 44-45.

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135 Thematic Study by the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities UN Doc A/HRC/10/48 (26 January 2009) para 50.
136 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 UN Doc.E/CN.4/2005/51 (11 February 2005) para 54.
137 European Coalition for Community Living Focus on Article 19 of the UN Convention on the Rights of Persons with Disabilities (ECCL Focus Report, London 2009) p. 8.
138 Article 4(2) CRPD and see also ibid.
139 ibid.

FOOTNOTES

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140 Note 125 above, para 15

141 The right to liberty and the corollary right not to be deprived of one's liberty arbitrarily is recognised in a number of international and regional conventions and in our own Constitution, Bunreacht na hEireann (Article 40.4).

142 Witold Litwa v Poland (2001) 33 EHRR 53 cited in Parker C 'Developing mental health policy: a human rights perspective' in Knapp et al (editors) Mental Health Policy and Practice across Europe: The future direction of mental health care (Open University Press, England, 2007) p. 324.

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143 Note 118 above, para 75, cited by Parker (ibid) p. 321.

144 CPT Standards (note 122 above) p. 61.

145 SM v Mental Health Commission and others (High Court 2008 No. 749 JR) McMahon J (judgment of 31 October 2008).

146 ibid,p. 3.

147 ibid,p. 4.

148 Take the example of Italy, where "Law 180" called for the closure of mental hospitals - according to the WHO the revolving door phenomenon (i.e. where discharged patients are re-admitted) "is evident only in areas that lack well-organised, effective, community based services" (WHO World Health Report 2001 (note 29 above) p. 86).

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149 The right to privacy, and the related rights of autonomy, bodily integrity and the right to be free from non-consensual treatment are recognised by a number of international and regional human rights conventions and the Irish Constitution (Article 40.3.1 Bunreacht na hEireann. Ryan v Attorney General [1965] IR 294, 313 per Kenny J. And Re a Ward of Court (No.2) [1996] 2 IR 79, 124-125.)

150 Article 3(a) CRPD (General Principles).

151 Bartlett P, Lewis O and Thorold O Mental Disability and the European Convention on Human Rights Martinus Nijhoff Publishers, Leiden (2007), p. 111.

SECTION 5

Existing Law in Ireland

To date, Ireland's approach to legislation in the area of mental health has been limited. The Mental Treatment Act 1945 previously provided the framework for the provision of mental health services in an in-patient/ hospital setting. Both the **Green Paper on Mental Health** published by the Department of Health in June 1992 and the Government's **White Paper: A New Mental Health Act** (Department of Health July 1995) called for the new Act to address the obligations of Health Boards (since replaced by the HSE) to provide access to comprehensive community-based services. However, the Mental Health Act was eventually introduced in response to the threat of a finding against the State by the European Court of Human Rights[152] , and for this reason is mainly focused on the issues of involuntary detention and treatment and the regulation of inpatient facilities.[153]

MENTAL HEALTH ACT 2001

While its introduction did mark an improvement on the situation pertaining under the Mental Treatment Acts 1945-61[154] , the Mental Health Act 2001 does not contain a framework for the delivery of mental health services needed to reflect a community-based, comprehensive and integrated service as recommended in successive mental health policy documents and as contemplated by the Green and White Papers.

Among the functions conferred on the Mental Health Commission under the 2001 Act is the approval and registration of hospitals and other in-patient facilities for the care and treatment of persons with mental health problems under Section 5 of the Act (Approved Centres).[155] Other mental health services are not subject to approval by the Mental Health Commission (although they do fall within the ambit of the commission's Quality

Framework for Mental Health Services in Ireland, which is discussed in more detail in Section 6). Accordingly, the statutory regulations[156] and much of the rules and guidance published by the Commission focus on issues relating to inpatient care and treatment in Approved Centres.

The functions of the Inspector of Mental Health Services are similarly more focused on in-patient services than community-based services. The Inspector is required under section 51(1) to carry out annual inspections of all Approved Centres and may inspect any other premises where mental health services are being provided as he or she thinks appropriate. While the Inspector has inspected some community-based services, the main focus of inspections to date has been on Approved Centres.[157]

Commenting on this situation in the most recent Annual Report, the Inspector of Mental Health Services has stated:

> "[I]t is somewhat ironic that while the "gold standard" of mental health service is one based primarily in the community, the Inspectorate was spending most of its time focusing on Approved Centres".[158]

The fact that our mental health legislation has mainly focused on inpatient services has diverted much needed attention from the lack of alternatives to in-patient care as well as the lack of specialist services anticipated in A Vision for Change. As has been accurately identified by Dr Brendan Kelly

> "[a]n exclusive focus on [the right to liberty] alone … fails to address or even acknowledge a range of broader social injustices and denials of human rights commonly experienced by individuals with enduring mental illness".[159]

It is AI's view that obstacles to accessing community care, which impede the ability of such persons to live a full life in the community, are included in such "social injustices".

OTHER HEALTH LEGISLATION

Under the Mental Treatment Act 1945, the mental hospital authorities were obliged to provide "treatment, maintenance, advice and services" to persons with mental health problems who were unable to afford the full cost.[160] They were also obliged to provide proper and sufficient accommodation for carrying out their functions and, in particular, to provide and maintain a district mental hospital for their district.[161] The Health Act 1970 places a general duty on the Health Boards (since replaced by the HSE) to provide (among other things) in-patient and out-patient services, which include psychiatric services, as well as certain home help and home nursing services to eligible persons.[162] However, these general duties fall short of providing a framework for modern mental health services, hence the proposals of the Green and White Papers that

> "a general obligation would be placed on each health board to provide a comprehensive psychiatric service to its population, a service that is community oriented and integrated as far as possible with other health services and organised in catchment areas and sectors".[163]

The Health Act 2004 states that the object of the HSE is "to use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public".[164] Section 7(4) of the Act places an obligation on the HSE to manage and deliver (or arrange to be delivered on its behalf) health and personal social services as defined in the Health Acts 1947 to 2001. The 2004 Act also goes on to state that, in performing its functions, the HSE shall have regard to "… policies and objectives of the Government or any Minister of the Government …" and "… the resources, wherever originating, that are available to it …", among other things.[165] Once again, these general duties do not provide a framework for the delivery of a modern and progressive system of mental health services.

As regards accountability for the delivery of mental health services, it is worth noting that neither the HSE Implementation Plan for A Vision for Change nor the Independent Monitoring Group for A Vision for Change have a statutory basis. The Health Act 2004 requires the HSE to prepare and submit an annual service plan to the Minister for approval and that plan is required to accord with the policies and objectives of the Minister and Government. Once approved the HSE must manage health and personal social services so as to ensure that the services are delivered in accordance with the plan. These very general obligations apply to all health and social services provided by the HSE and do not provide a specific framework setting out an obligation on the HSE to provide comprehensive and community-based mental health services. In addition, as service plans are prepared from year to year, they do not demand a multi-annual plan for how the mental health services will be reformed over time in accordance with the recommendations of A Vision for Change. To date, the HSE's service plans have contained relatively high-level commitments with few individual indicators for each care group, apart from for Child and Adolescent Mental Health Services. Moreover, a number of these targets were not met in 2009, including reductions in the number of readmissions as a percentage of total admissions, the rate of involuntary admissions per 100,000 population and the numbers of inpatient places per 100,000 population, each of which are indicators for the provision of alternatives to admission. While the HSE is also required to prepare a three-year strategic plan every three years (the HSE corporate plan), it also sets out very high-level strategic goals. Neither of these over-arching HSE service or corporate plans have incorporated a detailed, time-lined and resourced implementation plan for A Vision for Change. Furthermore, there is no published detailed multi-annual capital programme for mental health services infrastructure. Instead projects are approved on an ad hoc basis depending on service requirements, specific policy decisions and the overall funding context.[166] During 2009 the Mental Health Commission

sought project-managed, time-lined plans for the closure of the older hospitals and their replacement by appropriate alternative accommodation. However, the majority of plans received were disappointing in their lack of specificity.[167]

Schedule 5 of the Health Act 2004 (Savings and Transitional Provisions) established a separate Vote (Vote 40) for the HSE within the annual Budget Estimates of Receipts and Expenditure.[168] Under section 31(12) of that Act the HSE is required to submit to the Minister for Health and Children (with the service plan) a statement of its estimate of the income and expenditure relating to the proposed plan each year. This estimate must be consistent with the Vote for the HSE as published by the Government in the Estimates.[169]

Section 36(2) of the 2004 Act requires the HSE to prepare annual financial statements (AFS) in such form as the Minister for Health and Children may direct. In addition, under section 22 of the **Exchequer and Audit Departments Act 1866**, an Appropriation Account must be prepared annually in respect of the HSE Vote and sent for audit to the Comptroller and Auditor General and also to the Department of Finance.

However, this system of financial accountability does not provide the level of detail required to track spending on mental health services and progress towards implementation of A Vision for Change. Tighter controls on spending were introduced in relation to the HSE Vote following the review of HSE financial management undertaken by the Considine Review Group in 2008[170] and a new model for restructuring the HSE Vote was set out in the 2008 Revised Estimate Volume[171]. The Revised Estimates Volume now contains a dedicated subhead for new development funding within the HSE Vote and the prior sanction of the Department of Finance is now required before new development monies can be used for any purpose other than the purpose for which it was allocated.[172] For instance, a new multi-annual programme of investment announced in Budget 2010 is reflected in an allocation of €50 million which is protected within a dedicated subhead for new capital development monies in the Revised Estimates for 2010.

However, it remains the case that current expenditure funding lines for the mental health programme are not protected within the overall HSE Vote.[173] In other words, while the HSE will be required to specifically report on its expenditure of the allocated capital development monies in respect of 2010, the same level of accountability is not required in the case of current expenditure on mental health, because the mental health care group is not given a defined subhead under the HSE Vote. It has been confirmed to AI in response to a request under the Freedom of Information

Acts 1997 and 2003 that

> "[t]he HSE has been in discussion with the Department of Health and Children and the Department of Finance for a considerable period seeking the implementation of a single national accounting system which would include, among other benefits, standard national care group reporting". [174]

Moreover, there has been some inconsistency between the figures set out in the annual Service Plan and the Revised Estimates. The 2010 Indecon Report called for greater consistency between the figures presented on actual and planned mental health expenditure in the annual Revised Estimates published by the Department of Finance and the HSE's annual Service Plan.[175]

While Appendix 1 of the HSE Vote within the Revised Estimates provides more details of estimated current expenditures for the year ahead as between Long Stay Residential Care, Community Services, Psychiatry of Later Life, Counselling Services and Other Mental Health Services, it still lacks the depth of detail required to ensure a sufficient level of financial accountability.[176] In particular, it does not provide a breakdown of current expenditures according to service area or service catchment area.

The Health Act 2004 also requires the HSE to publish an annual report setting out, among other things, a general statement of the health and personal social services provided during the preceding year, a report on the implementation of the corporate plan, the service plan and the relevant capital plans for that year.[177] Again, this lacks the level of detail required to ensure value for money in mental health expenditure.

Furthermore neither the Appropriation Accounts published by the Comptroller and Auditor General nor the Annual Financial Statements of the HSE provide the level of detail required to facilitate full transparency in relation to funding and/or expenditure on mental health. These shortcomings highlight the urgent need for a mechanism to whereby the HSE is required to report in a transparent manner on funding allocations, expenditures and outcomes across mental health service programmes to ensure sufficient financial accountability and value for money.

DISABILITY ACT 2005

If and when implemented in full, the Disability Act 2005 will allow persons with enduring mental health problems[178] to apply for an assessment of need, that is, an assessment to determine the health and education needs (if any) occasioned by that person's disability and the health services or education services required to meet those needs. The Disability Act defines disability as "a substantial restriction in the capacity of the person to carry on a profession, business, or occupation or to participate in social or cultural life by reason of an enduring physical, sensory, mental health or intellectual impairment", so individuals with a mental health difficulty that fit this definition could fall within the provisions of the Act.[179] The applicant will then be provided with a service statement setting out the education and/or health services which will in fact be provided to him or her and the timescale within which such services will be provided. The Act also requires that public services for people with disabilities and those without be integrated wherever possible, thus underpinning non-segregation of services for people with a mental health disability.[180] There are a number of weaknesses with these provisions, not least of which is the fact that the legislation does not place an obligation on the relevant body to provide the services identified as needed in the assessment report or even a 'core minimum level' of basic health and education services as is required under international human rights law.[181] However, were the needs assessment provisions of the Disability Act to be implemented in full for all people with disabilities, they would undoubtedly benefit persons with mental health difficulties in accessing available health and education services and supports.

The Disability Act 2005 does make some provision for accountability for service delivery. The Act requires six Government Departments, including the Department of Health and Children, to develop Sectoral Plans on their services for people with disabilities, to consult with stakeholders on these plans, to review the plans every three years, and to lay the plans before the Oireachtas. Thus under the Disability Act, six Government Departments are accountable to the Oireachtas for the implementation of their respective Sectoral Plans. However, the Department of Health and Children's Sectoral Plans have not to date incorporated specific plans for mental health services.

Furthermore, under Section 13(1)(c) of the Act, the HSE is required to report annually, on an aggregate basis, on the unmet needs for services as assessed in Independent Assessments of Need. Although the Independent Assessment of Need has to date only been implemented for children aged 5 and under, this provision has the potential to highlight gaps in services for individuals with substantial and enduring mental health problems and thereby drive the provision of appropriate services.

While the Disability Act does contain a section on the provision of financial resources for the provision of services under the Act, this section has also been the subject of criticism in that it affords the Minister a wide discretion to deviate from the provision of necessary resources, thereby failing to effectively guarantee the progressive realisation of the rights to health and education of persons with disabilities.[182]

CURRENT GAPS IN LEGISLATION

In summary, legislation in Ireland currently provides for some aspects of mental health service delivery, in particular:

- registration of Approved Centres for in-patient care and treatment;
- compliance by Approved Centres with statutory regulations and rules and guidance that set minimum standards of care, as set out by the Mental Health Commission and verified through annual inspections by the Inspector of Mental Health Services;
- promotion by the Mental Health Commission of quality mental health services;
- production of a high-level Service Plan by the HSE that includes some mental health service commitments, including resources as well as preparation of a high level strategic corporate plan every three years;
- preparation by the HSE of an annual report setting out, among other things, the implementation of the corporate plan, the service plan and the relevant capital plans for that year;
- preparation by the HSE of annual accounts and appropriation accounts vis-à-vis the HSE Vote;
- an Independent Assessment of Need for individuals who fit the definition of disabled under Part 2 of the Disability Act 2005 (although this has only been implemented for children under 5 years to date);
- an obligation on the Department of Health and Children to produce a Sectoral Plan setting out its plans for services for people with disabilities, including people with a mental health disability;
- an obligation on the HSE to report on the aggregate unmet needs assessed through the Independent Assessment of Need; and
- a requirement to integrate services for people with disabilities with other services.

Despite this tapestry of legislation relevant to mental health, there is no legislative framework which coherently underpins the vision of the mental health system set out in Government policy. The gaps and weaknesses in the current legsislative framework include:

- an absence of statutorily-set principles to underpin planning and provision of all mental health services;
- weak statutory accountability for mental health-specific expenditure, which lacks the detail required to track current expenditure on mental health. There is no statutory requirement on the HSE to report on current expenditure by care group (i.e. mental health);
- lack of a statutory requirement on the HSE to prepare a thorough scheduled plan for the closure of unsuitable facilities and the development and ongoing provision of comprehensive and community-based mental health services in line *A Vision for Change*;
- lack of any statutory obligation on the HSE to provide comprehensive and community-based mental health services;
- lack of a statutory reporting mechanism for implementation of *A Vision for Change* which requires the level of detail which would enable a value for money review of mental health services; and
- lack of a statutory approval and registration mechanism for services outside of those providing inpatient care and an emphasis on in-patient services in the functions of the Inspectorate.

Our laws over-emphasise inpatient care and do not provide a framework for the delivery of mental health services as envisaged in *A Vision for Change*. In addition, they do not demand the level of planning and accountability necessary to track progress towards reform. These gaps must be addressed as a matter of priority. Law can make a difference. Take, for example, the introduction of the Mental Health Act 2001. Its introduction led to a substantial decrease in the numbers of people involuntarily detained.[183] The Government needs to explore what statutory measures could be introduced as a first step to demand increased accountability and underpin the provision of the core mental health services outlined in *A Vision for Change*.

FOOTNOTES

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152 Croke v Smith (unreported) High Court 31 July 1995; Croke v Smith (No. 2) [1998] IR 101; Croke v Ireland European Court of Human Rights Application no. 33267/96 (struck out 21 December 2000). This case was resolved by way of 'friendly settlement' between the parties. It was on foot of this settlement that the Mental Health Bill 1999 was introduced.

153 The 2001 Act also established the Mental Health Commission and the Inspectorate of mental health services.

154 There have been a number of developments in the international human rights framework since the introduction of the Mental Health Act 2001, most importantly the entry into force of the Convention on the Rights of Persons with Disabilities (CRPD), which Ireland has signed but not yet ratified. The Mental Health Act is out of step with these developments and needs to be comprehensively reviewed against up to date human rights law and standards so that its provisions can be amended as appropriate. AI is calling on the Government to ensure that its next review of the Act is completed by November 2011 as planned and that it is a substantive review of the Act carried out in consultation with service users, their representative organisations and all relevant stakeholders, using international human rights law and standards as its basis.

155 The Health Information and Quality Authority (HIQA), which has statutory responsibilty for driving quality and safety in Ireland's health and social care services, does not have a role in regulating mental health services, which fall under the remit of the Mental Health Commission. See Health Act 2007 section 8 (functions of the Authority).

156 Mental Health Act 2001 (Approved Centres) Regulations 2006, SI No 551 of 2006.

157 During 2009 the Inspector of Mental Health Services inspected 13 24-hour staffed community residences and 10 day hospitals . It is hoped that the scope of the inspection process will be to increase the inspection of community services in the future. Mental Health Commission Annual Report 2009 (note 4 above) p. 79.

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158 See Mental Health Commission Annual Report 2009 (note 4 above), p. 79.

159 Kelly Brendan D, MD, MA, MSc, MRCPI, MRCPsych, Senior Lecturer in Psychiatry, Department of Adult Psychiatry, University College Dublin 'Social justice, human rights and mental illness' (2007) 24(1) Irish Journal of Psychological Medicine, p. 3.

160 Mental Treatment Act 1945 section 19, repealed by the Health Act 1970.

161 Mental Treatment Act 1945 section 20, repealed by section 29(3) of the Health Authorities Act, 1960.

162 Health Act 1970 sections 52, 56, 60 and 61, as amended.

163 Green Paper on Mental Health Department of Health (June 1992) p. 120.

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164 Health Act 2004, section 7(1).

165 Health Act 2004, sections 7(5)(c) and 7(5)(d).

166 2009 Indecon Report (note 3 above), p. 8.

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167 Mental Health Commission Annual Report 2009 (note 4 above) p. 82

168 Health Act 2004, Schedule 5 section 7.

169 Health Act 2004 section 31(12).

170 'Study of certain accounting issues related to the Health Service Executive', report of the Considine Working Group, Department of Health and Children (September 2008).

171 See Revised Estimates Volume 2008, HSE Vote, Appendix 4 – Revised Vote Structure for HSE (http://www.finance.gov.ie/viewdoc.asp?fn=/documents/Estimates2007/REV2007.pdf).

172 ibid.

173 2010 Indecon Report (note 21 above), p. 53.

FOOTNOTES

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174 HSE response to AI request under the Freedom of Information Acts 1997 and 2003 received by AI on 26 April 2010.
175 ibid, p. 136.
176 ibid, p. 55.
177 Health Act 2004, section 31.

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178 And, on their behalf, other "specified persons" –Disability Act 2005 section 9.
179 Disability Act 2005 section 2(1). The appropriateness of this definition was discussed by the Irish Human Rights Commission in Observations on the Disability Bill 2004 15 November 2004 (available at: http://www.ihrc.ie/documents/article.asp?NID=123&NCID=6&T=N&Print=). The adoption of the CRPD once again calls into question the adequacy of this definition.
180 Disability Act 2005 section 26(1)(a).
181 Irish Human Rights Commission Discussion Document Making Economic, Social and Cultural Rights Effective (October 2006) (available at: http://www.ihrc.ie/documents/article.asp?NID=184&NCID=5&T=N&Print=) p. 79.

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182 ibid.

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183 See Mental Health Commission Annual Report 2008 (note 39 above), p.33 which shows a decrease of 25% in overall involuntary admission activity between 2005 and 2007 (the relevant provisions of the Mental Health Act 2001 came into effect in November 2006).

SECTION 6

THE ROLE OF LEGISLATION IN DELIVERING POLICY, STANDARDS AND HUMAN RIGHTS

If policy alone is not effective, the State is obliged under human rights law to consider other steps, such as legislation to fulfil its obligation to improve mental health services over time.[184] Legislation in and of itself is not the solution; rather it is one of a number of factors that could combine to bring about a mental health service that meets international human rights standards.

LEGISLATION AS A DRIVER FOR THE IMPLEMENTATION OF POLICY IN IRELAND

In the discussion of the first core value and principle, *A Vision for Change* recognises the important role of legislation:

> "The realisation of many of these human rights in mental health care requires that these principles should be embedded in legal and policy documents. Mental health legislation is essential to underpin the right to respect for the dignity of individuals and the protection of their human rights."

In its Third Annual Report (2008) on Implementation of *A Vision for Change*, the Independent Monitoring Group recommended that "[t]he Office for Disability and Mental Health should consider the role legislation might play in accelerating implementation of *A Vision for Change*"[185].

Many of the speakers at the Irish Mental Health Coalition conference held on 18 May 2009 discussed how legislation could assist the implementation of *A Vision for Change*.[186] Those discussions illustrated the need for an urgent and frank debate on how legislation could be used to best serve as a driver for reform and improve accountability for how money is spent on mental health.

In January 2010, John Moloney TD, Minister for Equality, Disability and Mental Health at the Department of Health and Children stated in response to a parliamentary question that the planned review of the Mental Health Act "will also consider whether further provisions are required in relation to community-based mental health services".[187]

But the idea that legislation has a role to play in underpinning mental health service provision is not new; paragraph 15.5 of the Green Paper on Mental Health published by the Department of Health in June 1992 stated:

> "The Government is of the view that new legislation should encompass more than the procedures for detention and the safeguarding of the rights of detained patients. It believes that it should also define the role of health boards in relation to providing services for people who

are mentally ill. In particular, new legislation offers an opportunity to provide a statutory framework for the development of psychiatric services as recommended in Planning for the Future and to integrate further the psychiatric services with health services in general."

The Green Paper went on to outline how a general obligation would be placed on each health board

"to provide a comprehensive psychiatric service to its population, a service that is community oriented and integrated as far as possible with other health services and organised in catchment areas and sectors".[188]

In commenting on the Health (Mental Services) Act 1981 (which was never implemented), the Green Paper went so far as to say that "one of the main drawbacks of the 1981 Act is that it does not provide a legal framework for the developing community psychiatric services". The Green Paper also proposed, among other things, that Health Boards would be obliged in the new legislation to provide every five years, or more frequently if requested by the Minister, a plan for the development of psychiatric services in the functional area of the health boards.[190]

The then Government's White Paper: A New Mental Health Act (1995) went on to propose that a statutory duty be placed on health boards to promote mental health and provide an appropriate range of services directly or in association with a voluntary organisation in line with policy for the development of services for people with mental health problems.[191]

In introducing the Mental Health Bill 1999 to the Dáil, then Minister for Health and Children, Micheál Martin TD acknowledged that a number of issues raised by the White Paper were absent from the Bill and explained that this had resulted from the necessity to provide urgently for reform of the existing legislation regarding involuntary admissions in order to bring it into line with the European Convention on Human Rights. The Minister went on to assure the House that it was his intention that the outstanding issues would be addressed by his Department as soon as possible.[192] However, this has not transpired.

WHO GUIDANCE ON THE ROLE OF LEGISLATION IN DRIVING POLICY OBJECTIVES

The WHO has highlighted the close relationship between mental health policy and law and recognises that mental health policy often relies on the legal framework to achieve its goals, and protect the rights and improve the lives of persons affected by mental health problems.[193]

Legislation can play an important role in fostering progressive mental health policies, like A Vision for Change, that seek to increase opportunities for persons with mental health problems to live fulfilling lives in the community by:

- preventing inappropriate institutionalisation; and
- providing for appropriate facilities, services, programmes, personnel, protections and opportunities.[194]

The WHO suggests that legislation and/or accompanying regulations can include a statement of responsibility for:

- developing and maintaining community-based services;
- integrating mental health services into primary health care;
- integrating mental health services with other social services;
- providing care to people who are unable to make health decisions due to their mental health problem;
- establishing minimum requirements for the content, scope and nature of services;
- assuring the coordination of various kinds of services;
- developing staffing and human resource standards;
- establishing quality of care standards and quality control mechanisms;[195] and
- assuring the protection of individual rights and promoting advocacy activities among mental health users.

LEGISLATION AS AN ENABLER FOR IMPLEMENTATION OF THE QUALITY FRAMEWORK

In exercising its legislative mandate "to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services"[196], the Mental Health Commission has produced a Quality Framework for Mental Health Services in Ireland. The scope of the Quality Framework is not confined to Approved Centres but applies to all mental health services. Several of its themes overlap with the framework for mental health service delivery set out in Chapter 8 of *A Vision for Change*. These include in particular Theme 1, which calls for "the provision of a holistic seamless service and the full continuum of care provided by a multi-disciplinary team". Fulfilment of this requires, amongst other things, that there be an integrated mental health service to serve each defined catchment/community area, with multi-disciplinary teams comprising professionals in psychiatry, clinical psychology, nursing, social work and occupational therapy. Such community-based services would also address prevention, early detection and mental health promotion in order to satisfy the criteria for these standards.[197] These multi-disciplinary teams are also crucial to bring about the necessary cultural shift within services that would see the service user at the heart of the service with clear focus on recovery.

The Commission has correctly identified the key enablers of the Quality Framework as including good governance, effective management and monitoring, evaluation and review.[198] Legislation designed to drive the roll out of comprehensive and community-based services with the full complement of multi-disciplinary staff would also be a valuable enabler for the implementation of those aspects of the Mental Health Commission Quality Framework which overlap with the framework for mental health service delivery set out in Chapter 8 of *A Vision for Change*. In addition many aspects of the Mental Health Commission's other guidance (such as its recently published Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre)[199] presuppose the existence of comprehensive and community-based services; legislation that drives the provision of such services would also act as an enabler for compliance with such important guidance.

ADVANTAGES OF USING LEGISLATION TO PROTECT RIGHTS

There are a number of advantages to protecting rights, such as the right to health services and the right to live and participate in the community, directly or indirectly in legislation. These advantages have been summarised by the Irish Human Rights Commission (IHRC) in the following terms:[200]

- Legislation can provide a more precise, detailed definition of the scope and content of the right or rights in question. In particular, legislation can **define the minimum core content of the right**. This is particularly relevant when considering the right to appropriate mental health services.
- Legislation can also **stipulate the financial arrangements for the delivery of rights**; the key requirement here being that legislation places the Executive arm of Government under a statutory obligation to ensure a transparent allocation of resources.
- Legislation can **promote accountability by prescribing the exact responsibilities and functions of the different levels of government at the national and local level**. By doing so legislation can also create a coherent and co-ordinated institutional framework for the delivery of the rights.
- Legislation can **prevent and prohibit violations of the right** by public bodies or officials.

There are many ways in which rights in relation to mental health can be protected in legislation. So, for example, legislation could set out a statutory right to appropriate mental health services. This could be coupled with a redress mechanism that could be invoked where the right in question was not fulfilled. On the other hand, rights can also be protected in legislation by placing statutory duties on the body responsible for the delivery of the right and by ensuring accountability for the discharge of such duty. Such a duty-based approach is discussed in more detail in Section 7.

LEARNING LESSONS FROM OTHER JURISDICTIONS: ITALY

Background to Law 180:
In 1978 the Italian Parliament passed "Law 180" which aimed to bring about a radical change in the system of care for people with mental health problems throughout the country.[201] The law comprised framework legislation (legge quodro) and left it to the regions to draft and implement detailed norms, methods and timetables for the translation of the law's general principles into practice.[202]

These legislative measures led to a complete overhaul of Italy's mental health services, with the gradual closure of all mental hospitals and the establishment of a nationwide network of Departments of Mental Health, which now deliver outpatient and inpatient care, as well as semi-residential and residential facilities.[203] Hospital care is provided in small psychiatric units in general hospitals with no more than 15 beds.[204]

The 1978 law had four principal components:

- A gradual phasing out of mental hospitals (MHs), with the cessation of all new admissions,
- The establishment of general hospital psychiatric wards (GHPW) for acute admissions, each having a maximum of 15 beds,
- The introduction of more restrictive criteria and administrative procedures for involuntary admissions, and
- The setting up of community mental health centres (CMHC) providing psychiatric care to geographically defined areas.[205]

Lessons from the Italian experience:

The WHO has summarised the lessons to be learned from the reform process in Italy as follows:

Firstly, the transition from a predominantly hospital-based service to a predominantly community-based service cannot be accomplished simply by closing mental hospitals; it requires appropriate alternative structures, which in turn require adequate time for planning and implementation.

Secondly, political and administrative commitment is essential to make the necessary investment in the infrastructure required for community-based services, including buildings, staff (including training) and back-up facilities.

Thirdly, monitoring and evaluation are important aspects of change; planning and evaluation must go hand in hand and evaluation should,

wherever possible, have an epidemiological basis.

Finally, a reform law should not only be a guideline law (as was the case with Law 180) but should be prescriptive. Minimum standards need to be determined in terms of care, and in establishing reliable monitoring, systems; compulsory timetables need to be set for implementing the envisaged facilities; and central mechanisms are required for the verification, control and comparison of the quality of services.[206]

Law 180 did not set out detailed standards for service and staff provision or allocate an appropriate budget for setting up new services.[207] This seems to have led to a disparity in service provision in different areas throughout Italy.[208] In order to facilitate a more even roll out of the reform on a national basis, which required a clear statement of objectives, interventions and standards, a series of national plans for mental health were launched during the 1990s to support the reform process. [209]

Despite its shortcomings, it is widely acknowledged that Law 180 prompted the development of community-based mental health service model in Italy.[210] And while there were uneven levels of implementation across the country, these inequalities have reduced over time and the implementation of the reform has ultimately been successful in most parts of Italy.[211] For example, in Rome, Mental Health Centres (MHCs) form the core of community mental health services. MHC staff include psychiatrists, psychologists, social workers, community psychiatric nurses, occupational therapists and rehabilitation therapists.[212] There are also day centres (non-residential services which provide personalised rehabilitation programmes). Inpatient care consists of acute/emergency inpatient units (with a maximum of 15 beds) located inside general hospitals (as specified by Law 180), day hospitals (semi-residential services aimed at diagnostic, therapeutic and rehabilitation activities in the short term) and private psychiatric clinics, where admission can only occur on a voluntary basis.[213] Non-hospital residential facilities are aimed at social integration and rehabilitation of people with long-term mental health problems.

To date Ireland has relied to a large extent on policy and standards to make the transition from a mental health service that is dominated by institutionalised care to a modern, comprehensive mental health service that has specialist community-based services at its core. And progress to date has been frustratingly slow. It is time we recognised the potential of legislation to act as a useful tool to complement existing policy and standards and ensure their implementation.

FOOTNOTES

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184 ICESCR article 2 para 1.
185 Note 18 above, p. 22.
186 IMHC conference Mental Health: Human Rights and Legislation – What's possible in Ireland? Radisson Hotel, Golden Lane Dublin 8 (18 May 2009).
187 Note 19 above.

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188 Note 151 above, pp. 119-120.
189 ibid, p. 70.
190 ibid, p. 120.
191 White Paper: A New Mental Health Act Department of Health (July 1995), p. 103.
192 Dáil Eireann Volume 517 (6 April 2000) Mental Health Bill 1999, Second Stage, 1004 (available at: http://www.oireachtas.ie/viewdoc.asp?fn=/documents/bills28/bills/1999/7099/default.htm).

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193 Who Resource Book (note 12 above), p. 3.
194 ibid, p. 6.
195 This is already covered under the Mental Health Commission's Quality Framework for Mental Health Services in Ireland (note 2 above).

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196 Mental Health Act 2001, section 33(1).
197 Theme 1 of the Mental Health Commission Quality Framework (note 2 above).
198 See presentation of Ms Patricia Gilheaney, Director Standards and Quality Assurance, Mental Health Commission delivered at the IMHC conference Mental Health: Human Rights and Legislation – What's possible in Ireland? Radisson Hotel, Golden Lane Dublin 8 (18 May 2009).
199 Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre Mental Health Commission (2009). This Code of Practice calls for early communication and collaboration between in-patient services and primary and community mental health care services in discharge planning.

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200 Irish Human Rights Commission Discussion Paper Making Economic, Social and Cultural Rights Effective (October 2006) paras 4.4.1-4.4.5 citing Liebenberg S 'The Protection of Economic and Social Rights in Domestic Legal Systems' in Asbjorn Eide, Catarina Krause and Allan Rosas (eds), Social, Economic and Cultural Rights (Second Revised Edition, Kluwer Law International, 2001), pp. 55-84.

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201 WHO Best Practices: Mental health, human rights and legislation Best practices series, Sheet 3 (WHO Geneva, 2007), p. 2.
202 ibid.
203 de Girolamo G, Bassi M, Neri G, Ruggeri M, Santone G and Picardi A "The current state of mental health care in Italy" (2007) 257 European Archive of Psychiatry and Clinical Neuroscience 83, p. 83.
204 ibid.
205 ibid, p. 84.

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206 WHO Best Practices: Mental health, human rights and legislation (note 188 above) citing de Girolamo G and Cozza M 'The Italian Psychiatric Reform: A 20-Year Perspective' (2000) 23(3-4) International Journal of Law and Psychiatry pp. 197-214, Tansella M and Williams P 'The Italian experience and its implications' (1987) 17 Psychological Medicine pp. 283-289 and de Girolamo G 'Italian Psychiatry and reform law: A review of the international literature' (1989) 27 International Journal of Social Psychiatry pp 21-37, respectively.

207 Piccinelli M, Politi P and Barale F "Focus on Psychiatry in Italy" (2002) 181 British Journal of Psychiatry 538, p. 539.

208 ibid. See also Gaddini A. Ascoli M and Biscaglia L 'Mental Health Care in Rome' (2005) 20 European Psychiatry 294, pp. 294-295.

209 Piccinelli et al (note 194 above), p. 539.

210 Gaddini et al (note 195 above), p. 295.

211 Piccinelli (note 194 above), p. 543.

212 Gaddini et al (note 195 above), p. 295.

213 ibid.

SECTION 7

From vision to reality: how legislation could deliver improved accountability and underpin reform

"Rights imply duties, and duties demand accountability."

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 UN Doc.A/HRC/711 (31 January 2008) para 65

The previous sections looked at the reasons why Government needs to consider legislation as a driver for improved accountability and as an enabler for the reform of mental health services over time in line with *A Vision for Change*. The previous sections also touched on the types of issues that such legislation could address. This section will briefly discuss the possible content of such legislation.

STATUTORY DUTIES ON THE HSE: A LEGISLATIVE FRAMEWORK FOR INCREASED ACCOUNTABILITY AND SUSTAINED IMPROVEMENT OF MENTAL HEALTH SERVICES

Both the Green and White Papers issued by the Department of Health in the early 1990s proposed that the planned new mental health legislation would place a statutory duty on health boards to promote mental health and provide an appropriate range of services in line with current mental health policy. However, the subsequent Mental Health Bill 1999 was much narrower in scope and did not contain a legal framework for a community-based mental health service. Health Boards have now been abolished and replaced with the centralised HSE structure, which was introduced under the Health Act 2004. It was the expressed intention of the Government that establishment of the HSE would delineate clearly between responsibility for policy, which would rest with the Department of Health and Children, and responsibility for management of services, which would rest with the HSE.[214] The long-term implications of this change include the necessity for greater regulation of the managing organisation (the HSE) than might have been necessary when the Department was directly responsible for service provision through the Health Boards. It also implies a need for strong accountability to the Department and the Oireachtas by the HSE.

Legislation could establish a framework for sustained improvement of mental health services and increased transparency and accountability in mental health expenditure by clarifying the obligations of the HSE and the principles that should guide its fulfilment of those obligations. AI recommends that legislation should:

→ place a statutory obligation on the HSE to prepare and publish a detailed, time bound plan for the closure of unsuitable facilities and the

development and ongoing provision of comprehensive and community-based mental health services in line with *A Vision for Change*. This statutory provision (or accompanying regulations) should stipulate the level of detail to be included in such a plan including measurable targets, milestones, outcomes and indicators as well as clear timeframes and details of funding, human resources and infrastructure needed for implementation. The plan should also include details of management structures and responsibilities and it should be subject to the approval of the Minister and possibly also any independent monitoring group established by the Minister from time to time (i.e. the Independent Monitoring Group in the current context);

- ➔ place a statutory obligation on the HSE to provide comprehensive and community-based mental health services including the specialist services identified in *A Vision for Change* over time in line with the detailed plan and to the maximum of available resources;
- ➔ place a statutory obligation on the HSE to report annually by catchment area and service area to the Oireachtas and any independent monitoring group established by the Minister from time to time (i.e. the Independent Monitoring Group in the current context) on progress towards the implementation of its plan and expenditure of allocated funding and to publish this report. This reporting requirement (or accompanying regulations) could point to key performance indicators[215](both transformation indicators and ongoing performance indicators[216]) relating to financial accountability, mental health services infrastructure, staffing/ human resources (by speciality/skill mix), scope and quality of services and outcomes such as those recommended in the 2010 Indecon Report; and
- ➔ enshrine principles to guide the planning and delivery of mental health services. These could include:
  - the principle that services and supports should be designed in such a way as to enable people to enjoy their right to live in the community and participate in community life and to prevent social exclusion and isolation;
  - that persons be able to access the appropriate range of treatments and supports suited to their needs in the least restrictive environment appropriate; and
  - that the mental health services be designed in a way that promotes and underpins the recovery ethos; and
  - that service user participation be a core element of service planning and delivery.

One of the key stumbling blocks for the development of comprehensive and community-based services is the lack of accountability to ensure efficient usage of existing resources towards meeting policy goals. The detailed planning and reporting requirements suggested above would go some way towards addressing accountability for efficient expenditure of allocated

funding on mental health services in line with mental health policy by emphasising the need to re-balance the allocation of resources between in-patient services and community-based care.

EXTENSION OF THE SCOPE OF PART 5 AND SECTION 51 OF THE MENTAL HEALTH ACT 2001

As discussed earlier in this paper, Part 5 of the Mental Health Act 2001 establishes a system of approval and registration of hospitals and other inpatient facilities for the treatment and care of people with mental health problems. An extension of the scope of these provisions so that the system of registration and approval would also apply to community-based services is a key component in re-focusing our mental health laws so that they reflect the modern vision of community-based mental health services. This change would also necessitate changes to the statutory regulations applicable to Approved Centres. For example, the statutory regulations could provide that CMHTs would only be approved where they had a defined minimum complement of multi-disciplinary staff.

This amendment could be combined with an amendment to section 51 of the Act (functions of the Inspector) to place equal emphasis on the periodic inspection of inpatient and community-based mental health services. AI is of the view that these amendments to the Mental Health Act 2001 could provide further impetus for the much needed reform process.

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CONCLUSION

For more than a quarter of a century, successive mental health policies have called for reform of Ireland's mental health services. However, despite the commitment of many individuals, transformation has been slow and uneven and there remains a lack of accountability for expenditure and value for money in mental health services.

The tools used in Ireland to date to reform mental health services have included policy (Planning for the Future (1984) and *A Vision for Change* (2006)) and standards, as well as planning and budgetary measures and, more recently, key infrastructures such as the Office for Disability and Mental Health and the Assistant National Director for Mental Health. However, these combined measures have not led to the level or speed of reform they set out to achieve.

Human rights demand that effective measures be put in place to progressively realise the right to the highest attainable standard of mental health. In Ireland we have not considered whether legislation could, in tandem with other measures, act as a driver for reform of our mental health services and increase accountability for how they are financed and delivered. Now is the time to recognise the role legislation would play in delivering the core mental health services envisaged by successive mental health policies.

Law can serve as a useful tool together with policy, standards, strong leadership, effective public administration and resources which together can deliver a mental health service that respects the dignity of the individual and enables the individual to realise his or her right to the highest attainable standard of mental health. Of course, political will also plays a vital role.

The aim of this paper is to stimulate meaningful debate on how legislation could serve as a driver for reform of the mental health services. It is hoped that this it will lead to increased recognition of the human rights of persons with mental health problems and contribute towards the implementation of the recommendations of *A Vision for Change*. The ultimate goal is the creation of a system of comprehensive and community-based mental health services which offers the range of services and supports required to cater for each individual's needs, and offer choices to service users, and thereby effectively promotes and supports the right of each individual to live in the community and participate in community life. AI calls on all relevant stakeholders to engage in this discussion on how law can help to make this a reality.

FOOTNOTES

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214 See: Tánaiste announces the publication of the Health Bill 2004 Press Release 19 November 2004 (available at http://www.dohc.ie/press/releases/2004/20041119.html).

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215 That is, indicators designed to facilitate monitoring of progress towards mental health service reform as recommended by *A Vision for Change*, see 2010 Indecon Report (note 21 above) p. 47.

216 That is, indicators designed to facilitate the ongoing monitoring of performance and financial accountability of the mental health service, see 2010 Indecon Report (note 21 above) p. 47.

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217 These provisions could be put in place by way of an amendment to the provisions of existing legislation (such as the Health Act 2004) or by the introduction of a new piece of legislation.