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Preface

Amnesty International began a campaign in February of this year calling on the Irish Government to respect its legal obligation under Article 12 of the International Covenant on Economic, Social and Cultural Rights to provide the best available mental health care to all. This is part of Amnesty's expansion of the range of rights we promote in the national sphere.

We believe that it is our responsibility to raise public awareness that human rights are not just about torture and imprisonment - they also include economic, social and cultural rights. The right to the highest attainable standard of mental health is one such right, as is the right to shelter. Often people think that human rights concerns are just about other people in other countries. Some forget - or others never know - that international human rights apply equally to everyone in Ireland.

Sadly, the right of Ireland's homeless population to equal access to the best available mental health care is even less respected than that of the remainder of society. This is firmly the responsibility of successive Irish Governments for whom, it seems, mental health just does not matter, and homeless people matter even less.

We hope that this report, and our 2003 campaign will add to the national voices calling for immediate and radical change in the way this marginalised group is treated by the Irish State. What we seek to contribute is the international human rights perspective on this inexcusable Government neglect. We earnestly hope that our engagement will afford the many national non-governmental agencies that have been campaigning on this issue for years the backup of this simple fact: human rights are binding rights.

When the Irish Government ratified this Covenant in 1989, it wasn't just making vague gestures towards some faraway day when it might consider placing some importance on economic, social and cultural rights. It bound itself there and then before the eyes of the world to fully respecting, to the very best of its ability, these most basic human rights of its population.

If we seek to live in a decent and caring world, the very notion underpinning the United Nations, we should urge our Government to respect the international order of human rights. We cannot sit quietly by as the rights of the most vulnerable in our society are persistently and systematically treated as if they didn't exist. We should not allow ourselves to stand in judgement over countries with human rights abuses without also looking critically at our own.

The Government might continue to tell us that progress is happening, that reports are being compiled, action plans being developed, and expert groups convened. But it surely cannot deny that every day, homeless people with severe mental health problems are being denied basic services. It cannot refute the manifest truth that the rights of homeless people under this Covenant are not being respected. Our message to Government is that this situation will no longer be tolerated. Our challenge to Government is to finally do something meaningful about it.

Seán Love

Director, Amnesty International (Irish Section)



Introduction

"The term 'homeless' refers to individuals who lack shelter, resources and community ties. A substantial proportion suffer from significant mental health problems which together with concomitant physical complaints and disabilities, add to their social disadvantage. For a lucky minority, an out-of-home experience is a once-off event. For others it is a long-term experience, compounded by inadequate and poorly co-ordinated statutory services which are known to exacerbate individual vulnerabilities."

Dr Joe Fernandez¹

Amnesty International (Irish Section) launched a campaign on the rights of people with mental illness in February 2003, with the publication of a report, 'Mental Illness: the Neglected Quarter',² outlining its concerns about the mental health services currently available in the Republic of Ireland (Ireland).³ Much progress, has of course, been achieved in Irish mental health care in recent years. For centuries, in Ireland as throughout much of the world, people with mental illness were separated from the rest of society and placed for long periods in large institutions with little or no treatment, or worse, with radical and dangerous therapies applied to them. Today, the situation has much improved with a shift towards community-based services and greater protection for those in in-patient care.

Notwithstanding these advances, the above report points to the failure of successive Irish Governments to meet their obligations under international human rights standards, and to implement the recommendations of a series of national and international reports on the mental health services. It highlights the longstanding neglect, inconsistent service planning and under-funding of the mental health care sector generally, and its conclusions and recommendations apply equally to the services for homeless people.

Homelessness and mental illness are firmly causally linked. However, the service provision for homeless people with, or at risk of mental illness, is even more unsatisfactory. The minimalist, piecemeal, and unintegrated manner of the central planning and delivery of homeless services to date has resulted in a seriously inadequate and under-evolved mental health care regime for this vulnerable population.

As will be outlined below, the statutory responsibility towards Ireland's homeless population is limited, data available on their mental health care needs and service provision is deficient, there is a dearth of supported residential accommodation, very few specialised mental health teams are available in larger urban areas, catchment area services are ill-equipped to provide for smaller urban communities, and there is little or no follow-up after discharge from in-patient care or from prison. Amnesty International welcomes the recent adoption of a number of government homeless strategies and plans, which, if implemented, could significantly improve mental health care for this vulnerable group; but remains concerned that, without considerable financial investment and binding statutory obligations, progress will be neither adequate nor timely.

The burden resulting from the gaps in statutory service provision for homeless people with, or at risk of mental illness falls on voluntary homeless service providers and on the wider health and social services, all of which are already under enormous strain. The consequences impact severely on the quality of life for homeless people with mental illness. The Simon Communities of Ireland, a voluntary homeless agency has said: *"[we] are extremely concerned at the increase ... witnessed in the numbers of people who are homeless who are presenting with mental ill health. The lack of access to assessment and treatment services by people who are homeless further exacerbates the problem - leaving individuals very vulnerable, and homeless services struggling to ensure they meet service users' needs."*⁴

Amnesty International acknowledges the dedication of the many thousands of people caring for people with mental illness throughout the country: carers, psychiatrists, psychiatric nurses, social workers, care workers, psychologists, psychotherapists, counsellors and other therapists, hospital administrators, health board workers, civil servants in the Department of Health and Children, etc., who are serious in their desire to ensure that the best possible service is provided. Amnesty International also pays tribute to the non-governmental homeless agencies without which the difficulties experienced by Ireland's homeless would be so much worse.

In a national mental health context, the World Health Organisation describes the role of an international organisation such as Amnesty International, vis-à-vis the national agencies thus:

"International non-governmental organisations help in the exchange of experiences and function as pressure groups, while non-governmental

organizations in countries are responsible for many of the innovative programmes and solutions at the local level. They often play an extremely important role in the absence of a formal or well-functioning mental health system, filling the gap between community needs and available community services and strategies”⁵

This aim of this report is to raise awareness of the fact that absolute or relative disregard of the needs of the homeless people with, or at risk of mentally illness is a serious human rights issue; and that Ireland's homeless population has the right to the best available mental health care, and the highest attainable standard of mental health, which is currently not being respected.

“A 22-year-old woman, well-educated but a wanderer and a drifter, is sleeping rough by the canal in Dublin. She’s in an odd state, obviously in distress. A concerned passerby stops and speaks with her. The girl is homeless, hungry, distraught. The passer-by brings her home, gives her a meal and a bed for the night. The girl seems grateful, but during the night she tries to kill herself. Her host discovers her within seconds of losing her life. The girl is brought to the casualty department of the Mater Hospital. The psychiatrist cannot find a bed for the girl. No one will take her. She has a southside city address, so on the north side there’s no hostel place, no outreach programme, no safety net. Somehow, the hospital manages. Another case: a man in his 20s is suicidal. He too is found by the canal. He has nowhere to sleep, no money, no food. He has left an abusive family situation. There is no “home”. He too is brought into the Mater Hospital casualty unit. The homeless services don’t have a place for him because, officially, the man is not homeless. To be defined as “homeless”, you must have been registered as living in a hostel for the previous three months. But the health board can’t place him in a hostel if he is not defined as homeless. It seems to be Catch 22.”

‘Left out in the cold’ Irish Times newspaper 8 February 2002

Methodology

This report compiles recent literature and research on the mental health needs of, and service provision for, Ireland's homeless population and is intended to provide an overview of current concerns and recommendations relevant to Ireland's binding obligations under international human rights law. It must be noted that there is distinct paucity of official data collection and needs analysis available on this subject in the Irish context. This report was carried out by desk research based on reports sourced mainly from the Department of Health and Children, and the homeless agencies, Simon Communities of Ireland and Focus Ireland. It is noteworthy that voluntary homeless agencies are filling gaps in government policy implementation, not alone in relation to service provision, but also in research and data collection. Interviews with staff of homeless agencies, mental health professionals, and family members were also conducted.

Chapter 1 International Standards

Introduction

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

The Right to Adequate Housing

The first principle in any discussion of homelessness, is that housing is a fundamental human right. Everyone should have access to suitable accommodation, and homelessness, as the most fundamental violation of this principle, should be eliminated. The United Nations (UN) has pointed out:

"At first glance, it might seem unusual that a subject such as housing would constitute an issue of human rights. However, a closer look at international and national laws, as well as at the significance of a secure place to live for human dignity, physical and mental health and overall quality of life, begins to reveal some of the human rights implications of housing. Adequate housing is universally viewed as one of the most basic human needs."

Article 11(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR), ratified by Ireland in 1989, provides: *"The States Parties to the present Covenant recognise the right of everyone to an adequate standard of living for himself and his family, including adequate ... housing."* The UN Committee on Economic, Social and Cultural Rights (CESCR), which supervises compliance with the ICESCR, has noted

that “the Covenant clearly requires that each State party take whatever steps are necessary” to fully realise this right.⁷

Naturally, the accommodation needs of homeless people with, or at risk of mental illness must be addressed if their mental health is to be safeguarded. As a 1999 non-governmental report stated: “It is surely taking de-institutionalisation to an unacceptable extreme to imply that people who are mentally ill can be cared for even if they have not been properly housed first.”⁸

Housing alone is not the solution, as the link between homelessness and other vulnerabilities is a very complex one. The European alliance of homeless organisations, FEANTSA notes:

*“Housing and homelessness are inseparable. Becoming homeless is generally the upshot of a series of life events which push some people into exclusion. But housing is often not their only problem: they also have health (lifestyle, sickness, dependency, etc.), psychological and social problems (isolation, loss of self-confidence, depression, etc.) which mount up into a fast-track to homelessness. ... Unfortunately, few countries take account of the special needs of the homeless in these areas. Mostly they stop short at treating homeless people’s problems just as a housing issue.”*⁹

The Right to Mental Health Care

International human rights apply equally to homeless people, including the right to the highest attainable standard of mental health in Article 12 of the ICESCR. The UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (the MI Principles) were adopted in 1991,¹⁰ and elaborate the basic rights and freedoms of people with mental illness that must be secured if states are to be in full compliance with the ICESCR.¹¹ The right to “the best available mental health care” is enshrined in MI Principle 1(1), which “includes analysis and diagnosis of a person’s mental condition, and treatment, care and rehabilitation for a mental illness or suspected mental illness”. MI Principle 1(2) lays down the basic foundation upon which states’ obligations are built: that “all persons with a mental illness, or who are being

treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person”.

In complying with the ICESCR, Ireland is also obliged to secure for homeless people *“the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country”.*¹² The entitlements under Article 12 *“include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health”.*¹³

The UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities provide: *“States are under an obligation to enable persons with disabilities to exercise their rights, including their human, civil and political rights, on an equal basis with other citizens.”*¹⁴ This means that services must not just be made available but that people are enabled to access them.

Furthermore, in order for Ireland to comply fully with the ICESCR, the UN CESCR says:

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

Consequently, the significant occurrence of mental illness within the population under review, places an extensive obligation on the Irish State to take positive measures to address any gaps in their human rights protection, and in any deficiencies in their

mental health care. Failure to do so amounts to non-compliance with Ireland's binding obligations under Article 12 of the ICESCR.

As the UN health agency, the World Health Organisation (WHO) reflects the former's understanding of what is meant by *"the best available mental health care"*. In 2001, it ran a year-long campaign on mental health, when, for the first time, WHO's annual report, World Health Day, and discussions at the World Health Assembly all focused on one topic, namely Mental Health, thereby revealing the urgency and importance attached at international level to this subject. The WHO 2001 annual report 'Mental Health: New Understanding, New Hope'¹⁶ provides a detailed account of what is expected of all states in their treatment of people with mental illness, and lays down a comprehensive package of recommendations for states to implement according to their means. In two years of relative prosperity, little action has been taken in Ireland on many of the core recommendations of the above report.

Chapter 2 Homelessness in Ireland

Who are Ireland's Homeless?

One of the difficulties in determining the number of homeless people throughout the world is the lack of universal agreement on the definition of the term "homeless". A concise definition favoured by some,¹⁷ is: anyone who *"lacks adequate shelter, resources and community ties"*.¹⁸ Dr Fernandez, Director of the Programme for the Homeless at St Brendan's Hospital in Dublin, observes: *"The term also describes a population living in a continuum of unsatisfactory accommodation ranging from cardboard boxes through to unsuitable social housing."*¹⁹ His operational definition is: *"heterogeneous groups of individuals ... who, in the absence of a stable base and supportive social networks, have peripatetic lifestyles characterised by poverty, by a lack of privacy, possessions and personal relationships, and by a tendency to poor physical health, psychological distress and psychiatric dysfunction"*.²⁰

The statutory definition of homelessness in the Irish Housing Act, 1988 includes people sleeping rough and those accommodated in direct access hostels, emergency shelters or in Bed and Breakfast accommodation, but excludes those involuntarily sharing with family or friends, in insecure accommodation, or living in inadequate or sub-standard accommodation.²¹ It also excludes those currently housed but who are likely to become homeless due to a variety of factors including economic difficulties, or health problems and other vulnerable groups.

The United Kingdom's definition, for example, is significantly wider. It defines a person as homeless if there is nowhere where they, and anyone who is normally with them, can reasonably be expected to live, and includes those *"threatened with homelessness"*.²²

How Many are Homeless?

How many people are homeless in Ireland is a matter of some debate. The most recent official figures for the total number in Ireland date from 2002, when 5581 individuals were assessed as being homeless,²³ the majority of whom were in the Dublin region.²⁴ It must be emphasised that voluntary homeless agencies, and many involved in mental health service delivery, believe that the figure would be substantially higher if all

categories of homeless individuals were included in official statistical reports. To date, only those using homeless services, recorded as homeless on local authority housing lists or are known to be sleeping rough are included. Thus, many individuals in general and psychiatric long-stay hospital care, or in community-based residences, or in other such environments; while meeting the criteria for homelessness expressed in the Irish Housing Act 1988, are not recorded in the official count as being homeless.²⁵ As will be seen below, the same applies to a significant number of prisoners who are believed to be homeless.

As mentioned earlier, the definition of homelessness varies throughout the world, and a quantitative international comparison of homeless figures is therefore quite pointless. Yet, one can look to Northern Ireland, which has a population a third of the size of Ireland's, to see that, under its definition, approximately 12,694 households are considered homeless there.²⁶ Some limited comparison with the UK situation can be achieved through looking at the numbers of people sleeping rough on the streets. In November 2000,²⁷ speaking on the results of the June 1999 count of 202 individuals (the most recently reported discrepant estimate is of up to 312 rough sleepers in Dublin²⁸), Dublin Simon observed:

*"Compared to the number of rough sleepers in cities of comparable size in the UK, the number of rough sleepers in central Dublin is very high. According to figures from the UK Government's Department of the Environment, Transport and the Regions Rough Sleepers Count of June 1999, there are more rough sleepers in Dublin than in Oxford (52), Manchester (44), Birmingham (43), Nottingham (31) and Liverpool (30) combined. According to the UK's Homeless Network Street Monitor Count of January 1999, the number of rough sleepers in central Dublin is more than two-thirds of the number of rough sleepers in central London (302)."*²⁹

A rising number of families are homeless in Ireland - for instance, a recent study of those in Dublin stated:

"In 1984 there were 37 women with 93 children in hostels in Dublin and no family was homeless for more than six months (Kennedy 1985).³⁰ By 1999 there were 540 families with 990 children (530 under 5 years of age) assessed as being homeless in the ERHA region (Williams & O' Connor, 2000).³¹ [...] The number of single-parent (usually mother-only) families with young children who find themselves in the vulnerable position of homelessness has increased at an alarming rate. The impact of this disruptive, unstable and often chaotic situation on young lives is becoming clear from research in various countries"³²

The 2002 official Dublin count recorded 640 families with 1140 children as being homeless.³³

Mental Illness and Homelessness

The true prevalence of mental illness in Ireland's homeless population is unknown. The mental health status or needs of Ireland's homeless does not form part of the state's triennial homeless count.³⁴ In advance of the 2002 count, the Simon Community commented: *"The data will tell us nothing about individuals' housing need, family status or age, all of which should be pertinent to planning for housing provision. Additionally they tell us nothing about routes into homelessness and the types of services people wish to access. In the absence of this information, both the appropriateness of current service provision and the planning of new services will continue to occur in a chasm."*³⁵ Policy makers and advocacy bodies must consequently operate on estimates.

According to Dr Fernandez,³⁶ a distinction must be drawn between *"mental health problems"* induced by homelessness, and *"mental illness"* which may be a factor in becoming or remaining homeless; both of which should be attended to primary care agents i.e. general practitioners, or by the mental health services. Research suggests that the experience of being homeless may contribute to anxiety or depressive illnesses.³⁷ On the other hand, a significant factor in precipitating homelessness is serious mental illness, and alcohol or drug addiction. It is also accepted that

homelessness may exacerbate a previous or existing mental condition: *“There is evidence that the longer the period of untreated mental illness, the more difficult it is for people to return to their premorbid degree of well being. The very nature of being homeless and mentally ill is usually synonymous with being untreated for large tracts of time.”*³⁸

With respect to prevalence rates, Dr Fernandez observes that *“estimates vary depending on one’s definition of homelessness and on other less scientific influences, shaded by considerations of a political or a campaigning nature”*.³⁹ He has concluded: *“Professional working with the homeless on these islands, will generally concede that 25 per cent of this group do not admit to having psychological problems, while 75 per cent do. Of the latter, 42 per cent are believed to have a history of mental health problems which are a consequence of their social deprivation and homelessness. The remaining 33 per cent are believed to suffer from severe mental and/or behavioural disorders which contribute significantly to their homeless state and are exacerbated by it. What is being described is the position at two ends of a continuum, without being able to identify the point at which distinctions between these groups get blurred or overlap.”*⁴⁰ The WHO 2001 annual report says, *“individuals may be predisposed to mental disorder because of their social situation and those who develop disorders may face further deprivation as a result of being ill. Such deprivation includes lower levels of educational attainment, unemployment and, in extreme cases, homelessness.”*⁴¹

An Irish study conducted in 1997 assessed the prevalence of chronic mental illness amongst a sample of 502 homeless persons: 32.5 per cent were deemed to have depression and 27.6 per cent an anxiety disorder.⁴² Another report calculated that, based on the official homeless count,⁴³ there were 1500 people homeless with mental illness in Ireland in 1999.⁴⁴ Again, the narrow categories of homelessness included in the official count must be borne in mind when contemplating these figures.

Dual diagnoses of mental illness and substance misuse is also quite high in homeless populations. The 1997 study above found that 30 per cent of its homeless sample misused alcohol while another 30 per cent misused other substances.⁴⁵

The circumstances of homeless families are unfortunate.⁴⁶ Studies in other jurisdictions have found very high levels of mental illness in homeless mothers.⁴⁷ The children of homeless families have also been found to have a much higher likelihood of developing significant mental health problems than the remainder of the population. For instance,

Focus Ireland found that 12 of the 31 children profiled in its study *“exhibited signs that they were likely to present with mental health problems of sufficient severity to merit referral for psychiatric assessment”*.⁴⁸ It concluded that *“the rate of psychiatric disorder is higher amongst homeless children than that of their housed counterparts”*.

The WHO 2001 annual report advises that states should conduct more research into biological and psychosocial aspects of mental health.⁴⁹ This should include epidemiological data collection and evaluation, considered by this WHO report to be *“essential for setting priorities within ... mental health, and for designing and evaluating public health interventions”*. Research into the mental health status of the homeless community should be undertaken regularly if services are to be planned to meet their needs.

Chapter 3 Homeless Accommodation

Local Authorities

Stable and appropriate accommodation is a prerequisite for sustaining mental health and for recovery from mental illness. The Irish 1988 Housing Act includes in its definition of homelessness those living in a hospital, county home, night shelter or other such institution (see note ²² above). However, Section 10 of the Act imposes only limited obligations on the housing authority to provide “reasonable accommodation” for a homeless person. Thus, it may:

- (a) make arrangements, including financial arrangements, with a body approved of by the Minister for the purposes of section 5 for the provision by that body of accommodation for a homeless person,
- (b) provide a homeless person with such assistance, including financial assistance, as the authority consider appropriate, or
- (c) rent accommodation, arrange lodgings or contribute to the cost of such accommodation or lodgings for a homeless person.

This has been accurately described thus: *“The 1988 Housing Act provides an enabling power rather than a statutory duty. The extent of assistance provided by local authorities to individual homeless people is left to their discretion and often amounts only to arranging short-term bed and breakfast accommodation.”*⁵⁰

Voluntary Service Providers

Voluntary agencies, to which local authorities are statutorily empowered to devolve their housing duty, provide much of the available emergency homeless accommodation. This is often accompanied by insufficient government financial assistance: *“In the absence of statutory provision the voluntary sector has tried to fill the gap to some extent although many organisations are struggling financially. While ‘bricks and mortar’ finance is accessible, the task of securing revenue support is a problem which has yet to be effectively tackled.”*⁵¹ In 2002, the Simon Community issued the following press statement:

*"[D]espite the fact that it is now the second year of (the implementation of Homelessness - An Integrated Strategy), many projects do not know what funding they will receive to cover this year's costs, let alone what they can hopefully plan to receive for 2003. This precarious position falls far short of the Government's originally stated commitment to provide three year funding for projects. In 2001 over 50 per cent of the essential running costs of Simon services throughout the country (approximately E8 million) still had to be met by the generosity of the public through donations and fundraising."*⁵²

In a recent survey of 14 homeless families with 31 children in Dublin in Focus Ireland's family transition units, *"the women and children had been homeless for approximately 8.5 months on average prior to entering the ... family transition units and intermittently homeless for 26 months on average before living in the family transition units"*.⁵³ The report revealed *"predictably high levels of parental stress and high level of mental health needs for children"*. It is of note that none of the parents profiled had ever accessed the psychiatric/psychology services or seen a community psychiatric nurse either before becoming or while homeless, but 52 per cent and 29 per cent respectively, had done so upon entering the unit.

Bed & Breakfast Accommodation

Since the 1990s, private Bed and Breakfast accommodation (B&B) has been increasingly used as an alternative to emergency homeless accommodation. A report by Focus Ireland in 2000 identified 1202 households (individuals, couples and families of which at least 691 had children), as living in emergency B&Bs in Dublin in 1999, at a cost £4.7 million (€5.97 million) for that year.⁵⁴ This report noted:

"Accommodating the homeless in Bed & Breakfasts (B&Bs) is an unacceptable, unhealthy, and expensive short-term solution to housing shortage. [...] Unfortunately, our research shows that over the last decade there has been a substantial rise in the use of B&Bs in Dublin, and an increase in the time people spend there."

It continued: *"The use of B&B accommodation is unacceptable for a number of reasons including its inherent lack of stability, its inappropriateness in terms of privacy and social isolation, its impact on the physical and emotional health of users, and the lack of appropriate support structures associated with this type of accommodation."* It also referred to evidence of drug and alcohol addiction, and mental and physical health difficulties among the homeless B&B population.

Chapter 4 Mental Health Care for the Homeless

Introduction

The quality of mental health service provision for Ireland's homeless population is under-researched by central government. Consequently, Amnesty International has had to rely largely on the reports of voluntary homeless agencies, individual health boards, non-governmental bodies, and on interviews with service providers, in particular with Dr Joe Fernandez, Director of the Programme for the Homeless at St Brendan's Hospital, in concluding on the availability and accessibility of services to homeless people.

According to Dr Fernandez, specialist homeless mental health services should be provided in urban conurbations where significant numbers of homeless people congregate. In these circumstances, specialist services would be expected to work in tandem with mainstream catchment area services and with voluntary service providers, to meet anticipated needs. In other parts of the country, such specialist services may not be necessary as mainstream catchment area services should be able to meet the particular needs of their much smaller number of homeless.⁵⁵ It is widely acknowledged that the services for homeless people with mental illness are seriously underprovided in both contexts.

De-Institutionalisation and Community Care

Over the last three decades, the process of de-institutionalisation has come to be increasingly implemented in Ireland with a de-emphasis on institutional care and an emphasis on a community-based model of service provision. This process was accelerated on foot of a government strategy, 'Planning for the Future',⁵⁶ in 1984. In response to the 1984 strategy, the Simon Community of Ireland published 'Send them home: Simon's response to the Government's report on the Psychiatric Services',⁵⁷ which warned of the dangers of failing to put in place a comprehensive and well-funded network of community care alternatives when proceeding with this policy of de-institutionalisation. Its fears would seem to have been realised as sufficient resources were not made available to ease the transition to community care. The 2001 WHO annual report, says: *"a sound de-institutionalisation process has three essential components:*

- Prevention of inappropriate mental hospital admissions through the provision of community facilities;
- Discharge to the community of long-term institutional patients who have received adequate preparation;
- Establishment and maintenance of community support systems for non-institutionalised patients.⁵⁸

De-institutionalisation in Ireland has generally failed to live up to this standard. One report has concluded: *"the rise in homelessness from the 1980s has often been linked to the de-institutionalisation of psychiatric patients into the community. In Ireland the evidence is less that discharged former long-stay patients became homeless but rather that the reduction of long-stay beds closed off what in effect was a residual social accommodation role performed by long-term psychiatric institutions."*⁵⁹

It has been accepted that the failure to couple the creation of alternative accommodation with the de-institutionalisation process is at least partially responsible for the high numbers of long-term homeless persons with chronic mental illness:

*"Thus far, policies aimed at dismantling institutions have ensured that positive bias is exercised in making available such sheltered or supervised accommodation as exists to the new 'deserving poor', mainly those old, long-stay patients who are deemed capable of being relocated outside of hospital. Given this, it is felt that many long-term homeless mentally ill are forced to resort to emergency social accommodation for their permanent abode. For the latter, remaining homeless is a decision mediated not by 'personal choices' but by a lack of statutory responses to their need. De-institutionalisation and the concomitant reduction in bed numbers had led - as elsewhere - to policies and practices that emphasise preclusive admissions and accelerated discharges."*⁶⁰

Homeless People and In-Patient Care

It is accepted that homeless people in need of acute psychiatric care require longer in-patient stays than their housed counterparts,⁶¹ but insufficient in-patient facilities are available to them throughout the regions. Conversely, due to the failure to implement the full range of community-based services recommended in 'Planning for the Future', an unknown proportion of acute beds remain inappropriately taken up by long-stay patients who have nowhere else to go. Because homeless services are widely deficient, with a particular shortage of supported residential care accommodation; homeless people were discovered to make up to one third of all persons inappropriately occupying acute psychiatric beds in the ERHA area in a 1999 report, 'We have no beds'.⁶² Many of the individuals in question were considered suitable for community-based residencies but appropriate facilities were reportedly not available.

The Inspector of Mental Hospitals has also remarked on this problem in his report for 2001 as follows: *"Time and again, the Inspectorate has been struck by the number of current psychiatric in-patients who are homeless and are accommodated in acute or long-stay hospital wards despite being suitable for community residential placement. There is hardly a service in Ireland where this is not a current issue."*⁶³ Failure to provide alternative supported accommodation for those who are consequently compelled to remain in hospital, does not comply with their *"right to be treated in the least restrictive environment"*⁶⁴

This situation also leads to silting up of bed places much needed by others.

*'We have no beds' discovered "an increasing number of reports of EHB psychiatric services which had no beds for patients who were acutely ill and who needed hospitalisation".*⁶⁵ The result is that, for many, their right to in-patient care is seriously compromised. In response to the Inspector's observation above, a mental health support organisation, Schizophrenia Ireland, commented: *"While we are aware that some service provision has been made there is a need to ensure that this problem is addressed urgently to ensure that people who are homeless do not end up in the prison population or are not receiving adequate mental health care supports".*⁶⁶

Another consequence revealed in 'We have no beds' was the emergence of *"a system of borrowing beds for short term purposes from one service by another"*, an arrangement described as *"unsatisfactory for patients, representing poor quality of service delivery to acutely ill persons"*. It also concluded: *"Because of the pressure on*

acute beds in some areas it was often not possible to offer respite care for patients with serious mental illness in an effort to avoid relapse."

Catchment Area Services

Currently, mental health, alcohol, and drug-related problems of homeless people cannot be effectively met by mainstream catchment area services, as there are far too many barriers to accessing these services. Firstly, it is well recognised that homeless people pay less attention to health care than they do to their basic requirements of food, shelter and physical safety, so many are unlikely to present at primary care level to a General Practitioner.⁶⁷ Secondly, the general mental health services are already overstretched throughout the country. Thirdly, specialist services such as alcohol and drug addiction services are inadequately provided. Fourthly, despite the significant occurrence of dual diagnosis of mental illness and substance misuse, many homeless people fall between the dedicated services for these conditions (see below). Finally, mainstream services are reported to be resistant to accepting homeless persons: *"The inflexibility of delivery in conventional psychiatric services and the negative attitudes of mental health professionals along with negative stereotypes, are believed to compound the problem. A proportion of the homeless mentally ill have a forensic history. This, together with a tendency to abuse alcohol and drugs, apparently does not endear this group to the general psychiatrist".*⁶⁸

Considerable difficulty arises for homeless people in accessing mental health care due to the sectorisation of services into catchment areas. Whereas Amnesty International understands that individual service providers are often flexible about these arrangements, the fact remains that strictly speaking, homeless people in need of mental health care are expected to return to their previous places of residence for such treatment as may be needed; effectively leaving many without a service. It is reported that: *"Sectorisation has [also] led to staff generally not trained to meet and understand the needs and special requirements of some people homeless."*⁶⁹ The difficulties in accessing mainstream services have also lead to increased pressure on the Programme for the Homeless at St Brendan's Hospital described below.

The need for catchment area services to adapt, in line with recommendations made by the Royal College of Psychiatrists in 1990 and 1991, was pointed out to the Department of Health and Children in 1993.⁷⁰ Regrettably, matters do not appear to have progressed in the Dublin area. The impact of the recommendations of the Royal College of Psychiatrists on other regions in Ireland has yet to be assessed.

Specialist Homeless Services

Mental health services for the homeless should be available within each catchment area in larger cities, where the majority of the homeless are concentrated and should possess certain essential features: *“Adequate, comprehensive and accessible psychiatric and rehabilitative services must be available and assertively provided. Services must provide outreach contact for the mentally ill in the community, whether domiciled, living on the streets or living in shelters. Psychiatric assessment and evaluation are required, as is crisis intervention and hospitalisation, when necessary.”*⁷¹

Specialist services are generally unavailable in Ireland. In Dublin where it is estimated that 75 per cent of homeless people live,⁷² there is one specialist service, a Programme for the Homeless, operating from St Brendan’s Hospital, which is also the only such service in the country. This service was established by Professor Ivor Browne and Dr Fernandez in 1979, and a Day Centre was subsequently provided. Currently, the Day Centre is located at Usher’s Island, and the Programme has three supported housing units throughout the city. In 1983, its Director observed that *“in time there is likely to be a greater demand for this type of facility as we are forced to confront the inevitable ageing of those able bodied mentally ill who, devoid of family supports, were placed outside of hospital during the rush to community care.”*⁷³ No further support programmes were subsequently put in place; and the pressure on the Programme at St. Brendan’s Hospital is enormous, as it is now expected to function as a regional centre, despite being poorly resourced with respect to necessary multidisciplinary staff e.g. psychologist, social worker and clerical staff. Its 16 in-patient beds, intended for acute care, have been completely blocked by long-stay patients due to a lack of community-based residential facilities, and the service is continually under intolerable strain.

Funding was to have been provided to the ERHA this year to enable an additional Consultant-led team to be established to provide an additional service to homeless persons with mental illness. While a Consultant has been appointed, some uncertainty remains at the time of writing about the status of the promised funding for the team.

Some other local planning for specialised services is evident; the Inspector of Mental Hospitals remarks in his report for 2001: *“Plans by the Southern Health Board to establish a consultant-led psychiatric programme for the homeless with a full multi-disciplinary team working closely with the Simon Community was welcomed.”*⁷⁴ This programme has not yet been provided.

Outreach Intervention

A 24-hour psychiatric crisis intervention service, as available in other jurisdictions,⁷⁵ has not been made available in a comprehensive or consistent fashion, despite plans do so for every sector in the 1984 strategy. While back-up facilities and services are an essential prerequisite, an outreach component for crisis intervention is considered vital. One of the findings of 'We have no beds' was that: *"Community-based, emergency out-reach, 24 hour, seven-day-week, crisis intervention services were generally unavailable."*⁷⁶ The result is that at weekends and at night many people are inappropriately admitted instead to acute psychiatric units. Others may not be detected by the mental health system at all, but may become caught up in the criminal justice system instead (see below).

Dual Diagnosis: Mental Illness, Substance Misuse & Personality Disorder

Many homeless people with a dual diagnosis of mental illness and drug or alcohol misuse find themselves without a service, since existing services consider themselves to be either psychiatric services or addiction services, with poorly defined collaborative functions. According to Dr Fernandez, *"the most difficult and deprived group of dually-diagnosed individuals are those who abuse alcohol and/or other psychoactive substances and who also suffer from a severe psychiatric disorder"*.⁷⁷ He further underscores the vulnerability of homeless dually diagnosed individuals by emphasising that: *"in this group, homeless operates metaphorically as yet another diagnosis of morbidity which confers upon (its members) the greatest amount of handicaps. Thus, homeless dually-diagnosed individuals have three distinct and interactive problems, leading to further physical and mental health problems including cognitive impairment which is now increasingly recognised as a significant factor which contributes to the constricted adaptive capabilities of homeless dually-diagnosed individuals"*.⁷⁸ What is required is the development of a programme to deal with homeless individuals with a variety of problems: *"a comprehensive and seamless system of care, that integrates and co-ordinates interventions in mental health, addiction, health, welfare and housing services."*⁷⁹

In discussing the implications of the Mental Health Act, 2001 on homeless populations, Dr Fernandez stated as follows: *"Our new Mental Health Act explicitly excludes Personality Disorder from the definition of mental disorder. In the absence of mental illness, significant mental handicap or severe dementia, it is highly unlikely that*

*individuals with personality disorder will either be admitted to psychiatric hospitals voluntarily or be detained involuntarily. Unless appropriate alternatives are provided to contain the predictable deviance displayed by some members of this group, the onus for the management of homeless individuals with significant personality disorder is likely to fall on: (a) untrained care-staff in the voluntary sector who service the majority of hostel and night-shelter beds in the community or (b) on the criminal justice system. In the former event, voluntary agencies will need to be provided with considerable support in their endeavours.*⁸⁰

*"Another problem is thrown up by homeless individuals who suffer from mild intellectual disabilities and from mental illness; who may or may not have a personality disorder; who abuse alcohol and/or other psychoactive substances and who display cognitive impairment and dysfunctional behaviour. While any single aspect of their cumulative indisposition may not be significant to secure admission for in-patient treatment - when warranted; their combined disability may be far greater than the sum of its parts and may be consigned to out-patient management, in insecure accommodation in the community, by untrained carers and in uncertain circumstances."*⁸¹

Discharge from In-Patient Care

Follow-up for homeless people after discharge from in-patient psychiatric care is often neglected:

*"There is little or no follow-up of patients after discharge from in-patient care. In 'Planning for the Future', the 1984 report by the Department of Health's on the future of the psychiatric service, there is a commitment to 'continuity of professional responsibility running through the different treatment services provided by the psychiatric team.' The reality as experienced by the Simon Community is that there is no follow-up. If the person fails to turn up at the clinic, no follow-up action is taken."*⁸²

Others may be discharged directly into the care of homeless emergency shelters operated by voluntary agencies,⁸³ which are not therapeutically appropriate for people with mental illness: *"The practice of directly discharging people who are without permanent accommodation from hospitals, including psychiatric hospitals, to emergency shelters for homeless people, has been documented by the Simon Community as long ago as 1992."*⁸⁴ Today this *modus operandi* is more common and is causing greater problems than ever before.⁸⁵ Another voluntary homeless service has reported a similar experience: *"Inappropriate discharge from psychiatric hospitals and inadequate care in the community continue to be a problem. Centrecare has worked with a number of people who have been discharged from hospital into the care of homeless services without any back-up medical support."*⁸⁶ It is unclear whether the discharging services referred to, released the patients in question to the care of shelters in which they were resident prior to their admission, or into shelters where they were not previously resident. One way or the other, this practice illustrates significant lacunae in aftercare, the pressures on existing services, and the deficit in supported accommodation; all of which need to be immediately addressed by the government authorities.

The government has acknowledged the above practice in its 2002 'Homeless Preventative Strategy', wherein it states: *"There is also evidence of prisoners and hospital patients being discharged directly into services for homeless persons and of a continuous link between homelessness, prisons and psychiatric hospitals."*⁸⁷ Amnesty International welcomes the publication of this Strategy, which is directed at adults leaving institutional care. However, it remains to be seen how its recommendations will be implemented, and how the programme for monitoring and evaluating the performance of the various government departments and health boards will be adhered to. There is no express provision for an increased number of supported housing units to receive homeless people with mental illness who are discharged from institutional care. Its recommendations in respect of follow-up after discharge through homeless multidisciplinary teams would not appear to have any relevance to many of the catchment area services where such teams do not exist.

Many of the actions specified in relation to discharge from psychiatric care are restatements of existing policy, which have never been properly implemented. For example, it recommends that every patient *"will have a formal and written Discharge Policy"*, an instruction given in the government 1998 'Guidelines on good practice'.⁸⁸ There is as yet no evaluation of how this recommendation is being adhered to in practice.

The Strategy recommends that *“records will be kept of the number of patients being discharged and the type of accommodation”*. The Programme for the Homeless at St Brendan’s Hospital devised its own ‘Pre-Discharge Checklist’ with a set of practical instructions and safeguards in 1979. The Department of Health and Children issued an identical checklist in 1985, and another similar checklist in 1987 advising all services to communicate with the Directors of Community Care in a prescribed manner when discharging homeless patients.⁸⁹ There is no evidence that the latter’s recommendations are being complied with.

Supported Accommodation

While there is a shortage of community-based residential facilities and hostels throughout the mental health service,⁹⁰ the deficit in such supported housing for homeless people is particularly worrying. For the many homeless people with mental illness who are incapable of unassisted independent living, but not in need of in-patient care: *“An adequate number of graded, step-wise community housing settings (with differing degrees of support) must be established.”⁹¹ [...] Many housing settings that require people to manage by themselves are beyond the scope of some people who are chronically mentally ill.*⁹² Yet, there is a glaring mismatch between the number of graded supported housing units and homeless people suitable for such placement. The Simon Community of Ireland has noted:

“In the European context Ireland is exceptional in the undeveloped nature of its services to mentally ill people who are homeless. In particular supported housing is a neglected and under provided area in Ireland, with less than 200 units of supported accommodation provided for mentally ill and homeless people, the great majority of these through the voluntary sector. Health boards do provide some supported accommodation for people who are mentally ill in the community but this is mostly for compliant groups. Those who are homeless, who are generally seen and treated across the system as a non-compliant group, are not provided for.”⁹³

A report commissioned by Simon concluded: *"There is a critical shortage of necessary supported housing and community supports for people with mental ill health. ...this remains the biggest problem for homeless service providers."*⁹⁴

A recent New York study indicates that the placement of homeless individuals with severe mental illness in *"supportive housing"* is associated with a substantial reduction in homelessness, a decreased need for homeless shelters, significant reduction in psychiatric hospitalisations and the length of stay per hospitalisation, and significant reduction in time spent in prison.⁹⁵

Support for Voluntary Housing Agencies

As mentioned above, the burden of sheltering homeless people with significant mental health problems, rests substantially with voluntary agencies and is exacerbated by the failure of the mental health services to provide supported accommodation through the mental health system. The in-house care support available to voluntary homeless shelters is also inadequate,⁹⁶ consequently: *"Homeless services, which are not specialists in mental health, are attempting to meet the needs of people with severe and chronic mental ill health who are without other housing or support options."*⁹⁷

The discharge of patients directly into the care of homeless agencies has been described earlier.

Homeless Children

Amnesty International is concerned that Ireland does not comply with its international obligations in its treatment of homeless children with, or at risk of, mental illness under the UN Convention on the Rights of the Child. This Convention provides *"the right of the disabled child to special care and ... the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance ... which is appropriate to the child's condition ..."*⁹⁸ The UN Committee on the Rights of the Child, in its last report on Ireland in 1998, stated particular concern about the incidence of child homelessness in Ireland. Focus Ireland, has highlighted the problem of child homelessness in Ireland,⁹⁹ and the particularly high rate of homelessness of children once they leave the state's residential care.¹⁰⁰

Research into the circumstances and mental health needs of children who are homeless, or at risk of homelessness, is very poor.¹⁰¹ For instance, the homeless agency,

Focus Ireland has found *“an absence of an adequate database on young people in the care of health boards and on leaving health board care”*.¹⁰² Of course, this is true of children in Ireland generally:

*“The absence of epidemiological information relating to children's mental health on a national basis is a significant limitation in our current system. No routine information system captures information on children's mental health problems, with the exception of the national psychiatric in-patient reporting system, which provides information on children admitted to psychiatric hospitals. However, since mental health problems in children rarely require admission, this source of information is of limited value. A highly developed information system is required, in order to underpin approaches to quality assurance and evaluation of mental health prevention and treatment services, to monitor trends in incidence, and to identify risk factors and risk groups.”*¹⁰³

Mental health services for children generally are quite inadequate, and those for adolescents almost non-existent.¹⁰⁴ The aforementioned UN Committee report said that it was *“concerned about the lack of a national policy to ensure the rights of children with disabilities and the lack of adequate programmes and services addressing the mental health of children and their families.”*¹⁰⁵ A ‘Youth Homelessness Strategy’ was published by the Department of Health and Children in 2001, the aim of which is to *“reduce and if possible eliminate youth homelessness through preventative strategies and where a child becomes homeless to ensure that he/she benefits from a comprehensive range of services aimed at reintegrating him/her into his/her community as quickly as possible”*. However, it provides little in the nature of tangible commitments or timeframes, other than an instruction to each Health Board to devise a *“two-year strategic plan to address youth homelessness in line with specific actions”*.

Chapter 5 Criminal Justice System

Crime and Homelessness

A 2002 study, 'Crime and Homelessness', concluded that *"periods of imprisonment can indeed lead to homelessness, [and] homelessness can also lead to imprisonment"*.¹⁰⁶ It observed: *"There has been little research in Ireland on the complex relationship between homelessness and crime or on the difficulties and problems faced by offenders on leaving prison."* It noted that Irish prison statistics yield little information on the number of prisoners who are homeless.¹⁰⁷ Without this sort of information, it would seem difficult to devise individual sentence and release plans as is the duty of the prison authorities. The report noted however:

"Recent profiles of male prisoners in Mountjoy prison in Dublin by O'Mahoney (1993, 1997)¹⁰⁸ indicate that 3 per cent and 7 per cent respectively of the sample populations were homeless. These figures are considerably lower than those found in comparative studies from the UK. A recent snapshot survey of the incidence of homelessness among male and female prisoners in Mountjoy Prison and the Dochas Centre respectively conducted by PACE in 2002 shows the incidence of homelessness to be closer to Taylor and Parrot's (UK) estimate than O'Mahoney's. The PACE survey¹⁰⁹ found that 33 per cent of all Irish female prisoners in the Dochas Centre will be homeless on release from prison and 35 per cent of men reported that they will not have accommodation upon their release"

It nevertheless found that significant numbers of homeless people with mental illness end up in prison because of public order or nuisance offences, often related to their homelessness and mental health or addiction problems.¹¹⁰

Prison Mental Health Services

This is of concern in two respects. Firstly, the mental health services available within the Irish prison system are most unsatisfactory. The report of a government-sponsored review in 2001 noted *“many deficiencies and shortcomings”,* and *“long-term under resourcing of prison health care services”*.¹¹¹ For prisoners in need of in-patient care, Rule 22(2) of the Standard Minimum Rules for the Treatment of Prisoners state: *“Sick prisoners who require specialist treatment shall be transferred to specialised institutions or to civil hospitals.”*¹¹² In Ireland however, special psychiatric units for prisoners do not exist within or outside prisons, and the only psychiatric hospital that will accept prisoners is Dublin's Central Mental Hospital (CMH). The CMH does not have sufficient beds to match demand, and much of its infrastructure is unsatisfactory due to insufficient capital funding. Very long waiting lists for admission to the CMH mean that many prisoners in need of in-patient care never receive a transfer, and other prisoners are returned to prison from the CMH before they are well. Both of these scenarios represent a serious lack of respect for the right to proper health care in MI Principle 20(2). Of further concern is that mentally vulnerable or ill prisoners have been placed in isolation cells in prison, often for significant lengths of time, in conditions which may amount to cruel, inhuman and degrading treatment, and sometimes while awaiting transfer to the CMH.¹¹³

Secondly, where a person's primary reason for the commission of a relatively minor crime is mental illness, proper mental health care should be afforded to them, not imprisonment. ‘Crime and Homelessness’ advises: *“There needs to be a review of the use of custodial sentences as part of our judicial system for people who are homeless. Committal to prison should be viewed as a ‘punishment of last resort’.*” This is in line with relevant international human rights standards.

The 2001 WHO report recommends that *“policies should be put in place to prevent the inappropriate imprisonment of the mentally ill and to facilitate their referral or transfer to treatment centres instead”*.¹¹⁴ In this regard, Amnesty International welcomes the publication of the Criminal Law (Insanity) Bill, 2002. While the stated purpose of the Bill is to reform the law on *‘criminal insanity’* and *‘fitness to be tried’*; to bring it into line with the jurisprudence of the European Convention on Human Rights, Amnesty International shares the concerns of other national organisations that the diversion scheme offered by this legislation will impossibly add to the demands on existing services, unless accompanied by significant expansion of, and capital and revenue investment in, the appropriate psychiatric facilities and manpower.

In its 1999 report on Ireland, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) commented: *"A mentally ill prisoner should be kept and cared for in a hospital facility which is adequately equipped and possesses appropriately trained staff."*¹¹⁵ In the absence of specialised psychiatric treatment units within the prison system for those diverted to *"designated centres"*, accessible alternatives in civil mental health facilities will have to be provided. This is an issue that must be resolved immediately.¹¹⁶ As stated above, the only psychiatric hospital which currently accepts patients from the prison system is the CMH, the services of which are already overstretched. Schizophrenia Ireland has commented thus:

*"The Minister (for Justice, Equality and Law Reform) should note that existing resources of mental health services are overstretched, most particularly, but not exclusively, in the Eastern Region where the prisoner population is greatest. The implementation of this Bill will place an even greater burden on these resources, and the Government should recognise and provide for the revenue and manpower implications accordingly."*¹¹⁷

The 'Crime and Homelessness' report advised: *"Education programmes for Gardaí, Judges, and other professionals working with the judiciary is necessary. It is essential that those in contact with homeless adults in a law enforcement capacity should understand more completely the particular difficulties that homeless men and women face and what the implications of imprisonment might be on their accommodation, family relationship or substance abuse status and on their likelihood of re-offending."*

Homeless Ex-Offenders

The CPT, in its 1999 report on Ireland, said: *"In comparison with the general population, there is a high incidence of psychiatric symptoms among prisoners."*¹¹⁸ A report commissioned by the Department of Justice, Equality and Law Reform revealed that all the mental health indicators were much worse for prisoners than the general population.¹¹⁹ A 2002 international study found that these prisoners *"were several times more likely to have psychosis and major depression"* and that one in seven inmates suffers from a mental illness that could be a risk factor for suicide.¹²⁰ These mental health problems accompany prisoners on their departure from prison, and their high

mental illness prevalence indicates a distinct need in those who may find themselves homeless upon release. Unfortunately, many are discharged to the community with no formal discharge plans, and no arrangements for community mental health services, or continuity of whatever limited care they had been receiving.

The 'Crime and Homelessness' report cautioned: *"The practice of releasing prisoners with no accommodation late on Friday evenings needs to be addressed as a matter of urgency. Most statutory services e.g. Homeless Persons Unit, CWO (Community Welfare Officer) etc are closed from Friday to Monday, hostel accommodation is usually assigned to people in advance of the weekend and voluntary organisations' supports are more limited - people in these circumstances have no option but to sleep out."* This is a failure to comply with the CPT's recommendation no. 37 in its 1999 report on Ireland: that *"in relation to aftercare for prisoners, appropriate arrangements are put in place where possible with community health care resources"*.

The 'Crime and Homelessness' report recommended: *"A variety of appropriate accommodation ranging from emergency accommodation hostels through to transition/supported housing through to permanent housing be that provided by local authorities, voluntary organisations or the private rented sector is needed."* The support of mental health and addiction services must also be available.

The Homeless Preventative Strategy, published in 2002, was designed, it said, to provide an integrated cross-departmental approach for the prevention of homelessness in prisoners following release. Its recommendations in relation to ex-prisoners are the establishment of a specialist unit by the Probation and Welfare Service, the creation of transitional housing units, and a programme to ensure that prisoners who are pursuing educational courses will be able to continue them following their release.

Alcohol and Substance use

Within its prison sample, the 'Crime and Homelessness' study found that *"those homeless prior to and those homeless after their experience in prison cited mental ill health, drug misuse and alcohol addiction as some of the main factors that contributed to their homelessness and their criminal behaviour"*.

This study observed: *"The issue of alcohol misuse is ... important. Sixteen respondents reported a direct link between their alcohol consumption and their offending behaviour. Seven participants reported that their drunken behaviour led to the offence being committed; these offences included Grievous Bodily Harm (GBH) and other types of*

assault. A further 3 participants had been arrested on drunk and disorderly charges." It recommended: *"The provision of alcohol treatment programmes should be improved."*

According to WHO standards, all states should *"ensure the accessibility of effective treatment and rehabilitation services, with trained personnel, for people with hazardous or harmful alcohol consumption and members of their families"*.¹²¹ It emphasises that: *"Early recognition of problem drinking, early intervention for problem drinking, psychosocial interventions, ... teaching new coping skills in situations associated with a risk of drinking and relapse, family education and rehabilitation are the main strategies proven to be effective for the treatment of alcohol-related problems and dependence."*¹²² Eurocare, an alliance of European agencies, has noted:

*"The Green Paper on Mental Health, published by the Government in June 1992, commented that, in the years since the publication of 'Planning for the Future' in 1984, some Health Boards have developed local alcohol/drug services and recruited addiction counsellors to work in sector services. But it also pointed to the extremely high rate of admission to psychiatric hospitals for alcohol-related disorders in some Health Boards and suggested that such rates demonstrated the need to develop alternative treatment facilities in the community."*¹²³

The 1999 report, 'We have no beds', also pointed to the need to address the *"uneven availability and responsiveness of alcohol services across the EHB area"*.^{124, 125}

Regarding drug misuse, 'Crime and Homelessness' noted: *"The inability to maintain addiction treatment following release from prison was also a significant problem for respondents and this was commented on by key informant interviewees. Homelessness made drug treatment programmes even more difficult to access, as provision is based on catchment area and possession of a permanent address."* It advised: *"There is urgent need for a consistent and continuous Drug Policy for offenders/ex-offenders so that prisoners can avail of drug treatment programmes while in prison and be able to continue drug treatment programmes in the community. The detoxification, therapeutic and rehabilitative facilities for drug users should be expanded and the links between prison facilities and community facilities strengthened."*

In relation to drug use, the WHO 2001 report advocates: *"Counselling and other behavioural therapies are critical components of effective treatment of dependence Medical detoxification is only the first stage of treatment for dependence, and by itself does not change long-term drug use. Long-term care needs to be provided, and comorbid psychiatric disorders treated as well, in order to decrease rates of relapse."* It further notes the economic benefit of such an approach: *"Drug dependence treatment is cost-effective in reducing drug use (40-60%), and the associated health and social consequences, such as HIV infection and criminal activity."¹²⁶ [...] Treatment has been shown to be less expensive than other alternatives, such as not treating dependents or simply incarcerating them."* The lack of drug dependence services in Ireland other than methadone maintenance treatment, for which there is a mismatch between demand and provision, is, therefore, doubly unfortunate.

While substance use services are inadequate, 'Crime and Homelessness' points out that the large numbers of homeless people with a dual diagnosis of mental illness and substance misuse can be further excluded from treatment: *"Substance misuse and psychiatric services have been reluctant to manage patients with a dual diagnosis as neither sees it as their responsibility. [...] Access criteria, whereby a person must be drug or alcohol free before they can access mental health services further marginalizes dual diagnosis clients."*

Chapter 6 Additional Support Structures

Personal Advocacy

Many homeless people with mental illness are not always in a position to assert their rights, for a number of reasons, chiefly the nature of mental illness itself.

Family members or friends are not always best placed to act on their behalf.

*"States are under an obligation to enable persons with disabilities to exercise their rights, including their human, civil and political rights, on an equal basis with other citizens"*¹²⁷

Consequently, Ireland is obliged to assist all people with mental illness in doing so, not alone by making services available, but their use accessible. A comprehensive system of personal advocacy for all who need it should be introduced to allow this to happen.¹²⁸

Family Support

WHO notes: *"families play a key role in caring for the mentally ill and in many ways they are the primary care providers. With the gradual closure of mental hospitals in countries with developed systems of care, responsibilities are also shifting to families.*

Families can have a positive or negative impact by virtue of their understanding, knowledge, skills and ability to care for the person affected by mental disorders.

*For these reasons, an important community-based strategy is to help families to understand the illness"*¹²⁹

'Planning for the Future' also noted in 1984 that the main burden of caring for a person with mental illness may fall on the family, and the cost to family carers, in terms of emotional stress, can be considerable. This is particularly so now given the widespread deficiencies in Ireland's community-based mental health services almost two decades after this strategy was launched, despite a commitment at the time to fully implement its recommendations.¹³⁰ In relation to families, the strategy advised that families should be given practical assistance and advice on dealing with the person with mental illness by the psychiatric team; the community nurse should provide the link between the family and the psychiatric service; day care should provide support to families where necessary; short-term respite care arranged, and support readily available in the event of a crisis. None of these have been satisfactorily provided. A study of carers' views in five European countries, including Ireland, by the European Federation of Associations of Families of People with a Mental Illness found:

"For almost all 'areas of care' or themes, between 22% and 44% of carers were unsatisfied or very unsatisfied. The low satisfaction found for "Advice on how to handle specific problems" and "Information" agrees with the findings of other studies. The findings in the areas of "Help for the patient with preserving and regaining social functioning", "Help in regaining structure and routine in their life" and "Prompt assistance in their own environment" shows the need for early intervention and outreach work in the community."¹³¹

"Relapse of schizophrenia is often heralded by social withdrawal and verbal or physical aggression. Family disputes leading to ejection from home or voluntary departure have been cited on many occasions as the starting point on the path to social isolation and homelessness for people with schizophrenia."¹³² Failure to provide assistance to relatives of people with mental illness who live at home can impact negatively on the future stability of family relationships: "Most people who use our mental health services return to their families on discharge from hospital. For some, difficult behaviour associated with the illness in its acute phase may have strained family tolerance to breaking point, making it difficult to return home."¹³³ For many, independent supported accommodation will be necessary, but for others, home-based family support services and information could facilitate a return to the family environment.

It is acknowledged that many homeless individuals will have lost contact with their families and will have come to rely on staff in voluntary agencies for help in meeting their many and varied needs. Acknowledgement has already been made above¹³⁴ of the type of support voluntary agencies are entitled to expect from the statutory services.

Stigma

Stigma may act as a barrier to the utilisation of available services by people with mental illness. WHO has said: *"Treatments are available, but nearly two-thirds of people with a known mental disorder never seek help from a health professional. Stigma, discrimination and neglect prevent care and treatment from reaching people with mental disorders.... Where there is neglect, there is little or no understanding. Where there is no understanding, there is neglect."*¹³⁵ The stigma surrounding mental illness has been well documented, and the public's attitude stems from its lack of awareness, and misconceptions about the nature of mental illness. Relative to public

perceptions about other forms of disability, a survey conducted by the National Disability Authority revealed the following:

*"In general, attitudes to people with mental health disabilities were less positive than those expressed towards people with physical disabilities. Firstly, respondents were much less likely to mention mental health as a disability than they were to mention physical disability. Secondly, respondents report lower levels of comfort with people with mental health disabilities. And, thirdly, respondents seem less sure about the rights of people with mental health disabilities to work and to have families."*¹³⁶

Negative public attitudes can have many consequences: *"Mental illness, despite centuries of learning is still perceived as an indulgence, a sign of weakness. This shame is often worse than the symptoms, with people making efforts to conceal the illness from others. Secrecy acts as an obstacle to the presentation and treatment of mental illness at all stages. The reality of discrimination supplies an incentive to keep mental health problems a secret."*¹³⁷

While stigma may never be eliminated, it can be reduced, and it is incumbent on the Irish state under human rights standards not alone to ensure that suitable services are provided, but that people are assisted and enabled to access these services.

The WHO 2001 report advises: *"Tackling stigma requires a multi-level approach involving education of health professionals and workers, the closing down of psychiatric institutions which serve to maintain and reinforce stigma, the provision of mental health services in the community, and the implementation of legislation to protect the rights of the mentally ill."*¹³⁸

The WHO report also recommends: *"Well-planned public awareness and education campaigns can reduce stigma and discrimination, increase the use of mental health services, and bring mental and physical health care closer to each other."*¹³⁹

Misconceptions about the reality of mental illness and homeless can lead to a hardening of public attitudes to homeless people. A recent American report has observed in respect of that country: *"Increasingly, people believe that homelessness is*

*caused by individual imperfections and moral failings. In particular, people with mental illnesses and substance use disorders are seen as more blameworthy and less deserving of compassion than homeless people who are merely 'down on their luck.'*¹⁴⁰ A public education campaign should also promote awareness of the causal links between mental illness and homelessness in order to avert such a reaction in Irish society.

Mental Health Legislation

Government policies and strategies to date have not led to comprehensive, accessible or equitable services for homeless people with, or at risk of mental illness. The right to the best available mental health care for all, including homeless people, should be enshrined in national legislation. The WHO report advises: *"Mental health legislation should codify and consolidate the fundamental principles, values, goals, and objectives of mental health policy. Such legislation is essential to guarantee that the dignity of patients is preserved and that their fundamental rights are protected."*¹⁴¹ While the Mental Health Act, 2001 is welcome in updating the law in relation to involuntary in-patient admission and detention, Irish legislation should reflect the full range of applicable international human rights standards.

The WHO Department of Mental Health and Substance Dependence is currently carrying out a Project on Mental Health and Human Rights,¹⁴² which aims to support countries in implementing strategies to protect and promote the human rights of people with mental illness, by focusing specifically on the development and implementation of mental health legislation, which, it says, represents an important means of rights protection. WHO is currently developing a Manual on Mental Health Legislation, which will bring together information on international norms and standards in the area of mental health and human rights, as well as best practice evidence on mental health law in countries throughout the world, in order to inform and assist countries in their formulation and implementation of mental health legislation. In November 2003, WHO also plans to hold an International Training Forum on Mental Health, Human Rights and Legislation, which will provide countries with a unique opportunity to gain core technical information about mental health legislation. Amnesty International strongly urges the Irish government to participate in this important and timely process.

Chapter 7 Government Planning for the Future

Introduction

On government responses to date, Dr Fernandez has commented:

*"Thus far, considerable emphasis has been placed on the anticipated housing needs of the homeless, against the backdrop of a nationwide dearth of affordable accommodation. However, specifics to safeguard the health needs of the homeless, notably their psychological well-being appear to be lost between the cracks which are repeatedly highlighted as characterising the delivery of community-care services to the mentally ill in urban centres in the Republic."*¹⁴³

On the lack of real progress since the National Health Strategy was launched in 2001, the Irish College of Psychiatrists have said: *"There have been a number of Consultants' posts approved in services for homeless people with mental illness, but these have not been adequately resourced, and there has been no provision for full multidisciplinary teams in this area, which are vital for such services. Services for homeless people must be seamless and fully integrated with the local authority, and a full service cannot be provided while working under the constraints of the present nine-to-five model. Any adequate service for homeless people with mental illness can only be implemented with a full team and resources. To date, the Department's implementation of such schemes has been piecemeal and completely inadequate."*¹⁴⁴

Homelessness Action Plans and An Integrated Strategy

In May 2000, 'Homelessness - An Integrated Strategy' was launched by the Department of the Environment and Local Government, and some of its key recommendations include:

- Local authorities and health boards, in full partnership with voluntary bodies, are to draw up action plans on a county-by-county basis to provide an integrated delivery of services to homeless people by all agencies dealing with homelessness.¹⁴⁵

- Local authorities will be responsible for the provision of accommodation, including emergency hostel accommodation for homeless persons and health boards to be responsible for the provision of their in-house care and health needs.
- A Director for homeless services in the Dublin area will be appointed by Dublin City Council and a centre to be established for the delivery of these services in Dublin.
- Preventative strategies, targeting at-risk groups including procedures to be developed and implemented to prevent homelessness amongst those leaving custodial care or health related care.

On foot of 'Homelessness - An Integrated Strategy', Homeless Action Plans were to be developed and adopted by all local authorities throughout the country to provide an integrated delivery of services, including mental health services, to homeless people by all agencies dealing with homelessness, and many such plans have allegedly been developed and adopted.

The Dublin plan, 'Shaping the Future',¹⁴⁶ was adopted in 2001, and the Homeless Agency was established to coordinate and manage the delivery of services to people who are homeless in Dublin. A long-term vision of this plan is stated thus: 'By 2010 long term homelessness and the need for people to sleep rough will be eliminated', and by the end of 2003, the foundations for achieving its vision are to be laid. Some of its objectives are to:

- homeless proof existing mainstream policies in the areas inter alia of mental health, substance abuse treatment and housing; improve the response to people on the streets with mental ill health, drug addiction and alcohol problems.
- ensure that people with mental ill health, who are homeless or at risk of homelessness, have access to seamless mental health treatment and support services, appropriate to their needs, regardless of which hospital catchment area they are in, have come from or are going to.

- ensure that people are not discharged from hospital into homelessness and to establish protocols and procedures which will ensure that all hospital staff are aware of the circumstances of people who are homeless and the services available to them.
- ensure that people with a drug addiction problem who are homeless or at risk of becoming homeless have immediate access to appropriate treatment and support services, in their local community and to ensure continuity of treatment if people are in prison or hospital.
- ensure that people with problem drinking have access to residential and community based services which will aim to minimise the harm caused by their drinking and link them to treatment services as appropriate.

An Integrated Services Advocate for those experiencing homeless and mental health service was appointed by the Homeless Agency to describe and document the interface between homeless services and mental health service providers.

A joint analysis by non-governmental homeless agencies of the Action Plans found the development of the plans *"a welcome start in building a considered and comprehensive response at local level to problems of housing and homelessness"*, and *"a useful exercise in terms of consultation and beginning the process of tackling homelessness strategically"*.¹⁴⁷ In relation to their provision for the development of health services, including mental health care; the analysis observed: *"The majority of plans recognise the importance of health care and the particular health needs of the homeless population, however, the language of the plans is conditional and non-committal"*. It also concluded: *"The plans do achieve a relatively sophisticated understanding of the nature and complexity of the problem, but policies for dealing with the multiple social and health problems linked to homelessness, prevention and the transition to permanent accommodation are weakly stated or absent."*

It also noted that the Action Plans have no statutory basis and there is no overall reporting structure; and called for effective and transparent monitoring of the implementation of their provisions. It suggested that an independent review of 'Homelessness - An Integrated Strategy' should be initiated, and be completed before the end of 2003, to address inter alia *"the inadequacies of targets, costings, and timeframes in the local homeless action plans"*.

National Mental Health Policy Framework Update

There is an urgent need for a major review of Ireland's mental health care services, to bring them finally into line with international best practice. The 2001 National Health Strategy¹⁴⁸ promised that a "national policy framework" updating 'Planning for the Future' would be prepared by the Department of Health and Children, with a target date of "Mid 2003". Based on information received by Amnesty International from the Department, it is anticipated that work on this policy framework will be begun this year by an Expert Group. Amnesty is concerned that planning appropriate effective responses for the homeless with mental illness may be seriously hampered by the lack of government data on service provision and needs analyses. WHO offers this advice to governments: *"Authorities responsible for delivering services, treatment and care are accountable to the consumers of the system. One important step towards achieving accountability is to involve consumers in the creation of services, in reviewing hospital standards, and in the development and implementation of policy and legislation."*¹⁴⁹ Included in shaping Ireland's future policy - particularly in view of the dearth of official research - must be the views of all stakeholders: service users and their families, voluntary agencies, psychiatrists, nurses, psychologists, psychotherapists, social workers, occupational therapists, senior health board management, and representatives from primary care. Their representative organisations should also be consulted in advance of this policy update. To this end, Amnesty International has written to the Minister for Health and Children outlining its position with respect to this policy update, and has submitted to his office a joint position statement on behalf of a number of national voluntary and professional organizations, outlining the fact that a transparent and accountable consultation process is essential.¹⁵⁰

Amnesty International also has concerns about the fate of this policy update, given the history of 'Planning for the Future'. Amnesty International reminds the government that many previous reviews, reports and strategies have not been adequately or comprehensively implemented, and urges the government to act promptly and effectively on all recommendations that may emerge from the policy update. Meanwhile, mental health care provision to Ireland's homeless continues to be deficient, and Amnesty International is concerned that this may amount at the very least to a failure to comply with Article 12 of the ICESCR.

Conclusion & Recommendations

In Ireland, as throughout much of the world, *“mental health care has simply not received until now the level of visibility, commitment and resources that is warranted by the magnitude of the mental health burden”*.¹⁵¹ A heightened impetus now exists at the international level to address the inequalities experienced by people with mental illness, and a drive for recognition of this issue as a human rights one.

The Irish Government has evidently failed to date to meet the requirements of best practice and international human rights standards in its provision for the mental health care needs of Ireland's homeless. Mental health policy, law and resource commitments remain worryingly inadequate; and recent government strategies are too aspirational to guarantee effectiveness, since they lack concrete undertakings, concomitant resource allocations or binding obligations. In this context, the importance of the planning and delivery of the revised mental health policy framework by the Department of Health and Children, cannot be overstated.

The recommendations made in 'Mental Illness: the Neglected Quarter'¹⁵² apply equally to homeless people with or at risk of mental illness, but more specific recommendations are made here. While Amnesty International endorses many of the more general recommendations made by the homeless agencies regarding the root causes and consequences of homelessness, in relation to mental health it recommends that the Irish Government take the following actions:

- In updating the national policy framework for mental health care, a comprehensive, needs-based, service-user-led, consultative review of the services must be undertaken, with particular emphasis on the needs of the homeless, and its recommendations be promptly and fully implemented, ensuring that they meet international human rights standards and best practice in line with the World Health Organisation 2001 annual report.
- Catchment area services should be appropriately resourced and adapted, and relevant staff trained to meet the particular needs of their homeless populations in both in-patient and community-based settings, so they are enabled to access a comprehensive range of services.

- Accurate data on the number and mental health needs of homeless adults and children should be regularly compiled.
- The particularly high level of mental health care needs of Ireland's urban homeless population should be addressed, by ensuring a comprehensive provision of specialised homeless mental health services, with an adequate number of specialist in-patient acute beds, full mental health multidisciplinary teams, and outreach services, with appropriate supports.
- Particular attention should be given to the services available to homeless children, and those living in, and leaving, state residential care.
- Integrated mental health programmes should be developed for homeless people with a dual diagnosis of mental illness, and alcohol or substance misuse and/or intellectual disability.
- An adequate range of community-based supervised and/or supported accommodation should be provided, with appropriate mental health supports for those capable of independent living.
- An independent review of 'Homelessness - an Integrated Strategy' should be undertaken to address the weaknesses evident in the development and implementation of the homeless action plans in relation to mental health care.
- Adequate revenue funding should be ensured for voluntary homeless agencies.
- A public education and awareness programme to counter the stigma of mental illness should be initiated, emphasising the rights of people with mental illness.
- Rights-based mental health legislation giving full effect to Ireland's international human rights obligations should be enacted.
- A comprehensive and adequately resourced system of personal advocacy, to assist all people with mental illness to assert their rights in relation to mental health care, should be provided.

- Family support and information services should be made widely available.
- Garda training in mental health needs and practices with particular emphasis on the needs of homeless people, should be introduced.

Endnotes

¹ Dr Joe Fernandez, Director of the Programme for the Homeless, St Brendan's Hospital, in an advance outline of his presentation, 'Caring for the Homeless Mentally Ill: Status and Directions', for the Irish Psychiatric Association at St Patrick's Hospital, April 2003.

² Crowley F, 'Mental Illness: the Neglected Quarter', Amnesty International (Irish Section), Dublin (2003).

³ The report, its summary, and information on the campaign are available at www.amnesty.ie

⁴ Noeleen Hartigan, Social Policy and Research Coordinator, Simon Communities of Ireland. Personal communication to Amnesty International, October 2002.

⁵ Note ¹⁶ below.

⁶ UN Centre for Human Rights, The Human Right to Adequate Housing, Fact Sheet No. 21, United Nations, Geneva, 1995. This is a useful guide to international human rights instruments on the right to housing, and notes "12 different texts adopted and proclaimed by the United Nations explicitly recognize the right to adequate housing". It is available on the web at 193.194.138.190/html/menu6/2/fs21.htm

⁷ CESCR General comment 4, 'The right to adequate housing (Art.11 (1))', 13/12/91.

⁸ McKeown K, 'Mentally Ill and Homeless in Ireland: Facing the Reality, Finding the Solutions', Disability Federation of Ireland (1999).

⁹ 'Analysis of the National Action Plans - Social Inclusion' (2001), available at www.feantsa.org/key_docs/fea_docs/naps/NAPs_analysis_EN_june_02.pdf

¹⁰ Adopted by General Assembly Resolution 46/119, 46 U.N. GAOR Supp. (No. 49) Annex at 188-192, U.N. Doc.A/46/49 (1991). The MI Principles apply to all persons with mental illness, whether or not in in-patient psychiatric care, and to all persons admitted to psychiatric facilities, whether or not they are diagnosed as having a mental illness.

In this report, Amnesty International refers to the MI Principles while recognising that they do not enjoy universal support. It has been suggested that they are in need of revision for a number of reasons. Some argue that they support the dominance of a medical model of mental illness, by endorsing medical explanations and treatments for 'mental illness'; by referring to the medical term 'patient' throughout, and because medication is the only type of treatment specified. The latter has the whole of Principle 10 dedicated to it. These Principles have however, been utilised by international non-governmental organisations in their assessment of the mental health systems of a number of countries. For a criticism of the MI Principles, see 'Human Rights Law in the Field of Mental Health: a critical review', Harding T W, *Acta Psychiatr Scand* 200; 101: 24-30.

¹¹ Although the MI Principles are a General Assembly Resolution and therefore not legally binding, General Comment No. 5, 'Persons with Disabilities', was adopted by the UN CESCR on 9 December 1994 to outline the application of the ICESCR to people with mental and physical disabilities, and recognised the MI Principles as one of the instruments to ensure respect for the full range of human rights for persons with disabilities.

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

¹³ Ibid.

¹⁴ Rule 15. Adopted by General Assembly Resolution 48/96 in 1993.

¹⁵ General Comment No. 5, 'Persons with Disabilities', UN Doc No E/C.12/1994/13 (1994).

¹⁶ 'Mental Health: New Understanding, New Hope', WHO, Geneva (2001).

¹⁷ See Dr Fernandez in Note ¹ above, for example.

- ¹⁸ The Alcohol, Drug Abuse and Mental Health Administration of the United States Department of Health and Human Services in 'A Special Report, Assisting the Homeless', Intergovernmental Perspective 15 (Winter 1989).
- ¹⁹ Personal communication to Amnesty International, May 2003.
- ²⁰ Fernandez J, 'The Homeless Mentally Ill' in the 'Report on the Position of Psychiatry in the Republic of Ireland, 1992', CR 23, Royal College of Psychiatrists, London, (1993).
- ²¹ Section 2 states: "A person shall be regarded by a housing authority as being homeless for the purposes of this Act if: (a) there is no accommodation available which, in the opinion of the authority, he, together with any other person who normally resides with him or who might reasonably be expected to reside with him, can reasonably occupy or remain in occupation of, or (b) he is living in a hospital, county home, night shelter or other such institution, and is so living because he has no accommodation of the kind referred to in paragraph (a), and he is, in the opinion of the authority, unable to provide accommodation from his own resources."
- ²² Sections 175 of the Housing Act, 1996. The UK's new Homelessness Act, 2002 widens this definition of homelessness, so that people leaving state "institutions", such as former members of the armed forces, teenagers leaving local authority care and young offenders released from prison - categories of homelessness that were removed by the Conservative government under the Housing Act 1996, are included. Local authorities in the UK have a duty under these Acts to provide temporary accommodation to homeless households who have a 'priority need'. Those who do not have a 'priority need' are entitled only to the local authority's advice and assistance.
- ²³ 'Annual Housing Statistics Bulletin, 2002', Department of the Environment and Local Government (2002), released in May 2003, showed a total national count of 3773 homeless households, comprised of 4176 adults and 1405 dependent children. This rose from 2501 individuals in 1996 and 5234 in 1999.
- ²⁴ Williams J & Gorby S, 'Counted In - The Report of the 2002 Assessment of Homelessness in Dublin Kildare', ESRI/Homeless Agency (2002) found 2920 adults and 1140 children in Dublin alone.
- ²⁵ Dr Fernandez suggests that the National Psychiatric In-patient Reporting System under-reports the number of homeless people with mental illness who seek in-patient treatment, since residents of direct access hostels are generally not reported as being homeless. A similar situation arises when individuals entering hospitals give an "address of convenience" as their own and are thereby "hidden" in official counts of homelessness. (Personal communication to Amnesty International, May 2003.)
- ²⁶ 'Northern Ireland Housing Statistics 2000-01', Statistics and Research Branch, Department for Social Development, Northern Ireland (2001).
- ²⁷ Bergin E, 'Sleeping Rough Report 2000', Dublin Simon, in association with Focus Ireland and Dublin Corporation (December 2000).
- ²⁸ Williams J & Gorby S, 'Counted In - The Report of the 2002 Assessment of Homelessness in Dublin Kildare', ESRI/Homeless Agency (2002). 140 individuals were identified during an actual one-night count of those sleeping rough, revealing a disparity with the reported figure of 312 individuals who were reportedly sleeping rough.
- ²⁹ '202 people sleeping rough in Central Dublin', press statement, 29th November 2000. "This 1999 count of those sleeping rough in Central Dublin during the week of 15th-21st October 2000 represents an increase of 60% on the street count of 8th -14th December 1997 (which found 125 persons were sleeping rough) and a 36% increase on the street count of June 1998 (which found 149 persons were sleeping rough)."
- ³⁰ Kennedy S, 'But Where Can I Go: Homeless Women In Dublin', Arlen Press, Dublin (1985).
- ³¹ Williams J & O'Connor M, 'Counted In - The Report of the 1999 Assessment of Homelessness in Dublin, Kildare and Wicklow', ESRI/Homeless Initiative, Dublin (2000).
- ³² 'The Mental and Physical Health and Well-being of Homeless Families in Dublin: A Pilot Study', Focus

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

³³ 'Counted In 2002', note ²⁷ above.

³⁴ The Housing Act, 1988 conferred on Local Authorities the responsibility of conducting an assessment of their housing need at least once every three years. A national assessment was carried out in 2002, note ²³ above.

³⁵ September 2002 newsletter, The Simon Communities of Ireland, Dublin. This agency is endeavouring to address this gap, and has commissioned a major piece of work in mental health assessment and data collection amongst its clients, expected to begin in 2003.

³⁶ Fernandez J, 'Caring for the Homeless Mentally Ill: Status and Directions', seminar presentation for the Irish Psychiatric Association at St Patrick's Hospital, April 2003.

³⁷ Feeley A et al, 'The Health of Hostel-Dwelling Men in Dublin', Royal College of Surgeons in Ireland & Eastern Health Board (March 2000), found that 64 per cent of the survey population were suffering from some form of mental health condition.

³⁸ 'The Homeless Mentally Ill - discussion document', Appendix A, 'Cluain Mhuire Adult Mental Health Service Proposal: The Homeless Mentally Ill', Barry Dr S, Cluain Mhuire Adult Mental Health Service, Dublin (2002).

³⁹ 'Caring for the Homeless Mentally Ill: Status and Directions', seminar presentation for the Irish Psychiatric Association, St Patrick's Hospital, April 2003.

⁴⁰ Fernandez J, 'The Homeless Mentally Ill: Aspects of Violence', paper presented at the Symposium on 'Aspects of Violence: The Care of the Disturbed Mentally Ill', Dublin, Ireland (1996).

⁴¹ Note ¹⁶ above.

⁴² Holohan T & Holohan W, 'Health and Homelessness in Dublin', Irish Medical Journal Volume 93 No 2, March/April 2000.

⁴³ Note ³¹ above.

⁴⁴ 'Mentally Ill and Homeless in Ireland: Facing the Reality, Finding the Solutions', note ⁸ above, based on an estimated average incidence of mental illness among the population of between 25 and 30 per cent.

⁴⁵ Note ⁴² above.

⁴⁶ See Focus Ireland pilot study, note ³² above, which found only 28.6 per cent 'psychiatric caseness' in its sample. However, it noted:

"The families involved had achieved some degree of accommodation stability in the family transition unit of Focus Ireland. This contrasted to some extent with [a recent study conducted in England] where the families assessed, were placed in short-term accommodation hostels. In that study they were assessed within two weeks of entering the hostels whereas in the Dublin pilot study the majority of the mothers interviewed had been in their accommodation for a number of months. ... [and they] reported a considerable improvement in their own mental health since obtaining some degree of stability of accommodation."

⁴⁷ For example, in the UK, see Adams C, Pantelis C, Duke P & Barnes T, 'Psychopathology, Social Cognitive Functioning in a Hostel for Homeless Women' (1996), Br J Psychiatry 168:82-86, and in the US, Bassuk E L, Rubin L, & Lauriat A S, 'Characteristics of Sheltered Homeless Families' (1986), Am J Public Health 76(9): 1097-1101.

⁴⁸ Note ³² above.

⁴⁹ Note ¹⁶ above.

⁵⁰ McCrum J, 'The Face of Older Homelessness', Simon Community Northern Ireland (2002). In Northern Ireland, the Housing Act 1988 provides a positive duty on the Housing Executive to provide temporary accommodation to a person homeless and with "priority need", the definition of which includes mental disability.

⁵¹ Ibid.

⁵² 'Simon has serious concerns for state funding of homeless services', Simon Communities of Ireland, press release, 5 November 2002.

⁵³ Note ³² above.

⁵⁴ Houghton F T & Hickey C, 'Focussing on B&Bs: The Unacceptable Growth of Emergency B&B Placement in Dublin', Focus Ireland, Dublin (2000) Recent government figures show €19.5m spent on B&B accommodation in 2002.

⁵⁵ Personal communication to Amnesty International, May 2003.

⁵⁶ 'The Psychiatric Services: Planning for the Future', The Stationery Office, Government Publications, Dublin (1984).

⁵⁷ Simon Community National Office (1989).

⁵⁸ Note ¹⁶ above.

⁵⁹ Harvey B, 'Homelessness and Mental Health. Policies and Services in an Irish and European Context', Homelessness and Mental Health Action Group (1998).

⁶⁰ Fernandez J, 'Homelessness: an Irish perspective', in Bhugra D (ed), 'Homelessness and Mental Health', Cambridge University Press (1996).

⁶¹ Dr Fernandez, personal communication to Amnesty International, May 2003.

⁶² Keogh F, Roche A & Walsh D, 'We Have No Beds: An Enquiry into the Availability and Use of Acute Psychiatric Beds in the Eastern Health Board Region', Health Research Board, Department of Health and Children (1999).

⁶³ 'Report of the Inspector of Mental Hospitals for the year ending 31st December 2001', Department of Health and Children, Government Publications Sales Office, (2002).

⁶⁴ MI Principle 9(1), note ¹⁰ above.

⁶⁵ Note ⁶² above.

⁶⁶ 'Schizophrenia Ireland's Response to the Inspector of Mental Hospitals Report 2001' (2002).

⁶⁷ 'Health and Homelessness in Dublin', note ⁴² above, found that 45 per cent of the 502 homeless people surveyed did not have a medical card even though almost half saw themselves as being in poor general health.

⁶⁸ Dr Fernandez, personal communication to Amnesty International, May 2003.

⁶⁹ 'Health Strategy 2001: Submission by the Simon Community of Ireland to the Department of Health on its review of the Health Service', Simon Communities of Ireland .

⁷⁰ Fernandez J, 'On Planning and Expanding a Service for the Homeless Mentally Ill', report submitted to the Programme Manager, Special Hospital Care, Eastern Health Board, 1993.

⁷¹ Note ³⁸ above.

⁷² 'Shaping the Future', note ¹⁴⁴ below, says: "Homelessness is a persistent and growing problem in Dublin. About three quarters of all people who are homeless in the country are in the Dublin area, 95% of them in the city."

⁷³ Fernandez J, 'Who cares for the NFA's', in 'Living on Fresh Air', Simon Community National Office, Dublin (1983).

⁷⁴ Note ⁶³ above.

⁷⁵ The UK mental health organisation, Mind, published a document entitled 'Mind's Model of a 24 Hour Crisis Service' (Cobb A, Mind Publications, (1995)), which provides an example of what a model crisis service might look like. See also Sayce, Christie, Cobb and Slade, 'Users' Perspective on Emergency Needs', in Phelan Dr M, Strathdee Dr G & Thornicroft Dr G (Eds), 'Emergency Mental Health Services in the Community', Cambridge University press (1994).

⁷⁶ Note ⁶² above.

⁷⁷ Fernandez J, 'Dual-diagnosis, dangerousness and dereliction', paper presented at the Fourth European Seminar on Mental Health and Social Exclusion, Madrid, Spain, April 1997.

⁷⁸ Ibid.

⁷⁹ Ibid.

⁸⁰ Ibid.

⁸¹ Ibid.

⁸² Simon Communities, note ⁶⁹ above.

⁸³ In relation to discharge from psychiatric care, the Simon Communities note: "...homeless services claim that they are being used as a 'dumping ground' by the mental health services, who send people presenting with mental illness to homeless hostels because the person and (it is claimed) the health service have no other option. However the Department of Health counters that from research they completed in 1992 tracing patients discharged from Mental Institutions, none of those discharged became homeless. The issue therefore may be that many people which the Psychiatric service classifies as having behavioural difficulties but not mental illness and therefore not part of their responsibility are finding their way into the 'homeless net' while previously they would have been housed in Mental Institutions." (Bergin E, 'Policy Audit of Recent Developments in the area of Mental Health and Homelessness', Simon Communities of Ireland, (2002).)

⁸⁴ "Still Waiting for the Future", Simon Community's response to the Government's Green Paper on Mental Health' (1992).

⁸⁵ Simon Communities, note ⁶⁹ above. It continues: "For example, during 2000, in Dublin Simon's shelter a total of 47 people or 7 per cent of all people accommodated came directly from hospital."

⁸⁶ 'CentreCare Annual Report 2001', Dublin.

⁸⁷ 'Homeless Preventative Strategy', published by the Cross Department Team on Homelessness in February 2002, Chapter 4 of which deals with people leaving mental health facilities.

⁸⁸ 'Guidelines on good practice and quality assurance in mental health services', Department of Health and Children (1998).

⁸⁹ Circular 5/87: 'Arrangements for Discharge from Hospital and Aftercare of Homeless Persons', Department of Health and Children (1987).

⁹⁰ The Inspector of Mental Hospitals for 2001, note ⁶³ above, also observed that the development of community-based accommodation is somewhat uneven throughout the country.

⁹¹ A recent report describes the forms of supported housing that exist throughout Europe: community lodgings, group homes, protected apartments, sheltered housing, transitional accommodation, and supported housing. It notes that a distinction is increasingly being drawn between 'supported housing' and 'support in housing'. The former, it says, describes an approach where a planned programme of support is provided in a particular physical space (which may even have been purpose built); the support is centred on the accommodation which people move through. The latter term, it suggests, indicates a situation where people live in ordinary housing (self-contained or shared) in the community and support is provided (either permanently or temporarily) as required by tenants. The preferred approach is perceived by most to be in the form of 'support in housing'. (Edgar B, Doherty J & Mina-Coull A, 'Support and Housing in Europe - Tackling social exclusion in the European Union', Joint Centre for Scottish Housing Research, University of Dundee and University of St Andrews (2000)).

⁹² Note ³⁸ above.

⁹³ Note ⁶⁹ above.

⁹⁴ Bergin E, 'Policy Audit of Recent Developments in the area of Mental Health and Homelessness', Simon Communities of Ireland, (2002).

⁹⁵ Culhane D P, Metraux S & Hadley T, 'Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing', *Housing Policy Debate* 13, 1 (2002): 107-163. Considerable cost savings were also found due to the decreased use of these services.

⁹⁶ One staff member of an emergency shelter spoke to Amnesty International of the particular demands on an already overburdened service of having a resident with severe mental illness for a number of months, despite a commitment from the local mental health service that this placement would only be a temporary measure while more suitable accommodation was arranged.

⁹⁷ Mary Higgins, Director of the Homeless Agency, Homeless Agency press release, 14 April 2002.

⁹⁸ Article 23(2).

⁹⁹ Ivan Mahony, Section Manager, Young Person's Services, Focus Ireland, in 'No homes to go to', *Poverty Today*, March/April 2000, No. 46, states: "The current state of child homelessness in Ireland is nothing short of a national disgrace. Section 5 of the Child Care Act 1991 conferred a legal duty on health boards to provide accommodation for all homeless children in their area. Yet the number of homeless children re-referred (i.e. those who remain homeless for periods of time) through both health boards and non-statutory services is staggering."

¹⁰⁰ Kelleher P, Kelleher C & Corbett M, 'Left Out on Their Own: Young People Leaving Care in Ireland' (2000), Focus Ireland.

¹⁰¹ The UN Committee on the Rights of the Child recommends: "the system of data collection and development of indicators be adjusted to include all children up to the age of 18, with a view to incorporating all the areas covered by the Convention ... with specific emphasis on vulnerable children and children in especially difficult circumstances. Adequate disaggregated data should be gathered and analysed in order to monitor and assess progress achieved in the realisation of children's rights and to help define

policies to be adopted to strengthen the implementation of the provisions of the Convention." (Concluding observations of the Committee on the Rights of the Child: Ireland, 04/02/98, CRC/C/15/Add.85.)

¹⁰² Note 100 above.

¹⁰³ 'The Health of our Children', Second Annual Report of the Chief Medical Officer, Department of Health and Children (2001).

¹⁰⁴ "Approaches to the promotion and development of sound mental health for children, and the identification and treatment of psychological and psychiatric disorders, have been patchy, uncoordinated and underresourced." (Ibid.) See Chapter 6 of 'Mental Illness: The Neglected Quarter' note ² above for Amnesty International's general concerns and recommendations in relation to mental health care for children and adolescents.

¹⁰⁵ Note ¹⁰¹ above..

¹⁰⁶ Hickey C, 'Crime and Homelessness', Focus Ireland & PACE, Dublin (2002).

¹⁰⁷ The report suggests: "Inclusion of prisoners who are homeless in homeless statistics is essential so as to provide a clearer picture of both the homeless and prisoner populations for planning purposes."

¹⁰⁸ O'Mahoney P, 'Crime and Punishment in Ireland', Roundhall, Dublin, (1993) and O'Mahoney P, 'Mountjoy Prison: A Sociological and Criminological Profile', Stationery Office, Dublin (1997).

¹⁰⁹ Prisoners and Homelessness, PACE, Dublin, (2002), unpublished and conducted for internal information purposes.

¹¹⁰ "The criminal behaviour of those who are homeless is often characterised by the survivalist nature of the crimes they commit e.g. begging, shop lifting and other types of larceny and by crime carried out to escape the physical reality of homelessness e.g. drug and alcohol related offences." International literature identified in this report indicates a very high level of arrest and imprisonment of homeless people. It is not

known if homeless offenders are more likely to be sent to prison than offenders with homes for the commission of the same crime, but the report's author suggests that this might merit further study.

¹¹¹ 'Report of the Group to Review the Structure and Organisation of Prison Health Care Services' (2001).

¹¹² Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolution 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977.

¹¹³ Amnesty International, in a letter to the Minister for Justice in August 2001 in relation to an Irish report ('Out of Mind, Out of Sight: Report on Confinement of Mentally Ill Prisoners in Ireland', Bresnihan Dr V, Irish Penal Reform Trust (2001)), expressed its concern at this practice as a substitute for medical or psychological care, which may constitute a violation of international standards for humane detention. Amnesty International welcomes a commitment given by the Minister for Justice, Equality and Law Reform in a letter to the IPRT that padded cells will be replaced by safety observation cells that will fully meet the needs and respect the dignity of the prisoner. Amnesty International urges that this instruction be complied with immediately, and that the alternative meet the requirements of international best practice and human rights standards. In tandem, vigilance in the operation, monitoring, and recording of use of observation cells must be ensured so as to avoid a repeat of the practices documented by the IPRT. Amnesty International also welcomes the Minister's statement in this letter that "no mentally ill prisoner who is awaiting transfer to the Central Mental Hospital will be held in a padded cell, unless this is unavoidably necessary as an immediate and time-limited measure for the protection of the prisoner from harm". Amnesty International is nevertheless concerned that, given the continuing absence of suitable

alternatives for prisoners with mental illness within the prisons, and as the Minister's edict is similar to that contained in the Rules for Government of Prisons, 1947 (S.I. number 320 of 1947) under which the practice in question operated, this grave situation may continue. Consequently, special psychiatric facilities and treatment for prisoners must be provided as a matter of the utmost urgency.

¹¹⁴ Note ¹⁶ above.

¹¹⁵ Report to the Irish Government on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 31 August to 9 September 1998, CPT/Inf (99) 15 [EN], Publication Date: 17 December 1999.

¹¹⁶ Some argue that civil mental hospitals are the better option. The CPT simply said in its 1999 report on Ireland: "That facility could be a civil mental hospital or a specially equipped psychiatric facility within the prison system."

¹¹⁷ 'Position Paper of SI on the Criminal Law (Insanity) Bill 2002', Schizophrenia Ireland, February 2003.

¹¹⁸ Note ¹¹⁵ above.

¹¹⁹ 'General Healthcare Study of the Irish Prisoner Population', Centre for Health Promotion Studies, Department of Health Promotion, National University of Ireland, Galway (2000). It found that 48 per cent of male and 75 per cent of female prisoners were classed at 'case1 level' using the GHQ-12 instrument.

¹²⁰ 'Serious mental disorder in 23,000 prisoners: a systematic review of 62 surveys', Fazel S & Danesh J, *Lancet* 2002; 359: 545-50.

¹²¹ WHO European Charter on Alcohol, drawn up at the European Ministerial Conference on Health, Society and Alcohol hosted by WHO, Paris, France, December 1995.

¹²² Note ¹⁶ above.

¹²³ 'National Alcohol Policy Ireland', Eurocare - Advocacy for the Prevention of Alcohol Related Harm in European, available at www.eurocare.org/profiles/irelandsect2.

It also notes the lack of research in this area: "The dearth of alcohol research in Ireland, with youth research the exception, means that we over-rely on international research. We continue to need clarification on important alcohol related issues such as the economic, social and psychological causes and effects of alcohol consumption, the extent of alcohol dependence and treatment effectiveness. We also have many unanswered questions in relation to the most effective alcohol prevention models in different alcohol cultures with a group and settings approach. Alcohol research must be improved to provide important measures for public health assessment and to allow for both effective and efficient use of resources."

¹²⁴ Note ⁶² above. The Inspector of Mental Hospital's report, note ⁴³ above, cautions:

"... 'detoxification' from alcohol toxicity is inappropriate and, in severe toxicity, an unsafe procedure, in a psychiatric setting. Where toxicity is severe, with the likelihood of severe withdrawal symptoms and possible neurological complications, the safest place for such persons is on general medical wards, not in an isolated psychiatric setting."

¹²⁵ Conversely, the report of the Inspector of Mental Hospitals for 2001 refers to "the extensive provision of community-based alcohol treatment services".

¹²⁶ 'Crime and Homeless' found: "Thirty-seven respondents (out of 46) reported that their criminal behaviour was directly linked with their drug misuse, and 35 of them (95 per cent) reported that they had committed their offence in order to finance their drug habit. The life experiences reported by the respondents were echoed in the discussions with professionals working in the welfare and prison services and voluntary organisations. All of these recognised drugs as a major factor in offending behaviour."

¹²⁷ Rule 15 of the UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities.

¹²⁸ For a comprehensive analysis of personal advocacy, its various models, and how it operates in different countries, see 'Advocacy: A Rights Issue', Forum of People with Disabilities, Ireland (2001).

¹²⁹ Note ¹⁶ above.

¹³⁰ See Chapter 3 of 'Mental Illness: The Neglected Quarter', note ² above.

¹³¹ 'Breaking the Silence: Carers' views on the help given during the first episode of psychosis, A European perspective', European Federation of Associations of Families of People with a Mental Illness, Madrid, October 2001.

¹³² Note ³⁸ above.

¹³³ 'Tumbling down the ladder', Martin Rogan, Director of Mental Health Services, South Western Area Health Board in 'CornerStone, The magazine of the Homeless Agency', issue no. 11, April 2002, The Homeless Agency, Dublin.

¹³⁴ Support for Voluntary Agencies.

¹³⁵ 'The World Health Report 2001: Mental Disorders Affect One In Four People, Treatment available but not being used', WHO Press Release, WHO/42.

¹³⁶ 'Attitudes to Disability: Preliminary Findings of a survey commissioned by the National Disability Authority', NDA Research Unit & Research and Evaluation Services, October 2001.

¹³⁷ Irish Psychiatry Online, the web page of the Irish College of Psychiatrists: www.irishpsychiatry.com/public.html#2.

¹³⁸ Note ¹⁶ above.

¹³⁹ Ibid. It points to the "Open the doors" project launched by the World Psychiatric Association in 1999, the first-ever global programme against stigma and discrimination associated with schizophrenia, which aims to increase awareness and knowledge about the nature of schizophrenia and treatment options; to improve public attitudes to people who have or have had schizophrenia and their families; and to generate action to eliminate stigma, discrimination and prejudice. The WPA has produced a step-by-step guide to developing an anti-stigma programme, and reports on the experience of countries that have undertaken the programme, as well as collecting information from around the world on other anti-stigma efforts. The materials have been put to trial use in Austria, Canada, China, Egypt, Germany, Greece, India, Italy and Spain.

¹⁴⁰ Beatty C A & Haggard Loretta K, 'Legal Remedies to Address Discrimination Against People Who Are Homeless and Have Mental Illnesses', National Resource Centre on Homelessness and Mental Illness, Policy Research Associates Inc, Delmar, New York (1998).

¹⁴¹ Note ¹⁶ above.

¹⁴² For information, see www.who.int/hhr/mental_health

¹⁴³ Note ¹ above.

¹⁴⁴ 'Quality and Fairness: A Health System for You, Health Strategy 2002 - A Year On, The lack of implementation of the Health Strategy on Mental Health', Irish College of Psychiatrists (2003).

¹⁴⁵ "Local homeless persons centres will be established jointly by local authorities and health boards, in consultation with the voluntary bodies, throughout the country. The service provided will be enlarged to involve a full assessment of homeless persons' needs and to refer persons to other health and welfare services." Arising out of this, some local authorities plan a dedicated service delivery system to people out of home - a one-stop-shop. Others see a mixed type of service delivery with the development of a dedicated centre or unit for advice and some

direct service provision but with other services delivered through a number of different sources e.g. other statutory service providers, voluntary organisations and community groups.

¹⁴⁶ 'Shaping the Future: an action plan on homelessness in Dublin 2001-2003' (2001).

¹⁴⁷ Punch M et al, 'Housing Access for All? An Analysis of Housing Strategies and Homeless Action Plans', Focus Ireland, Simon Community, St. Vincent de Paul, Threshold, Dublin, (2002).

¹⁴⁸ 'Quality and Fairness - A Health System for You', Department of Health and Children (2001).

¹⁴⁹ Note ¹⁶ above.

¹⁵⁰ 'Joint NGO Position Statement on the Planned Review of Mental Health Policy', May 2003.

¹⁵¹ 'Mental Health: A Call for Action by World Health Ministers', Ministerial Roundtables 2001, 54th World Health Assembly, Geneva, WHO/NMH/MSD/WHA/01.1.

¹⁵² Note ² above.

