Irish Penal Reform Trust

ACCESS TO RIGHTS FOR PEOPLE DETAINED IN SECURE FORENSIC MENTAL HEALTH FACILITIES IN IRELAND

Coimisiún na hÉireann um Chearta an Duine agus Comhionannas
Irish Human Rights and Equality Commission

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The Irish Penal Reform Trust (IPRT) is Ireland's leading non-governmental organisation campaigning for the rights of everyone in the penal system, with prison as a last resort. IPRT is committed to reducing imprisonment and the progressive reform of the penal system based on evidence-led policies. IPRT works to achieve its goals through research, raising awareness, and building alliances.

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A note on language
IPRT is cognisant of the language and terminology we use in our publications. IPRT is committed to using 'person first' language as much as possible. However, for purposes of clarity, the term 'prisoner' is used often throughout this report; this is to distinguish between staff and people detained.

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Foreword

In 2021, IPRT commissioned the University of Galway's Centre for Disability Law and Policy to carry out a scoping study to examine whether people currently detained in forensic mental health facilities in Ireland, namely the Central Mental Hospital (CMH), can access their rights. This was funded by the Irish Human Rights and Equality Commission (IHREC) and the report builds on the identified gaps in our 2020 *Making Rights Real for People with Disabilities in Prison* report which was also funded by IHREC.

It is clear from this study that people with psychosocial disabilities who are currently detained in the CMH are not afforded the rights enshrined in the UN Convention on the Rights of Persons with Disabilities (CRPD), an international human rights treaty which Ireland ratified in 2018. While meeting the high threshold to comply fully with the CRPD appears to be a long way off, the State should continue to take measures to bring us closer to that ultimate goal. It is telling that, in this study, it is the staff and professionals who interact with these individuals who have identified breaches of human rights standards. It is clear from the snapshot of interviews that profound change is needed.

We in IPRT recognise that this report is challenging in places. Perhaps this is inevitable, given that it deals with people at the intersection of two complex structures – the criminal justice system and the mental healthcare system – who often fall between the cracks of both. Part of the rationale for conducting this research was to identify the gaps, determine who is best placed to address them and look at short-term steps the State can take to protect, respect and fulfil the human rights of people who

come into contact with the criminal justice system but who clearly require a healthcare response.

In some instances, where a person has been convicted and sentenced to imprisonment the obvious solution is to ensure that they can receive the mental healthcare they require within the prison setting on a consensual basis. Unfortunately, given the constraints and pressure on the current system we know that this is not always possible. Hopefully with the publication of the Final Report and Action Plan of the High Level Task Force on Mental Health and Addiction, in September 2022, further investment and resources will ensure that the prison estate is better equipped to cater for all people within its care, including those with a psychosocial disability.

In contrast to the prison system, the research outlines cases where people have been deprived of their liberty in a forensic mental health setting - including where they have not been found guilty or been afforded due process - sometimes indefinitely and in circumstances where consent to treatment is not required. There are also stark examples provided of the denial of very basic human rights, for example open access to bathroom facilities during the night. Such rights violations are serious and must be urgently addressed.

It is clear that the circumstances surrounding many of the individuals in the CMH are complex. Often these people were failed long before they came into contact with the criminal justice system due to their lack of access to the mental healthcare they required when they were most in need. Sometimes this has resulted in tragedy. However, indefinite detention is not the answer. Access to appropriate mental healthcare in the appropriate setting – whether that is prison or the community – is. Ireland

needs to continuously work towards a system that respects the rights of all people in its care and take meaningful measures to address current violations of those rights in line with our international human rights commitments.

Saoirse Brady

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Introduction

This report is a scoping exercise regarding access to rights for people detained in secure forensic mental health facilities in Ireland.[1] The Central Mental Hospital (CMH) in Dundrum is the sole secure forensic mental health facility ('designated centre') in Ireland. Built in 1852, the Victorian-era institution has been deemed 'not fit for purpose for the care and treatment of service users experiencing mental illness' by the Inspector of Mental Health Services for several years.[2] It is anticipated that the facility will be transferred to a new site in Portrane by the end of 2022.[3]

The report provides an overview of the issues arising regarding access to rights for people detained in the CMH, as well as an analysis of Ireland's rights obligations under the UN Convention on the Rights of Persons with Disabilities (CRPD) and other human rights instruments. Ireland signed the CRPD in 2007 and ratified it in 2018. Ireland has yet to ratify the Optional Protocol to the CRPD which is a mechanism which would allow individuals to raise complaints with the CRPD treaty body, the Committee on the Rights of Persons with Disabilities ('the Committee').

It is important to note that this report was finalised before the Final Report of the 'High Level Task Force to consider the mental health and addiction challenges of those who come into contact with the criminal justice sector'

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[1] This report was commissioned by the Irish Penal Reform Trust funded by the Irish Human Rights and Equality Commission and prepared by the following researchers at the Centre for Disability Law and Policy, University of Galway: Dr. Suzanne Doyle Guilloud, Maria Ní Fhlatharta, Eilís Ní Chaoimh and Professor Eilionóir Flynn with additional research support from Renée Payne.

[2] See annual Mental Health Commission reports, *Central Mental Hospital Approved Centre Inspection Report* from 2017-2021.

[3] See Department of Health, *Sharing the Vision Implementation Plan 2022 – 2024* (2022), 86.

('the Task Force') was published at the end of September 2022.[4] The findings of the Task Force's Final Report are therefore not included or referenced in the present report.

Methodology

The first phase of the research was a literature review mapping the Irish laws and policies relevant to forensic mental health detention, as well as identifying relevant research and academic commentary on these settings and on applicable international human rights law. The second phase was qualitative research in order to include the perspectives of different stakeholders within the forensic mental health system. Over the course of this project, we interviewed two staff members of the National Forensic Mental Health Service (NFMHS) (S1, S2), five advocates working in the field of disability rights (A1, A2, A3, A4, A5), one lawyer working in the area (L1) and two organisations working with the forensic mental health system (O1, O2). Regrettably, the scope of this project meant that it was not possible for the research team to speak directly with individuals detained in the CMH. This is a clear limitation and should be addressed in future research which builds on this initial study.

[4] See Department of Health & Department of Justice, *Final Report of the High Level Task Force to consider the mental health and addiction challenges of those who come into contact with the Criminal Justice Sector* (2022). The Task Force was established as a cross-departmental initiative in April 2021 and the Final Report represents the culmination of its conclusions and recommendations for action.

The Rights of Persons with Disabilities and the Forensic Mental Health System

The UN Convention on the Rights of Persons with Disabilities

The detention of people in secure forensic facilities raises a number of human rights concerns – it has implications for the right to liberty, the right to equal recognition before the law, rights to privacy and bodily integrity, as well as the right to health. Historically, much of the human rights analysis of detention in secure forensic mental health facilities has focused on the conditions of that detention and procedural safeguards relating to the decision to detain the person. However, following the adoption of the CRPD, a new approach to understanding the human rights violations which occur in these settings has emerged, based on the human rights model of disability.

The CRPD challenges the legitimacy of separate settings in which people labelled with mental health diagnoses are placed, under different conditions from those in the mainstream penal system, and questions whether prisoners are really 'better off' in settings where they can be subject to involuntary psychiatric treatment, as compared to their treatment in the penal system. This was recognised by an Interdepartmental Group that was set up to examine issues relating to people with mental illness who come in contact with the criminal justice system. In its first interim report in 2016, it recommended that the Departments of Health and Justice carefully consider

the implications that ratification of the CRPD has for the governing legislation in this area – the Criminal Law (Insanity) Act 2006.[5]

In this report, we consider the extent to which individuals detained in the CMH have their rights vindicated, the human rights challenges to the legitimacy of maintaining separate forensic mental health facilities which disability rights law poses, as well as examining relevant domestic case law which has emerged regarding individuals' placements in these settings.

The compatibility of systems of forensic mental health with the requirements of the CRPD

While there are many different standards, rules, and principles governing the treatment of people detained in forensic settings, for the purpose of this scoping exercise, we are focusing our analysis on the CRPD. This is because the CRPD is the *lex specialis* (law governing a specific subject) in the area of disability rights, and is therefore the most relevant, as well as the most recent, international human rights law instrument, to address these concerns. The Committee has been clear that disability-specific forms of deprivation of liberty, including in forensic mental health settings, are contrary to a number of provisions of the CRPD, most particularly Articles 12 and 14 - the rights to equal legal personhood and to the liberty and security of the person respectively. Both of these provisions can find their roots in Article 5 of the CRPD, which guarantees the rights to equality and non-discrimination for persons with disabilities. Importantly - and relevant to the question of access

[5] Department of Justice, *Interdepartmental Group to Examine Issues Relating to People with Mental Illness Who Come in Contact with the Criminal Justice System: First Interim Report* (2016), 5.

to rights within forensic settings - within the CRPD's equality norm, discrimination on the basis of disability includes the denial of reasonable accommodation for persons with disabilities, including within the criminal justice system.

In its Guidelines on Article 14, a document intended to provide guidance to States on how to interpret the right to liberty of persons with disabilities, the Committee has criticised the fact that persons with disabilities are frequently denied equal protection under the criminal law 'by being diverted to a separate track of law', noting that those laws 'commonly have a lower standard when it comes to human rights protection, particularly the right to due process and fair trial, and are incompatible with article 13 [access to justice], in conjunction with article 14, of the Convention'.[6] Specifically regarding deprivation of liberty on the basis of disability within the criminal justice system, the Committee was clear that:

> **... declarations of unfitness to stand trial or incapacity to be found criminally responsible in criminal justice systems and the detention of persons based on those declarations are contrary to article 14 of the Convention, since they deprive the person of his or her right to due process and safeguards that are applicable to every defendant. The Committee has called for States parties to remove those declarations from the criminal justice system.[7]**

Further, the forced treatment which frequently accompanies detentions in forensic settings is contrary to Article 25 of the CRPD, which requires States to

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[6] Committee on the Rights of Persons with Disabilities, *Annex to the Biannual Report of the Committee on the Rights of Persons with Disabilities - Guidelines on the Right to Liberty and Security of Persons with Disabilities* (A/72/55, 2017), para.14.
[7] ibid, para.16.

vindicate the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. A fundamental aspect of the right to health is the provision of healthcare on the basis of free and informed consent.[8] In a 2017 report on the *Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*[9] the UN Special Rapporteur on the Right to Health urged states to reduce and ultimately eliminate coercion in all mental health settings, including forensic settings.

A corollary to the provisions of the CRPD which prohibit coercive healthcare is the right to live independently and be included in the community under Article 19, which prohibits persons with disabilities from being obliged to live in a particular living arrangement. The Committee has emphasised its link with the recognition and exercise of legal personality and legal capacity, as well as the CRPD's 'absolute prohibition of detention on the basis of disability'.[10]

A number of academic commentators have also highlighted the incompatibility of systems of forensic mental health detention and forced treatment with the requirements of the CRPD and made proposals for alternative, support-based models.[11] While recognising the State's obligations under CRPD, it is clear that

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[8] Convention on the Rights of Persons with Disabilities, Article 25(1).
[9] See UN Human Rights Council, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* (2017).
[10] Committee on the Rights of Persons with Disabilities, *General Comment No. 5 (2017) on Living Independently and Being Included in the Community* (CRPD/C/GC/5, 2017), para.27.
[11] Piers Gooding, Bernadette McSherry and Anna Arstein-Kerslake, 'Supported Decision-Making in Criminal Proceedings: A Sociolegal Empirical Study' (2021) Journal of Disability Policy Studies; Piers Gooding and others, 'Unfitness to Stand Trial and the Indefinite Detention of Persons with Cognitive Disabilities in Australia: Human Rights Challenges and Proposals for Change' (2017) 40 Melbourne University Law Review 816; Piers Gooding and others, 'Supporting Accused Persons with Cognitive Disabilities to Participate in Criminal Proceedings in Australia: Avoiding the Pitfalls of Unfitness to Stand Trial Laws' (2017) 35 Law in Context 64; Anna Arstein-Kerslake and others, 'Human Rights and Unfitness to Plead: The Demands of the Convention on the Rights of Persons with Disabilities' (2017) 17 Human Rights Law Review 399; Tina Minkowitz, 'Rethinking Criminal Responsibility from a Critical Disability Perspective: The Abolition of Insanity/Incapacity Acquittals and Unfitness to Plead, and Beyond' (2014) 23 Griffith Law Review 434.

there is a significant gap between the goals of the CRPD and the current position on the ground in Irish prisons and forensic settings. In order to bridge this gap, it will be important to work to achieve parity between how physical and mental healthcare is offered to people who are detained in the criminal justice system. A significant change in systems and an increase in as well as a redistribution of resources will be required to ensure that prisoners seeking mental health supports have the same rights as those seeking physical healthcare to access services and supports based on their informed consent.

The following section will examine how the criminal justice system could operate in greater compliance with the requirements of the CRPD.

Alternatives to forensic mental health systems

The CRPD Committee has asked States to provide persons with disabilities with the support and accommodation they require to allow them to participate in criminal proceedings on an equal basis with others.[12] The Committee has also reaffirmed the incompatibility of separate criminal justice systems for persons with disabilities in a number of its Concluding Observations to States it has examined.[13] In addition, when considering the construction of alternatives to forensic detention, the Committee has been clear that deprivation of liberty in criminal proceedings should only take place 'as a matter of last resort and when other diversion programmes, including

[12] Committee on the Rights of Persons with Disabilities (n 6), para.16.
[13] Committee on the Rights of Persons with Disabilities, *Concluding observations on the initial report of Belgium* (CRPD/C/BEL/CO/1, 2014), para.28; Committee on the Rights of Persons with Disabilities, *Concluding observations on the initial report of Ecuador* (CRPD/C/ECU/CO/1, 2014), para.29(c); Committee on the Rights of Persons with Disabilities, *Concluding observations on the initial report of Germany* (CRPD/C/DEU/CO/1, 2015), paras.31-32.

restorative justice, are insufficient to deter future crime'.[14] Further, any such diversion programmes should not include transfer to systems of coercion under the civil law such as mental health laws or pathways which oblige an individual to receive mental health services.[15]

The decision of the CRPD in *Noble v. Australia*[16] is particularly relevant to the Committee's position on practices of forensic detention, as well as serving as a form of guidance to States Parties on what CRPD-compatible reform would require. The applicant, Marlon James Noble, had been found unfit to plead to criminal offences with which he had been charged and, on foot of this finding, he was detained in a correctional centre from March 2003 to January 2012, at which time he was released on a conditional release order. This meant that, with the period of remand included, he had been detained for 10 years and three months. The Committee noted that under the relevant legislation, once a person was found unfit to plead, they could be detained indefinitely and that a presumption of unfitness to plead will remain unless proven otherwise. The person could not exercise their legal capacity, e.g. to enter a plea of not guilty and proceed with a criminal trial. Further, no supports or accommodation to do so were considered or offered to the applicant. The Committee found that this amounted to a violation of Article 12 of the CRPD. The Committee also found that he had been deprived of his right to a fair trial as provided for under Article 13 of the CRPD (access to justice) and that this amounted to discriminatory treatment in violation of Article 5 of the CRPD.

Most importantly in terms of the validity of systems of forensic detention based on findings of mental incapacity, the Committee noted that the

[14] Committee on the Rights of Persons with Disabilities (n 6), para.21.
[15] ibid, para.21.
[16] *Noble v. Australia* (CRPD/C/16/D/7/2012, 2016).

applicant had been deprived of his liberty under Article 14 'because of the lack of available alternatives and support services', even though the State authorities were themselves clear that prison 'was not the appropriate environment' for him.[17] In addition, the Committee found that the applicant's subsequent conditional release was 'a direct consequence' of his detention and therefore also constituted a violation of Article 14(1)(b) of the CRPD. The Committee recommended that Australia revoke the conditions attached to the applicant's release order, 'replacing them with all necessary support measures for his inclusion in the community'.[18]

While Ireland has lodged a declaration in respect of Article 14 when it ratified the CRPD in 2018, and in doing so sought to retain the right of the State to detain individuals on the basis of 'mental disorder', it is unlikely that this declaration is compatible with the interpretative provisions of the CRPD, as well as other aspects of the law on international treaty interpretation. The decision of the Committee in *Noble*, as well as the Committee's other pronouncements on the validity of disability-based detention, should therefore inform law and policy reform efforts in Ireland. As the Special Rapporteur on the Rights of Persons with Disabilities has stated:

> **Evidence shows that when Governments, service providers, courts and communities take concerted action to move away from coercive practices, they are likely to be successful.[19]**

[17] ibid, para.8.7.
[18] ibid, para.9.
[19] Special Rapporteur on the rights of persons with disabilities, *Deprivation of Liberty of Persons with Disabilities* (A/HRC/40/54, 2019), para.70.

Such evidence for alternatives to coercion is growing, with a number of pieces of research commissioned by the UN Special Rapporteur on the Rights of Persons with Disabilities providing examples of promising and good practices.[20]

An example of a practice which has the potential to address the intersection of disability and justice is transformative justice (TJ). Adapted for the disability context by Mia Mingus, a self-described queer disabled trans-racial adoptee, TJ is a response to violence and harm (created by and for people from minority communities) which goes beyond punishment and places at its centre the repair and wellbeing of both the individuals involved in and impacted by a particular act, as well as that of the broader community. A core objective of TJ is avoiding the recreation of systems and structures which impose and perpetuate violence. TJ-based interventions focus on the 'healing, accountability, resilience and safety'[21] of all those engaged in the process.[22] TJ processes mirror the CRPD norms in their focus on agency and relational autonomy, alternatives to coercion and/or retribution (including deprivation of liberty and forced psychiatric treatment), and the grounding of the individual in their community, particularly in light of the historic harms which have been created by State structures and institutions.

The obligation on States Parties to the CRPD to dismantle forensic mental health structures, (including pathways of diversion which are based on coercion) is clear. While this dismantling is the ultimate goal in the longer-

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[20] Eilionóir Flynn and María Gómez-Carrillo, 'Good Practices to Promote the Right to Liberty of Persons with Disabilities' (Centre for Disability Law and Policy, 2019); Eilionóir Flynn, Mónica Pinilla-Rocancio and María Gómez-Carrillo de Castro, 'Disability-Specific Forms of Deprivation of Liberty' (Centre for Disability Law and Policy, 2019); Piers Gooding and others, 'Alternatives to Coercion in Mental Health Settings: A Literature Review' (Melbourne Social Equity Institute, University of Melbourne, 2018).

[21] Mia Mingus, 'Transformative Justice: A Brief Description' (*Leaving Evidence*, 10 January 2019) <https://bit.ly/3FbjcpN> accessed 24 August 2022.

[22] For an example of an organisation working at the intersection of disability and TJ, see the SOIL transformative justice project <https://www.soiltjp.org/home> accessed 24 August 2022.

term, there are steps that can be taken immediately to better protect the rights of persons with disabilities within these systems. However, it is important to emphasise that these steps are not a replacement for the need to dismantle coercive mental health systems entirely in accordance with human rights obligations. The following section will therefore examine some of the key aspects relevant to vindicating the rights of those in forensic settings.

Secure Forensic Mental Health Facilities in Ireland

Admission to the Central Mental Hospital

There are four primary mechanisms by which an individual is detained in the Central Mental Hospital (CMH). These are:

1. A finding of unfitness to be tried under section 4 of the Criminal Law (Insanity) Act 2006
2. A finding of not guilty by reason of insanity under section 5 of the Criminal Law (Insanity) Act 2006
3. Voluntary or involuntary transfer from prison under section 15 of the Criminal Law (Insanity) Act 2006
4. Detention under the voluntary or involuntary provisions of the Mental Health Act 2001

The legislation also provides for the possibility that an individual found unfit to be tried or found guilty but insane by a court martial may be transferred to the CMH under section 202 or 203 of the Defence Act 1954.

While wardship under the Lunacy Regulation (Ireland) Act 1871 is not a separate pathway of admission to the CMH, the latest Inspection Report by the Mental Health Commission notes that four people detained in the CMH on the date of the inspection were wards of court.[23] The *Re M, A Ward of Court*[24] case demonstrates that wardship has been used by the CMH in order to

[23] Mental Health Commission, *Central Mental Hospital Annual Inspection Report 2021* (2022), 14.
[24] *Re M, A Ward of Court* [2022] IEHC 21.

extend the detention of an individual following the expiration of their prison sentence. A lawyer interviewed for this research raised concerns regarding the basis upon which an individual is detained in the CMH.

> **What does every person in the CMH, what does their file say about them? What is their basis for being there? Is it wardship? Is it the 2001 Mental Health Act? Is it the 2006 Insanity Act as amended? How are those records supervised? Who supervises them? How often are they supervised?**
>
> **(L1)**

The Mental Health (Criminal Law) Review Board estimates that between 80 and 90 people are detained in the CMH at any one time.[25] The nature of the population within the CMH is both transient, due to transfers to and from prison, and semi-permanent, with the detention of some individuals for long periods of time. Most individuals in the CMH are detained as a result of a finding of 'not guilty by reason of insanity' (75% of Review Board hearings).[26] Smaller numbers of people are detained due to a determination of unfitness to be tried (12%) or due to voluntary or involuntary transfer from the prison setting (13%).[27] Figures relating to the number of people detained in the CMH under provisions of the Mental Health Act 2001 do not appear to be publicly available.

[25] Department of Justice, *Mental Health (Criminal Law) Review Board Annual Report 2021* (2022), 7.
[26] ibid, Appendix D.
[27] Ibid, Appendix D.

Fitness to be tried

The 2006 Act provides for the detention of the individual in the CMH until such time as they are considered fit to plead if they are deemed to have a 'mental disorder' within the meaning of the Mental Health Act 2001.[28]

The fitness to plead regime raises several human rights concerns, most notably that a finding of unfitness to plead may lead to an extended period of detention in the CMH, as noted by a staff member working in the NFMHS:

> **Yeah, there are a small, very small number of patients who are unfit to plead, and it's... it's a difficult one, because, you know, somebody could remain unfit to plead for a very long time...**
>
> **(S2)**

There is no limit on the length of time an individual can be detained under a finding of unfitness to plead. One staff member working in the NFMHS noted a case where an individual had been held in the CMH due to a finding of unfitness to plead since the 1970s.[29]

> **I actually think we have a patient who's been unfit to plead since the 1970s.**
>
> **(S2)**

The fitness to plead regime has been framed as a means of securing the right to a fair trial for individuals with a mental disorder. However, the Committee in *Noble v. Australia* held that a similar regime to that in operation in Ireland

[28] Mental Health Act 2001, s.3.
[29] Since this interview was completed, the individual in question has been moved from the CMH to an alternative placement.

amounted to a violation of Articles 12 (legal capacity), 13 (right to a fair trial) and 5 (non-discrimination) of the CRPD.

The degree to which the fitness to plead regime places an individual at risk of detention for an extended period of time due to their perceived inability to participate in a trial was highlighted by a staff member working in the NFMHS:

> **Because if somebody never gets fit, how can they be… be tried, is the idea I think.**
>
> **(S2)**

The case of *G.C. v. Governor of Cork Prison*[30] demonstrates the degree to which individuals fall into a 'legal limbo' once their ability to plead is called into question. In this case, the Court ruled that it was not permissible for the District Court to make a finding regarding fitness to plead as the individual in question was deemed to lack the capacity to decide to have the matter dealt with summarily at District Court level rather than on indictment.[31] The Court interpreted section 53(1)(b) of the Criminal Justice (Theft and Fraud Offences) Act 2001 to include a functional assessment of capacity – namely that the individual must understand what they are being told about their right to elect to have the matter tried in the District Court and, on the basis of that understanding, they do not object to the matter being tried summarily. The result was that the District Court was obliged to send the theft charges forward to the Circuit Criminal Court which would then determine whether G.C. was fit to plead.

In delivering this decision, the Court adopted a paternalistic attitude stating that were he to be released into the community, 'not only would he represent

[30] *G.C v. Governor of Cork Prison* [2021] IEHC 563.
[31] ibid, para.61.

a great danger to members of the community, he would in all probability become homeless, as referred to in the medical records, and, given his lack of insight into his medical condition and his refusal to take antipsychotic medication, his condition would likely deteriorate more rapidly'.[32] The Court therefore held that 'while his detention in Cork Prison is not ideal from a treatment perspective, it is the best treatment and the most optimal placement for the applicant, outside of an admission to the CMH'.[33] Accordingly, G.C.'s detention in Cork Prison did not amount to a violation of his right to bodily integrity such as would render his detention unlawful.

The Committee has made clear in General Comment No. 1 that functional assessments of mental capacity as a mechanism to deny legal capacity are contrary to Article 12 of the CRPD.[34] Therefore, the fitness to plead regime in Ireland is likely contrary to Article 12 of the CRPD. Furthermore, the fitness to plead regime only applies to an individual who has a mental disorder and therefore in the view of the Committee, it effectively operates as a status-based test denying legal capacity on the basis of disability.

Rather than supporting individuals to exercise their fair trial rights, the Irish fitness to plead regime focuses instead on detention and/or treatment of the individual in order that they may have sufficient capacity to participate in the legal proceedings against them. Furthermore, the Irish fitness to plead regime is essentially a mechanism by which disabled people who have been accused but not convicted of a crime may be detained in a mental health setting for an extended period of time with the possibility of non-consensual medical

[32] ibid, para.73.
[33] ibid, para.74.
[34] Committee on the Rights of Persons with Disabilities, *General comment No. 1 (2014) Article 12: Equal recognition before the law* (CRPD/C/GC/1, 2014), para.15.

treatment, seclusion and restraint, all of which are practiced within the CMH.[35] This is a clear violation of Article 14 of the CRPD which states that 'the existence of a disability shall in no case justify a deprivation of liberty.'

In addition to acting as a mechanism of detention of disabled people, the concept that a disabled individual may be 'unfit to be tried' may itself be a violation of the CRPD. Article 12 of the CRPD recognises the legal capacity of disabled persons on an equal basis with others. In removing the ability for a disabled person to choose to proceed with the trial process, the fitness to plead regime is a denial of the equal legal capacity of disabled persons. In its 2017 Concluding Observations on Canada, the Committee urged the State party to 'Set up a minimum core obligation... regarding the right to stand trial for persons with disabilities, with appropriate accommodation during criminal proceedings'.[36] Mechanisms to support disabled people in the trial process as an alternative to a finding of unfitness to plead were explored in a study by the Melbourne Social Equity Institute and include the provision of a support person, communication assistance and court-based support such as environmental changes or the possibility of video testimony.[37]

It is possible for the court to order out-patient treatment at the CMH for individuals deemed unfit to plead. However, this seems unlikely for individuals who reside outside Dublin, where the only designated forensic centre (i.e., the CMH) is located. Whelan notes that this was added as a late amendment when the legislation was passed, as the Minister believed that 'no one with a mental

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[35] Mental Health Commission, *The Use of Restrictive Practices in Approved Centres: Seclusion, Mechanical Restraint and Physical Restraint Activity Report 2020* (2021).
[36] Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Canada*, (CRPD/C/CAN/CO/1, 2017), para.32.
[37] Bernadette McSherry and others, 'Unfitness to Plead and Indefinite Detention of Persons with Cognitive Disabilities: Addressing the Legal Barriers and Creating Appropriate Alternative Supports in the Community' (Melbourne Social Equity Institute, University of Melbourne, 2017).

disorder should be inappropriately held in police custody or in prison'.[38] Whelan also notes that the possibility of out-patient treatment does not exist for those found not guilty by reason of insanity.[39]

Not guilty by reason of insanity

Section 5 of the 2006 Act provides for a verdict of 'not guilty by reason of insanity' where a jury has found that an accused has committed the alleged act but finds that the accused was suffering at the time from a mental disorder such that they 'ought not to be held responsible for the act'. The definition of a 'mental disorder' is the same as that which applies to fitness to plead and includes 'mental illness, mental disability, dementia or any disease of the mind, but does not include intoxication'.[40] In its Guidelines on Article 14 of the Convention, the Committee frames capacity-based defences such as the insanity defence as a breach of Article 14 and a form of discrimination against disabled people. The Committee considers such defences as a mechanism that denies disabled people equal access to due process and other 'safeguards that are applicable to every defendant'.[41]

Particularly relevant from a human rights perspective is the significantly different result flowing from a finding of 'not guilty' rather than 'not guilty by reason of insanity'. An accused found 'not guilty' of a crime departs a courtroom, no longer subject to supervision by the law. The accused found 'not guilty by reason of insanity', in contrast, may be involuntarily admitted to

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[38] Darius Whelan, *Mental Health Law and Practice* (Thomson Reuters 2009), 17-26.
[39] ibid.
[40] Criminal Law (Insanity) Act 2006, s.1.
[41] Committee on the Rights of Persons with Disabilities, *Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities: The Right to Liberty and Security of Persons with Disabilities* (2015).

the CMH if the court believes they are suffering from a 'mental disorder' within the meaning of the Mental Health Act and are 'in need of in-patient care or treatment'.[42] One staff member working in the NFMHS noted that once an individual is detained in the CMH under a finding of not guilty by reason of insanity, they can be detained for an extended period of time:

> **They're here, and then they could be here for quite a long period of time, getting treatment, managing the risk, and determining what to do.**
>
> **(S1)**

Unlike fitness to plead, which can be raised on behalf of an individual without their consent, the insanity defence, as it operates in Ireland, is not imposed upon disabled defendants.[43] Instead, it is a mechanism by which they can seek to excuse conduct that would otherwise be criminal. The burden of proof lies with the defence.[44] A lawyer interviewed for this research spoke about the degree to which clients refuse to utilise the defence due to their awareness of the potential for indefinite duration following a finding of not guilty by reason of insanity:

> **But when you have a client who can give instructions, often they do not want to run the defence of insanity which would leave them without a conviction and would be and leave the slate clean because of the spectre of a section 13 review system with no end in sight and it horrifies and frightens clients because of the, at least if somebody gets a sentence or a suspended sentence, they've a date on the door, they**

[42] Criminal Law (Insanity) Act 2006, s.5.
[43] The Supreme Court ruled in *DPP v. Redmond* [2006] IESC 25 that a defendant cannot be compelled to utilise the insanity defence.
[44] *M'Naghten's Case* [1843] UKHL J16.

can walk out. He or she can walk out. Not so, under the section 13 review system. And that is a concern. And it's a real legitimate concern.

(L1)

This lawyer also noted the lack of clarity as to whether an individual must be detained in the CMH for in-patient treatment following a finding of not guilty by reason of insanity. There is a discrepancy here between the fitness to plead and not guilty by reason of insanity regimes as under the fitness to plead regime it is possible for an individual to receive outpatient rather than inpatient treatment. The lawyer interviewed noted a case where his client had been unwell at the time of the commission of the crime but had improved to the point where his treating team did not believe he required inpatient treatment, but because a psychiatrist at the CMH disagreed, he was detained:

This man had been out for a year. He had been well for a year. He had the head of the particular outpatient services, a very prominent psychiatrist say, the worst thing that could happen now for this man was for him to go back into the CMH and assessed. He needs to be out. This particular CMH psychiatrist says no, he's only behaving himself because he is under a bail order which keeps him off drink. My expert who was dealing with the man, on a far more regular basis, said, no, that is not correct. He had great supports etcetera. The District Judge remanded him in custody. It was appalling.

(L1)

This situation, where someone has been living in the community, and well for a number of years, but is then detained in the CMH following a finding of not guilty by reason of insanity, was also noted by a staff member working in the NFMHS:

... if somebody was convicted and got bail, then they could be out untreated for two years, and then when they get sentenced, if they get an NGRI [not guilty by reason of insanity], they could come to the CMH, so ultimately then you're detaining somebody and treating them possibly against their will and possibly that they have lived and they have been okay for two years while they've been on bail, so there's kind of weird pieces like that as well.

(S2)

Transfer from prison

Section 15 of the 2006 Act governs the circumstances under which an individual can be transferred from the prison setting to the CMH. Such a transfer can take place where an individual is suffering from a mental disorder, and it is determined that they cannot receive appropriate treatment in the prison setting. This transfer can be done on a voluntary (with the consent of the person) or involuntary (without their consent) basis.

An advocate interviewed as part of this research expressed surprise and concern that an individual could be involuntarily transferred from prison to the CMH:

... one of the things that's kind of alarming to me is just like how there is just one... how one of those processes only has the informed consent of the prisoner... I think that the idea that it... it violates like so many articles of the Convention.

(A1)

A staff member working within the NFMHS described the process as follows:

> **So our teams work in the prison to help support and address mental health issues there, however where… I suppose conditions for a patient are so severe that require an inpatient facility, then they would come here. The intention is then, is they're brought in here, they're treated when they're here, they're stabilised and they return to prison. So that's one category… and I suppose the challenge with that is that how long will somebody be here? Will they be stabilised? When they're returned to prison, will they continue with the medication regime that has stabilised them? And the factors within the prison service could contribute to relapse, so that creates its own challenges.**
>
> **(S1)**

A question arises as to why an individual would need to be transferred to the CMH rather than receiving mental health treatment in the prison setting, as is currently being done in a number of prisons (albeit there are currently limitations to the services available across parts of the prison estate). One key difference is the permissibility of coercion and forced treatment within the CMH. This was highlighted in *G.C. v. Governor of Cork Prison*[45] and *S.M v. The Governor of Cloverhill Prison,*[46] where the only differentiation in treatment related to the inability of the prison mental health services to compel the individuals in question to take medication. When receiving mental health treatment within the prison system, an individual retains their right to refuse such treatment.

[45] *G.C. v. Governor of Cork Prison* [2021] IEHC 563.
[46] *S.M v. The Governor of Cloverhill Prison* [2020] IEHC 639.

A staff member working in the NFMHS noted the arguable ineffectiveness of this approach – whereby an individual is forced to receive treatment in the CMH and then released to the prison setting where such coercion is not permitted:

> **… sometimes we treat them and we get them back, and successfully responding to that treatment, and then we send them back to prison to go back and do the exact same thing again, so again that's not great, you know?**
>
> **(S2)**

Furthermore, an advocate expressed concerns regarding the circumstances in which an individual would be transferred from prison to the CMH:

> **… in terms of the admission process as well is that like it can… it can also very much hinge on preconceived biases and preconceived notions that staff might have as well. For instance, people might not… that it might often hinge on somebody who has, let's say, a difficult relationship with a Prison Officer, or a difficult relationship with the Governor of a prison as well.**
>
> **(A4)**

Detention under the Mental Health Act 2001

The CMH is an 'approved centre' under the Mental Health Act 2001. If someone is detained in a regular psychiatric hospital, they may be moved to a forensic setting where the director of the hospital they are detained in thinks that being moved there would benefit the person or that they can only receive certain treatment in the forensic setting.

A staff member interviewed for this research noted that the circumstances in which an individual would be transferred from another approved centre to the CMH may relate to the perceived challenging behaviour of the individual and the supposed need to treat the individual in a setting which has greater recourse to restrictive practices such as seclusion and restraint:

> **So then you have the group of patients that would have been in other approved centres where their delivery of care to them was problematic. You know they… I suppose in one sense their behaviour and their treatment outgrew the approved centres, so then there's a request for them to be considered for here.**
>
> **(S1)**

The same staff member noted that individuals transferred to the CMH under the Mental Health Act can be detained in the CMH for an extended period of time and then face particular challenges regarding release:

> **So again I think historically, I suppose the concern from my reading of our patient profile here, we would have had patients over the years that were in local areas, weren't managing well, were brought in here for a period of time, and 20 years later they're still here. They have nowhere to go back to, or their families' situations have changed and nobody wants them, there's no… so there's a real challenge there.**
>
> **(S1)**

A lawyer interviewed for this research raised particular concerns regarding a case where there was a difference of opinion as regards whether an individual required admission to the CMH:

> **So he went through the mental health system. He was taken from the High Court, released but taken to a Garda station and there was a GP**

who said he needed to go to the, needed to go to an approved centre. A consultant in [X hospital] said he needed to be detained under the Mental Health Act. But an independent psychiatrist said this man does not suffer from a mental disorder. He should not be detained and the Tribunal agreed and he was released back into the community and has never been back, to my knowledge, to the Central Mental Hospital. Or never been back under a detaining order. So, unless we would have brought that case where he was found to be fine, he would probably still be in the Central Mental Hospital until now.

(L1)

Wardship

Under the Lunacy Regulation (Ireland) Act 1871, an individual is taken into wardship where they are deemed to be of 'unsound mind and incapable of managing his person or property'.[47]

In *Re M, A Ward of Court*[48], the wardship jurisdiction of the High Court was used in order to continue to detain an individual in the CMH once their prison sentence had expired. An interim protective order for Mr M's involuntary detention in the CMH was granted on the basis that he 'was a person of unsound mind' and 'that his current therapeutic needs and best interests required that he be detained in the CMH and that the making of the interim protective orders was necessary and appropriate to vindicate Mr. M's rights and to protect the rights of the public'.[49] Mr M was later admitted to wardship

[47] Lunacy Regulation (Ireland) Act 1871, s.6.
[48] *Re M, A Ward of Court* [2022] IEHC 21.
[49] ibid, para.8.

to continue his treatment in the CMH following the end of his prison sentence.[50]

Such an approach is clearly at odds with the CRPD, which requires the elimination of all forms of substitute decision-making and that the existence of a disability is not a ground upon which to justify detention. Rather than being a mechanism by which to vindicate an individual's rights, wardship has been recognised as an extreme violation of an individual's rights. Furthermore, there are no annual statistics to determine how many individuals are being detained in the CMH due to their status as wards without reference to other legislation such as the Mental Health Act 2001 or the Criminal Law (Insanity) Act 2006. This raises significant concerns given the lack of oversight and review of detention of wards.

Detention in CMH solely under wardship was deemed permissible by the Supreme Court in *HSE v. A.M.*[51] In this case, the appellant was transferred to the CMH. The HSE wished to have him made a ward of court. The issue identified for determination was whether the HSE, or any other person who seeks to have a person involuntarily detained on mental health grounds, can do so by way of wardship procedure. MacMenamin J held that the Court's wardship jurisdiction was sufficiently broad to allow it to have been invoked in this case and in addition that the appellant was of 'unsound mind' and that he was required to be in the CMH. In the circumstances, the Judge found that the orders made were necessary and appropriate to vindicate the rights of the appellant and also to protect the rights of the public.

[50] ibid, para.11.
[51] *HSE v. A.M* [2019] IESC 3.

It also appears that wardship has been used by the CMH in circumstances where an individual, whose length of detention has already been referred to above, was detained in the CMH under unfitness to plead for an extended period of time:

> **I think the long-term patient that we have, that's been unfit to plead for so many years, I think recently was made a ward, but not only… you know, 40/50 years later maybe.**
>
> **(S2)**

This individual has subsequently been moved to an alternative placement, although it is unclear if this was linked with the decision to take the person into wardship.

Human Rights in Daily Life within Forensic Settings

This section will address key issues regarding the human rights of people detained in forensic settings in Ireland, including the right to access physical and mental healthcare on the basis of informed consent; confinement, seclusion and restraint; connections to community; leave; advocacy; gender; and the move to the new location of the Central Mental Hospital (CMH).

Access to healthcare

The clinical model of service in the CMH is based around seven pillars of care, which each patient must engage with: physical treatment; illness, insight wellness and recovery; drugs and alcohol; offending behaviour; psychosocial occupational and rehabilitation; education and occupational creativity; and family and social networking.

Physical Healthcare

Staff outlined that physical healthcare within the CMH was managed by a GP clinic three times a week and a full-time primary care team, which included access to ancillary health care such as physiotherapy. Not much information was given in terms of consent for patients with regards to physical healthcare. It was noted by a staff member that a vaccine protocol was followed with regards to the COVID-19 vaccine:

> **... we have five patients here who did not consent, and they wouldn't give them the vaccines because they didn't want them, and they continued to be unvaccinated.**
>
> **(S1)**

It was noted that the same staff members questioned whether those who did consent had the right information to consent.

Advocates also raised concerns that the physical side effects of medications were not fully explained to patients in forensic settings:

> **There's always the great thing of doctor knows best, but if the side-effects are worse than... you know for the person as they already are, why would you want to take a medicine that is going to really have horrendous side-effects? So we have to be cognisant of that within any hospital setting.**
>
> **(A3)**

For patients who have additional diagnosis of intellectual disability, an alternative pathway exists in the mental health and intellectual disability unit:

> **... the cohort of patients on that unit as well have a different pathway and that has all been changed and adapted and amended for those patients. And then on top of that, like where they were mainstream if you like patients, if it's picked up on their pathway that they have additional needs, then the team will adapt their working with that patient to meet their needs...**
>
> **(S2)**

Mental Healthcare

The operation of mental healthcare in forensic settings was a core focus for all participants in this research, in particular consent. The voice of the patient was very much seen as relevant to care planning, but it was clear that the patient themselves did not have the final say on all healthcare decisions:

> **... their views are sought. I mean I suppose the question sometimes I'd have is what weight is given to that?**
>
> **(S1)**

The paternalistic culture that exists in wider mental healthcare settings was considered by some advocates to be more acute within the CMH:

> **... the gap between the Central Mental Hospital and the Community-Based Healthcare, it's just very, very vast at the moment.**
>
> **(A5)**

The biggest concern was that people were not making their own decisions on mental healthcare, and that they were not offered support in making decisions. One advocate (A3) said this included having decision supporters, while another indicated the importance of having time and space to make decisions and having access to appropriate information (A4). It also was raised that previous negative experiences and the knowledge of the patients may be dismissed:

> **... it's about drilling down what's behind that because a lot of individuals have had negative experiences with the current system.**
>
> **(A5)**

Staff interviewed for this research noted the central role of the CMH multi-disciplinary team in making decisions about patients' treatment, and at times questioned whether the operation of this team was truly focused on the preferences of the person receiving treatment:

> **... well was the MDT [multi-disciplinary] ward round for the benefit of the members of the team, or was it for the benefit of the patient?**
>
> **(S1)**

Many advocates and organisations raised concerns about the information patients were given about their mental healthcare:

> **It's absolutely important that the patient knows exactly why they're there, they know exactly what their programme is every day, and it's about continuity.**
>
> **(A3)**

Night-time confinement

One practice which was repeatedly referenced as an infringement on rights was the blanket use of night-time confinement, where the majority of persons within the hospital are confined to their rooms for extended periods overnight. This included all units, bar one, with most units being under lockdown from before 9pm. One unit remains open until 11pm. While confined to their rooms, patients do not have open access to bathroom facilities (O2).

Seclusion and Restraint

The Mental Health Commission report on the use of seclusion, mechanical and physical restraint in approved centres demonstrates higher rates of the use of these restrictive practices in the CMH than in any other approved setting. The CMH has the longest average length of time spent in seclusion at 185 hours and 28 minutes (nearly eight days).[52] The CMH also had the greatest use of seclusion for periods of time longer than 72 hours (three days).[53]

> **... we've had a number of cases here where seclusion has been ongoing for a long period of time, and I mean a long period of time, and I suppose it's generated the question 'what are we doing differently to try and end that seclusion?'**
>
> **(S1)**

The CMH was one of only two approved centres that utilised mechanical restraints in 2020.[54] This involved the use of both hand and leg restraints. The CMH also has the highest rate of physical restraint amongst approved centres.[55] Advocates interviewed for this research expressed concerns about the justifications for restraint:

> **... you may not have necessarily done anything to get physically restrained or it may have been the refusal of a medication or an injection, and you could have three or four nurses holding you down and forcibly injected.**
>
> **(A4)**

[52] Mental Health Commission (n 35), Appendix 4.
[53] ibid, 17.
[54] ibid, 20.
[55] ibid, Appendix 5.

The use of seclusion and restraints in psychiatric institutions (including forensic settings) has been criticised by the Committee as being contrary to Articles 15 (freedom from torture or cruel, inhuman or degrading treatment or punishment), 16 (freedom from exploitation, violence and abuse) and 17 (protecting the integrity of the person) of the CRPD. The Committee also advocated for a prohibition on 'the forced use of neuroleptics to contain persons with psychosocial or perceived disabilities and, in general, the use of medicine and chemical containment as a way of social control'.[56]

The issue of seclusion and restraint was given significant attention by participants in this research. While staff focused on the use of seclusion over restraint, all participants raised concerns about either the extent of the use of the practice or the operation of the practice. The grounds for seclusions were varied with staff framing the use of seclusion as a risk management tool which is used infrequently (S2) and advocates noting that the use of seclusion is much higher than in other settings and that there is a concern that they have failed to embrace alternatives:

> **... you know, the poor environment does have an impact on people and one of the issues that we have highlighted for example, is the, you know the seclusion facilities and the fact that some people continue to be secluded in their bedrooms...**
>
> **(O2)**

Advocates also noted that disability related behaviour 'could lead many autistic people to act in such ways that can be perceived as violent or could

[56] Committee on the Rights of Persons with Disabilities, *Observations on the Standard Minimum Rules for the Treatment of Prisoners* (2013), para.11.

be perceived as aggressive by others which would in turn lead people to be more likely to... for seclusion and restraint to be used against them' (A1).

With regards to chemical restraint, one issue which was raised was that chemical restraint could not be properly separated, or identified as separate from, therapeutic use of similar medications:

> **... like is it being used to just manage people's behaviour, or is it used to address a mental health concern?**
>
> **(S1)**

Alternatives to Restraint

The use of alternatives to seclusion and restraint was also highlighted, with advocates expressing concern that they were not being utilised. One advocate noted the need for:

> **... promoting both rights-based and trauma-informed practice approaches to support over practices... such as seclusion and restraint which are inherently abusive...**
>
> **(A1)**

One staff member (S1) noted that using an alternative to restraint had been successful in the one instance they knew of where it was tried, but that this was only used after seclusion had failed:

> **So the question is what's the alternative? And alternatives have been addressed with one particular patient here, and significant progress has been made, so that raised the question for me then, which was maybe we should have done this sooner?**
>
> **(S1)**

Connections to Community

Family Visits

Family visits were identified as crucial to improving the lives and respecting the rights of those detained in the CMH. The suspension of visits during COVID-19 was something which was raised consistently throughout the research as an issue, with visits being suspended for a large portion of the pandemic. The suspension of visits also caused the CMH to revisit the systems of visitation that it was using. Previously the visitor list was controlled by the patient which was seen as a risk:

> **Sometimes people were kind of bringing stuff in that were prohibited, putting patients at risk, taking pictures, bringing in phones, so the approved visitor register was my idea in collaboration with nursing that we would screen people, and we would do a... assessment of people, not only to ascertain a little bit about the wraparound, but when had they last seen their loved one, what do they know about mental illness, have they ever been to the CMH before?**
>
> **(S1)**

The new system allows for oversight of the entire visitor list, and also provides for the hospital to monitor the amount of visitors people get, and ascertain if some people rarely or never receive visitors:

> **Well why are patients in unit three never getting visits?**
>
> **(S1)**

This new approach to the visitor list results in an increased level of scrutiny in the name of safety, but can also further restrict visits for people in the CMH.

One positive aspect of recent reforms is that the visits were extended in length to one and a half hours, as previously they had been restricted to 45 minutes (S1). Given that CMH patients come from all over Ireland, there is a push within the service to extend this further 'maybe do a half-day with somebody travelling that far' (S2). It was seen that this was of benefit to patients:

> **So it's about that quality of time and then who's coming in, and that it actually adds value for the patient...**
>
> **(S1)**

During the COVID-19 pandemic technology was used at the CMH to facilitate connections to family and community:

> **The positive thing about that was that patients began to have visits with people that they never have visits with, because Mary would never get in the car and come up from Kerry here for an hour, whereas she'd go online to visit.**
>
> **(S1)**

A final issue is that those who enter the CMH through prison settings were identified as less likely to get visitors or maintain connections to the community (S2).

Family Access for Parents of Children

For parents in the CMH, maintaining the connection to their children was crucial. While the CMH has a room to facilitate child visits, only a small number of patients make use of it. One participant noted 'the women we really have pushed for kind of child visits more, and the role of parenting from

afar' (S2), in contrast to the approach to men who are also parents where 'there are still a number of men scattered throughout the hospital who have children as well, which the same emphasis isn't really on' (S2).

It was noted that the limitations that are placed on child visits might be influenced by an over-protective attitude that may have negative consequences:

> **Sometimes I wonder are we minding the child more than we should be minding the child, but that's another day's work...**
>
> **(S1)**

Leave

Alongside the importance of facilitating connections to family and community through visits, it is important that those detained in the CMH have access to the broader community through 'leave' from the setting. Currently leave is limited and has been further limited during the ongoing COVID-19 pandemic, and this is a significant rights issue for people detained in the setting:

> **... the process of leave is that the MDT [multi-disciplinary team] assess and make recommendations, and the Psychiatrist then requests the leave through a leave committee, which is chaired by the Executive Clinical Director, and they might say, you know 'I'd like Joe Bloggs to start off with 30 minutes leave in the local area, with two nursing staff'. And that is literally just to start off that first piece of leave. It may only be over to the coffee shop across the road, or whatever, but it's quite significant.**
>
> **(S2)**

Resources were also an issue for those who wanted to connect with the wider community or access leave as discussed further below in relation to conditional discharge and connections to community. There seems to be a greater focus on leave for patients who are on course to be rehabilitated back into the community, however, leave for patients who are not deemed to be at that point in their recovery was further limited. Staff spoke highly of the community services that do exist, but it was clear that this was restricted in terms of the number of patients that could access them, and that it was only for longer-term patients (S2).

Advocacy

There is a peer advocacy system in place within the CMH, but concerns were raised that the current structure of advocacy within the CMH has resulted in a service that is not fully independent. A staff member in CMH made the following comment about the peer advocates:

> **There's two staff part-time, but they cover six days a week, okay? So we pay them a full salary to be here. There's a bit of work I've been doing with them, and I suppose it's not to do with the organisation as such, but it had to do with what I perceived when I came here, which was it was easy for the advocates to turn rogue, in the context that they became part of the staff, they became part of the system here, part of the structure here, and were well able to navigate around, but after a while in navigating around were they actually asking the questions that should be asked?**
>
> **(S1)**

One advocacy element which was continually cited as a strong force for change was the carers' group, comprised of family members of patients in CMH, with staff recognising the positive contribution they make (S2). However, one staff member did note that the interests of the group may be different from the interests of the patients:

> **... am I engaged with the carers to advocate on behalf of the patients, or their relatives? And that sometimes is not clear...**
>
> **(S1)**

While calls have been made to increase the role of families in decision-making regarding the detention and treatment of people in CMH, care would need to be taken to prioritise the rights to legal capacity, informed consent and privacy of the detained person, to ensure respect for their human rights.

Gender

The impact of gender was raised at various points throughout the research, with it being a substantial and underexplored aspect of the forensic mental health system in Ireland. One staff member noted: 'we are [a] patriarchal service here' (S1).

The categorisation of patients in terms of risk and the role which gender played in the categorisation emerged as a concern during this research. While male units were stratified, and patients could be in less restrictive environments, this was not the case for women in the CMH.

> **So the hospital has categorised, the categorised medium... high, medium and low for men, and we have a system. So it also has categorised the**

same for women, but we don't have the reflective system here. So it's one unit, all the women are in it.

(S1)

Alongside the failure to stratify the women's unit, the point was also raised that women are often marked as being a high security risk while not presenting the same risk as an equivalent man (S1). Some of those issues were hoped to be alleviated somewhat by the relocation of the CMH, but it was noted that this could also cause issues, as the capacity for women patients expands:

... we've never really had more than ten women. Now is that because that's the size of the unit and we only fill to capacity? So the question that arises is 'Well if you actually make 20 beds, will you get 20 patients that might not need to be here, but would be diverted elsewhere?'

(S1)

One advocate also raised concern that Lesbian, Gay, Bisexual and Trans disabled people who come into contact with the forensic system may be particularly disadvantaged by the 'paternalistic attitudes' towards them (A1).

The relocation of the CMH

Many of the concerns raised by interview participants were focused on the physical infrastructure and issues with the current CMH campus that they hoped would be addressed by the move to the new facility. However, the management of the move, and the impact that it has had on patients was criticised by a significant cohort of those interviewed. It was noted that a large portion of the complaints made by patients were in relation to the move (S1).

Alongside this, one staff member felt that the move to the new campus has been used in such a way as to defer or undermine issues that could have been dealt with on the Dundrum campus (S2). While the physical infrastructure of the new campus is an improvement, this does not address the underlying human rights issues raised throughout this report.

Other issues relating to patients' rights at the CMH

This research identified various pathways to make a complaint that mirror the complaints mechanisms that other settings use, including through contacting the Mental Health Commission, the 'confidential recipient' option and internal mechanisms. It was noted that some people would find these systems inaccessible, and that a record of complaints would help transparency (A4). For example, one staff member noted that complaints could be made internally to staff at CMH directly by patients, or raised by peer advocates, or made via the carers group. Externally, complaints could be directed to the HSE Confidential Recipient, or the Inspector of Mental Health Services. There was therefore no single, accessible, repository of all complaints made through these various mechanisms available (S1). A lack of respect for the right to privacy was flagged by interview participants (A1, A4 & O2), and has also been referenced in reports of the Mental Health Commission.[57]

Information access was an issue, both in terms of the systems and procedures in place, but also the rights to information that people could assert. Greater access to varied forms of information including audio, easy to read and other formats was called for by participants. Advocates in particular called for

[57] See annual Mental Health Commission reports (n 2).

increased access to decision supports, including accessible information, decision supporters and time to make an informed decision (S2). The impact of COVID-19 restrictions on the rights of people in forensic settings was also a concern, in particular where access to visits, leave, advocacy and other activities was severely impacted (O2). While some activities were available to patients including art, music, drama and the gym, staff and advocates both raised concerns about the institutional nature of their operation, and a lack of flexibility, freedom and choice for patients on which activity they wished to engage in. This was raised as a general challenge, not specific to COVID-19 restrictions.

Review of Detention and Discharge

This section will examine the system of review of detention and discharge for those detained in the Central Mental Hospital (CMH). However, it is important to emphasise once again that the very existence of separate systems of detention based on the existence or label of psychosocial disability (or 'mental disorder' as it is termed in the legislation) is incompatible with Ireland's obligations under the CRPD. It is therefore not possible to make recommendations for CRPD-compatible reform of review mechanisms which are applied solely to individuals detained under forensic mental health legislation such as the 2006 Act. Nevertheless, this section will identify particular rights concerns that arise in the operation of review and discharge under the 2006 Act.

The Operation of Reviews of Detention

Section 11 of the Criminal Law (Insanity) Act 2006 establishes the Mental Health (Criminal Law) Review Board to review the detention of individuals referred to the CMH due to a decision by the court regarding their unfitness to stand trial or having been found not guilty by reason of insanity. The Review Board also reviews the detention of prisoners who have been transferred to the CMH from a prison setting.

The Review Board is made up of a retired judge, two consultant psychiatrists and a counsellor psychotherapist. Three of those members review each case. Multi-disciplinary team meetings regarding the individual take place in advance of the Review Board hearings, and the treating psychiatrist also speaks to the individual (S2). It is notable that there are no lay members of the Review

Board, nor individuals with lived experience of the forensic system. This is something that was criticised by an advocate interviewed for this research:

> **I think that's something that's really important; having a layperson… the phrase so often used is 'lack of insight'. Where maybe the people lacking insight are the ones treating the person [as they] aren't looking at the circumstances, looking at the environment in which they're living, or not living in, the issues that are causing people to end up in the prison system or the CMH. You know, it's a lack of insight into people's lives and trauma and whatever that can lead to this.**
>
> **(A4)**

Article 4(3) of the CRPD states that where there are decision-making processes which concern 'issues relating to persons with disabilities', there is a requirement for States Parties to 'closely consult with and actively involve' persons with disabilities through their representative organisations. As Ireland reforms this area of the law to achieve compliance with the requirements of the CRPD, an interim measure would be to ensure that membership of Review Boards includes the voices of persons with experience of the forensic mental health system.

Recognition of chosen support for decision-making is a core aspect of vindicating the decision-making rights of people with disabilities. An organisation working within the forensic mental health system noted that individuals detained in the CMH had the option of requesting that a peer advocate support them during their Review Board hearings. A friend, family member or advocate can also be granted permission to attend hearings with the person. However, the advocate is not permitted to speak during the proceedings (O1).

The Review Board can only make a finding as to whether an individual still requires inpatient treatment in the CMH. Unlike Mental Health Tribunals under the Mental Health Act 2001, it cannot consider procedural questions and there is no requirement for it to be provided with the view of an independent psychiatrist (although reform on this point would not be sufficient to meet the requirements of the CRPD[58]). The current Review Board structure violates Articles 12 and 25 of the CRPD by removing an individual's decision-making rights regarding medical treatment.

Linked to this paternalistic focus on psychiatric opinion is a deficit highlighted by a lawyer experienced in litigation concerning the 2006 Act, around access to independent experts where legal proceedings are taken concerning individuals detained in the CMH:

> **I think it's very hard to get a forensic psychiatrist outside of the Central Mental Hospital set up... I have often said, it's very hard to get a psychiatrist on the forensic side in a criminal case outside of the CMH, almost impossible. Sometimes you have to go to the UK and that is difficult and expensive and cumbersome in trying to arrange consultations. Less so maybe with some Zooms. But it is never the same quality when you have examination over Zoom and examination in person... I often wish there was a group of psychiatrists, truly independent in the same way there are truly independent psychologists around the place that you can get expert views on, not so on the psychiatrist areas and I think that is a concern.**
>
> **(L1)**

[58] The Mental Health Act 2001 itself does not comply with the CRPD. This is because it fails to vindicate, amongst other rights, those to legal capacity (Article 12), to liberty (Article 14), to live independently and be included in the community (Article 19), and to health (Article 25).

Discharge from the CMH can either be into the community or in the form of a return to a prison setting if there is still time remaining on their sentence. In the case of person deemed fit to be tried (having previously been found unfit to be tried), it may mean the recommencement of the prosecution.

Participation of the Individual in Review Boards

Under section 13 of the 2006 Act, the detention of persons found either unfit to be tried or not guilty by reason of insanity must be reviewed at intervals of not greater than six months. Apart from these periodic reviews, the Board can review a detention on its own initiative, at the request of the individual, the Minister or the Director of the CMH. In light of the highly restrictive nature of the CMH, the default period of six months for reviews of detention is of concern and inconsistent with the approach taken under the Mental Health Act 2001, which provides for an initial review period of 21 days. In addition, the way in which information regarding the right of the individual to initiate a review of their detention is provided is unsatisfactory. An advocate interviewed spoke directly about how the default length of time between reviews might particularly impact on certain groups of people with disabilities with particular impairments:

> **... I think that that's a long time – six months – for somebody with dementia. I think they need to be reviewed, three months. I think it's too long.**
>
> **(A3)**

A staff member working in the NFMHS also raised the concern that:

... there are occasions where I have questioned whether or not the process is being... followed, and whether a patient is actually participating, or be carried along by the process, and that is the challenge.

(S1)

In order to actively participate in the review process, individuals need to be provided with accessible information which allows them to understand and engage in procedural matters relating to their detention. This is a core requirement of Articles 9 and 13(1) of the CRPD and has also been recognised by the European Court of Human Rights in *Z.H. v. Hungary*.[59] Staff members working in the NFMHS acknowledged that the manner in which information regarding rights, including reviews of detention, is provided to detained individuals, may be inadequate. Although improvements are currently being made to this system of information provision, it did not appear that this process was being done in consultation with those with lived experience of the forensic mental health system, or those trained in the creation of accessible materials:

... we've been doing a bit of work here about our policies and our procedures on that, we can tick all the boxes to say that, you know, they've got them the information, that they've met the Nurse Manager, but the reality is does that actually impact on that patient, because we don't know where the patient is at. You know when we're ticking the boxes, saying we've given out the documents... the sense of where people are at because they're unwell when they come in, they're quite unwell when they come in, and we kind of said, we were going through a

[59] *Z.H. v. Hungary* [2012] ECHR 1891.

process here, we were saying 'Well actually, do we repeat this every couple of weeks? Are we reinforcing the message, or at what point do we know that the person has heard?' You know 'That is Tommy, that is... you know is the Nurse Manager here.' 'This is the Advocate, this is the Social Worker.' As time goes on it's evidenced that the patients pick that up, that information, but at admission it's a difficult one, because of the medical position people are in.

(S1)

Section 12(1) of the 2006 Act requires the Review Board to assign a legal representative to each individual whose detention is under review, unless the individual in question chooses to engage their own legal representative. The Mental Health (Criminal Law) Legal Aid Scheme provides for a panel of legal representatives (approximately 25 solicitors) that an individual detained in the CMH may engage under legal aid. A total of 196 Review Board hearings regarding the detention of 87 people took place in 2021, with the majority of these being for individuals who had been found 'not guilty by reason of insanity'. While there are understandable reasons for creating a pool of lawyers experienced in acting on behalf of individuals detained in the CMH, this also creates a risk of a standardised approach to advocacy, in what is already a constrained system of review.

Decisions about discharge framed by paternalism and 'risk'

Under the 2006 Act, the Review Board has the power to order the continued detention of individuals or to order their conditional or unconditional release.

In making a decision as to discharge, a core consideration of the Review Board is supposed to be 'the welfare and safety of the person whose detention it reviews… and to the public interest'.[60] But there was concern from a staff member in the NFMHS that assessments of risk were interpreted in the context of potential liability of clinicians:

> **What happens if you make an informed decision and they don't do well, and something… and this is always the issue, is that if the patient has done something significantly wrong, particularly wrong – killing somebody – the question would be if that happens again, where does the accountability fit? So and that would be a constant debate in the unit here between Consultants, and the psychologists, and the MDTs [multi-disciplinary teams], and that's to help I suppose understand how we can move patients on. If somebody is going back to prison, that's different – they're going back into an environment that has a level of control, but if you're looking at somebody moving through here either to be left out on a licence, then that raises its own real challenges.**
>
> **(S1)**

Another factor relevant to recommendations for discharge is progress on the 'seven pillars of care' (as described above at page 28). Compliance with the goals contained within those pillars forms part of clinical recommendations for discharge. Yet, for some individuals detained in the CMH, movement along the pillars is hindered by the fact that the course of treatment (which, as already noted above, can be involuntary) is not seen to be effective. As a staff member interviewed for this research stated:

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[60] Criminal Law (Insanity) Act 2006, s.11(2).

... the model of care is very much, get them in, get them the best treatment we can, and rehabilitate them back to the community. But for some patients, they don't, they're not responding to medication, they don't respond to treatment – and it's really sad when that happens, and they end up on a slower stream pathway where lots of treatments and medications have been tried and they are... they just don't respond, they're just not responding to the treatment.

(S2)

The lawyer interviewed for this research raised concerns about the formulaic nature of the reports from psychiatrists based in the CMH when these were requested for litigation:

... if you look at the reports that I have for 15, 16, 17 years, it's a real concern that they are actually the exact same, almost the exact same template they work off... there's a particular way of approaching cases I think, speaking generally and broadly, when approaching a case now, the way CMH now, slightly obvious, each psychiatrist will bring their individual views to bear, but I certainly over the years... I've thought, there is a certain approach and you can see that the way you think about every case follows the same sets of paragraphs, the same issues.

(L1)

The role of family members in decision-making about discharge was an issue which had a diverse range of views amongst those interviewed. For some, family members were an important part of ensuring that the return to the community was successful:

... it's important to try and create that link of getting people back into the... back integrated into their community with the support of the

family. Now it may not… I totally take on board that may not always be possible, but it could be possible in terms of that they weren't living in the family home, that there were some visiting rights, or that the family could visit them, and meet with them, and… and have coffee, or you know have some kind of an engagement with them. I think from a rehabilitative point of view the family is really important.

(A3)

However, members of staff working in the NFMHS flagged the potential issues which arose around family involvement:

… the risk associated with return to community is because that's normally where the offence was committed. So whether it's directly with the family, or whether it is in that area, can be real challenge, and more often than not families can be divided around, you know 'Tommy's best left in the Central Mental Hospital and don't be encouraging him to come back here' in contrast to somebody, and we all have this in families, where something has happened, we all have a different understanding from what actually happened, so we've come across that where families are in dispute amongst themselves around the care of the patient.

(S1)

From a human rights perspective, while chosen support and involvement of family can play an important role in vindicating the right of persons with disabilities to live in the community, their inclusion should be based on the wishes of the person. The participation of family should also not be a prerequisite for the release or reintegration of the person into the community.

Conditional discharge into the community – a tightrope with little support

The Review Board can place any conditions relating to treatment and/or supervision as it 'considers appropriate' when an individual is released from the CMH. These can include conditions relating to out-patient treatment or supervision, medication, review by mental health services, requirements to engage with occupational therapy, social work or psychological or other therapeutic interventions or activities. Conditions can be imposed regarding place of residence and individuals conditionally released from the CMH may have an obligation to share intimate details of their personal life with their treating team following their release.[61] In many cases, conditional discharge means living in supported accommodation run directly by the NFMHS for a period of time. The Supreme Court has recently affirmed that a decision to conditionally discharge an individual from the CMH lies with the Review Board and that the Clinical Director of the CMH must therefore put in place arrangements for the individual's conditional discharge even if they disagree with the decision.[62]

In 2021, six people were conditionally discharged from the CMH (the same number as were conditionally discharged the year before). The average length of detention for those conditionally discharged was eight years.[63] While there is no express prohibition on a person being unconditionally discharged directly under the 2006 Act, it is not clear if this ever occurs or whether there is instead a practice on the part of the Review Board of only authorising a

[61] *M.C. v The Clinical Director of the Central Mental Hospital* [2020] IESC 28.
[62] ibid, para.102.
[63] Department of Justice (n 25), 9-10.

conditional discharge for an initial period. Where a person is conditionally discharged, they may only apply for an unconditional discharge after the expiration of 12 months from the date of their conditional discharge.[64] One unconditional discharge was approved in 2021, although it is not clear if this was after a period of conditional discharge.

Pursuant to section 13B of the Criminal Law (Insanity) Act 2006 (as amended), a person will be deemed to be in breach of their conditional discharge order where the Clinical Director 'on reasonable grounds' believes that a person is in breach of one or more conditions of his or her conditional discharge, and that:

> (a) there is a serious likelihood of the person causing serious harm to himself or herself or to other persons, or
>
> (b) the person may be in need of in-patient care or treatment.

There is usually a requirement for the person concerned to be informed in writing of the fact that the Clinical Director holds this reasonable belief and the reasons for it. However, where the Clinical Director believes 'on reasonable grounds' that there is 'a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons', the requirement to inform in writing does not apply prior to being returned to the CMH but it must be done 'as soon as may be' upon their return.

If an individual breaches the terms of the conditional discharge order, they may be returned to the CMH, with the assistance of the Gardaí where this is deemed necessary. Members of the Gardaí may also arrest without warrant

[64] Criminal Law (Insanity) Act 2006 (as amended), s.13A(8)(b).

any person they believe to be 'unlawfully at large' due to a material breach of the terms of their conditional release from the CMH.[65]

The 2006 Act provides that in a situation where a person has been returned to the CMH due to a breach of their conditional discharge order, the Clinical Director must inform the Review Board of that fact. The Review Board must then review the person's detention 'as soon as may be' in the same manner as it would for general periodic reviews of detention. One person was recalled from conditional discharge in 2021.[66]

The existence of a safeguard in the form of a review by the Review Board is positive. However, the fact that only a single individual - the Clinical Director of the CMH - is empowered to make a determination as to whether there has been a 'material breach' of a conditional discharge order is of concern in light of the implications that such a finding has for the liberty and bodily autonomy of an individual in the process of establishing a life in the community.

Conditional discharge is an extension of the discriminatory system of detention to which persons with psychosocial disabilities within the criminal justice system can be subject. In *Noble*, the Committee has found that as such conditions are 'decided as a direct consequence of the detention' of the complainant, they also amount to a violation of Article 14.[67]

The option of conditional discharge is itself constrained by limitations on the availability of placements within the community. A staff member in the NFMHS explained:

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[65] ibid, s.14(7).
[66] Department of Justice (n 25), 10.
[67] *Noble v. Australia* (n 16), para.8.8.

I have met a number of patients here who say 'Look I've done the pillars plan, I've done five, six… I've done them all, I've done this, I've done that, when am I moving on?' And I say well, because we currently have three beds out in the community, and there's a challenge around moving patients into the community, because there's a sense that patients have to have done A, B, C, D in here, and they probably didn't do A, B, C, D, because over the past two years we've had COVID which was stopping the amount of Clinicians or whatever involved with them, so or they haven't had leave, or they… so the condition is well you have to have so many hours leave done before you move on, that they haven't those done.

(S1)

An initial point to highlight here is that the requirement to progress across the 'pillar' system is itself ableist and not human rights focused in its approach to psychosocial disability.

The same interviewee also explained how the perceived staffing needs of the CMH as an institution impacted on the ability of the NFMHS to provide support in the community:

… if we send staff out to do what we think they need to do, who's minding the house? So here it's who's minding the hospital? So we still have, you know, 100 patients here that they've to be minded, so there's that fear of wanting to go off and do A, B, C with patients that were here – that's great – but how do we backfill the job that needs to be done here? And that's the risk. So the only way I answer to do that is that the system is out in the community and it has to be connected, and that's part of the challenge.

This lack of 'space' in the community, as well as the perceived lack of capacity to allow NFMHS staff to support those detained in the CMH in engaging in authorised leave or conditional discharge, illustrates the consequences of maintaining institutional systems of forensic mental health provision, such as the CMH, rather than reforming the system towards community and consent-based models of care. The maintenance of the existing institutional system therefore has direct implications for the creation, funding and sustainability of consent and community-based models of care.

The CRPD, in recognising the legal capacity of every individual, as well as their right to live independently in the community, provides an alternative model which would do much to resolve this issue of resource and personnel constraints. Instead of the institutional approach currently found in the Criminal Law (Insanity) Act 2006, a CRPD-compliant service would focus on chosen support in the community, including peer support and informal supports chosen by the person.[68] For example, the practice of circles of support has enabled ex-offenders to reintegrate in communities and reduced recidivism, as well as the practice of family group conferencing with great success as an alternative to forced psychiatric treatment for people experiencing emotional distress or mental health crisis.[69]

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[68] Gooding and others (n 20); Kanna Sugiura and others, 'An End to Coercion: Rights and Decision-Making in Mental Health Care' (2020) 98 Bulletin of The World Health Organization 52; Laura Davidson, 'From Pipe Dream to Reality: A Practical Legal Approach Towards the Global Abolition of Psychiatric Coercion' in Charlene Sunkel and others (eds), *Mental Health, Legal Capacity, and Human Rights* (Cambridge University Press 2021); Flynn and Gómez-Carrillo (n 20); Eilionóir Flynn and Anna Arstein-Kerslake, 'Legislating Personhood: Realising the Right to Support in Exercising Legal Capacity' (2014) 10 International Journal of Law in Context 81.

[69] See Carla Cesaroni, 'Releasing sex offenders into the community through "Circles of support"-A means of reintegrating the "Worst of the worst"' (2001) 34(2) Journal of Offender Rehabilitation 85; Ellen Meijer and others, 'Regaining ownership and restoring belongingness: impact of family group conferences in coercive psychiatry' (2017) 73(8) Journal of Advanced Nursing 1862.

Support after discharge

A staff member in the NFMHS spoke about the challenges individuals experienced in accessing sustained support once they were released into the community:

> **There's an increase in patients wanting to stay on with the community team. Now, there's lots of reasons why that would be really helpful... for them, like, they know the team, they know the keyworker, they know how often they've to come in for their bloods and their medication and stuff like that. But as well, I suppose from a resourcing point of view, our caseloads are increasing and increasing as well and we don't have capacity to take and keep everybody, but at the same time I think when someone is well enough, where you would imagine that somebody would want to run a mile from the CMH, we're getting more and more patients who want to stay on, and that's a worry and that's something that we need to look at.**
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> **(S2)**

This was echoed by the other staff member of the NFMHS interviewed for this research, who also saw the absence of community-based supports as impacting on the length of time that people are detained in the CMH, and that this was often determined by the supports available to the individual in the community which they were returning to (S1).

A number of advocates also noted the implications that detention in the CMH can have for individuals when they return to live in the community. A

representative of an organisation working within the forensic mental health system stated:

> **… once you mention to somebody you've been in a secure unit for your mental health, there's that stigma, regardless of any crimes committed. It's still not talked about enough.**
>
> **(O1)**

The impact of institutionalisation on the autonomy and decision-making capacities of individuals, as well as the stigma that they experience when they return to their communities and try to re-establish their lives, has been recognised by the Committee in its General Comment on Article 19.[70]

Discharge back to prison

Both the Review Board and the Clinical Director of the CMH may order the return of an individual who was transferred from a prison setting back to prison. The Review Board decision to return a person to prison is based on whether or not they continue to have a mental disorder for which they 'cannot be afforded appropriate treatment' in the prison setting.[71] In addition, the Clinical Director can decide to return a person to prison if they believe they are no longer in need of in-patient treatment without the person's case going before the Review Board, however this must be done in consultation with the Minister for Justice.[72]

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[70] Committee on the Rights of Persons with Disabilities (n 10), para.5.
[71] Criminal Law (Insanity) Act 2006 (as amended), s.17(3)(a).
[72] Department of Justice (n 25), 7.

An individual must first be returned to the prison setting prior to becoming eligible for parole[73] and cannot apply for early release as they would if they had remained in the prison setting. This places those who have been transferred to the CMH from prison at a distinct disadvantage to their counterparts who have remained in prison settings, and in many cases will mean that they are deprived of their liberty for longer.

A staff member in the NFMHS also queried whether the legal requirement to return an individual to prison was the best approach, linking this to concerns they also had about lengths of detention before a person is discharged into the community:

> **I suppose the argument is we've treated them, we've put them on a medication program, we've done, you know, X amount of work, so now they're well enough to return to prison but sometimes you would wonder whether or not that's the best thing for them, like. Kind of the return to the community, like, in a way I think at times we hold onto people too long ...**
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> **(S2)**

While an examination of the supports available to people with psychosocial disabilities in prison settings in Ireland is outside the scope of this report (and has already been the subject of analysis elsewhere),[74] the absence of appropriate supports which a person can choose to avail of within such a setting is in violation of Article 25 of the CRPD, which guarantees the right to the highest attainable standard of both physical and mental health. This does not, however, provide a justification for the imposition of forced treatment in a

[73] *M v. The Parole Board* [2020] IESC 24.
[74] Irish Penal Reform Trust, *Making Rights Real for People with Disabilities in Prison* (2020).

forensic setting such as the CMH. It also means that an individual should not be returned to an environment (such as a prison) in which their mental health may deteriorate. In such circumstances, as in the case of a person with a physical medical condition or disability, they should be offered medical treatment where it can be provided in a manner consistent with their right to the highest attainable standard of health. That may be in the prison setting or in the community. If they make an informed decision to refuse psychiatric treatment, they should remain in prison to serve their sentence, with the reasonable accommodation(s) that they are entitled to being provided, in accordance with Article 5(3) of the CRPD. For example, a reasonable accommodation for a person experiencing distress might involve a change of timetable, access to peer support, or use of technology to facilitate remote visits. The availability of reasonable accommodations like this often prevents deteriorations in the person's mental health and avoids more intrusive interventions being pursued.

Further, as in the case of a physical health condition, the existence of such a psychosocial disability requiring treatment outside of the prison setting may form the grounds for an approval of an application for early release or (if eligible) parole.[75] If a cancer patient would not be returned to a prison setting that cannot meet their physical health needs, neither should a person seeking mental health treatment which is only available in the community, be returned to a prison setting that cannot provide what they need.

[75] The new Parole Act 2019 makes clear that only those individuals serving a life sentence are currently eligible to apply for parole: this may change in the future to include long-sentenced prisoners serving over eight years but that will be dependent on the Minister for Justice making relevant regulations under s.24(3) of the Parole Act 2019. It is also clear that patients detained in the CMH are not eligible for parole, see s.24(7) of the Parole Act 2019.

End of prison sentence

Section 16(1) of the 2006 Act provides that when someone is transferred to the CMH, the Governor of the prison from which they were transferred shall inform the Clinical Director of the CMH of the date on which the person will cease to be a prisoner. However, the 2006 Act also states that, upon the end of the person's sentence, it is possible for them to be admitted, on either a voluntary or involuntary basis, to an approved centre under the Mental Health Act 2001 and from there to the CMH as described above. This has the potential to substantially increase the time a person is deprived of their liberty when compared with a situation in which they served their sentence in prison and is incompatible with the CRPD given its implications for the rights to liberty, bodily integrity and to live in the community.

In addition, it is possible for the courts to make 'protective orders' extending the detention of a person in the CMH after the expiry of their prison sentence. For example, one individual had been detained in the CMH for at least 21 months beyond the expiration of his sentence by the time legal proceedings came before the High Court, having been placed under wardship just before the expiration of his prison sentence.[76] This potential for a judicial role in decision-making on forensic mental health detention is of particular relevance given the current proposals for the retention of the inherent jurisdiction of the High Court for the purposes of making orders regarding 'care, treatment or detention' of persons deemed to lack decision-making capacity in the Assisted Decision-Making (Capacity) (Amendment) Bill 2022.

[76] *Re M, A Ward of Court* [2022] IEHC 21.

Analysis and Recommendations

Irish law regarding the detention of individuals in the Central Mental Hospital (CMH) is at odds with the requirements of the CRPD. The Committee on the Rights of Persons with Disabilities has been clear that disability-specific forms of deprivation of liberty are contrary to numerous provisions of the CRPD, most particularly Articles 12 and 14, which provide for the rights to equal legal personhood and to the liberty and security of the person respectively. However, referral to the CMH is currently characterised by the courts as a means of vindicating the rights of persons with disabilities, rather than a violation of rights. Ireland's ultimate objective in any process of law reform should be working towards the abolition of the current forensic mental health system in the longer-term, consistent with its obligations under international law. In the more immediate term, there are a number of rights-based changes which could be made to the existing system to better align it with CRPD.

Recommendations on admission

Several interviewees noted concerns regarding waiting lists for admission to the CMH. In this regard, several court cases have characterised admission to the CMH as a mechanism for vindicating individual's rights. However, from the current analysis, detention in the CMH has the opposite effect and effectively denies individuals some of their rights. While working towards a complete overhaul of the current system, to ensure it is more human-rights compliant, there are a number of changes that should be considered and implemented in the shorter-term.

Recommendation 1: Increase transparency on the basis for detention.

The CMH should publish annual statistics on the legal basis for detention of all its patients to ensure greater transparency. Legal aid should be extended to everyone detained in the CMH, including wards of court, to challenge the legitimacy of their ongoing detention.

Recommendation 2: Start to offer mental health treatment outside CMH for those unfit to plead and for individuals who have been found 'not guilty by reason of insanity'.

Work should begin to expand outpatient treatment on the basis of free and informed consent for those deemed unfit to plead or who have been found 'not guilty by reason of insanity'. This should include a roadmap with defined timelines and targets to ensure outpatient treatment will be made available both in the CMH and other mental health facilities across the country. Oversight is required to ensure that these outpatient programmes are based on informed consent and do not lead to coercive treatment in the community.

Recommendation 3: Provide meaningful support to enable people to participate in the trial process rather than being deemed unfit to plead.

Rather than focusing solely on treatment, the fitness to plead regime should be reformed by law in order to allow for an individual to be supported to make their own informed decisions regarding the trial process. This would require the creation of mechanisms of support similar to those relating to support for exercise of legal capacity but adapted to the context of a criminal trial process.

Recommendation 4: Begin to provide more options for mental health treatment to people in prison without relying on admission to the CMH.

There are limited resources in the prison system at present to respond when prisoners request mental health support. Therefore, more resources should be allocated (alongside redistribution of existing resources) to reduce reliance on admissions to the CMH. Where adequate and appropriate individualised mental healthcare cannot be provided in prison, this could be considered as a factor to apply for either parole (if eligible) or early release into the community in order to obtain this treatment.[77]

Recommendations on daily life in the CMH

To ensure greater respect for the totality of the individuals' human rights while they are in the CMH, the following recommendations would expand advocacy, create greater community connections, ensure all forms of healthcare are provided based on free and informed consent, develop a restraint-free environment, ensure transparency around complaints, and explore the gender implications of detention and treatment.

Recommendation 5: Ensure access to independent advocacy.

Independent advocacy should be provided by external staff, and should be available to all those in CMH. Peer advocacy offered should be expanded to include persons with experience of forensic systems.

[77] As noted above, the Parole Act 2019 makes clear that – as it stands and until the Minister for Justice makes regulations extending parole to long-sentenced prisoners serving over eight years – only life-sentenced prisoners are currently eligible for parole, see s.24 of the Parole Act 2019. It is also clear that patients detained in the CMH are not eligible for parole, see s.24(7) of the Parole Act 2019.

Recommendation 6: Increase visiting hours and remote visiting options.

Provide longer visits and increase the use of technology to facilitate greater connections with visitors who cannot travel in person. People should have the freedom to decide who they wish to visit them and these chosen visitors should not be denied access by CMH.

Recommendation 7: Expand access to leave.

All patients should be able to avail of leave. Greater resources must be allocated to support this and ensure that people detained in the CMH have more choice and control in directing their leave.

Recommendation 8: Move to ensure all healthcare provided within the CMH is based on the informed consent of patients.

While the current law allows for psychiatric treatment to be provided without consent, it is not mandatory, so the CMH should move to a model based on informed consent as mandated by international human rights law.

Recommendation 9: Mandate alternatives to seclusion and restraint.

This should be done with the goal of moving to a restraint-free environment at CMH. All reported uses of seclusion and restraint must include information on alternatives attempted prior to the use of these practices. Further research and allocation of resources to support expanding these alternatives should be provided.

Recommendation 10: Provide accessible information.

Information should be produced and regularly distributed to patients in clear and accessible language on the systems that are in place at CMH, the processes and rules that apply during detention and treatment, and how the rights of patients will be protected.

Recommendation 11: Increase transparency and accessibility of complaints mechanisms.

The CMH should develop a single, central and accessible robust complaints mechanism to ensure an efficient and effective resolution to their complaint. This should replace the existing parallel systems of complaints. Accessible information on how to use the complaints process must regularly be given to all patients at the CMH and anonymised records on the number and type of complaints maintained.

Recommendation 12: Conduct further research on the gendered impacts of detention.

Further research on gendered experience of treatment in the CMH is necessary, and reforms are needed to ensure that women and gender minorities are not held in disproportionately restrictive settings.

Recommendations on review and discharge

The following recommendations are offered as starting points for reforming the system of review and discharge from the CMH, to ensure greater respect for the rights to access justice and to be included in the community under Articles 13 and 19 of the CRPD.

Recommendation 13: Recognise lived experience on the Review Board.

Membership of the Review Board should include persons with lived experience. Review Board hearings should provide a greater role for chosen supporters of the detained individual.

Recommendation 14: Engage broader expertise in Review Board procedures.

The Review Board's rules of procedure should be amended so as to permit a broader range of expert evidence (not limited to the Clinical Director and

multi-disciplinary teams) to form a holistic perspective of the person's experience and options for discharge.

Recommendation 15: Review ongoing detention of individuals more frequently.

Reviews of detention in the CMH should occur at more frequent intervals in order to ensure parity between the Criminal Law (Insanity) Act 2006 and the Mental Health Act 2001. In addition, the provision of information about reviews should be accessible and provided periodically to individuals.

Recommendation 16: Begin the process of abolishing the system of conditional discharge.

Consider how the practice of conditional discharge will be abolished and replaced with a system which is based on chosen support (e.g. housing, employment, healthcare) in the community. In meeting Ireland's obligations under Article 19 CRPD, the dismantling of the current institution-based structures would result in greater financial and personnel resources being made available for this.

Recommendation 17: Abolish extensions of detention beyond prison sentence.

The power to extend detention after the term of imprisonment has expired should be abolished and replaced by access to chosen supports in the community upon release.

Conclusion

The over-arching goal of this scoping exercise has been to begin to explore how the rights of people in forensic mental health settings in Ireland are impacted by their detention and treatment, and this research remains only a starting point for further enquiry in this area. The human rights goal set for Ireland under the CRPD is clear – to end involuntary treatment and to abolish separate tracks of detention for all people with disabilities, including those labelled with a mental disorder. While this cannot be accomplished overnight, all reform of forensic settings needs to be scrutinised as to whether it helps to achieve this goal, or serves to undermine it. The suggested recommendations outlined in this report are those which we believe can support this ultimate goal, and lessen the harms caused to people currently detained in these settings until they are dismantled. In all further research into these practices and conditions, it is imperative that the voices of those who have experienced these settings are brought to the fore, to ground arguments for further reform. This is consistent with the motto of the global disabled people's movement: 'Nothing about us without us.'

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