NORTHERN IRELAND HUMAN RIGHTS COMMISSION

RESPONSE TO DHSSPS CONSULTATION ON THE PERSONALITY DISORDER STRATEGY FOR NORTHERN IRELAND

1. The Northern Ireland Human Rights Commission (the Commission) is a statutory body created by the Northern Ireland Act 1998. It has a range of functions including reviewing the adequacy and effectiveness of Northern Ireland law and practice relating to the protection of human rights,[1] advising on legislative and other measures which ought to be taken to protect human rights,[2] advising on whether a Bill is compatible with human rights[3] and promoting understanding and awareness of the importance of human rights in Northern Ireland.[4] In all of that work the Commission bases its positions on the full range of internationally accepted human rights standards, including the European Convention on Human Rights and Fundamental Freedoms (ECHR), other treaty obligations in the Council of Europe and United Nations systems, and the non-binding 'soft law' standards developed by human rights bodies.

Introduction

2. The Commission welcomes the opportunity to comment on the development of a personality disorder (PD) strategy for Northern Ireland. It should be noted that we do not consider it our remit to adjudicate on the particular design of health care systems but rather we can assess and advise on human rights compliance and highlight any areas of concern. To that end, our response will address areas of concern that the

[1] Northern Ireland Act 1998, s.69(1).
[2] *Ibid.*, s.69(3).
[3] *Ibid.,* s.69(4).
[4] *Ibid.,* s.69(6).

Commission has through its investigations, legal and policy work gained valuable knowledge, in relation to mental health and detention. The response will also detail a human rights framework for the 'right to health' which government departments are obligated to 'respect, protect and fulfil' for the people of Northern Ireland. In this regard, we note that references to human rights standards are largely absent from this consultation.

Areas of concern

3. Overall, the consultation paper appears to agree with the general thrust of the Bamford Review of Mental Health and Learning Disability and it is positive that the paper attempts to engage with the report *"A Strategic Framework for Adult Mental Health Services" (June 2005)* arising from the Bamford review . In particular, we note the references to the 'Tiered Model' as a 'Structure for Tiered Personality Disorder Services Provision', as well as sourcing models in England and Wales (Thames Valley Initiative). Nevertheless, the Commission notes that the consultation document proposals fall short of the excellent examples provided, primarily due to lack of resources. While this is certainly a valid reason for not being able to immediately fulfil the right to mental health, it does not hinder the Department from presenting a structured plan of action to 'progressively realise' this right. The 'Right to Health' stems primarily from Article 12 of the International Covenant on Economic, Social and Cultural Rights (1966) which states:

> "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"

4. However, all economic, social and cultural rights detailed in this covenant are guided by Article 2, which acknowledges that certain aspects of these rights may not be realised immediately due to resource constraints. This principle is commonly known as 'progressive realisation' which is recognised as a: "*flexibility device, reflecting the realities of the real world and the difficulties involved for any country in ensuring full realization of economic, social and cultural rights".*[5] Despite this, State parties are still required to 'take steps by all appropriate means' towards the full realisation of the rights contained in the Covenant. These steps can

[5] Para 9, CESCR General Comment no.3 "The nature of States parties obligations (Art 2, par.1)" 1990, www.unhchr.ch/tbs/doc.nsf/(symbol)/CESCR+General+comment+3.EN?OpenD.

include: “legislative, administrative, judicial, economic, social and educational measures, consistent with the nature of the rights”.[6]

5. For example, the consultation paper recognises ‘residential therapeutic communities’ as an effective model (p 35) yet it is noted that the establishment of these units would require significant resources and should be explored at a later date, which in our opinion is an ambiguous statement. It would be preferable, in keeping with the Department’s human rights obligations, to state that the Department will definitely explore facilitating this model by a specific date, while noting that implementation is guided by available resources. Similarly, the Department proposes to initially develop only services at Tiers 0-3 due to lack of resources and insufficient numbers of trained staff and, again, these are valid reasons for an incremental approach. However, in our view, the consultation document needs to be clearer in its goal to ‘progressively realise’ the right to mental health by stating that the Department plans to fulfil the full model in the future, specifying a reasonable deadline. As it appears presently in the consultation document there are no plans to implement specialised services at Tier 4, rather patients will continue to be transferred to services in England. Despite the fact that resources may not currently be available to implement Tier 4 in Northern Ireland, the Department should at the very least be considering future provision of these specialist services for people with a personality disorder.

6. The Commission is aware of a number of people from Northern Ireland diagnosed with personality disorder who have been sent to England for long-term residential care (18-24 month programme) and their experiences have raised serious concerns. Firstly, having to travel some distance into another jurisdiction for long term treatment, has resulted in difficultly for the patient to maintain family relationships. Frequently these families come from a low socio-economic background and the travel costs are not fully met by the Department, causing financial hardship. Subsequently the patient may not see their family for months at a time. This is all the more pertinent for the patient because they can experience isolation in the residential unit exacerbated by cultural differences and in some cases discrimination felt because of those differences. For people with personality disorders, in the first instance, committing to a set programme is a significant challenge for

[6] Limburg Principles, www.unimaas.nl/bestand.asp?id=2453.

them, to add to this burden by sending them to another jurisdiction for long term treatment brings a greater risk of failure to complete the programme. In addition, people in Northern Ireland can experience a time delay in receiving appropriate treatment due to the practicality of making arrangements to send them to another jurisdiction. The current situation, as it stands in Northern Ireland and described above, engages with Articles 8 and 14 of the European Convention on Human Rights (ECHR), i.e. the right to privacy and family life, and to be free from discrimination, respectively.

Personality disorder services in a prison setting

7. The consultation document makes reference to the 'prevalence of personality disorders in the prison population to be between 60 and 80%' (p.7), which by any standard is a very significant figure. Later in the document it is noted: "The lead responsibility for prison healthcare within Northern Ireland transferred to the DHSSPS in April 2008, and the high prevalence of personality disorder within prisons will therefore lead to an increasing need for such specialist input both within custodial and community settings" (P.15). Within the Northern Ireland context the Department mentions only one initiative related to prisons, the REACH Unit based at HMP Maghaberry (p.25). This unit has only 20 places and due to its location it is presumed only caters to adult males, which leaves open to question the nature of services available to women prisoners and young offenders?

8. At page 26 'General Principles for Service Provision' are listed, we would seek clarification if this list applies to those who have been diagnosed with personality disorders currently resident in the prison system? The Commission is concerned that very little detail has been offered as to how the PD strategy extends to prisons. The consultation notes the huge list of tasks assigned to Tier 3 (Hub) (one of the current Trusts) which will provide 'specialist input to Criminal Justice Services and 'In reach into prison establishments to support work with personality disorder offenders' (p 35). The Commission would question what this means in practical terms for the 60 to 80 per cent of the prison population who suffer from a PD. Again the consultation document refers to models in England for the management of offenders with personality disorder, with the Merseyside Probation Project highlighted as appropriate for Northern Ireland (p 37). Yet this model refers to treatment pathways for offenders once they are released

from prison and does not address treatment of offenders while in prison. The consultation document needs to clearly lay down the action points the DHSSPS will take to ensure the 'progressive realisation' of mental health for prisoners. In our view, the provision of mental health services for persons in detention in Northern Ireland falls short of the standards required by the international principles for the protection of persons with mental illness and for the treatment of prisoners.[7]

9. The Commission has itself provided much valuable research into the mental health of women in prison: see *"The Hurt Inside, The imprisonment of women and girls in Northern Ireland" (June 2005)*. This investigation brought to light serious concerns:

> "It is clear from the research that women's healthcare needs are not being appropriately met within the prison system in Northern Ireland. Many of the women in Mourne House had evident mental health needs and should not have been in prison at all – an analysis which Prison Service management and most staff concurred with. This report recommends that as a matter of urgency, relevant Government departments and agencies must develop a coherent and multi-agency strategy on women and girl 'offenders' who are diagnosed mentally ill and 'behaviour' or 'personality disordered'" (p 92, The Hurt Inside).

10. In a similar vein, the Independent Monitoring Board's (IMB) Annual Reports for 2007/08 for Hydebank Wood Prison; the Young Offenders Centre; Magilligan and Maghaberry Prisons detail serious concerns with general healthcare and in particular mental health care. In their Maghaberry report

[7] The United Nations Principles for the Protection of Persons with Mental Illness also specifically address the matter of the health care of prisoners (Principle 20 thereof and the Principles generally; adopted by General Assembly resolution 46/119 of 17 December 1991). Also relevant are (a) the UN Basic Principles for the Treatment of Prisoners, adopted by General Assembly resolution 45/111 of 14 December 1990; (b) the UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, adopted by General Assembly resolution 43/173 of 9 December 1988; and (c) the UN Standard Minimum Rules for the Treatment of Prisoners, adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolution 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977. In particular, under paragraph 22 of the Standard Minimum Rules, medical services for prisoners should include "a psychiatric service for the diagnosis and, in proper cases, the treatment of states of mental abnormality". The Commission would emphasise that the reference to psychiatric services is not a subsequent amendment but was acknowledged 50 years ago, on 30 August 1955, as a *minimum* requirement regarded even then as realistically attainable by all member States.

they note: “Many people with personality disorder end up in prison because there is nowhere else for them to go so we would recommend again that a secure unit should be opened in Northern Ireland for the treatment of people with personality disorders” (p 9). In a related comment: “In September 2007 a Crown Court Judge criticised the lack of a secure in-house facility in Northern Ireland to treat young people suffering from severe personality disorder” (p 31, Hydebank Wood Prison and Young Offenders Centre the IMB Annual Report 2007/08). Subsequently, the young person was sent to England for treatment at considerable cost and again IMB recommended the opening of a secure unit in Northern Ireland dedicated to treatment of prisoners with personality disorders.

11. At several places the consultation document mentions training of staff (p 35) and the development of a ‘robust training programme’ (p 38). The Commission would like to seek clarity on whether this training will include prison staff. It seems apparent that the Department needs to present a clear strategy for the treatment of prisoners with PD and this would include a timetable for training prison staff.

Indicative staff requirements

12. The consultation document proposes at point 9 the type of strategy the Department intends to develop for Northern Ireland, using one of the existing Trusts as the ‘hub’ and the other four trusts as ‘spokes’ in providing either outreach or outposts. At appendix 6, the Department provides a suggested list of staff requirements for the ‘hub’ and ‘spokes’. The Commission would like to see greater clarity on what is meant by the list of posts detailed in appendix 6. For example, is the Department suggesting these are new posts to be recruited or will they be sourced from existing staff levels? Does the list relate to full-time staff dedicated to treating PD or are these mental health professionals who will be required to take on these duties in addition to their existing workloads? This is important in terms of funding as the Department has already made clear in the document its limited ability to create a full PD strategy. Yet it also has the potential to impact on the implementation of other important Bamford recommendations.

Conclusion

13. In conclusion, as mentioned in our introduction, the Commission is disappointed that the consultation document pays little attention to human rights standards. The Commission is compelled to remind the Department that it is a major duty bearer in relation to human rights in Northern Ireland. With this in mind the Department should be aware that the UK Government will shortly be examined under the International Covenant on Economic, Social and Cultural Rights, taking place in Geneva in May of this year. This is an opportunity for the government to publicly confirm how it is 'progressively realising' human rights. Health is a fundamental human right indispensable for the exercise of other human rights and it is one of the rights which the Commission will address in its shadow report to the UN Committee. The Commission hopes that the Department will address its human rights obligations more clearly in developing its PD strategy and in future consultations.

March 2009

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