INTRODUCTION

Recovery Experts by Experience (REE) is a group of experienced users/survivors of Mental Health Services, formerly known as the Expert by Experience Advisory Group (EEAG) to Amnesty International Ireland’s Mental Health Campaign. Between us, we have a wealth of expertise and ideas on the benefits and failures of the current Mental Health System, which enables us to advocate for reform of current system.

Whilst there are many individuals who feel they benefit from the services provided by the Psychiatric System, many others have had their lives shattered by the coercive practices of Psychiatry (regardless if well intentioned or otherwise). In effect Psychiatry feel they can subject a patient to any treatment if they feel it will ‘save’ the individual, either to deal with an immediate incident of Emotional Distress or to treat long term to eliminate some perceived risk that they have assessed. There are no biological tests for these Diagnoses and are in many cases subjective, with no objective criteria other than presentation of Emotional Distress. The rule of thumb would appear to be ‘if in doubt’ then ‘medicate’ and medicate for life to treat ‘life long illness’.

REE had representation at the briefing jointly hosted by the Human Rights Unit, Department of Foreign Affairs & Trade and Department of Justice & Equality on Friday 13th June 2014, and commented on a range of issues where Human Rights are being breached. We thank the respective Departments and personnel for facilitating same. We hope as many of these comments as possible will be incorporated into the speech by Frances Fitzgerald, Irish Minister for Justice, when she addresses the UN Human Rights Committee. We became aware only on Friday, that REE could make a submission directly to the UN Human Rights Committee, and are delighted to have this opportunity, however rushed to do so.

ICCPR: Articles 7, 9, 10, 12, 14, 24

Detention in Psychiatric Units or Hospitals

A carrot and stick approach is used to ensure compliance to Treatment Regimes. Threat of being given ‘involuntary’ status routinely used if a patient is deemed to be non compliant. From the moment the patient enters Hospital, the typical response of Psychiatry is to pathologize the Emotional Distress of the individual and medicate to eliminate ‘symptoms’. If a given dose does not achieve that, you keep increasing the dose to the maximum permitted, or you change drugs, or prescribe off label in certain cases. The DSM (Diagnostic Statistical Manual of Mental Disorders) now has a Diagnosis for ‘unresolved Grief’ after two weeks. ‘Oppositional Defiant Disorder’ is now being used regularly in USA, to detain people for political control. Allen Francis, Professor
Emeritus, Duke University, who was one of the main people involved in writing the previous edition of DSM has spoken out against many of the changes in the current DSM (article Huffington Post 12/03/2012 ‘DSM - 5 is a Guide, Not a Bible: Simply Ignore Its 10 Worst Changes’.

A clip of Paddy McGowan, now Interim Head of Service User/Family Member & Carer Engagement input for HSE (the State Health Service Executive), is featured on www.genio.ie. Genio is a Charitable Trust, who receives 50% of its funding from HSE itself, presentation can be see under Media, Presentations, ‘a Day in the Life’. Paddy talks about what he had to do to get out of a Psychiatric Hospital after ten years, in effect he had to become a ‘Professional Psychiatric Patient’ and lie to get out, as many individuals have to, when reality dawns they will not regain their liberty unless they resort to lying, either claiming ‘symptoms’ have been eliminated, reduced or that the issues that caused the distress in the first place never existed.

**If compliant you will usually:**
- Get your clothes (usually taken away even if ‘voluntary’ for a period until it is ascertained you are ‘compliant’). In some cases patients are given theatre scrubs gear to wear, the Psychiatric Unit in Tallaght Hospital still issues Orange coloured suits, instead of pyjamas, despite having given assurances to a Carer Representative that the practice would discontinue a number of years ago.
- Allowed phone/technology
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- Get to go to coffee shop
- Get hours out (usually accompanied and where patient has to be ‘signed out’)
- Get overnight stay at home or days out
- SEE YOUR CHILDREN (the fear installed by Psychiatry and other professionals ) in individuals where this threat is made openly or indirectly is palpable.

**If you are seen to be non compliant, penalties can include:**
- Seclusion
- Restraint
- Forced Medication Regimes (including pinning people down and forcibly removing their clothes for depot injections)
- Threat of being given ‘involuntary’ status if non compliant
- Not allowed avail of Occupational Therapy etc.
- Not allowed or reduced access to Visitors
- Not allowed make or receive phone calls or limits put in place
- Not allowed take exercise
- Not allowed smoke/or buy cigarettes

**If you are seen to be non responsive to drug therapy:**
- ECT can be given against individuals wishes (sometimes even when family objects) Regardless, if you have Advance Health Care Directive in place, stating categorically that you never want this form of ‘Treatment’. Regardless of any long term damage to memory and the brain, and the actual trauma itself of being subjected to that treatment. Mary Maddox, of Mindfreedom Ireland (affiliated to Mindfreedom International) has done Trojan work around the issues involved in the Human Rights Abuses in prescribing and giving ECT.
- You can be held until Psychiatry deems it is unnecessary: Often patients with private health cover (both voluntary & involuntary) who are staying at these facilities are routinely kept until the Health Insurance Cover has run out, i.e. for a six month period, regardless if that means they have no cover for serious medical issues if they subsequently arise during that claim period for
their medical insurance. In most cases the patient then has to leave the facility regardless if zero improvement in their Emotional Distress.

Medication

Most patients whether voluntary or involuntary have very little if any say in their prescribed Medication in these facilities. Usually side effects are not discussed or if they are, they are minimised and patients are not routinely given information like increased suicidal/homicidal thoughts (black box warnings in USA), agitation, Tardive Dyskinesia (a condition involving repetitive, involuntary movements often of the mouth, tongue, facial muscles and upper limbs), Parkinsonism (neurological condition), increased risk of diabetes & heart disease etc. Current research is indicating that prolonged used of anti-psychotic medications are reducing life expectancy compared to peers by up to twenty years. The idea is to medicate until symptoms are eliminated rather than understand the causes of the Emotional Distress and Trauma and what would help alleviate it for a given set of circumstances. The off-label prescribing e.g. anti-psychotic Abilify is approved by FDA for use in adults who do not respond to antidepressants alone, is a worrying trend, and patients are not being given the necessary information to make informed decisions.

The indignity of an individual being forced to drop their clothing for a Depot Injection (especially if the disagree with treatment) cannot really be understood unless experienced, particularly if they vehemently disagree with the Diagnosis and Treatment Regime. When accompanied by force, it can only further regarded as inhumane and degrading treatment, which is not appropriate in civilised society. Sometimes the ‘Treatment’ reinforces and exacerbates the Emotional Distress that brought the individual to come in contact with Services in the first place, and sadly many may never recover from that abuse.

Often the Sectioning process continues after the individual leaves the ‘Treatment’ Facility, as it may be a condition of discharge that the individual accepts visits from Community Mental Health Nurse or attends a Day Hospital for months afterwards. In particular where the threat of loosing ones children has arisen, the individual often feels they have no choice but attend, even if there are no services on offer they feel will be therapeutic. Essentially the individual cannot in most cases define what services they want and feel will help alleviate distress and help get them put their life together again.

*The Committee is urged to ask the State Party why most patients have little or no say in the Medications being prescribed, and also why they are not being given the appropriate information to give ‘informed’ consent, where consent is apparently recorded on the patients file?*

*The Committee is urged to ask the State Party when these Human Rights violations of forcibly medicating people, including repeatedly pinning them down to be injected against their will, will be deemed illegal under Irish Law?*

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serious drug induced medical conditions develop, or compensate families where iatrogenic (drug induced) Suicide happens?

(see research of David Healy, an Irish Psychiatrist working in UK who has extensive expertise in this area).  www.davidhealy.org

Voluntary & Involuntary Patients detained in locked wards.

After a country visit to Ireland in 2010 by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) it stated:

‘Many so-called ‘voluntary’ patients were in reality deprived of their liberty, they were accommodated in closed units from which they were not allowed to leave and, in at least certain cases, were returned to the hospital if they left without permission. Further, if staff considered it necessary, these patients could also be subjected to seclusion and could be administered medication for prolonged periods against their wishes’.

Often ‘voluntary’ wards will be locked or locked on occasions, with security men in situ. Some wards have a mix of voluntary and involuntary patients, so everyone is essentially ‘locked in’.

The Committee is urged to ask the State Party why it feels it is appropriate to have ‘Voluntary’ patients in locked wards and what measures it will take to stop this practice?

The Committee is urged to ask the State Party why in many cases ‘Voluntary’ patients are deprived of their liberty and freedom of movement whilst staying at these facilities, and in effect treated as ‘involuntary’ patients without the appropriate review mechanisms afforded to those with ‘involuntary’ status.

The Committee is urged to ask the State Party why individuals have been detained in High Dependency Units, sometimes even against the recommendations of Nursing Staff, when they are clearly neither a threat to themselves or another person/persons?

Individuals detained often with ‘involuntary’ status in Psychiatric Units, when they could receive treatment in the community.

The Committee is urged to ask the State Party why in many cases individuals are not allowed to define the services they need and avail of them on a voluntary basis in the Community as they so wish?

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The Committee is urged to ask the State Party to provide details of when it will ratify this Convention?

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The Committee is urged to ask the State Party what steps have been taken to ensure that proposed legislation will enhance rights and not lead to a ‘flexible’ ‘see-saw’ concept of functional capacity which would essentially allow Psychiatry continue the practice of almost instant switching from voluntary to involuntary status and vice versa when suits?

The Committee is urged to seek clarification from the State Party regarding when this legislation will be brought before the Oireachtas (Irish Parliament) to facilitate its enactment?

A State appointed Decision Maker/Assisted Decision maker should only be as a very last resort. It should be open for the individual patient to have a second opinion of their choice, at every stage of the process. REE is horrified that individuals would be detained on Psychiatric Wards, purely because they have an intellectual disability, and would urge the State Party to address this issue immediately.

The Committee is urged to ask the State Party to guarantee that every individual, if they so choose, will have the right to have a family member, friend, peer support person, nominated professional or member of their community to advocate for them, assist with decision making or substitute decision making and that AHCD will be respected where individuals have specified their will and preference?

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The individual should have the right to be able to research and advocate for the type of services/treatment they want to deal with a given situation. At present if an individual with ‘voluntary’ status disagrees with Treating Psychiatry Team, often a 2nd opinion is called in to rubber stamp the opinion, and the person is promptly given ‘involuntary’ status. Freedom of Choice should be respected and freedom to have an opinion regarding what constitutes therapeutic treatment for the individual. Often if a patient expresses a different opinion regarding ‘Treatment’, it is taken as a ‘symptom’ of mental illness, rather than an expression of the individual’s intelligence and autonomy to make their own decisions.

Currently there is vigorous debate regarding the dubious nature of many of these Diagnoses and alternative approaches to Emotional Distress, e.g. ‘Hearing Voices Approach’ – v – Schizophrenia (Biomedical Model). Some professionals including, Nurses, Psychologists, Occupational Therapists etc. have trained recently with Jacqui Dillon & Rachel Waddingham, along with Service Users (voice hearers), Carers and Advocates, but Psychiatry themselves are not engaging for the most part in these alternative approaches. (see TED talk given on utube by Eleanor Longden, Psychologist & Voice Hearer). There is only limited use of Open Dialogue Approach as used in Finland with great success, and very difficult to get Psychiatry to engage in Trialogue Meetings.

The Committee is urged to ask the State Party, that under current legislation, do individuals experiencing Emotional Distress & Trauma, who present themselves in a voluntary capacity to a Hospital, realise they may well be switched to ‘involuntary’ status (albeit with a 2nd opinion that usually rubber stamps original), if they disagree with Treatment proposed?
The Committee is urged to ask the State Party what steps will be taken when the Mental Health Act is revised to ensure that the individual detained, has the autonomy to research, define and advocate for the treatment they feel will be therapeutic to them to alleviate Emotional Distress?

The Committee is urged to ask the State Party to ensure Service Providers & Psychiatry engage meaningfully with service users/ex service users, to actively seek alternatives to Biomedical Model of dealing with Emotional Distress?

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The Department of Health recently tagged on Advance Health Care Directive proposals onto proposed Capacity Legislation. There was a Public Consultation Process which most members of our Oireachtas knew nothing about, let alone the General Public. It received little or no media coverage, despite a member of REE contacting almost every programme in RTE (national broadcaster) to try and have the issue debated. Proposals as they stand, plan to exclude those with ‘involuntary’ status from having their AHCD held legally binding, even if made at a time when they have Capacity. There was little take up from Journalists or anyone contacted to air this issue. The State placing a small advertisement in newspapers was clearly insufficient to debate this issue. The Centre for Disability Law & Policy at National University of Ireland, Galway, submitted a detailed proposal, which REE was part of, though we do not endorse some the organisations who came under the umbrella of that submission, e.g. St Patricks Hospital (where ECT is given against an individual’s wishes or families wishes for that matter).

A member of REE, is 76 years old and has to live with the fear that if she ever experiences a period of Emotional Distress again, she may be given ECT against her expressed wishes. Despite having made an AHCD, stating she doesn’t want ECT ever, current proposals will not respect this. No human being should have to live with that fear, let alone at her stage of life. REE sees no reason why there should be a distinction between AHCD made in relation to Medical Care or Emotional (‘Psychiatric’) Issues.

We urge the Committee to clarify from the State Party why it thinks it is appropriate to disregard the will and preferences of individuals, who have made an Advance Health Care Directive (when deemed to have Capacity), specifying that they do not want ECT or any other treatment?

We urge the Committee to ask the State Party why it considers it appropriate to distinguish between Advanced Health Care Directives (made when someone has Capacity) in respect of general medical issues or issues that relate to Emotional Distress (Mental Health)?

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Recovery Experts by Experience (REE)
Submission to the UN Human Rights Committee

on the Examination of Ireland’s Fourth Periodic Report under the
INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS (ICCPR)

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ICCPR Article 18

RELIGION

An individual detained in a Psychiatric Detention Facility should have the right to practice their religion (if any), e.g. attend services when they are provided within the Hospital (accompanied by a Nurse or another if so required, unless there is a very clear risk to life of the individual or another). Individuals are routinely stopped from going to Mass, e.g. in Blanchardstown Hospital, even when nurses are willing and available to accompany them.

Sometimes if an individual changes religion, or dispenses with their religion, Psychiatry can interpret this as ‘Mental Illness’, particularly if their family disagrees with their choice.

The Committee is urged to ask the State Party to take steps to ensure that individuals deprived of their liberty under the Mental Health Act are free to practice their religion (or have no religion), if they so wish?

CCPR Article 19

Freedom of choice and access to Services, as defined by user not Psychiatry

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We acknowledge the work, of individual professionals involved in setting up and facilitating ‘Hearing Voices’ Groups, like the one in Hill Street Resource Centre in Dublin City Centre and other individuals such as Bernadette Bushe who works tirelessly on her own time and expense, unfortunately we cannot name them all. We are grateful for their dedication, and also for the support of the Schools of Nursing & Midwifery, Professor Agnes Higgins, TCD, Mark Monahan, TCD, Siobhan Smith, School of Nursing Galway, Eithne Cusack, Director Nursing & Midwifery, Planning & Development at HSE and all the other people involved. In addition the Critical Voices Network Ireland Conference (CVNI) organised and hosted by Lecturers in UCC every year, has brought Academics, Professionals, Service Users & other interested parties together to explore more humane approaches to Emotional Distress and Trauma, on a tiny budget, where presenters like Gail Hornstein, John Read etc. give their time free of charge, to share expertise and ideas. The launch of the Hearing Voices Network this year and extension of support groups will hopefully reach out to many people who ‘hear voices’ who feel stigmatised and written off by Psychiatry.

We urge the State Party to continue funding to facilitate the foresight shown by these people in exploring new ways of helping individuals in emotional distress.

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Articles 2, 9, 14, 16, 17, 19

Challenging Lawfulness of Involuntary Detention or Treatment

What steps has the State taken or will they take to ensure that the individual who is deprived of their liberty, where possible, is at the centre of all decisions made in relation to legal proceedings, respecting their rights enshrined in Articles 2, 9, 14, 16, 17, 19:

List of rights which should be respected and given status in law:

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