# Working Notes

facts and analysis of
social and economic issues

**Issue 67 September 2011**

Jesuit Centre for Faith and Justice
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# Contents

# Editorial

Two of the three articles in this issue of *Working Notes* deal with the distinct but not unrelated issues of drug policy and prison overcrowding; the third with the broader topic of the reform of public services generally.

In the opening article, Fr Peter McVerry SJ calls for a radical appraisal of current approaches to dealing with illegal drug use. Pointing out that 'drug policy' encompasses both policies to deal with the supply of drugs and policies to deal with demand, he says that addressing supply absorbs by far the greater share of public expenditure. Yet, despite successes by the authorities in intercepting supplies, the inflow of drugs continues, with powerful criminal gangs controlling this trade. Fr McVerry says there is need for a serious rethink of policy in relation to how the State can control the supply of drugs and suggests that the findings and recommendations of the Global Commission on Drug Policy, published in June 2011, provide some useful guidelines for the much-needed public and political debate on the issue.

In relation to policies to control demand, Fr McVerry highlights the importance of addressing demand among those who are habitual users or who are addicted to drugs. He emphasises the need for a comprehensive range of detoxification, rehabilitative and after-care services, and says that it is essential that these be accessible without undue delays. While the importance of all these elements has long since been recognised in official policy and strategy statements, provision falls far short of need, and existing services are endangered by current cutbacks in public funding.

Overcrowding is widely recognised to be a core problem of the Irish prison system, one which affects every aspect of prison life.This issue is addressed in an article by Patrick Hume SJ who notes that many Irish prisons are overcrowded even in terms of the most basic level of 'bed capacity' – simply the number of beds which can be fitted into a prison building. Moreover, he says it would appear that the prison authorities have now abandoned the principle that 'one person per cell' should be the norm.

Fr Hume shows that international human rights agreements provide only general guidance as to what constitutes 'desirable' cell capacity and that in any case the provisions of such agreements can be appealed to in Irish courts only if they have been explicitly made part of domestic law. He shows too that while judgments of the Irish courts have upheld the basic rights of prisoners it is clear that the courts are unwilling to meddle in the administration of the prison system by specifying the conditions under which prisoners may be detained. He concludes that there is limited scope for a legal route through the courts towards ensuring that our prisons provide adequate accommodation, and argues that there is need for an informed public to advocate strongly for the changes necessary to close the gap between the prison conditions to which we should be aspiring and the reality of the conditions now prevailing.

The economic crisis of the last few years has focused increased attention on the importance and urgency of reform of Irish public services. In the third article in this issue, Dr Fergus O'Ferrall points out that the outcomes of services are in fact 'co-produced' by users and providers and so it makes sense to ensure public participation in the design and implementation of public services. However, he says, too often services are based on 'passive models of delivery and narrow understandings of solidarity', with citizens being seen as dependants or clients. Dr O'Ferrall argues for a 'human development and capability approach' to public service reform, one which would see citizens as 'active, creative and able to act on behalf of their aspirations', and which would allow for 'participation, public debate, democratic practice and empowerment' in the framing and implementation of services. He suggests that a capability approach is particularly necessary in relation to the reform of our health services, pointing out that effectively addressing the key public health problems of our times – obesity, harmful alcohol consumption and socio-economic differentials in health – will depend not on spending ever-increasing sums on health services (even if that were possible) but on the active commitment of informed and engaged citizens.

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# Drug Policy: Need for Radical Change?

*Peter McVerry SJ*

## Introduction

What began as a heroin problem in inner-city Dublin in the 1980s has now spread like a cancer throughout Irish society. A wide variety of drugs, from cannabis to heroin to cocaine and on to crack cocaine, are now available in almost every town and village in Ireland. Crystal meth will probably be the next wave of drugs to hit our shores. While many of us have lived our entire lives without ever seeing an illegal drug, this most certainly cannot be assumed to be the case for the children and young people now growing up in our society.

The monetary value of the illegal drug trade in Ireland probably runs to hundreds of millions of euro per year.[1] This 'business' has created about twenty violent drug gangs, who import illegal drugs and control their sale. Despite the successes of the Gardaí in seizing huge quantities of drugs and arresting those who are dealing in this trade, there is no shortage of drugs on our streets. As long as a kilo of cocaine can be bought in South America for €700, and sold on the streets of our cities and towns for €70,000, there will be no shortage of people willing to risk imprisonment – or worse – for this kind of profit. Each new generation of drug dealers is more violent and more alienated from the society around them than those who went before, and the factors which trigger their violence are becoming more and more trivial. Their violence and threats of violence discourage all but the bravest from providing information or evidence to the Gardaí.

How are we to tackle this scourge? There are two basic dimensions to any drug policy:

- Policies to deal with the supply of drugs;
- Policies to deal with the demand for drugs.

## Policies Relating to the Supply of Drugs

The emphasis in current drug policy is on trying to reduce the supply of drugs. Spending related to the 'war on drugs' – on, for example, policing, customs controls, courts and prisons – accounts for the vast bulk of what can be considered drug-related public expenditure. By comparison, spending which attempts to deal with the demand for drugs – on education and drug treatment, for example – is a miniscule part of public expenditure. The imbalance between the levels of expenditure on these two elements of the response to the drug problem is not, in my view, justified.

Any discussion of drug policy must begin with what I consider to be a self-evident statement: *current policy isn't working*. I would suggest that a debate on drug policy should start with the following three questions, which I would address to both politicians and the wider public:

1. *Do you believe that Ireland will ever again become free of illegal drugs?*

If your answer is 'yes', where is the evidence for your optimism? Our experience in Ireland, over the past thirty years, suggests that drug availability is likely to continue to be a major problem, despite the successes of the Gardaí. The recession has led to a reduction in the overall demand for drugs and in particular in the demand from recreational drug users.[2] However, the scale of the problem is still enormous and it is possible that the economic hardship associated with the recession will increase use among some groups and will draw into drug-dealing young people who were not previously involved and who would not have become involved were it not for a lack of employment opportunities in the current economic climate.

In this globalised economy, it seems impossible to stop the movement of drugs from country to country, whenever there is a demand for them. Almost every country in the world – including those that execute drug dealers! – has a drug problem.

2. *If illegal drugs are here to stay, who should control the supply of drugs?*

At present, the supply of illegal drugs is obviously controlled by criminal gangs. I doubt if anybody wants the criminal gangs to continue to supply illegal drugs, with all the consequence that follow.

3. *If drugs are here to stay, and if we do not want the criminal drug gangs to control their supply then who should do so?*

That is a question that we continue to avoid. Politicians run scared of it. But it is a fundamental question. In my view, the State should take control of the supply of drugs – what is commonly referred to as 'legalising drugs'. The term 'legalising drugs' is not one that I am comfortable with, as most people will, rightly, associate it with that other legalised drug, alcohol, and nobody in their right mind would want heroin or cannabis to become as readily available as alcohol. But 'controlling the supply of drugs' differs from the situation regarding alcohol in two ways:

Firstly, alcohol is widely available in every supermarket, corner store and petrol station. Indeed, Government decisions over the past decade have allowed a considerable expansion in the range of outlets licensed to sell alcohol. No-one suggests that drugs should be available in such a manner.

Secondly, hundreds of millions of euro are spent every year on the promotion of alcohol. No-one is suggesting that drugs should be advertised and promoted.

A better model for the 'legalisation' of drugs is the provision of methadone. Methadone is a highly dangerous, very addictive, drug which is available, free of charge, to those who want it – basically heroin users. The supply of methadone is tightly controlled by the State. The result is that it is very difficult to obtain on the streets. Criminal gangs see no point in trying to deal in methadone since it can be obtained through legal channels.

If we are to effectively deal with the supply of drugs, then a public discussion on alternative policies that are evidence-based needs to begin immediately. Of course, any change in drug policy would require considerable education of parents and the broader public. Much of the discussion of drug policy takes place in a context of fear: parents are scared to death of discovering that their son or daughter is a drug user – understandably so. Parents need to be reassured that the 'legalisation' of drugs will actually make it *more* difficult for their children to access drugs.

***Global Commission on Drugs Policy***

Such discussion may be timely. Globally, the traditional 'war on drugs', has come under scrutiny. In January 2011, the Global Commission on Drug Policy was launched. The Commission's international membership included former Presidents of three Latin American countries (Colombia, Mexico and Brazil) – statesmen who had enthusiastically embraced the 'war on drugs' in their respective countries, a 'war' supported by billions of dollars from the United States. The Commission also included Kofi Annan, former Secretary General of the United Nations; Javier Solana, former European Union High Representative for the Common Foreign and Security Policy; George P. Shultz, former U.S. Secretary of State, and George Papandreou, Prime Minister of Greece.

The Commission issued its report in June 2011 and set out a number of principles and recommendations to guide national and international drug policies and strategies. These were summarised by the Commission as follows:

- *End the criminalization, marginalization and stigmatization of people who use drugs but who do no harm to others.*
- *Encourage experimentation by governments with models of legal regulation of drugs to undermine the power of organized crime and safeguard the health and security of their citizens.*
- *Offer health and treatment services to those in need. Ensure that a variety of treatment modalities are available, including ... the heroin-assisted treatment programs that have proven successful in many European countries and Canada. Implement syringe access and other harm reduction measures that have proven effective in reducing transmission of HIV and other blood-borne infections as well as fatal overdoses.*
- *Apply much the same principles and policies stated above to people involved in the lower ends of illegal drug markets, such as farmers, couriers and petty sellers. Many are themselves victims of violence and intimidation or are drug dependent ... Drug control resources are better directed elsewhere.*
- *Invest in activities that can both prevent young people from taking drugs in the first place and also prevent those who do use drugs from developing more serious problems ... The most successful prevention efforts may be those targeted at specific at-risk groups. Focus repressive actions on violent criminal organizations, but do so in ways that undermine their power and reach while prioritizing the reduction of violence and intimidation*.[3]

The Commission supports the arguments it puts forward by drawing on the experience in Switzerland of policies and programmes based on public health considerations rather than criminalisation. It referred to a study on the heroin substitution programme adopted, which indicated that:

- *[The programme] substantially reduced the consumption amongst the heaviest users and this reduction in demand affected the viability of the market.(For example, the number of new addicts registered in Zurich in 1990 was 850; by 2005, the number had fallen to 150.)*
- *It reduced levels of other criminal activity associated with the (drug) market. (For example, there was a 90% reduction in property crimes committed by participants in the program.)*
- *[The removal of] local addicts and dealers [meant that] Swiss casual users found it difficult to make contact with sellers.*[4]

The Commission also draws attention to the fact that the percentage of people who inject heroin in the Netherlands is the lowest in the EU-15 countries and heroin has lost its appeal to mainstream young people who consider it now to be a 'dead-end street drug'. The report notes: 'Medically prescribed heroin has been found in the Netherlands to reduce petty crime and public nuisance, and to have positive effects on the health of people struggling with addiction.'[5]

The last in the list of the Commission's recommendations is simply: *Act urgently: the war on drugs has failed, and policies need to change now*.[6]

## Policy Relating to the Demand for Drugs

The other dimension of a proper drug policy is tackling the demand for drugs. In the first instance, we as a society need to look at the issue of the 'primary' demand for drugs: what are the factors that lead people to decide to use drugs in the first place? We know that drug abuse is strongly associated with economic and social deprivation – but we must also acknowledge that Irish society has long since gone past the stage where drug use is confined to a small minority of the population, among whom socially deprived people are disproportionately represented.

Availability, curiosity, and peer pressure may be among the immediate reasons that a person might experiment with drugs. But we need to look deeper and consider how the ways our society is ordered and the values by which it is shaped may influence the resort to drugs. We need, for example, to consider the relevance of the inequality and insecurity that impact so profoundly on people's daily existence and to acknowledge the aloneness and the spiritual emptiness that lie behind the consumerist culture that is still pervasive. Are these factors giving rise to a 'need to escape', a need which finds expression not just in illegal drug use but in the extremely unhealthy and socially damaging patterns of alcohol consumption that have now become entrenched in Ireland?[7]

If we are to reduce the demand for drugs we need to look hard at what young people growing towards adulthood are offered by our society – not just in material terms but in terms of an overall quality of life, which includes relationships with family, peers and the wider community, as well as the quality of the educational, recreational and cultural opportunities available to a young population that has diverse needs, interests and abilities. Clearly, then, addressing the factors influencing the initial demand for drugs must go further than educational measures and specific prevention programmes – though these are, of course, extremely important.

And what of demand associated with those who have become habitual users or seriously drug dependent? The obvious answer is that we should be doing everything possible to provide treatment – ensuring that there is, in the words of the Global Commission on Drugs Policy, 'a wide and easily accessible range of options for treatment and care for drug dependence'.[8]

The issues relating to encouraging and enabling people to access services for their drug problems are, of course, complex; even after people have come to acknowledge the seriousness of the impact of their drug use, they may still resist entering treatment. But one thing should surely be clear: where a person with a drug problem expresses a willingness to enter treatment they should be able to access that treatment without undue delay.

In fact, almost all drug users with whom I have worked have wanted to give up drugs at some point in their life. The reality is, however, that the provision of services is very patchy, and too often access depends on which part of the country, or even which part of Dublin, a person lives in.

Even if a place becomes available, a person may have to travel a long distance, on a daily basis, to the nearest treatment programme. There can be delays of months, or years, in gaining access to a methadone treatment programme. These are serious obstacles for drug users wanting to access help.

The window of opportunity that exists when a person is motivated to seek treatment may last only a few weeks, or at most a few months, and if access to treatment is not available during that time, discouragement sets in. One of the recommendations of the inter-agency Steering Group which carried out the *Mid-term Review of the National Drug Strategy 2001–2008* (published 2005) was that access to treatment should be available to drug users within one month of assessment.[9] Six years later, we are a long way from implementing this recommendation.

The use of drugs imposes enormous costs on society, in terms of crime, ill-health and family break-up. In the current recession, drug services have seen their funding cut by as much as 25 per cent; in some cases, services have closed. While this saves money in the short term, the medium and longer term costs to society far outweigh any short-term savings. The recession may well deepen the problems associated with illicit drug use, with inevitable consequences for the well-being and safety of society. Reducing services and increasing waiting lists makes no sense, financial or otherwise. In fact, services ought to be moving in the opposite direction – with a radical expansion in the range of treatment options. The Global Commission on Drugs Policy noted:

*Preventing and treating drug dependence is ... a key responsibility of governments – and a valuable investment, since effective treatment can deliver significant savings in terms of reductions in crime and improvements in health and social functioning.*[10]

While methadone treatment is a useful treatment option it still leaves the person addicted. Methadone is even more addictive than heroin. For those who wish to come off heroin or other drugs and become completely drug-free, the scarcity of residential services presents an enormous problem. Those who live in stable, supportive families may be able to undergo detoxification while remaining at home, but many people – especially those living in families with other family members who continue to use drugs, or who live in areas where drugs are widely available, or who are homeless – will require residential treatment.

Official reports on drug policy consistently acknowledge the significant gaps in the availability of residential detoxification facilities, including the overall shortfall in places relative to need, geographic disparities in provision and the fact that detoxification beds are provided in general and psychiatric hospitals, rather than being located, in accordance with best practice, in dedicated units.[11] In effect, waiting times for admission can be so lengthy that many give up on their intention to seek treatment. Despite the official recognition of the need for more detoxification places, there is no indication that there is any plan or time line for ensuring an adequate level of provision.

***Rehabilitation***

After-care and rehabilitation services are an essential aspect of a drug policy that aims to reduce the demand for drugs. When someone manages to become drug-free, there still continues the difficult struggle to remain so. As in the case of treatment services, official documents acknowledge the importance of rehabilitative services – referring to the need for a comprehensive range of services and a 'continuum of care'.[12] But again, the reality is a serious shortfall in provision.

*Reducing services and increasing waiting lists makes no sense, financial or otherwise*

After-care should include the availability of drug-free, supported accommodation for those who do not have a safe or supportive place to live, as well as useful occupation during the day. However, there is virtually no supported, drug-free, after-care accommodation available in the whole country. *The National Drugs Strategy (Interim) 2009–2016* recommended that: 'Dedicated supported accommodation, staffed appropriately, should be provided to cater for those who have difficulties with an independent living environment.'[13] However, two years after the publication of the Interim Strategy, there is no evidence of any progress in relation to this recommendation.

The biggest barrier to recovery can often be the boredom and meaninglessness of each day's existence. While on drugs, a person's day is fully occupied. They have a reason to get up: they

have to get their drugs and they have to find the necessary money; then they have to contact their drug dealer; then they take their drugs. And when the effects wear off, they have to start all over again. The day is full, and has its 'structure', however dysfunctional that may be. But for many people who come off drugs, there is a huge vacuum: there is nothing to get up for, and each day is one long boring hour after boring hour, with nothing to do – except think of what life was like when they were using drugs, when it was anything but boring!

*The biggest barrier to recovery can often be the boredom and meaninglessness of each day's existence*

There are Community Employment (CE) schemes, some long-established, which provide places specifically for people who are in recovery. For many former users, such schemes fill the vacuum that arises once they are no longer spending their day seeking the means to meet their habit. In many instances, involvement in such a scheme can make all the difference between staying drug-free and relapsing. The cost of these schemes is very small: an administrative charge plus the incentive of a small increase over and above the welfare payments the person would otherwise receive. However, as is the case with so many other aspects of treatment and after-care, such places are limited relative to the scale of need, and few are available outside Dublin. A guaranteed place for every person who comes off drugs and needs this type of employment support would cost a little money, but save a great deal.

***Drugs and Penal Policy***

Many drug users end up in prison; some go to prison repeatedly, usually for crimes committed to feed their habit. Hence any drug policy must address the situation of drug users in prison. The scale of the challenge is indicated by studies showing the extent to which people in prison have had a history of using illegal drugs:

- A national study, published in 2000, of a representative sample of prisoners found that 52 per cent had used heroin.[14]
- Another study, carried out in 2003, of five different groups of prisoners found that a very high percentage in all groups had experience of illicit drug use – for example, 56 per cent of a sample of all males committed to prison in 2003 were current drug users and 48 per cent of females committed in 2003 had a current drug dependence problem.[15]
- In 2009, more than 28,000 voluntary tests were carried out in Ireland's fourteen prisons to monitor drug use and responses to treatment among prisoners. The percentage testing positive varied between different prisons but overall, and excluding methadone, 'between one-tenth and two-fifths of those screened tested positive for at least one drug'.[16]

Despite the efforts of the Irish Prison Service to stem the flow of drugs into prison, many drug users continue to use drugs during the time they are imprisoned. Even more alarming is the fact that some people use drugs for the first time while they are in prison. One factor in this is that because of overcrowding, non-drug users often have to share a cell with others who are using heroin. Over the past decade or so, at least forty people have told me that they had never touched drugs before being imprisoned but had emerged from prison as heroin addicts. Imprisoning non-drug users in such an environment is a disaster, not just for them but for the whole of society. The ready availability of drugs outside of Ireland's main cities may be explained, in some instances, by the fact that non-drug using people from an area have been committed to prison for a relatively minor crime but, while there, have developed a drug habit, which on release they maintain by selling drugs in their home town.

Within many Irish prisons, there has developed a drug culture which successfully perpetuates pro-drug attitudes. While the introduction of drug counsellors into our prisons has been a positive step, it is very difficult for such a service to be effective in an environment where drugs may be 'in your face' and where there is a strong temptation to use drugs to counter the boring, meaningless, existence that is so often prison life. Many prisoners would welcome the opportunity to tackle their addiction while in prison, if the opportunity existed. There are nine detox beds in the whole system for a prison population of around 4,500!

Perhaps the most important addition to drug treatment services would be a custodial drug treatment centre. The Misuse of Drugs Act, 1977 (enacted even before drugs became a serious issue for Irish society) included an enlightened and far-sighted section which allows the court, following

receipt of medical and other assessments, to order that a person convicted of certain drug offences be detained in a custodial drug treatment centre for a period not exceeding one year.[17] The Act further provided that where a person successfully completed the programme in the custodial centre, then a period of probation, or a suspended sentence, would be imposed in lieu of imprisonment. Thirty-four years after this legislation was enacted, no such custodial centre exists. Not only would an option of this kind be far more effective than sending a drug-user to a wasteful existence in a prison where they could still access drugs, but it would help to relieve the chronic overcrowding in our prisons and would ultimately save money.

While the proposed new prison at Thornton Hall, in north County Dublin, has been widely, and rightly, criticised as being too big and too remote, its location would actually be an ideal one for a custodial drug treatment centre. It is disappointing that this option was not considered by the Thornton Hall Review Group in its Report, published at the end of July 2011.[18]

## Conclusion

The failure to tackle adequately the problem of drug abuse when it first began in Dublin's inner city allowed it to grow out of control and expand to other deprived neighbourhoods in the capital. The failure to tackle adequately the emerging drug problem in other cities and towns of Ireland again allowed the problem to expand. More and more drugs became available to more and more people – and to people of all social classes. Unless the political will exists to deal with this threat to the children growing up today, then our society will pay the price in the destruction of more lives, the tearing apart of more families, and increasing demands on our already overstretched health and justice systems.

## Notes

1. There are indicators but no accurate figures regarding the value of the illegal drug trade in Ireland. A *Sunday Business Post* journalist, John Burke, suggested in 2007 that: 'The total value of the illegal drugs market here is almost certainly worth hundreds of millions, or possibly in excess of €1 billion. However, all attempts at calculating the value of the trade come with the caveat that no one can say they are certain their estimate is correct' (see John Burke, 'Boom Time for Dealers', *The Sunday Business Post*, 9 December 2007). Illicit drug seizures by the Gardaí are obviously only a portion of all drugs being brought onto to the Irish market, but what proportion they represent is again an unknown. In 2006, Gardaí seized illicit drugs of the five main drug types to the value of €95 million; figures for seizures of such drugs in 2007 and 2008 were greatly in excess of this (€178 million and €224 million respectively), but part at least of the increase was attributed to the seizure of large hauls of cocaine destined for Britain. In 2010, Garda seizures had dropped considerably to €30.9 million; see Conor Lally, 'Drug Seizures and Use at Lowest Level Since Before Boom', *The Irish Times*, Monday, 20 June 2011.
2. Conor Lally, *op. cit.* See also Conor Lally, 'Large Increase in Seizures of Heroin over Last Year', *The Irish Times*, Thursday 18 August 2011.
3. *Report of the Global Commission on Drug Policy*, 2011, pp. 2–3 (www.globalcommissionondrugs.org).
4. *Ibid*., p. 7.
5. *Ibid*., p. 7.
6. *Ibid*., pp. 10–17.
7. For recently published statistics on one dimension of this problem – deaths related to alcohol – see Suzi Lyons, Ena Lynn, Simone Walsh, Marie Sutton and Jean Long, *Alcohol-related Deaths and Deaths among People who were Alcohol Dependent in Ireland, 2004 to 2008*, Dublin: Health Research Board, 2011 (HRB Trends Series, 10). A comprehensive picture of the personal and societal damage of harmful alcohol consumption is provided in Ann Hope, *Alcohol Related Harm in Ireland*, Dublin: Health Service Executive, 2008.
8. *Report of the Global Commission on Drug Policy*, *op. cit*., p. 16.
9. Department of Community, Rural and Gaeltacht Affairs, *Mid-term Review of the National Drugs Strategy 2001–2008, Report of the Steering Group*, Dublin: Department of Community, Rural and Gaeltacht Affairs, March 2005, p. 38.
10. *Report of the Global Commission on Drug Policy*, *op. cit.*, p. 16.
11. See, for example, Department of Community, Rural and Gaeltacht Affairs, *Mid-term Review of the National Drugs Strategy 2001–2008*; Department of Community, Rural and Gaeltacht Affairs, *National Drugs Strategy (Interim) 2009–2016*, Dublin: Department of Community, Rural and Gaeltacht Affairs, 2009; Health Service Executive, *Report of the HSE Working Group on Residential Treatment and Rehabilitation (Substance Users)*, Dublin: HSE, 2007.
12. Department of Community, Rural and Gaeltacht Affairs, *Mid-term Review of the National Drugs Strategy 2001–2008*, p. 58.
13. Department of Community, Rural and Gaeltacht Affairs, *National Drugs Strategy (Interim) 2009–2016*, p. 121.
14. F. Hannon, C. Kelleher and S. Friel, *General Healthcare Study of the Irish Prisoner Population*, Dublin: Stationery Office, 2000.
15. H.G. Kennedy *et al*, *Mental Illness in Irish Prisoners: Psychiatric Morbidity in Sentenced, Remanded and Newly Committed Prisoners*, Dublin: National Forensic Mental Health Service, 2005.
16. Jean Long, 'Drug Tests in Irish Prisons, *Drugnet Ireland*, Issue 35, Autumn 2010. p. 24
17. Section 28.2(b) of the Misuse of Drugs Act, 1977 states: '[T]he court shall, if in its opinion the welfare of the convicted person warrants its so doing, b) order that the person be detained in custody in a designated custodial treatment centre for a period not exceeding the maximum period of imprisonment which the court may impose in respect of the offence to which the conviction relates, or one year, whichever is the shorter.'
18. *Report of the Thornton Hall Project Review Group*, Dublin: Department of Justice and Equality (http://www.justice.ie/en/JELR/Pages/ThorntonHallReviewRpt).

***Peter McVerry SJ is a member of the Jesuit Centre for Faith and Justice team and a Director of the Peter McVerry Trust, which provides accommodation and care for homeless young people.***

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# Public Participation: Involving Citizens in Designing Public Services

*Fergus O'Ferrall*

## Introduction

'There is nothing so practical as a good theory', the famous maxim of Kurt Lewin, has particular relevance for the reform of our public services. In that challenging task, there is need for a coherent theoretical perspective and clarity as to the fundamental goals we as a society wish to strive for in the coming decades. I want to argue for a radical new paradigm for public services and to describe such a paradigm. I will discuss the implications of this paradigm using the case example of health services and will seek to draw some broad applications for the community and voluntary sector in relation to the design and delivery of public services.

I believe that the OECD Public Management Review, *Ireland: Towards an Integrated Public Service*, completed in 2008, has a failed paradigm at the heart of the thinking it presents. The very opening sentence of the report is illustrative of this:

*Ireland's economic success story is one that many OECD countries would like to emulate. While the reasons underpinning Ireland's success are varied, the Irish Public Service has played a central role in ensuring that the right economic, regulatory, educational and social conditions are in place to facilitate growth and development*.[1]

Even without the benefit of hindsight, this would have to give rise to serious questioning.

## The Need for Change

There are compelling reasons for reforming Irish public services. These include the many failures and defects documented in reports relating to these services, the unsustainable costs of providing services through the present delivery systems, and the mounting case that our public services are not 'fit for purpose', especially given the challenges facing a changing and crisis-laden society.

Confronted by the need for radical reform, it would be a fundamental error simply to surrender to a 'neo-liberal' recipe for withdrawal of services in order to achieve fiscal consolidation. Indeed, we need to recognise that there are powerful forces which see the current crisis as providing the ideal conditions for pursuing an ideology-based assault on the very notion of tax-funded, publicly provided or supported services. And we need to recognise also that there are those who see the 'solution' to the problems in our public services as requiring nothing more than adopting the precepts and practices of dominant management approaches in the private sector. This is advocated without regard to either the values and ethos of the public sector or the reality that some of these management approaches have led to catastrophic failures in the private sector. Instead, we need to grasp the opportunity provided by the current deep-seated crisis to explore fundamentally a model for Irish public services appropriate for the twenty-first century. We need to devise a new paradigm which will deliver essential and quality public services at a cost that people in Ireland will be able to support in the future.

## A New Paradigm: The Human Development and Capability Approach

Our challenge is to build what might be described as a 'citizen society'.[2] There is an extensive philosophical and practical literature which describes the building blocks of such a society and the approaches essential to putting the citizen[3] at the centre of the design and delivery of public services.

In this regard, there are two broad and converging streams of thought which are directly relevant to the challenges now facing Irish society. The first relates to the revival of civic republicanism as a normative political theory, and the second to a human development and capabilities approach. The former is associated with the Irish political philosopher, Philip Pettit, and the latter is associated with Amartya Sen and Martha Nussbaum.[4]

Both these vital streams of thought have as their essential focus the creation of what may be described as a 'flourishing society'.[5] The fundamental question we need to ask is: 'what are citizens actually able *to do* and *to be*?' It follows that the political and social arrangements that we, as a society, put in place, and in particular the design of our public services, should have as their

*raison d'etre* the expansion of people's capabilities – the freedom and equality of condition to achieve, for every person, valuable 'beings' and 'doings'. This approach radically subverts the dominant paradigm whereby the national measure of progress relates only to GDP or GNP.

Fundamentally, the wisdom underlying this approach is very ancient indeed. Aristotle was adamant that the pursuit of wealth is *not* an appropriate *overall goal* for a flourishing society: in his *Ethics*, he states: 'clearly wealth is not the good we are seeking, since it is [merely] useful [choiceworthy only] for some other end.'

The human development and capability approach sets out to measure our progress on the basis of human development across a wide range of dimensions and asks whether human capabilities are being developed in each key area of living. Eddie Molloy has advocated a 'balanced scorecard' to chart our progress, or lack of it, arguing that we need measures in the following key areas: wealth creation capacity, infrastructure, quality of life and social justice, and in regard to public services institutions that are ethical, competent and accountable.[6]

The core concepts around which a 'citizen society' may be developed include:

*The Common Good*: the public services of the State should serve the common good, the *res publica*, not private or vested interests.

*Inclusion*: the design and delivery of public services must involve and include citizens directly and as a matter of course.

*Deliberation*: every public service must be shaped by a process of public deliberation where reasoned justification is presented in open discussion as to how decisions and services pertain to the common good.

*Independence and 'non-domination'*: public services should create conditions which prevent citizens dominating each other in social and economic life and seek to develop the human agency of each citizen on the basis of the equal regard and dignity of every person.

*Participation*: public services must facilitate citizens in developing their capabilities so that progressively we are able and willing to participate in collective decision-making in a public-spirited fashion.

*Equality*: public services must be based around the goal of creating 'equality of conditions' so that we achieve a fundamental equality of income and wealth in order to ensure the equality of citizenship essential to a republican and flourishing society.

These are extremely challenging concepts. In our political culture they are *not* well understood, and where they are articulated with effect they meet fierce ideological resistance. However, in a situation where the prevailing ideology has been shown to result in disastrous consequences, there are now opportunities for reconstruction of our failed political entities. We need to conceive of a new model of citizenship as the basis for a transformed state. We need to understand the potential for citizenship development which may reside in the design and delivery of public services: civic engagement must be at the heart of developing political communities at local level and at national level.

*Our public services ... have evolved from a 'Poor Law' mentality and with impoverished concepts of human development*

Our public services to date have been underdeveloped from a civic perspective because of passive models of delivery and narrow understandings of solidarity; indeed, they have evolved from a 'Poor Law' mentality and with impoverished concepts of human development. The task of collective government is to empower and enable all citizens to pursue a dignified and at least a minimally flourishing life: to achieve this we need participative public services that enrich citizenship as each person has a real opportunity to contribute to policy development, and to the design and provision of services.

Outcomes of services such as those in the health, education, security, environment, and other policy arenas, are 'co-produced' by users and providers; hence it makes sense to ensure public participation to facilitate successful outcomes. This simple truth is ignored by centralisers, bureaucrats, 'power-hoarders' and vested interests across every public service in Ireland: no wonder, then, that our outcomes are so appalling for the money invested.

***Essence of Capability Approach***

Before looking briefly at the implications of the human development and capability approach for public service reform in relation to one key set of public services – those concerning health – it may be helpful to say a little more as to what such an approach involves. Instead of conceiving of human beings as simply self-interested, as in the neo-liberal paradigm, the human development approach recognises that human beings are social beings with altruistic concerns and that they aspire to have regard for others. In this approach, people are seen to be active, creative and able to act on behalf of their aspirations – there is a fundamental concern for human agency and this means that participation, public debate, democratic practice and empowerment are to be fostered as essential to our human well-being.

If our state apparatus perceives people as dependants, supplicants, clients or 'patients', the result will be the phenomenon which might be described as 'capability deprivation'. The realisation of this is not new: the words which John Stuart Mill wrote in the concluding section of his classic work, *On Liberty*, published in 1859, ought to be to the forefront of our approach when reforming our public services:

*The worth of a State, in the long run, is the worth of the individuals composing it; and a State which postpones the interest of* their *mental expansion and elevation, to a little more of administrative skill, or that semblance of it which practice gives, in the details of business; a State which dwarfs its [people], in order that they may be more docile instruments in its hands even for beneficial purposes – will find that with small [people] no great thing can really be accomplished; and that the perfection of machinery to which it has sacrificed everything, will in the end avail it nothing, for want of the vital power which, in order that the machine might work more smoothly, it has preferred to banish.*[7]

The words of Wilhelm Von Humboldt, used by Mill for his 'Dedication' in *On Liberty*, might be another guiding light in the debate on reforming public services:

*The grand, leading principle, towards which every argument unfolded in these pages directly converges, is the absolute and essential importance of human development in its richest diversity*.

So, in designing public services we need to ask how they are assisting the essential human functionings and capabilities – the valuable activities and states that make up people's well-being. Martha Nussbaum's proposal that we seek to secure for all citizens at least a threshold level of her ten 'central capabilities' provides one very thoughtful framework for a total reform of how we design and provide services. The ten central capabilities are spelled out under the headings: life; bodily health; bodily integrity; senses, imagination, thought; emotions; practical reason; affiliation; other species; play; control over one's environment.

To ask how we are expanding human capabilities is an even more important question than asking what the State should provide in the way of public services.[8] Sen's important question is: 'what substantive freedoms does one enjoy to lead the kind of life one has reason to value?'[9] The key idea in the capability approach is that social arrangements should aim to expand people's capabilities – their freedom to promote or achieve valuable 'beings' and 'doings'.

This is a radically different paradigm to the one which has predominated to date and which is governed by goals of maximising income or commodities or utility. We now know that if policies aim *only* to increase these goals they distort and diminish people *and* the lives they have the potential to lead. Much conventional economic thinking is based upon a utilitarian approach – how best to have most 'desire-fulfilment', as measured by commodities or money. What the human development economists, such as Sen, are saying is that the basic objective ought to be to create an enabling environment for all people to enjoy long, healthy and creative lives. This may appear to be a simple truth but it has been quite ignored in the dominant concern for the accumulation of commodities and the growth of income. This may have resulted in rises in average incomes and wider access to consumer goods, but we are now increasingly aware that it has in the process led to staggering levels of inequality in incomes and wealth and a concentration of power in the hands of the elites in our society.

The Human Development Index, developed by the UN, is a better index of well-being and capability than GDP per capita because it includes income but also literacy and schooling and life expectancy as indicators of well-being. In Ireland, we have as yet inadequate levels of data in relation to many

of the indicators we will need to measure if we are to adopt more a comprehensive measurement of development. However, much progress in relation to data collection and dissemination has been made by the Central Statistics Office and others in recent years and this will need to be built on if we are to begin to develop and use a 'balanced scorecard' of our progress.

## Health Capability

Let us look at one area of our public services to explore how the capability approach might lead to a vast change in effectiveness and efficiency: our troubled health services.

***Scale of Morbidity***

First, consider some statistics from the most recent HSE Annual Report about the levels of morbidity in our society of just 4.58 million people. In 2010, 1.1 million people attended the 33 emergency departments of our public hospitals; of these, 30 per cent required admission to inpatient care. There were 3.5 million attendances in outpatients departments (of which one million were new attendances); 588,860 people received inpatient hospital care (involving the use of 3.6 million 'bed days'); over 730,000 day case treatments were provided.[10]

These figures relate only to the levels of morbidity cared for in the public hospital sector and do not take account of illnesses cared for in the primary and community care sector where, in 2010, we spent €7.7 billion as against €5.2 billion in the hospital sector. The Irish College of General Practitioners estimates that each year in Ireland there are 16 million GP consultations with patients.[11]

Are we a sick society and getting sicker? People are living longer but why are so many living with chronic diseases? Such diseases are now at epidemic levels; treating them accounts for between 70 and 80 per cent of health care expenditure. The Chief Medical Officer has written:

*Our ageing population, together with adverse trends in obesity, diet, exercise and other risk factors means that the level of chronic health conditions will certainly increase. There is much which can be done because approximately two thirds of the predicted disease burden is caused by risk factors which can be prevented ...*

*In parallel with the ageing of the population there will be a very significant increase in the prevalence of chronic diseases such as cancer, diabetes, cardiovascular disease, mental illness, dementia and locomotor disabilities*.[12]

***Resources and Health***

It is clear that conventional approaches to health care are simply not adequate to cope with the challenges presented by the key public health issues now facing our society (including obesity levels, harmful patterns of alcohol consumption and socio-economic differentials in health status) and that these current approaches are becoming unsustainable.[13] By looking at health from the perspective of the human development and capability approach, a sustainable public health service may be conceived and overall population health may also improve. What we need to reflect on very seriously is that the resources devoted to health systems are not the determining factor in achieving optimum health outcomes: what is key is how societal resources are used and distributed.

The USA is the classic warning case in this regard: there, over 16 per cent of national wealth is devoted to the health system for very poor returns in terms of either the outcome for large numbers of people who need to use health services, or overall population health. Economic growth only contributes to human flourishing (in terms of improved health) when it is followed by a shift in resource-allocation towards effective health interventions and by equitable distribution of income and employment opportunities.

Angus Deaton has highlighted how many contributions to health do not depend on economic growth or income – there are examples of countries where health gains have been achieved without high incomes.[14] As Sen and others point out, we can improve health without high economic growth but that depends upon adopting a radical new paradigm for health improvement. One of the distinguishing features of the human development and capability approach is its focus on the process of generating health. Sen writes:

*The factors that can contribute to health achievements and failures go well beyond health care, and include many influences of very different kinds, varying from (genetic) propensities, individual incomes, food habits and lifestyles, on the one hand, to the epidemiological environment and work conditions on the other… We have to go well beyond the delivery and distribution of health*

*care to get an adequate understanding of health achievement and capability*.[15]

***'Good Health Policy' or 'Good Policy for Health'?***
Health policy and public services in health cannot be isolated from the overall set of public policies pertaining to the distribution of the 'social determinants of health'. For example, health policy is not only about providing treatment for people with diabetes but about dealing with the social and economic drivers of the obesity epidemic. In relation to designing and delivering public services across all public service areas, what we need is to enable people to develop, to the maximum extent possible:

- the ability to be well nourished;
- the ability to be free from illness;
- the ability to live long lives.

*The Department of Health: Willing to envisage 'shared health governance'?* *© D. Speirs*

Jennifer Prah Ruger's book, *Health and Social Justice*, is a seminal work on the application of the capability approach to health and the promotion of social justice. Her argument is that justice demands that society should as far as possible ensure that individuals are capable of avoiding premature death and escapable morbidity to a threshold that is their unique maximum; that they are enabled to do this through appropriate and necessary medical care, public health interventions and health research; and that the implementation of these measures involves the active participation of all the relevant actors while using the least amount of resources. Health capabilities are the *focal variable* for assessing equality and efficiency in health policy. As Sen states, we need to distinguish between 'good health policy' and 'good policy for health': 'The pursuit of health justice has to go well beyond getting the institutions of health care right, since people's health depends on a variety of societal influences, of which health care is only one.'[16] Ruger's 'health capability paradigm' seeks to map out steps by which we get to the point where citizens – through their health functioning and health agency – voluntarily embrace changes in our economic and social structures, and in their own behaviour, to achieve a shared vision of the 'flourishing society'. We need to articulate new public norms supporting our best aspirations. Here there is a vital role for the community and voluntary sector: grass-roots initiatives, strong leadership and public education are all part of the required norm-building process. The community and voluntary sector in Ireland is very extensive: it employs 36 per cent of the country's healthcare staff and has the capacity to lead the debate towards the new paradigm.[17]

The 'health capability paradigm' envisions *shared health governance* in which citizens, providers, and public institutions work together to create a social system and environment enabling all to have the opportunity to be healthy. This will mean consensus-building around substantive principles and distribution procedures, accurate measures of effectiveness, changes in attitudes and norms, and open deliberation to resolve problems. Ensuring health capabilities requires promoting health agency and equipping individuals and communities with the tools they need to pursue and achieve health outcomes they value and have reason to value. We need to develop a people-based health culture which will equip our citizens to participate in designing public services, to deliver changes in their behaviour, to take responsibility for health outcomes and for the health status of their own areas and communities. We must re-imagine 'an enabling State' in place of the 'controlling and dependency-creating State' which now exists.

It is relevant to the current Irish health policy arena that Jennifer Prah Ruger maintains that the 'health capability paradigm' rests on medical necessity and appropriateness, *not* on the ability to pay. Writing in an American context, she argues that progressively financed universal health insurance is fundamental and essential for human flourishing: she argues that it reduces vulnerabilities and insecurity throughout our lives and this *protective security* supports 'both overall health and capabilities beyond health – the capability to work, to manage a household and family, to engage in civic affairs, to live a flourishing life'.[18]

In sum, as a people we must seek good health and the ability to pursue it: our conventional approach

to the provision of health services sees people as consumers or patients rather than as citizens and health agents. The 'health capability paradigm' integrates health outcomes and health agency – health agency being defined as the ability of people to achieve the health goals they value and to act as agents of their own health. Attributes such as self-management, decision-making ability, skills, knowledge and competence, and the exercise of personal responsibility are crucial to the citizen's participation in all public services but especially with regard to their own and other people's health status and health outcomes.

The notion of social obligation is central to the new paradigm: we have a fundamental societal obligation to ensure the conditions for all to be able to be healthy. This is underpinned by universal health insurance. We must enable and empower citizens to shape and design and help govern not only our health system but also the wider provision of public services; as already noted, the broader environment is as relevant to raising the health status of people as are the health services.[19]

The National Economic and Social Council (NESC) report, *Well-being Matters: A Social Report*, published in October 2009, is the first major report to relate the human development and capability approach to public policy-making in Ireland. Placing policy-making in the context of a 'developmental welfare state' model, the report proposes a 'Well-being Test' (as outlined below) which ought to be applied in reforming our public services.[20]

### The Role of the Community and Voluntary Sector in Public Services

A range of approaches or models is apparent in regard to the relationships which may exist between the voluntary sector and the State in the provision of public services:

**The philanthropic approach** – essentially, the State is content for charitable bodies to fund and provide services which it cannot currently fund – or does not want to;

**The protest approach** – voluntary bodies and social movements seek to advocate for changes in services;

**The self-help approach** – whereby citizens seek to provide some service by themselves without interaction with the State;

**The co-production approach** – where the voluntary sector and the State have an effective partnership in the design and provision of services.

The 'co-production approach' is similar to the 'active partnership' model which I outlined in a book published over ten years ago, *Citizenship and Public Service*.[21] In it, I set out the philosophical basis for active citizenship in a pluralist democracy which legitimates voluntary action in our society. That key argument of that book I would make in even stronger terms in 2011. The co-production or 'active partnership' models stand in sharp contrast to the 'dependent partnership' model which still remains the experience of the vast majority of voluntary providers of public services through service agreements with State agencies.

Finally, the essence of the task of promoting the active involvement of citizens in the design and delivery of public services, including health care, is well captured in the 'C.L.E.A.R. Framework of Factors Driving Public Participation':

## Well-being Test

| Well-being Criteria | Description |
|---|---|
| *Capability* | A focus on what an individual can do with a view to developing capabilities |
| *Agency* | Respect for the capacity of individuals to make decisions about their lives |
| *Purpose* | Recognising the importance of having a sense of purpose by encouraging and supporting people to engage in meaningful activity |
| *Social Interaction* | The recognition that we operate in the context of a set of relationships – family, community and wider society |
| *Common Good* | As individuals and as societies we do better in more equal and fairer societies |
| *Sustainability* | We live in a finite world and have to use our resources wisely now and for future generations |

- People participate when they **can** – when they have the resources necessary to organise, mobilise and make their argument.
- People **like** to participate when they think they are part of something – because the arena is central to their sense of identity and their lifestyle.
- People participate when they are **enabled** – by an infrastructure of good civic organisations that channel and facilitate participation.
- People participate when they are **asked** for their opinion.
- People participate if they are listened to, not necessarily agreed with, but able to see a **response**.[22]

## Notes

1. OECD, *Public Management Reviews – Ireland: Towards an Integrated Public Service*, Paris: OECD, 2008, p. 11.
2. I take the phrase from Stuart White and Daniel Leighton (eds.), *Building a Citizen Society: The Emerging Politics of Republican Democracy*, London: Lawrence and Wishart, 2008.
3. The word 'citizen' is used here not in an exclusive sense – referring only to those who live in Ireland and hold citizenship of this country – but rather in the broader sense of including those who are living here and are part of society.
4. See Philip Pettit, *Republicanism: A Theory of Freedom and Government*, Oxford: Oxford University Press, 1997, and Martha C. Nussbaum, *Creating Capabilities: The Human Development Approach*, Cambridge, MA: Harvard University Press, 2011.
5. TASC – the progressive think-tank – has underway a project to articulate a vision for a flourishing society in Ireland and to produce a series of papers addressing aspects of this vision (see www.tascnet.ie).
6. See Eddie Molloy, 'Ireland's Sixth Crisis – Severe Implementation Deficit Disorder', Paper to the 30th MacGill Summer School on 'Reforming the Republic', 19 July 2010; see also National Economic and Social Council, *Well-Being Matters: A Social Report for Ireland* (two volumes), Dublin: NESC, 2009 (Report No. 119), for an excellent overview. In a paper to the 2011 MacGill Summer School, Eddie Molloy drew attention to the fundamental importance of values, at both individual and institutional level, in bringing about political, economic and public sector reform (Eddie Molloy, 'Public Service Reform: The Central Role of Character and Culture', Paper to the 31st MacGill Summer School, 26 July 2011).
7. See John Stuart Mill, *On Liberty* (edited and with an introduction by Gertrude Himmelfarb), London: Penguin Books, 1974, p. 187.
8. See Nussbaum, *op. cit.*, pp. 33–34.
9. The work of Nobel prize winning author, Amartya Sen, crosses many disciplines but his corpus may be best approached in the following: Amartya Sen, *Development as Freedom*, Oxford: Oxford University Press,1999 and *The Idea of Justice*, London: Penquin Books, 2009, and in Christopher W. Morris (ed.), *Amartya Sen*, Contemporary Philosophy in Focus Series, Cambridge: Cambridge University Press, 2010.
10. Health Service Executive, *Annual Report and Financial Statements 2010*, Dublin: HSE, 2011, pp. 40–41. (www.hse.ie)
11. Irish College of General Practitioners, *Submission to Joint Committee on Health and Children*, January 2009, p. 2.
12. See Chief Medical Officer, 'On the State of Public Health', Brief for Minister for Health and Children, March 2011. (http://www.dohc.ie/publications/briefings_foi_2011.html)
13. See Fergus O'Ferrall, 'The Reform Challenges in Irish Healthcare', *Studies, An Irish Quarterly Review*, Vol. 100, No. 398, Summer 2011, pp. 155–166. I have set out the argument for increasing citizen participation in more detail in Fergus O'Ferrall, 'The Erosion of Citizenship in the Irish Republic: The Case of Healthcare Reform', *The Irish Review*, Vol. 40, Nos. 40–41, Winter 2009, pp. 155–170; see also Fergus O'Ferrall, 'Citizen Participation in Healthcare', in Eilish McAuliffe and Kenneth McKenzie (eds.), *The Politics of Healthcare: Achieving Real Reform*, Dublin: The Liffey Press, pp. 179–206. On health inequalities see Sara Burke and Sinéad Pentony, *Eliminating Health Inequalities: A Matter of Life and Death*, Dublin: TASC, 2011.
14. See Angus Deaton, *Global Patterns of Income and Health: Facts, Interpretations, and Policies*, Cambridge, MA: The National Bureau of Economic Research, 2006 (Working Paper 12735).
15. See Amartya K. Sen, 'Why Health Equity?', *Health Economics*, Vol. 11, Issue 8, December 2002, pp. 659–666 (at p. 660).
16. Foreword by Amartya Sen in Jennifer Prah Ruger, *Health and Social Justice*, Oxford: Oxford University Press, 2010, p. ix.
17. The Health Spoke, The Wheel, *Scoping the Community and Voluntary Healthcare Sector in Ireland: A Literature Review, Dublin*, 2005.
18. Jennifer Prah Ruger, *op. cit*. pp. xv–xvi.
19. See Jennifer Prah Ruger, 'Health Capability: Conceptualization and Operationalization', *American Journal of Public Health*, Vol. 100, No. 1, January 2010, pp. 41–49; see especially, Box 1, 'Health Capability Profile', which sets out select concepts and domains for a health capability classification and the components of a working health capability profile, and Figure 1, 'Conceptual Model of Health Capability'.
20. National Economic and Social Council, *op. cit.*, p. 156.
21. Fergus O'Ferrall, *Citizenship and Public Services: Voluntary and Statutory Relationships in Irish Healthcare*, Dublin: The Adelaide Hospital Society in association with Dundalgan Press, Dundalk, 2000. The contribution of community and voluntary healthcare organisations is the focus in: Fergus O'Ferrall, 'People Centredness: The Contribution of Community and Voluntary Organisations to Healthcare', *Studies, An Irish Quarterly*, Vol. 92, No. 367, Autumn 2003, pp. 266–277.
22. Vivien Lowndes, Lawrence Pratchett and Gerry Stoker, 'Diagnosing and Remedying the Failings of Official Participation Schemes: The CLEAR Framework', *Social Policy and Society*, Vol. 5, Issue 02, 2006, pp. 281–291, cited in National Economic and Social Forum, *Improving the Delivery of Quality Public Services*, Dublin: NESF, 2006 (Report 34), p. 48.

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# Working Notes

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# Contents

# Overcrowding and Cell Capacity in Irish Prisons

*Patrick Hume SJ*

## Introduction

Any discussion of prison conditions or overall prison policy in Ireland cannot but give close attention to the question of the overcrowding that is pervasive throughout the prison system.

This overcrowding starkly reflects the reality that the numbers imprisoned, both on remand and under sentence, have grown significantly over the past thirty years, with the daily average number of people in prison increasing more than three-fold, reaching well over 4,000 in 2010.

There *has* been an expansion in prison places – with, for example, the building of large extensions to many prisons, but the number of additional places has not matched the increase in the number of people detained. The result is that, in most of the country's prisons, cells designed for one person now routinely accommodate two or even more people. On 7 December 2010, 63 per cent of those detained in Irish prisons – 2,762 people out of a total prison population of 4,416 – were *not* accommodated in a single cell.[1]

It is, of course, very much open to debate whether the extent to which imprisonment is being used at present is justified, either in terms of the best use of the financial resources made available by our society for dealing with people who break the law, or in terms of trying to ensure that those convicted of a crime do not re-offend. This is a fundamental issue for penal policy – but is not one that can be explored here. Instead, the concern in this article is with the possible role of international standards regarding prison conditions, and of clear benchmarks as to what may constitute acceptable levels of cell capacity, in promoting greater commitment to addressing the issue of overcrowding.

## What is 'Overcrowding' in a Prison?

Three terms are frequently used to describe the capacity of prisons: 'design capacity', 'operational capacity' and 'bed capacity'.[2] The terms, in effect, refer to increasingly larger numbers of people being accommodated in the same space. It is possible for a prison to be overcrowded in terms of one but not another of these definitions – or to be overcrowded under all three.

**'Design capacity'** refers to the number of people a prison has been designed to detain. The planner or architect is given specific instructions and guidelines and, on the basis of these, presents a design to meet the accommodation levels requested. The specifications may follow international standards as to building regulations, fire safety, general health and safety regulations, and minimum standards regarding space. The first 'stage' of overcrowding occurs when the stated design capacity is exceeded.

The second category, **'operational capacity'**, is not defined by the Irish Prison Service but a useful definition may be found in the regulations of HM Prison Service for England and Wales: 'the total number of prisoners that an establishment can hold *without serious risk to good order, security and the proper running of the planned regime*' (emphasis added).[3] 'Operational capacity' permits a greater intake of people than design capacity, yielding to the need for extra places for those sent to prison by the courts, while still recognising the inherent limits imposed by the built capacity and safety requirements. Overcrowding that occurs as a result of the operational capacity being exceeded is clearly more serious than that resulting from a breach of design capacity.

Finally, there is the notion of **'bed capacity'** – where capacity is defined in terms of the number of beds available. In the Irish prison system, the definition of a 'bed' includes a single bed and a bunk bed. Capacity is limited only by the number of beds that fit in the building. A cell designed for one person may end up accommodating a bed and a bunk bed, so that the 'capacity' of the cell increases from one to three. In effect, the focus is on fitting the maximum number of beds into the available space with little regard for 'the proper running of a planned regime'. While it might be considered that 'overcrowding' under this definition occurs when there are more prisoners than beds available, it could be argued that, in fact, a level of overcrowding is an in-built, inescapable, feature

under such an approach to defining capacity.

## Overcrowding in Irish Prisons

A look at six of Ireland's fourteen prisons – Mountjoy Prison, the Dóchas Centre (for women), Cork, Castlerea, Cloverhill and Limerick – gives an idea of the seriousness of the problem of overcrowding in the system. Without considering the question of the degree of overcrowding in terms of 'design' or 'operational' capacity, it is evident that all these prisons exhibit overcrowding even at the level of 'bed capacity'.[4]

**Table 1: Overcrowding in Irish Prisons**

| Establishment | Average Bed Capacity 2010 | Average Number in Custody 2010 | Population as % of Bed Capacity |
|---|---|---|---|
| Mountjoy | 610 | 667 | 109 |
| Dóchas | 95 | 131 | 138 |
| Cork | 272 | 303 | 111 |
| Castlerea | 351 | 378 | 108 |
| Cloverhill | 431 | 465 | 108 |
| Limerick (male)<br>Limerick (female) | 290<br>22 | 307<br>26 | 106<br>118 |

Source: Irish Prison Service, *Annual Report 2010*, Table 2.7, p 13

As Table 1 shows, the average defined bed capacity of Mountjoy, in 2010, was 610 but there was an average of 667 people in the prison during the year; in Cork Prison, the average bed capacity was 272 but the average number in custody was 303. It is clear from Table 1, then, that each day Irish prisons are having to accommodate numbers significantly in excess of even their bed capacity. What exactly this means is not clear from the data provided. However, it is known that people in prison are placed in cells where there is no bed for them but where they sleep on a mattress on the floor; alternatively, they may be accommodated in rooms which are not designated for accommodation, and be given mattresses on the floor instead of a bed.

It is important to re-iterate how low a standard is being adopted if overcrowding is being assessed at the level of 'bed capacity': the assessment ought instead to be in terms of the capacity provided for by the original design of a prison, assuming this to be in line with best practice in prison design.

### *Implications of Overcrowding*

Overcrowding has profound implications for the whole experience of being in prison. It must be remembered that, for the generality of people in Irish prisons, out-of-cell time is limited to around seven and a half hours each day, so in real terms overcrowding can mean being confined in a space originally designed for just one person which is now accommodating two or three people, for perhaps sixteen or seventeen hours out of every twenty-four.

The fact that most Irish prisons are full to capacity – or beyond – makes all the more difficult the task of dealing with feuds and threats of violence which are now a major problem within the Irish prison system, resulting in significant numbers of prisoners being deemed to require 'protection'. Overcrowding means there is reduced scope for moving people to different institutions where they could be safely detained without having to be locked up for their own protection for extended periods. In January 2011, there were 250 people in prison who were locked up for 23 hours or more a day. A further 250 were locked up for between 18 and 23 hours a day.[5]

The impact of overcrowding is felt not only in terms of the cell conditions in which people are detained but also in terms of access to facilities and services (such as education and work training). A greatly increased prison population over the past decade has not been accompanied by a corresponding increase in provision in such areas – indeed, in recent years, budgetary restrictions have resulted in cutbacks in some services.

Overcrowding is all the more problematic given the reality that a very high percentage of the people detained in Irish prisons suffer from mental illness and/or addictions.[6] For such people, imprisonment inevitably imposes great difficulties – but these are compounded by enforced sharing of cramped cells.

One of the worst features of the increased incidence of double or multiple occupancy of cells is that greater numbers of prisoners are accommodated in cells which do not have internal sanitation and therefore are subjected to the degrading and unhealthy procedure of 'slopping out'.

Moreover, double or multiple occupancy of cells means that prisoners in both cells *without* internal sanitation and cells *with* integral sanitation have to the use the toilet in the presence of others. Figures provided in a written reply to a Dáil Question show that on 17 December 2010 only 30 per cent of the 4,397 people detained in Irish prisons on that day were 'sole occupants of a cell that has a normal flush toilet installed or have access to toilet facilities in private at all times'. Around 1,000 prisoners (22 per cent of the total) were required to slop out.[7] The majority of prisoners who have to 'slop out' are accommodated in a shared cell.[8]

## International Standards as Benchmarks?

Irish domestic legislation does not set down a clear minimum standard of provision which might be used as a benchmark to measure overcrowding in prisons. What guidance is provided by international standards regarding prison conditions?

Several international agreements or covenants deal with the rights of people who are in prison and the responsibilities of States which have ratified these agreements to ensure that these rights are upheld. As a member of the United Nations, the Council of Europe, and the European Union, Ireland has signed up to a range of agreements touching on prison conditions, which have been drawn up by these international bodies.

Article 10 of the United Nations *Standard Minimum Rules for the Treatment of Prisoners* states:

*All accommodation provided for the use of prisoners and in particular all sleeping accommodation shall meet all requirements of health, due regard being paid to climatic conditions and particularly to cubic content of air,* ***minimum floor space,*** *lighting, heating and ventilation.* (Emphasis added.)

In neither this nor in other international instruments is a specific figure given to indicate what is considered an acceptable minimum amount of space to be provided for each prisoner. The *European Prison Rules* adopted by the Council of Europe give only a fluid guide, stating in Article 18:

*The accommodation provided for prisoners, and in particular all sleeping accommodation, shall respect human dignity and, as far as possible, privacy, and meet the requirements of health and hygiene,* ***due regard being paid to climatic conditions and especially to floor space****, cubic content of air, lighting, heating and ventilation*. (Emphasis added.)

However, the Committee for the Prevention of Torture (CPT), the Council of Europe body which has responsibility for visiting countries which are signatories to the Council's *European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment*, has adopted as a 'rough guideline' the criterion that cells should be 7 square metres ('2 metres or more between walls, 2.5 metres between floor and ceiling').[9]

Ireland's *Prison Rules 2007* do not set out in

**Table 2: Some Instruments Relating to the Treatment of People in Prison**

| Body | Instruments Relating to the Treatment of People in Prison |
|---|---|
| **United Nations** | *Universal Declaration of Human Rights* (1948) |
| | *International Covenant on Civil and Political Rights* (1966) |
| | *Standard Minimum Rules for the Treatment of Prisoners* (1977) |
| **Council of Europe** | *European Convention on Human Rights* (1950) |
| | *European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment* (1987) |
| | *European Prison Rules* (2006) |
| **European Union** | *Charter of Fundamental Rights* (2000) |
| **Ireland** | *Constitution of Ireland* (1937) |
| | *Irish Prison Rules* (2007) |

specific terms the minimum space to be provided for people in prison but instead lay down general standards:
*The Minister shall, in relation to a prison or part of a prison, certify that all such cells or rooms therein as are intended for use in the accommodation of prisoners are,* ***in respect of their size,*** *and the lighting, heating, ventilation and fittings available in the cells or rooms in that prison or that part, suitable for the purposes of such accommodation.*[10] (Emphasis added.)

Given the apparent vagueness regarding what might be an agreed minimum floor area available for each person detained in a prison, and the consequent floating definitions of overcrowding, it is significant that in 2010 Ireland's Inspectors of Prisons, Judge Michael Reilly, made specific recommendations regarding the space to be provided for each prisoner. In a report on the 'duties and obligations owed to prisoners', which he described as a 'road map for our prisons which will ensure that we, as a country, adhere to our obligations',[11] Judge Reilly proposed the following minimum requirements for the size of cells:

- **Single occupancy cells**: these should be at least $7m^2$ in size, 'with a minimum of 2m between walls'. Moreover, in-cell sanitation should be provided and 'it would be preferable', that the sanitary facilities be screened off from the rest of the cell.
- **Multi-occupancy cells**: In addition to the basic cell size of $7m^2$, there should be an extra $4m^2$ for each additional prisoner. Furthermore, in the case of multi-occupancy cells, 'there must be in-cell sanitation which, in all cases, must be screened'.[12]

**Table 3: Minimum Size of Prison Cells: Recommendations of the Inspector of Prisons**

| No. of People per Cell | Minimum Space $m^2$ |
|---|---|
| 1 | 7 |
| 2 | 11 |
| 3 | 15 |
| 4 | 19 |

The Inspector of Prisons states that in arriving at recommendations regarding the minimum acceptable size of prison cells he had 'regard to' the following:

*… the Irish Constitution, our domestic laws and jurisprudence, the International Instruments that bind our country, the various reports of the CPT, the decisions of the European Court of Human Rights, International Rules that refer to prisoners, the European Prison Rules, the Irish Prison Rules, Standards for the Inspection of Prisons in Ireland, best practice and my observations of prisons*.[13]

The Inspector of Prisons turns to the European Court of Human Rights to support his proposals regarding cell size, and quotes from the decision in *Kalashnikov v Russia* (2002):

*… the Court recalls that the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment ("the CPT") has set 7 $m^2$ per prisoner as an approximate, desirable guideline for a detention cell*.[14]

The Inspector suggests that this clear and precise minimum standard has permitted the European Court of Human Rights to take the view that overcrowding *per* se amounts to a violation of Article 3 of the *European Convention on Human Rights*, as decided in *Orchowski -v- Poland.*[15]

While the setting of minimum standards by the Inspector of Prisons is a significant development, it is important to note the limitations of the proposals.

*The principle of having single cells as the desired norm has apparently been abandoned.*

The most serious is the apparent acceptance of the continued use of multi-occupancy of cells. Over the past number of years, as plans emerged in relation to the development of a new prison at Thornton Hall, in North County Dublin, it has become apparent that the Irish Government and the Irish Prison Service have come to view multioccupancy as an 'acceptable', in-built, feature of prison development – no longer being seen as just an unfortunate outcome of the increasing overcrowding in Irish prisons.[16] The principle of having single cells as the desired norm has apparently been abandoned. It is particularly disappointing that the Thornton Hall Review Group, established by the current Minister for Justice, Alan Shatter TD, accepted this approach: in its Report, published in July 2011, the Group

recommended that: 'the design of the prison should provide for 300 cells capable of accommodating 500 prisoners'.[17]

It should be noted also that in reality the minimum capacity proposed in the Inspector's report would still mean a very limited amount of space for people who are locked up for more than half their waking hours. This is highlighted if we consider the Regulations, provided under Statutory Instruments, which are now in place in Ireland regarding the minimum 'floor space' to be made available to children being cared for outside their homes in pre-schools.[18] The *Explanatory Guide* to the Regulations outlines the space requirements concerning facilities for rest and play: 'If the sleep area for babies and children aged under 2 years is accommodated in the baby room, the overall space measurement of the baby room will then be 4.2 sq metres per child.'[19]

**Table 4: Minimum Space Requirements under Pre-School Regulations**

| No. of Children under Two Years | Minimum Space $m^2$ |
|---|---|
| 1 | 4.2 |
| 2 | 8.4 |
| 3 | 12.6 |
| 4 | 16.8 |

The fully grown person who is imprisoned might be five times the size of a child under two years of age. Furthermore, the person detained does not have a space outside the prison to which he or she returns every evening. If a baby who sleeps for only a couple of hours in a day at pre-school must be provided with a minimum of 4.2 sq metres per child for sleeping, as well as extra play space, then it could be suggested that an adult in confined conditions such as prison needs much more space and at a minimum twice the space requirement of a baby. Using this optic, the minimum space requirement for every person in places such as prisons would be 8.4 square metres. In effect, this approach would *not* permit a smaller space allocation per individual when more than one person was being detained in a shared cell.

## Decisions of the Irish Courts

Irish courts have recognised that people in prison have rights (*The State (C) v Frawley* [1976]) and have underlined specific rights – the right to bodily integrity; the right of the person detained not to have his or her health exposed to risk or danger; the right not to be exposed to inhuman or degrading treatment.

However, actions by prison authorities must be glaringly wrong before any court considers it reasonable to criticise or condemn them. The possibility, held out by the decision in the 1976 *Frawley* case, that the courts might became a vehicle for defending the rights of people in prison was soon smothered. Just four years later, in *The State (Richardson) v Governor of Mountjoy* [1980], the court held that: 'the prison authorities must be allowed a wide area of discretion in the administration of the prisons in the interests of security and good order'.[20]

It is clear that, thirty years on from that decision, this 'wide area of discretion' still applies in cases relating to prison conditions. *In Mulligan -v- Governor of Portlaoise* [2010], concerning the continued use of 'slopping out', the High Court readily accepted that this procedure is 'repugnant by today's standards'.[21] However, it refused to accept that Mr Mulligan's human rights had been breached. The court considered that it had to take account of the 'overall conditions',[22] the 'cumulative effects'[23] and the 'totality of circumstances'[24] – and thereby even the repugnant becomes acceptable in the eyes of the court.

In Ireland, it is the Constitution which provides the fundamental law to be applied in the courts. Article 29.6 of the Constitution explicitly limits the extent to which international treaties may apply within the State: 'No international agreement shall be part of the domestic law of the State *save as may be determined* by the Oireachtas'. (Emphasis added.)

The enactment of the *European Convention on Human Rights Act 2003* introduced the *European Convention of Human Rights* into domestic Irish law. However, Chief Justice Murray, in *McD. -v- L. & anor* [2009] IESC 81, has set out in clear terms the limits on the application of the European Convention, and of the decisions of the European Court of Human Rights, in Ireland, relying on the provisions of Article 29 of the Constitution to support his position.

Early in his judgment he states:

*... I think it is clear that the Convention is* ***not directly applicable*** *as part of the law of the State and may only be relied upon in the circumstances*

*specified in the European Convention on Human Rights Act of 2003*. (Emphasis added.)

He adds:

*The European Convention may only be made* ***part of domestic law through the portal of Article 29.6*** *and then only to the extent determined by the Oireachtas and subject to the Constitution.* (Emphasis added.)

Furthermore, he states that the provisions of the Constitution mean that: 'An international convention cannot confer or impose functions on our Courts'. He goes on to say:

*Of course the Courts may be given jurisdiction to enforce or adjudicate on rights which the State has agreed, in an international treaty, to promote or protect. But it can only be conferred by national law and if sought to be done by making an international agreement, wholly or partially, part of domestic law then it must be done in accordance with Article 29.6 and in a manner consistent with the Constitution as a whole.*

Given the reluctance on the part of the courts to meddle in the administration of the prison system, and the serious limitations on the application of relevant international treaties which Ireland has ratified, it seems prudent to recall the recommendation of the authors of a book on Irish prison law, published thirty years ago:

*… the appropriate place to seek alterations or complete changes in these areas is* ***not in a Court but through the Oireachtas.*** *The function of the Judiciary is to interpret the law as it is, not as it ought to be.*[25] (Emphasis added.)

The courts walk a fine line between applying the law and making the law. In matters concerning prison law, the courts in Ireland seem to have taken the most cautious of approaches, trying not to trespass in any way on the role of the Oireachtas as the law-maker.

## Conclusion

In the light of the restrictions on the courts as law-makers, of the requirement that they respect and uphold administrative decisions unless these are clearly in error, and the restriction imposed by the Constitution at Article 29 as regards the application of international human rights treaties, it seems clear that there is limited scope for a legal route towards expansion of the understanding of prisoners' rights in Ireland.

However, the coming into force of the EU *Charter of Fundamental Rights* could result in a situation whereby Irish courts may be obliged to follow the jurisprudence of the European Court of Justice of the EU, which is binding on Irish courts in matters of EU competence. It remains to be seen how Court of Justice decisions may affect Irish jurisprudence in relation to human rights, including the rights of EU citizens in Irish prisons.

In the meantime, given the gap between the desired treatment of people in prison and the actual conditions, there is much work to be done to persuade the public and politicians as to the necessity of change. Advocacy must attempt to influence not only the minds but also the hearts of those who can bring about change. The success of this advocacy depends on the whole institution of law-makers – the legislature, the judiciary, the executive *and* an informed public. Without this last element, the 'established' tripartite structure of law-makers (the legislature, the judiciary, and the executive) will continue to flounder in that crevice between how we actually house people detained in our prisons and the desire to uphold international standards in regard to prison accommodation.

## Notes

1. See written reply on 8 December 2010 by the then Minister for Justice and Law Reform, Dermot Ahern TD, to a Dáil Question by Ciarán Lynch TD.
2. I am grateful to Fr Peter McVerry for his outlining of these categories.
3. HM Prison Service, *Prison Service Order – 1900 Certified Prisoner Accommodation* of 8 August 2001. 'Operational capacity' is often used with reference to other public buildings such as schools and offices: buildings are often modified, after they go into use, to accommodate changed conditions and needs.
4. Data from Irish Prison Service, *Annual Report 2010*, Longford: Irish Prison Service, 2011, Table 2.7, p. 13.
5. Written reply on 27 January 2011 to Dáil Question by Ciarán Lynch TD (information relates to 26 January 2011).
6. See for example, H.G. Kennedy *et al, Mental Illness in Irish Prisoners: Psychiatric Morbidity in Sentenced, Remanded and Newly Committed Prisoners*, Dublin: National Forensic Mental Health Service, 2005.
7. Written reply by the then Minister for Justice and Law Reform, Dermot Ahern TD, on 27 January 2011, to a Dáil question by Ciarán Lynch TD.
8. Judge Michael Reilly, Inspector of Prisons, *The Irish Prison Population – An Examination of Duties and Obligations Owed to Prisoners,* Nenagh: Office of the Inspector of Prisons, July 2010, par. 3.19, p. 20. (www.inspectorofprisons.gov.ie)
9. CPT, *2nd General Report on the CPT's Activities Covering the Period 1 January to 31 December 1991*, Strasbourg, CPT/Inf (92) 3 [EN], 13 April 1992. (www.cpt.coe.int/en/docsannual.htm)

10. *Prison Rules 2007*, n. 18.1, p. 21.
11. Judge Michael Reilly, Inspector of Prisons, *op. cit*.
12. *Ibid*., par. 2.3, p. 10.
13. *Ibid*., par. 2.4, p. 10.
14. Council of Europe, European Court of Human Rights, *Kalashnikov v. Russia* (Application no. 47095/99), Judgment, Strasbourg, 15 July 2002 (http://www.unhcr.org/refworld/docid/416bb0d44.html ), quoted in Judge Michael Reilly, *op.cit.*, par. 2.8, p. 13.
15. Council of Europe, European Court of Human Rights, *Orchowski -v- Poland* (Application no. 17885/04), Judgment, Strasbourg, 22 October 2009, Final 22/01/2010. (http://cmiskp.echr.coe.int/tkp197/view.asp?action=html&documentId=856497&portal=hbkm&source=externalbydocnumber&table=F69A27FD8FB86142BF01C1166DEA398649)
16. See Press Release from the Jesuit Centre for Faith and Justice in response to comments on single cells by Dermot Ahern TD, Minister for Justice, 28 July 2010 (www.jcfj.ie/news).
17. *Report of the Thornton Hall Project Review Group,* July 2011, p. 16 (www.justice.ie). See comment on the Review Group Report by the Jesuit Centre for Faith and Justice, 'Inadequate Prison Conditions now Cemented in Policy of the New Government', Press Release, 29 July 2011 (www.jcfj.ie/news).
18. *Child Care (Pre-School Services) (No 2) Regulations 2006* (Statutory Instrument S.I. No. 604 of 2006) and *Child Care (Pre-School Services) (No 2) (Amendment) Regulations 2006* (Statutory Instrument No. 643 of 2006).
19. See 'Regulation 28: Facilities for Rest and Play' in the 'Explanatory Guide to Requirements and Procedures for Notification and Inspection' regarding Child Care (Pre-School Services) Regulations.
20. *The State (Richardson) v Governor of Mountjoy* [1980] ILRM 82.
21. *Mulligan v Governor of Portlaoise Prison & Anor* [2010] IEHC 269, par. 14.1. (http://www.courts.ie/Judgments.nsf/09859e7a3f34669680256ef3004a27de/70edce35d14d515a80257761003be166?OpenDocument)
22. *Ibid*., par. 8.
23. *Ibid*., par. 129, quoting from the European Court of Human Rights decision *Bakhmutsky v. Russia* (Application No. 36932/02, 25th June, 2009) which specifically uses this phrase.
24. *Ibid*., par. 154–155; in par. 154 the court quotes from a Northern Ireland decision, *Martin v. Northern Ireland Prison Service* [2006] N.I.Q.B. 1.
25. Raymond Byrne, Gerard Hogan and Paul McDermott, *Prisoners' Rights: A Study in Irish Prison Law*, Dublin: Co-op Books, 1981.

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