
DEPARTMENT OF HEALTH

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1 Introduction and Context 3

1.1 Background to review
1.2 Terms of reference and establishment of Steering Group

2 Structure of First Phase of Review 5

2.1 General work plan
2.2 Documentation considered as part of review
2.3 Number of meetings
2.4 Public consultation

3 Key Themes Emerging and Recommendations 8

3.1 Human Rights and Paternalism
3.2 A Vision for Change
3.3 Children
3.4 Voluntary, Involuntary Patients and Capacity
3.5 Consent To Treatment
3.6 Detention
3.7 Authorised Officers

4 Next Steps 31
## APPENDICES

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix A</td>
<td>33</td>
</tr>
<tr>
<td>Public Consultation Advertisement</td>
<td></td>
</tr>
<tr>
<td>Appendix B</td>
<td>39</td>
</tr>
<tr>
<td>Steering Group Meetings</td>
<td></td>
</tr>
<tr>
<td>Appendix C</td>
<td>41</td>
</tr>
<tr>
<td>Submissions Received by the Steering Group</td>
<td></td>
</tr>
<tr>
<td>Appendix D</td>
<td>44</td>
</tr>
<tr>
<td>Key Themes Emerging from Consultation Process</td>
<td></td>
</tr>
</tbody>
</table>
1 Introduction and Context

1.1 Background to Review

At the time of its introduction, the Mental Health Act 2001 was acknowledged as a very significant legislative step in advancing human rights protections for people admitted involuntarily to approved centres in this country. It replaced the Mental Treatment Acts 1945 to 1961 and brought Irish mental health law into compliance with international human rights conventions. While the commencement of the full provisions of the Act was widely welcomed, for the following reasons it is now timely to look again at the body of our mental health legislation to ensure that it remains relevant and enables us to progressively realise our developing obligations under international human rights law to the maximum within available resources:

- The Mental Health Act 2001 was enacted five years before the publication of A Vision for Change and, accordingly, does not reflect the significant changes in thinking about the delivery of mental health services that have taken place in the last ten years, such as the shift to community based services, the adoption of a recovery approach in every aspect of service delivery and the involvement of service users as partners in their own care and in the development of the service.

- Since the enactment of the 2001 Act, two statutory reviews have been undertaken. Section 75 of the Act obliged the Minister to carry out a review of the operation of the Act not later than 5 years after the establishment day - 5 April 2002; the report ‘Review of the operation of the Mental Health Act 2001 – Findings and Conclusions’ was published in May 2007. The Mental Health Commission was also required under section 42 (4) of the Act to prepare and submit a report in writing to the Minister on the operation of Part 2 of the Act, not later than 18 months after the commencement of that Part – 1 Nov 2006. The Commission’s document ‘Report on the Operation of Part 2 of the Mental Health Act 2001’ was submitted to the Minister and published in April 2008. The findings and conclusions of both reviews will inform the current review.
The Government signed the Convention on the Rights of Persons with Disabilities on March 30th 2007 and is committed to its ratification as quickly as possible. The Convention provides for a rights based approach to disability and in this context, the potential implications of some of the Articles of the Convention for our mental health legislation require further consideration.

While there can be no doubt that the Mental Health Act 2001 introduced a human rights ethos into our mental health law, there are growing concerns that this ethos is diluted by an emerging paternalistic approach that has been adopted by the judiciary in the interpretation of the Act. There have been widespread calls from civil society to refocus the Act away from ‘best interests’ in order to enhance patient autonomy.

The ‘Programme for Government’ includes a commitment to “review the Mental Health Act 2001 in consultation with service users, carers and other stakeholders, informed by human rights standards, and introduce a Mental Capacity Bill that is in line with the UN Convention on the Rights of Persons with Disabilities”.

1.2 Terms of Reference and Establishment of Steering Group

On taking up office, both the Minister for Health, Dr James Reilly T.D. and the Minister of State with responsibility for Mental Health, Ms Kathleen Lynch T.D. made it clear that they were keen to follow through on the commitment to review the Act as set out in the Programme for Government. Minister Lynch approved the establishment of a Steering Group with the following terms of reference:

“to review the provisions of the Act having regard to:

a) its general operation since its commencement;
b) the extent to which the recommendations of ‘A Vision for Change’ could or should be underpinned by legislation;
c) the provisions of the UN Convention on the Rights of People with Disabilities, and
d) the current economic environment,
and to make a report to the Minister by June 2012 with recommendations, including recommendations for legislative amendments where appropriate.”

The Steering Group was comprised as follows:

Luke Mulligan, Principal Officer, Mental Health Unit, Department of Health, Chair
Ms Patricia Gilheaney, CEO, Mental Health Commission
Mr Tony Leahy, Mental Health Specialist, HSE
Ms Joan Regan, Mental Health Unit, Department of Health
Mr Gerry Steadman, Mental Health Unit, Department of Health
Mr Stephen O’Brien, Mental Health Unit, Department of Health, (Secretary to Steering Group)

2 Structure of First Phase of Review

2.1 General work plan

The deadline for reporting to the Minister on the review of the Act was set out in the terms of reference as being June 2012. The Minister also asked that throughout the review, the Steering Group should work closely with the National Service Users Executive.

It was agreed that the review should be in two phases. The first phase would be an initial scoping exercise which would seek to identify the key areas of the Act to be examined. A public consultation exercise was planned in order to seek the views of the public and relevant interested groups/parties on what changes should be introduced to improve the operation of the Act. This would be followed by a series of meetings with key stakeholders i.e. HSE, Mental Health Commission, professional representative bodies, service user groups. Analysis of the main issues raised through the consultation
process and meetings, along with a review of issues raised by key documentation identified by the Steering Group would then allow for an interim report to be provided to the Minister by end 2011.

The substantive work of the review where issues would be examined in greater detail would then commence with the final report, as has been said, to be completed by June 2012. It is now envisaged that the full process should be completed by end 2012 / early 2013.

2.2 Documentation considered as part of review

Included in the Group’s Terms of Reference are two key documents, ‘A Vision For Change’ which introduced significant changes in mental health policy in this country and the ‘UN Convention on the Rights of People with Disabilities’ which raised standards in the area of international human rights law. Both documents were published after the Mental Health Act 2001 was enacted and both are considered central to this legislative review.

In addition, the considerable documentation received from groups and individuals as part of the public consultation exercise highlighted for the Steering Group the improvements to the legislation that many would like to see.

The Steering Group also drew up a list of principal documentation which helped to inform the members on a broad range of issues associated with mental health law and policy as well as human rights developments, and the problems identified with the operation of certain sections of the Act. This list was mentioned on the Department’s website in relation to the public consultation exercise and can be seen at Appendix A. While it is wide ranging in terms of its scope, it should not be seen as an exhaustive list of documentation considered in the course of the Steering Group’s work.
2.3 Number of meetings

The Steering Group first met on 15 July 2011 and subsequently met on a further 8 occasions. Following the public consultation exercise, the Group also met with a number of key stakeholders including the HSE, the Mental Health Commission and certain professional representative bodies and service user groups. The full list of meetings held by the Group is set out in Appendix B.

2.4 Public consultation

While there was a great deal of documentation available to the Group on the background to and operation of the Act, nonetheless it was considered essential that a public consultation exercise be undertaken to ensure that the most up to date views of stakeholders in the area of mental health and members of the public were available to the Steering Group.

Given the limited time available, it was decided that a four week period be set aside for the consultation process and advertisements were placed in four national newspapers on 6 September 2011 inviting the public and stakeholders to make submissions on the issue under review by the closing date of 7 October 2011. (A copy of the advertisement is at Appendix A.) The advertisement also advised any interested parties that further information that might assist individuals to make a submission was available on the Department’s website. That material is also attached at Appendix A.

The Group was also keen to ensure that as many service users as possible were informed about the review to allow them, if they wished, to forward a submission. In this context the Steering Group is grateful to the National Service Users Executive (NSUE) who included a document advising of the review in a leaflet drop NSUE was sending to some 4,000 members in early September.

In all, 102 submissions were received, with 62 coming from groups/organisations, 12 coming from professionals with an interest in this area and 28 from individual members
of the public. The full list of those who made submissions is attached at Appendix C. The Steering Group would like to record their sincere appreciation to those who took the time to make submissions on this important matter. The Steering Group found these to be invaluable to their work.

### 3 Key Themes Emerging and Recommendations

The public consultation process, meetings of the Steering Group and documentation considered has allowed the Steering Group to focus attention on the key points and themes that should be considered in the context of the substantive phase of the review of the Act. As the first phase of the review is intended to be a scoping exercise only, the Group was not in a position to get into the detail of each individual point at this stage.

It emerged from many of the submissions received that a large number of the important points being put to the Group could be made under a number of key headings or themes and it was decided, therefore, that the comments of the Steering Group and limited recommendations at this stage should be broadly categorised under the following seven headings:

- Human Rights and Paternalism
- A Vision for Change
- Children
- Voluntary, Involuntary Patients and Capacity
- Consent to Treatment
- Detention
- Authorised Officers
The views received ranged from firm recommendations in some cases to suggestions, questions and general comments in other areas of the Act that were seen to warrant attention. Some of the suggestions made came from a particular perspective and to deal with a specific issue and occasionally these conflicted with suggestions for other areas of the Act made by another group. *Appendix D* sets out in more detail the broad range of issues and the main salient points raised with the Steering Group.

It is important to reiterate the point that the following comments and recommendations being put forward by the Steering Group relate to the main points brought to the Group’s attention only. It is not possible in preparing the interim report to be exhaustive or definitive about the vast array of issues and sometimes contradictory viewpoints on those issues that have arisen as part of the review.

The comments of the Group that follow are intended to point a way forward and be a guide for the substantive phase of the review which will look at the issues raised in more detail.

**3.1 Human Rights and Paternalism**

The Mental Health Act 2001 introduced a human rights ethos into our mental health law. It was anticipated that the introduction in the Act of the statutory “best interests” principle would lead to a new emphasis on the rights of the patient, but the reality is that the principle has been interpreted by the Courts in a paternalistic manner. This paternalistic interpretation of the 2001 Act is undermining the significant advances in mental health law which the Act was intended to enshrine, and has given rise to concerns that the human rights aspects of the legislation have been diluted and diminished.

Section 4 sets out the guiding principles of the Act – effectively setting the tone for the operation of the Act. Section 4(1) provides that the patient’s “best interests” should be the “paramount consideration’ while section 4(3) provides that in making decisions under the Act “due regard shall be given to the need to respect the right of the person to dignity, bodily
integrity, privacy and autonomy”. The term best interests was not defined in the legislation. Thus, it was left to the Courts to balance best interests with human rights and the Courts appear to have given higher regard to the best interests provisions in Section 4(1) which has led to an overly paternalistic interpretation of the Act. Indeed the Courts have referred on numerous occasions to the need to interpret the Act in a paternalistic manner. In MR v Byrne and Flynn, O’Neill J found that “section 4 of the Act … in my opinion gives statutory expression to the kind of paternalistic approach mandated in the case of Philip Clarke and approved in the case of Croke v. Smith…”. Likewise Peart J in the High Court in JH v Lawlor, & ors, found “a purposive approach to the interpretation of the Act, consistent with its paternalistic and protective nature”. In the Supreme Court in EH v Clinical Director of St Vincent’s Hospital, Kearns J stated that “any interpretation of the term ‘voluntary patient’ in the 2001 Act must be informed by the overall scheme and paternalistic intent of the legislation as exemplified in particular by the provisions of sections 4 and 29 of the Act”.

The paternalistic approach to medicine presumes that the doctor knows best i.e. the doctor is the best person to determine the treatment a patient should receive. On the other hand, the autonomy approach supports the right of a patient to make their own treatment decisions, including the provision of support to help a patient make those decisions. There has been a general move worldwide away from paternalism in favour of autonomy with a growing recognition that all adults, including those living with a disability, have a right to autonomy and self-determination. In human rights debates, challenging the exclusion of persons with mental illness from the medical decision making process, has become a central theme.

The Convention on the Rights of Persons with Disabilities (CRPD) guarantees all rights and fundamental freedoms to all persons with disabilities and requires us to rethink our mental health laws. The paradigm shift which is called for by the CRPD poses many challenges. Ireland has signed the convention but ratification is delayed pending the adoption of Capacity legislation. The CRPD provides that supportive measures should be undertaken so as to facilitate individual autonomy and seeks to ensure that persons with disabilities are viewed as active subjects of human rights and dignity and not as objects of treatment and charity.
In terms of the public consultation and the follow up meetings with various stakeholders, the overwhelming view was that autonomy should have primacy in any revised Act.

**Recommendation**

The Group believes that a rights-based approach to mental health law should be adopted; unless there is evidence to the contrary, capacity should be presumed. A human rights based approach would underscore the fundamental rights of a person to participate in care and treatment decision making processes which affect them. Paternalism is incompatible with such a rights-based approach and accordingly the Act should be refocused away from ‘best interests’ in order to enhance patient autonomy.

It is recommended that the guiding principles of the revised Act should be human rights focused with the right to autonomy and self determination being the key principle. Other principles such as dignity, bodily integrity, recovery and least restriction should also be included and in this regard the Act should list a hierarchy of rights to guide decision making; this will ensure that there will be no carry over of paternalism into any new legislation. Further consideration is necessary as to the hierarchy of rights to be included which should involve in depth discussions with service users and other stakeholders.

### 3.2 A Vision for Change

*A Vision for Change* was published in 2006, five years after the enactment of the Mental Health Act 2001 and as such, the proposed community model of mental health service delivery and the recovery ethos underpinning *Vision* are not reflected in the legislation. The Act, in the main, provides a regime for the involuntary detention and protection of persons suffering from mental disorders.
**Community Based Services**

During the consultation, the Steering Group was informed as to how the current system mitigates against the transition to a community based service model. The Act charges the Inspector to visit and inspect approved centres at least once annually and to make a report to the Mental Health Commission; the Commission may apply sanctions in respect of non compliance with regulations made under the Act. There is some evidence to suggest that because of the statutory registration/licensing system, when assigning staff, priority is given to approved centres, and vacancies in approved centres are being filled by the redeployment of community based staff. This undermines the community service and in turn may increase the need for hospitalisation as service users are not receiving the necessary supports to keep them well in the community. While under the 2001 Act the Inspector may visit and inspect *any* premises where mental health services are provided *as he/she thinks appropriate*, the reality is that the focus of the Inspectorate is largely on the approved centres.

**Recommendation**

The Steering Group believes that the focus of the inspectorate on the community based service should be increased. In order to achieve this within existing resources the Group recommends that the inspection interval for approved centres should be increased. It is suggested that approved centres should be inspected at least once every 3 years but flexibility should be built in to allow for more frequent inspection based on risk (such as size of centre and previous inspection history etc). The resource freed up by the less frequent inspection of in patient facilities should be utilised by increasing the rate of inspection of community based services. This may however necessitate the registration of community based services such as day hospitals, day centres and multi-disciplinary community teams.

**Recovery**

During the public consultation many representations were received regarding the need to embed the recovery ethos in any new legislation.
A Vision for Change places a firm emphasis on recovery and on facilitating active partnerships between service users, carers and mental health professionals. One of the key recommendations of Vision is that a recovery orientation should inform every aspect of service delivery and service users should be partners in their own care. Since the publication of A Vision for Change in 2006, and in line with the report’s recommendations, the National Service Users Executive has been established and has developed into a vibrant, independent voice in the mental health arena. NSUE works on a partnership basis with the Department, the HSE and the Mental Health Commission on issues relating to service user involvement and participation in planning, delivering, evaluation and monitoring of mental health services.

Patients should be regularly informed of the reasons for their detention, their condition, treatment, rights and care plans. Carers and family members of patients should be kept informed of the patients’ condition in the approved centres, their treatment and care plans, subject to the patient’s consent.

**Recommendation**

It is recommended that recovery should be one of the guiding principles of the revised Act. The care planning function, which is already a statutory requirement in approved centres, should be strengthened and extended to all persons in receipt of mental health services. Care plans should reflect the service user’s particular needs, goals and potential and should address community factors that may impede or support recovery. An in-patient should have an individual care plan at the earliest point following admission. This in essence would represent a discharge plan and would provide a seamless recovery based approach towards discharge and support in the community.

The Group also believes that establishing a legislative basis for Mental Health Advance Care Directives, which allow mental health service users to specify their treatment preferences in advance of an incapacitating mental health crisis, could serve to underscore *Vision’s* recovery ethos. Such directives have the potential to enhance autonomy, empowering service users to participate in their future treatment decisions. The Department of Health is currently examining the need for legislation to provide a statutory basis for Advance Healthcare Directives. It is the view of the Group that legislative provisions for Mental Health Advance Care Directives should be included in
any overarching legislation on Advance Healthcare Directives rather than be dealt with in isolation in Mental Health legislation. However, if it is decided not to proceed with such general legislation, the Group recommends that the revised Mental Health Act should include provisions relating to Mental Health Advance Care Directives.

**Advocacy**

Advocacy services are currently available principally in the in-patient setting. The Group believes that further consideration should be given as to how the advocacy service might be expanded in line with the development of community based services.

The Group notes that no advocacy services are available to children in the mental health services. While accepting that the provision of peer advocacy services for children is not practicable, nonetheless the Group is of the view that the provision of advocacy services to children and to the families of children in the mental health service, is desirable. Further consideration is required, taking into account any broader child protection issues which might arise.

### 3.3 Children

The provisions relating to children in the Mental Health Act 2001 have for some time been the subject of debate and criticism and it is accepted that the provisions require to be updated. In July 2011, the Law Reform Commission (LRC) published their Report *Children and the Law: Medical Treatment*, chapter 3 of which dealt with Mental Health. The Commission made a number of recommendations regarding the amendment of the 2001 Act and these recommendations have informed the Steering Group in the context of this review.

Section 25 of the Act sets out child specific provisions and this includes 15 subsections and also 16 sections of the Child Care Act 1991 apply to proceedings under Section 25. The significant cross referencing of the 1991 Act makes reading the provisions of Section 25 unnecessarily complex. It is also unclear the extent to which other provisions within
the Mental Health Act 2001 apply to children. The need to dedicate a separate part of the Act to children and young people was highlighted in many of the submissions made to the Steering Group.

There was consensus in the submissions received on the need to have child specific overarching principles to guide decision making in terms of the admission and treatment of children. A number of representations were received regarding the need for a specialised child advocacy service; at present all adult patients have access to a peer advocacy service. The Group is of the opinion that a peer advocacy service for children is not practicable, however in principle we accept that the availability of an advocate to the child would be very helpful not only for the child but also for the parents.

**Recommendation**

The Group recommends that the provisions relating to Children should be included in a standalone Part of the Act and any provisions of the Child Care Act 1991 which apply should be expressly included rather than cross referenced. The dedicated children’s Part of the Act should open with a set of guiding principles reflecting human rights principles enshrined in international human rights law including the United Nations Convention on the Rights of the Child. The Group notes that the guiding principles relating to children will of necessity differ from those relating to adults. The Group has proposed that the right to autonomy and self determination should be the key principles insofar as adults are concerned, but these cannot be the guiding principles for children. The Group accepts that paternalism will always be a necessary feature of mental health legislation relating to children but believes that due regard should be had to the evolving capacity of a child and the ability and the willingness of the child to be part of the decision making process.

While further consideration needs to be given to the content of these principles, the Group believes that the following are of importance:
• Admission of children should be decided in the context of the best interests of the child objectively assessed by reference to their rights
• The welfare of the child is the first and paramount consideration
• The views of the child should be heard and given due weight in accordance with the child’s age and maturity
• The evolving capacities of the child should be respected
• The right to accessible and appropriate information
• The right to be treated in the least restrictive, and age appropriate setting
• The right to be treated in the least intrusive manner possible
• A specialised child advocacy service

The Department of Children and Youth Affairs should be further consulted as these principles are developed. This will ensure that any child policy issues which arise in the context of the proposed constitutional referendum on the child and in relation to obligations under international conventions, are fully considered.

Capacity to Consent

The Mental Health Act 2001 amended the definition of ‘child’ and brought it in line with the Child Care Act 1991; a child is now defined as a person under the age of 18 years, other than a person who is, or has been, married.

This definition has given rise to some difficulties particularly in the context of capacity to consent to treatment. Section 57 of the Mental Health Act 2001 requires as a general principle, the consent of the patient to treatment. However, the definition of patient does not encompass children so it would appear that children cannot consent / refuse admission or treatment and that it is a matter for the parent(s) to give/withhold consent. In this regard there is a lack of clarity in relation to the interface between the Mental Health Act 2001 and the Non-Fatal Offences against the Persons Act, 1997 (NFOAPA)
which provides that a 16 or 17 year old can consent to treatment and where such consent is given, it is not necessary to obtain the consent of the parent / guardian. There is significant uncertainty as to whether Section 23 of the NFOAPA has any application in relation to admission for, and provision of, treatment for mental illness. It has been the Department’s and the Mental Health Commission’s understanding that the NFOAPA does not confer any positive rights on the minor to consent to treatment but rather is a means to protect medical practitioners from being sued in the event that they administer treatment to 16/17 year olds without parental consent.

The Law Reform Commission recommends *inter alia* that ‘*the Mental Health Act 2001 be amended to provide that a person who is 16 or 17 years of age is presumed to have capacity to consent and refuse healthcare and medical treatment including psychiatric treatment*’. This recommendation is in line with the principle in the Convention on the Rights of the Child that the evolving capacities of the child be respected (Article 12) and has been endorsed in many of the submissions made to the Steering Group and in particular by the Children’s Mental Health Coalition (a group representing 50 member organisations).

**Recommendation**

The Steering Group recommends that children aged 16 or 17 should be presumed to have capacity to consent / refuse mental healthcare and treatment. The admission and treatment of Children under 16 requires the consent of the parent(s), however the views of the child should be heard and given due weight in accordance with the child’s age and maturity.

**Involuntary Detention**

The detention of children gave rise to a lot of debate during the consultation process and there was a general view that the provisions need to be strengthened in order to increase the protections for children. The lack of a mechanism for a child to challenge or seek a review of their detention was raised frequently.
Recommendation

At present the involuntary detention of a child requires a Court Order and the Group believes that this should remain unchanged i.e. any child under 18 should only be detained on foot of a Court Order. However the Group believes that the child should have the automatic right to an independent review of their detention and sees merit in the introduction of child friendly Tribunals for children detained by the Court. In addition a child should be provided with a legal representative. For children under 16, the parents should have a right of access to the Tribunal. The composition of the Tribunal and the review mechanism will need further consideration; however it is important that the Tribunal should have access to appropriate child expertise.

Voluntary child patients

The LRC suggested that all children admitted to approved centres by way of consent of their parent(s) should be entitled to a review of their detention. The Group considered this recommendation at length, in particular the added value of such a review mechanism in the context of the inalienable and imprescriptible rights of parents under the constitution and concluded that we could not recommend the introduction of such a review mechanism at this stage.

Powers of Gardaí to Remove Children

Section 12 of the 2001 Act gives the Garda Siochana the power to take a person believed to be suffering from a mental disorder into custody; however it is unclear if Section 12 can be applied in the case of children. While the wording of Section 12(1) read in isolation could be interpreted to include children, a consideration of the provision in light of Section 12 subsections (2), (3) and (4) and Section 25 suggests that the provisions of Section 12 relate to adults only.

While the Gardaí already have powers to remove a child under the Child Care Act 1991, there is some confusion as to the interplay between Section 25 of the Mental Health Act and the relevant provisions of the Child Care Act 1991, and this has posed challenges at operational level.
Recommendation

The Group recommends that the matter should be clarified by giving the Gardaí the specific power to remove a child believed to be suffering from a mental disorder to an age appropriate approved centre. (Further consideration is required regarding the provision of any necessary safeguards for the child in such circumstances). The HSE may then, if necessary and appropriate, initiate the process for the involuntary admission of the child.

Definition of Child

A child should be defined as a person under 18 and thus brought into line with the Children Act 2001. The need to exclude those persons under 18 who are or have been married is no longer relevant or necessary.

3.4 Voluntary, Involuntary Patients and Capacity

The 2001 Act in the main deals with involuntary patients and provides considerable protections for that cohort. During the course of the consultation issues regarding voluntary patients generated significant comment and it was identified as a major area of concern with the current legislation. A voluntary patient is defined as a person receiving care and treatment in an approved centre who is not the subject of an admission order; it is a definition by default as it describes what a patient is not.

The reality is that many of the voluntary patients in approved centres lack the capacity to consent to admission and treatment. Thus they are voluntary patients, not because they have consented to admission, but rather because they have not objected. They are what has become known as the ‘compliant incapacitated’ – they are de facto detained yet do not enjoy the protections provided to involuntary patients in the Act. (Protection for incapacitated voluntary patients is provided in common law). We thus have the situation where many patients who lack or have fluctuating capacity, remain for lengthy periods in our approved centres without external review of their admission, detention or capacity. Similarly treatment decisions for voluntary patients are made without external oversight.
Two patients in the same centre may receive the same medication for their mental illness, yet one, the involuntary patient, is entitled to automatic review by a second consultant where it is proposed to further administer medicine following the administration of that medicine for a continuous period of 3 months, while the voluntary patient will enjoy no such oversight.

It is anticipated that many of the shortcomings in the 2001 Act which arise because of capacity issues will be addressed by the proposed Capacity legislation which is at an advanced stage of preparation by the Department of Justice and Equality. The purpose of the proposed Mental Capacity Bill is to provide a statutory framework governing decision-making on behalf of adults who lack capacity and will provide for the introduction of supported and substitute decision making for persons who lack capacity. The Group met with the Department of Justice and Equality and there is a shared understanding that the revised Mental Health Act must dovetail with the Mental Capacity Bill.

**Recommendations**

The scope of the Mental Health Act should be extended to include voluntary patients and the protections provided for involuntary patients should where appropriate and necessary apply equally to voluntary patients. Further recommendations to this end are made in this report.

The Act should include a statement that a person is presumed to have capacity to make decisions in relation to admission and treatment. However, where there are reasonable grounds to believe that the patient lacks that capacity, arrangements should be made to assess the person’s capacity to make a particular decision at that point in time, with a view to establishing the supports necessary to assist the person in making the decision. At present the treating psychiatrist determines the capacity of the patient to consent to treatment. Where the patient is deemed to lack capacity, that psychiatrist then makes any necessary treatment decisions. While accepting that the clinician providing care and treatment is well placed to determine the capacity of the patient, nonetheless the
Group believes that there is a need to establish independence in the capacity assessment. It is recommended that assessment of capacity should be undertaken by a trained mental health professional with multi-disciplinary input as necessary from the treating Mental Health Team. The Mental Health Commission should have a role in training and accrediting professionals in relation to capacity assessment.

Any new legislation should recognise that decisions on admission and treatment for persons who lack or have fluctuating capacity should be made in the context of the proposed capacity legislation i.e. the patient should receive all the necessary supports provided in that legislation to make a decision to be admitted and treated, up to and including substitute decision making. Substitute decision making should be applicable only as a last resort and even then the person charged with making the decision on behalf of the patient must be obliged to do so with regard to any known will or preferences of the patient.

The definition of voluntary patient should be amended such that a voluntary patient is a person who consents on his own behalf or with the support of others to admission to an approved centre for the purposes of care and treatment for mental illness, or on whose behalf a Personal Guardian appointed under the proposed Capacity legislation consents to such admission.

Essentially a voluntary patient may be:

1. a patient who has the necessary capacity to make a decision in relation to admission and a decision(s) in relation to treatment, and has consented to admission and treatment
2. a patient who has fluctuating capacity and requires support to make a decision in relation to admission and treatment
3. a patient who lacks capacity, and consent for admission and treatment has been provided by a Personal Guardian.
Protections for voluntary patients

The Group believes that where a patient has capacity and consents to admission and treatment, external oversight is not required. For patients with a Personal Guardian appointed under the proposed capacity legislation, the Group is of the view that the protections provided under the capacity legislation will provide sufficient protection of the rights of the individual.

However with regard to those patients with fluctuating capacity (including those who may have had capacity to consent to admission in the first place but that capacity has subsequently diminished), the Group recommends that a level of external oversight should be provided to ensure that the process provided for supported on-going decision making is sufficient and is properly applied.

Where the Inspector has concerns about the adequacy of the consent process in respect of any voluntary patient in relation to either admission or treatment, he/she should have the necessary powers to have the case referred to a Tribunal.

There have been suggestions that many (capacitated) voluntary patients are not truly voluntary, as they have consented to admission or to treatment only because of the threat of detention. The Group is of the view that voluntary patients should be voluntary in all respects and not only should they be informed of the rights provided under the existing Act and regulations made thereunder, but that there should also be a statutory requirement that they be informed of their common law rights to give or withhold consent and to leave the approved centre.

Change to patient’s legal status from voluntary to involuntary (Sections 23 and 24)

At present a patient’s status cannot be changed from voluntary to involuntary unless and until they indicate a wish to leave the approved centre, and then only if they are found to have a mental disorder.
Some submissions suggested that the requirement for a person to indicate that he or she wishes to leave is too restrictive and that the consultant psychiatrist should be permitted to detain the person if the criteria for a mental disorder are met. It was submitted that a voluntary patient who might meet the criteria for a mental disorder could withhold consent to treatment and consequently their condition might deteriorate yet their status cannot be changed unless they indicate a wish to leave the approved centre.

On the other hand the UN Committee against Torture in their concluding observations on their examination of Ireland in June 2011 drew attention to the lack of clarity on the reclassification of mentally ill persons from voluntary to involuntary and recommended that the Mental Health Act 2001 be reviewed in order to ensure that it complies with international standards. The Committee further recommended that Ireland should report on the specific measures taken to bring its legislation in line with internationally accepted standards in its second periodic report. During the course of Ireland’s examination, concerns were expressed that voluntary patients who wished to leave a facility could be detained for assessment and it was felt that this undermined the status of the voluntary patient.

**Recommendation**

The Group is of the view that changing the legal status of a patient from voluntary to involuntary should not be undertaken lightly. To avoid the situation where a voluntary patient can remain as such in an approved centre refusing treatment provided they do not express a desire to leave, the Group recommends that acceptance of a need for treatment should be implicit in voluntary admission. On admission the informed consent of the patient to admission and a course of treatment should be required. Where a patient refuses the treatment offered the admission should not proceed. Where a voluntary patient refuses all treatment they should be discharged from the approved centre.
The Group also recommends that the provisions of Sections 23 and 24 should be amended such that where a voluntary patient wants to leave, they should be allowed to do so. However where staff of the Centre consider that a person suffering from a mental illness may be a risk to himself/herself or others, the person should be detained for a maximum period of 12 hours and an authorised officer should be called to the Centre to have discussions with the patient and staff. The authorised officer will consider the alternatives available, offer advice and mobilise support for the service user and the family where necessary. Where the officer believes that the person represents a risk to himself/herself or others and there is no alternative to detention, the officer should make an application for an involuntary admission in the normal way and a medical practitioner, who is not a member of staff of the Centre, should examine the person and determine if there is a need to make a recommendation for admission.

3.5 Consent to Treatment

The 2001 Act requires consent to treatment as a general principle, except in circumstances where the treatment is necessary to safeguard the life of the patient, to restore his/her health, to alleviate his/her condition or his/her suffering, and the consultant psychiatrist is of the opinion that the (involuntary) patient is incapable of giving such consent. For ECT and long term medication the written consent of the patient is required; however where a patient is unable or unwilling to give consent, the treatment may be administered if it has been approved by the consultant psychiatrist responsible for the care and treatment of the patient and also authorised by another consultant psychiatrist.

Recommendation

The Group has already recommended that the guiding principles of the revised Act should be human rights focused, with the right to autonomy and self determination being the key principles. The Group further recommends that the Act should explicitly provide that patients should be supported to make informed decisions regarding their care and treatment. The need for such a statement, or the extent of any such statement, will need to be examined in the context of the forthcoming capacity legislation. However it is clear that treatment decisions in respect of all patients (either voluntary or
involuntary) who lack or have fluctuating capacity, will be taken in accordance with the provisions of the capacity legislation i.e. by way of supported decision making or by a personal guardian appointed under that legislation.

In no circumstances should a patient who is capable of giving informed consent in relation to a particular decision at a given time be forced to take treatment against their will – accordingly ‘unwilling’ should be removed from Sections 59 and 60. This amendment will provide that where the person concerned has the capacity to make this decision, any refusal to accept ECT, or medicine after a continuous period of three months, will be respected.

The provisions of Sections 59 and 60 in regard to patients who are ‘unable’ to give consent will need further examination in the light of the proposed capacity legislation. The Group is hopeful that the protections provided to patients under that legislation will be sufficient and no further protections will be required under mental health legislation. Thus, it may be possible to repeal Sections 59(1) (b) and 60(b) of the Mental Health Act 2001.

**Definition of Treatment:**

The definition of treatment should be expanded to include ancillary tests required for the purposes of safeguarding life, ameliorating the condition, restoring health or relieving suffering.

**3.6 Detention**

Many representations were made during the consultation regarding the detention process. The issue of detention is obviously emotive and there are many and varied opinions as to when, if and how a person should be detained. *A Vision for Change* proposes a community model of service delivery and in that context the detention of a person should, very clearly, be seen as the treatment of last resort.
Recommendations

The Group accepts that a person should be detained for treatment as a last resort and that the Act should be underpinned by the least restrictive principle, stressing that a patient should not be detained longer than absolutely necessary. It is recommended that any new legislation should explicitly require that all less restrictive options for care and treatment should be considered and exhausted before a person can be detained, and in the admission process, the admitting clinician should be required to certify that it is not possible for the person to receive the necessary care and treatment in the community. In line with the previous recommendation that the revised Act should incorporate human rights focused guiding principles, the autonomy principle should be central to the detention provisions in the Act.

Criteria for detention

Significant intellectual disability should not be grounds for involuntary detention – a person with significant intellectual disability should only be detained where they have a co-morbid mental illness of such severity that meets the threshold for mental disorder. Further consideration needs to be given as to whether a treatability requirement should apply across the board and thus introduce a principle of reciprocity into the legislation.

The Group also recommends that the “or” between Sections 3(1)(a) and 3(1)(b) be amended to “and/or”. In the Judgement delivered by Mr Justice O’Neill in the case of M.R., the Court found that sections 3(1)(a) and 3(1)(b) “are not alternative to each other” and ruled that “the compulsion of an alternative choice between Sections 3(1)(a) and 3(1)(b) is incorrect”. While the Judgement does not mandate an amendment to the Act, an amendment is desirable in the interest of clarity. The Judgement also refers to the interpretation of the terms “serious likelihood” and “immediate and serious harm” in Section 3(1)(a), and in that context, consideration should also be given as to the need to provide a definition of those terms.
Procedural issues

The 24 hour initial detention period, within which time the person must be examined by the consultant psychiatrist in the approved centre, should be reduced to 12 hours. The Act should be clear that no treatment should be provided until such time as the person has been examined and an admission order has been made. It is accepted that a person may be very unwell and may require treatment as a matter of urgency. It is the view of the Group that in such circumstances it will be necessary to ensure that the person is examined immediately with a view to an early decision as to whether the person should be admitted and this will enable the administration of treatment.

Renewal Orders at present can be for up to 3 months, 6 months or a year. The Group believes that the 3rd renewal order of up to 12 months is too long and could be reduced to up to 9 months. Thus a long stay patient would have an entitlement to a Tribunal review at intervals of at least every 9 months.

The Group recommends that a patient should be empowered to nominate a person (family member/friend/advocate) to attend the Tribunal in addition to the legal representative.

The Group also recommends that where a patient has indicated that they do not wish to have their detention reviewed by a Tribunal, and they have the capacity to make this decision, this wish should be respected. There may be a need to review the role of legal representatives, where a patient refuses a Tribunal.

Role of the Independent Psychiatrist

Currently admission orders are for a 21 day period and a person is automatically entitled to a review of their detention within this period; however some 8% of patient’s admission orders were revoked before they had their Tribunal in 2011. Even if the admission order is revoked and the Tribunal is not held, the costs that have already
been incurred in preparation for the Tribunal are payable. This is a waste of mental health resources.

At present the Commission appoints an independent psychiatrist to provide a second clinical opinion to the Tribunal. The independent psychiatric report must be provided to the Tribunal and copied to the patient’s legal representative within 14 days of the making of the admission order. The Group believes that the role of the independent psychiatrist should be reviewed and a number of options were considered.

One such option is that the independent psychiatrist’s report be completed within 10 days of the detention, and if the independent psychiatrist finds following examination that the patient does not have a mental disorder, the person should be discharged or have the option of receiving treatment as a voluntary patient. If the psychiatrist confirms that the patient has a mental disorder, the person should be detained for a further maximum period of 11 days (giving a total of 21 days detention) and should be automatically entitled to a review of their detention. Therefore the automatic right to a Tribunal arises only if the patient has not been discharged by day 10, either by the independent psychiatrist or by the treating psychiatrist. The Tribunal should be held, as is the case at present, within 21 days of the making of the admission order. A person who was detained but discharged within 10 days should have a right to have a review by a Tribunal on request.

Another option is that the independent psychiatrist should be the Consultant Psychiatrist on the Tribunal and that the patient should be examined by that psychiatrist on the day of the Tribunal. This would provide the Tribunal with an assessment of the patient’s mental state on the day of the Tribunal and therefore assist them in determining if the person is suffering from a mental disorder at that time. This would obviate the need for a third psychiatrist in the detention process and possibly facilitate earlier Tribunals. The Group recommends that these options be explored further in the next stage of the review.
Appeal to Circuit Court

Noting that current legislation provides very limited grounds for appeal of Tribunal decisions - a detained patient may appeal their detention to the Circuit Court only on the grounds that they dispute the fact that they have a mental disorder – the Group recommends that grounds for appeal should be amended such that the onus of proof as to the existence of a mental disorder does not fall on the patient.

Involuntary admissions to general hospitals

The 2001 Act provides for the removal of persons and involuntary admission to approved centres only. The Group was informed of many situations where the acute medical needs of the patient dictated that the person should first be admitted to a general hospital for treatment. The Group recommends that special provisions should be included in any new Act which provides that in emergency situations a person could be brought to an Emergency Dept for treatment and/or admission and that the patient could be assessed there for the purposes of their detention under the Act.

Examination by a GP

Some concerns were voiced during the consultation regarding the examination by a GP following the making of an application for a recommendation. Service Users felt that the Act was vague on the type of examination required and that only cursory examinations were at times undertaken. While this may be understandable where the patient is known to the doctor or where the doctor is aware of the patient’s emerging mental health crisis, it was submitted that on-call doctors and locums sometimes made decisions on a patient not known to them without adequate examination and that a patient might be in an agitated state not because of a mental health crisis, but rather because of the threat of detention. The Group therefore recommends that the nature of the examination required should be clear and that the doctor recommending detention should certify how he/she came to the view that the person is suffering from a mental disorder.
Absence with Leave

Section 26 of the 2001 Act provides that a detained patient may be granted permission by his/her treating psychiatrist to be absent from an approved centre for a specified period. The Group has some concerns that such provisions may potentially be used as community treatment orders and believes that if a person is well enough to be absent from an approved centre, the need for their continued detention as an involuntary patient is questionable. At the same time the Group accepts that there may be occasion when a detained patient may need to be absent e.g. funeral etc. It is recommended that the provisions of Section 26 should be further examined with a view to clarifying the precise need for this section and to ensure that it is used correctly and for a very limited period.

Definition of Clinical Director

The introduction of Executive Clinical Directorates in the Mental Health Service has led to some confusion regarding the statutory role of Clinical Directors under the Act. For the purpose of clarity, the title ‘Clinical Director’ should be renamed ‘Director of the Approved Centre’ – however no change in the definition is person is required.

3.7 Authorised Officers

Authorised Officers (AOs) are persons who have been authorised by the CEO of the HSE to exercise the powers conferred on AOs i.e. to make an application for the involuntary admission of a person under the Mental Health Act 2001. It was envisaged at the outset that the authorised officer service would provide an accessible 7 days a week service. However since the beginning there have been difficulties with the implementation of a comprehensive service and there have been complaints regarding a shortage of AOs nationally. This is borne out by the fact that only 8% of applications were made by AOs in 2011 compared with 24% made by Gardaí.

The Group believes that the implementation of a full authorised officer service would have considerable benefits as such officers are best placed to consider alternatives to detention, can offer specific advice and mobilise support for the service user and the
The Group therefore recommends that Section 9 be amended in order to establish a hierarchy of persons who can make application for detention and an AO should be the first-mentioned applicant. It will be necessary to clarify the role of AOs - who should be suitably qualified mental health professionals - and consider if such officers should be involved in the removal of persons to approved centres. The work involved in implementing an authorised officers service should be incorporated into the functions of community based mental health teams.

4 Next Steps

Having now set out the main issues relating to the Mental Health Act 2001 and made recommendations on what should be the focus of attention for the second phase of the review, the Steering Group would like to comment on the existing draft Mental Health (Amendment) Bill and the proposed structure for the second and substantial phase of the review.

The existing draft Mental Health (Amendment) Bill was drawn up in 2010 to provide for technical amendments to the Mental Health Act 2001 which were recommended following the review of the Act which was undertaken by the Department of Health and Children in 2007, and by the Mental Health Commission in the context of their review of the operation of Part 2 of the Act in 2008.

The Steering Group considered whether the Department of Health should proceed with the existing draft Mental Health (Amendment) Bill in its own right or incorporate it into the current review and it was decided to recommend the latter option. However, those Heads deemed urgent i.e. ECT/Administration of medicine/MHC rules applying in designated centres, should if possible, be incorporated into a Health Miscellaneous Provisions Bill or some other suitable Bill.

In relation to the second and substantial phase of the review, it is recommended that the existing Steering Group be expanded and that an Expert Group should take over the
review process. The new Group should continue to be chaired by the Department and retain the existing Steering Group representatives from the Department of Health, the Mental Health Commission and the HSE, while representatives of the College of Psychiatry, the Mental Health Nurse Managers Association and NSUE should be invited to join the Group. It is envisaged that the Expert Group should have three subgroups working to it with each subgroup focusing on certain aspects of the Interim Report vis children, detention/consent and general issues including advocacy and guiding principles.

It is a matter for the Minister to ultimately confirm membership of the Group and it is envisaged that the Expert Group should complete their work by end 2012 / early 2013.

27 April 2012
APPENDICES

Appendix A

Public Consultation Advertisement

The following is the advertisement placed in four of the daily national newspapers on Tuesday 6 September informing people of the review and inviting submissions.

Review of the Mental Health Act 2001
Submissions Sought

The Programme for Government includes a commitment to review the Mental Health Act 2001, “informed by human rights standards and in consultation with service users, carers and other stakeholders”. Minister of State Kathleen Lynch T.D. has now established a Steering Group to review the provisions of the Act having regard to
(a) its general operation since its commencement;
(b) the extent to which the recommendations of ‘A Vision for Change’ could or should be underpinned by legislation;
(c) the provisions of the UN Convention on the Rights of People with Disabilities, and
(d) the current economic environment.

The group now invite the public and stakeholders to make submissions on the issue under review.
All documentation received will be subject to the Freedom of Information Act 1997, as amended
Submissions should be concise, focused and limited to ten pages. Full contact details for the individual/organisation concerned should also be included to allow the Steering Group seek further elaboration if required.

Submissions should be sent to the address below or by email to be received by 5pm on Friday 7 October 2011.
In addition to placing the advertisement in national newspapers, it was also listed on the Department’s website, which also included the following additional material:

“The Steering Group is anxious to hear from members of the public and stakeholders, and actively encourages them to make a submission in relation to the operation of the Act since its enactment.

While there is no restriction on the nature or content of submissions it would be helpful from the group’s point of view if submissions could be as concise and focused as possible (ten page limit) while also taking account of the commitment in the Programme for Government as well as the group’s terms of reference.

In that regard, the following may be helpful to people in considering their views on some key aspects of the Act.

Mental Health Act 2001 - Arrangement of Sections

Part 1 Preliminary and General
The definitions set out Part 1 of the Act such as ‘mental disorder’, ‘mental health services’, ‘patient’, ‘treatment’ and ‘voluntary patient’ are central to the successful operation of the Act. It is important therefore that there is clarity on these fundamental definitions. Can these definitions be improved? Also, we are keen to hear from individuals and groups as to how ‘best interests of the person’ currently set out in s.4 of the Act should be defined.

Part 2 Involuntary Admission of Persons to Approved Centres
Part 2 of the Act was commenced on 1 November 2006 and has been in operation for almost five years now. It relates to the system of involuntary admission of persons to
approved centres and there are a range of important features included in this part regarding who can apply for such admissions, the making of recommendations regarding such admissions, the referral of admissions to Tribunals, the powers conferred on Gardaí and the transfer of patients. Comment is invited on the operation of this part of the Act to date and what changes may now be required consistent with the Group’s terms of reference.

**Part 3 Independent Review of Detention**
This part of the Act deals with the establishment and functions of both the Mental Health Commission and the Inspector of Mental Health Services. Among the key sections within part 3 is the role allocated to the Commission in setting up Tribunals and the powers conferred on them. Given the vitally important role played by Mental Health Tribunals, people may wish to pass on their views as to the effectiveness and transparency of Tribunals under the existing legislation and suggest how we can try to improve quality standards in terms of their operation and outcomes.

**Part 4 Consent to Treatment**
This part of the Act confirms that consent is required for treatment except in certain circumstances as laid down in s. 57. It also deals with psycho-surgery, ECT and the administration of medicine. The issue of consent will also be relevant in the context of decision making for those who lack capacity, an issue to be addressed in a new Scheme of Mental Capacity Bill in respect of which the Department of Justice and Equality is the responsible Department.

**Part 5 Approved Centres**
The registration and regulation of Approved Centres is provided for in part 6 of the Act. Suggestions are welcome as to how this part of the Act has operated thus far and how it can be improved.

**Part 6 Miscellaneous**
Part 6 deals with miscellaneous issues including bodily restraint and seclusion, participation in clinical trials, clinical directors and the requirement for leave of the High Court for certain proceedings. Suggestions are welcome on how this part of the Act has operated thus far and how it can be improved.
General Issues for Consideration

The Operation of the Act to date

It would be useful if people with a knowledge of the operation of the Act were to convey their impression of the application of the Act in a general sense before going into specifics about areas for change. While clearly any review of this nature will focus on areas that are perceived to require change, mention of the parts that are perceived to be working well and making a difference also merit comment.

The general scope of the Act and the question of expanding its provisions
Some may feel that a broader approach is required for our mental health legal framework and that the Act should be expanded to include references to multidisciplinary teams, care in the community and recovery as set out in A Vision For Change. We would also like to hear from people about the key principles they believe should be specifically mentioned in the Act and the balance the Act should have between a human rights and/or a paternalistic approach. As the main focus of the Act is currently on involuntary patients, the possibility of including further measures and protections in relation to voluntary patients also requires examination.

The Treatment of Children under the Act
The provisions of the Act relating to the treatment of children require close examination. Views on the changes that may be considered necessary are welcome. The Law Reform Commission has just issued a report entitled ‘Children and the Law: Medical Treatment’ which is a very useful input in the context of the review of the Act. 
http://www.lawreform.ie/_fileupload/Reports/Children%20and%20the%20Law103%20011.pdf

Detention and Treatment under the Act
There are many key issues which require close scrutiny in this review, including for example, the requirement to treat people in least restrictive environment, the criteria for involuntary admission, the removal of the persons to approved centres, the duration and renewal of admission orders, whether the provisions relating to the requirement for second opinions need to be updated and improved, as well as the reclassification of
patients from voluntary to involuntary. These are all areas which merit specific and focused comment.

Finally
The issues and sections of the Act referred to above are mentioned purely to invite comment and should not be seen as the only areas of the current Act on which people should share their views.

Please feel free to contact the Mental Health Unit on (01) 635 4022 on any point relating to the submission of views which should be forwarded to the Department no later than Friday 7 October.

Other Documents
The following documents may be of use to you in considering your response to the call for submissions - it should not be viewed as an exhaustive list of relevant documents in this area.

Mental Health Act 2001 -
Mental Health Commission ‘Your Guide to the Mental Health Act 2001’ -
Mental Health Act 2008 (relates to renewal orders under the MHA 2001) -
Health Miscellaneous Provisions Act 2009 (s.63 amends the MHA 2001) -
S.I. No. 550/2006 — Mental Health Act 2001 (Authorised Officer) Regulations 2006 -
S.I. No. 551/2006 — Mental Health Act 2001 (Approved Centres) Regulations 2006 -
http://www.mhcirl.ie/documents/publications/MHC_Section42%284%29_Review%202008.pdf
A Vision For Change (published in 2006) -
http://www.dohc.ie/publications/vision_for_change.html
UN Convention on the Rights of People with Disabilities -
Irish Human Rights Commission Policy Paper concerning the definition of a ‘Voluntary Patient’ under section 2 of the Mental Health Act 2001 -
Law Reform Commission Report on ‘Children and the Law: Medical Treatment’ -
http://www.lawreform.ie/_fileupload/Reports/Children%20and%20the%20Law103%202011.pdf
Law Reform Commission Report on Vulnerable Adults and the Law (2006) -
Department of Justice Scheme of Capacity Bill 2008 -
Appendix B

Steering Group Meetings

9 meetings of the Steering Group were held between July 2011 and April 2012 on the following dates:

15 July 2011
30 August 2011
20 October 2011
28 October 2011
9 December 2011
21 December 2011
11 January 2012
20 January 2012
23 April 2012

In addition, the Steering Group invited a number of key groups to individual meetings to elaborate on their submissions to the Group. The organisations met, and dates of those meetings are as follows:

- Department of Justice and Equality 16 September 2011
- National Service Users Executive (NSUE) 3 October 2011
- Irish Human Rights Commission (IHRC) 20 October 2011
- Childrens Mental Health Coalition 24 October 2011
- Irish Mental Health Lawyers Association 24 October 2011
- Irish College of General Practioners (ICGP) 28 October 2011
- Irish Advocacy Network (IAN) 28 October 2011
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### Appendix C

**Submissions Received by the Steering Group**

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<td>Balfie Karol</td>
<td>Amnesty International Irish Section</td>
<td>Mental Health Campaign Co-ordinator</td>
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<td>St. Vincent's Hospital Fairview</td>
<td>Development Co-ordinator</td>
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<td>Byrne Niall</td>
<td>Health Information and Quality Authority</td>
<td>Deputy Director for Operations</td>
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<td>Carroll Deirdre</td>
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<td>Charles Karla</td>
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<td>Research &amp; Development Advisor</td>
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<td>Head of School of Nursing and Midwifery /Professor Mental Health</td>
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Appendix D

Key Themes and Views Emerging from Consultation Process

The work of the Steering Group was greatly assisted by the public consultation process which was undertaken and followed up in some cases by meetings with key representative groups.

The broad range of issues and the main salient points raised with the Steering Group are set out below.

1. Human Rights and Paternalism

- The term ‘best interests’ needs to be defined. The failure to define ‘best interests’ in the Act has led to an overly paternalistic interpretation by the Courts and to a failure to adequately protect the rights of autonomy and dignity.
- The best interests of a person must be a guiding principle in relation to all decisions under the legislation.
- Consideration should be given to adopting the best interests principle in accordance with the rights based approach of the CRPD. Guiding principles should include: the recovery approach, respect for inherent dignity, individual autonomy including the freedom to make one’s own choices and independence of persons; respect for bodily integrity and privacy of the person; the principle of non-discrimination and equality; participation; informal care; least restrictive alternative; reciprocity; respect for diversity; the role of family/carers; confidentiality; effective communication and the provision of information.
- Best Interests needs to balance the rights of the individual with the risk of serious harm to others. It should also balance the various rights of the person namely the right to life of the person, right to dignity, privacy and autonomy.
- Best Interests requires that the person should be treated in the least restrictive environment and in the most appropriate place.
- The Act should provide that any act done or decision made for or on behalf of a person who lacks capacity must be done or made in his or her best interests.
- In relation to children, the best interests principle should be child centred and any ‘best interests’ test must be focused on promoting the rights of the child.
- The Act should be amended to reflect an autonomy-based approach to best interests using the Capacity Bill’s definition of best interest.
• A new definition of best interests needs to ensure that people are properly involved in their own care and recovery, and to deter the judiciary from misinterpretation.
• The best interests definition should give priority to the wishes of the patient, or the assumed wishes as far as they are ascertainable.
• It should be made clear that best interests should be defined as more than medical best interests.
• There is a concern that the medical dominated approach to mental health care and treatment continues to display a paternalistic attitude towards patients.
• The principle of consultation and active participation of the person in decisions should be strengthened as a key underpinning of A Vision For Change (AVFC).
• Too often the representations made by patients are not considered or recorded. The provisions of the Act should be expanded to ensure that there is advocacy or representation for patients to allow their best interests to be clearly articulated.

2. A Vision for Change (AVFC)

• The revised Act should give legislative underpinning to the key aspects of AVFC. These principles include recovery, community care, least restrictive alternative, partnership and multi-disciplinary teams. The WHO has recognised that legislation can play a major role in promoting community-based care for people with mental health problems and reducing involuntary admissions.
• AVFC acknowledges that mental health legislation is essential to underpin the right to respect for the dignity of individuals and the protection of their human rights.
• In keeping with the ethos of AVFC, ‘treatment’ should be redefined in such a way as to include a statement about recovery which should be put at the heart of mental health services care and treatment.
• The revised Act should explicitly highlight the importance of individual care and recovery plans.
• The title of the Act should be inclusive of the focus towards community care.
• The Act should be amended to provide for the role of the National Directorate of Mental Health Services (with budgetary power) in the same way that the Mental Health Commission, the Inspectorate of Mental Health Services, and the Mental Health Tribunals are recognised as essential.
• AVFC should be implemented so as to ensure that sufficient community supports are put in place to minimise the number of involuntary admissions to approved centres under the Act.
• The significant powers under the Act of consultant psychiatrists should be re-examined and the role played by community based mental health professionals should be increased. With the emphasis of the current Act on the role of consultant psychiatrists, treatments tend to be from the bio-medical model rather than placing the emphasis on the recovery model.

• Mental health services should include community care services. The definition for mental health services in Section 2(1) does not refer to community care services.

• The HSE should be statutorily obliged to provide comprehensive and community-based mental health service including the specialist services identified in AVFC.

• The role of peer advocate is established but is in need of expansion within the monitoring mechanisms of the Act.

• The principle of consultation and active participation of the person in decisions should be strengthened as a key underpinning of AVFC.

• The possible registration of mental health services in the community needs to be examined.

3. Children

• The need for a separate section of the Mental Health Act to deal specifically with children was frequently mentioned.

• The Law Reform Commission (LRC) report ‘Children and the Law: Medical Treatment’ was acknowledged as being very helpful in charting a way forward for dealing with children with mental health problems.

• The definition of a child in the Act needs to be re-examined.

• The Act should make it clear that treatment must be focused on recovery.

• Capacity and consent are major issues relating to children with under 16s, 16 – 18 year olds and parental consent all needing to be examined in the context of proposed Capacity legislation and the LRC recommendations.

• The LRC has recommended that in general a person who is 16 or 17 years old is presumed to have capacity to consent to, and refuse, health care treatment. Under 16s cannot be presumed to have this capacity. Instead under 16s should be assessed to see if they have the maturity and understanding to appreciate the nature and the consequences of the specific health treatment decision.

• The LRC proposal for a third ‘intermediate’ category of detention for children detained with the consent of their parents or guardians was cited by a number of groups.
In relation to children, ‘best interests’ should be defined in a way that is informed by the views of the child, bearing in mind that those views should be given due weight in accordance with the age and maturity of the child.

Section 25 should include a specific reference to best interests of the child in deciding to make an application.

Children admitted on an involuntary basis should have the same rights available to them as adult involuntary patients. Children’s rights following detention need to be improved.

A Guardian ad Litem should be appointed to protect a child’s rights where he/she is detained under section 25.

There can be confusion over which District Court should hear an application for a renewal order, the Court who made the initial admission order or the Court in whose area the child is being detained.

An independent consultant’s report should be presented for any application for an extension of a child’s detention.

Maximum periods for renewal orders criticised as being too long.

Greater clarity is required where a child under 16 is detained but then attempts to leave the approved centre.

Acknowledgement that section 25 of the Act is used on occasion to partly protect the child/parent relationship.

The need for an Independent Advocacy Service for children was raised.

The need for an Independent Complaints system for children was also raised.

Involuntary admissions for young people are better discussed at a Mental Health Tribunal rather than the District Courts as Tribunals have the specialist skills necessary to carry out this task. The LRC recommends that the District Court should continue to handle children’s admission but Tribunals (age appropriate) should deal with reviews of admissions.

Psycho-surgery and ECT on those under 18 years of age should be banned.

Acknowledgement that sometimes children can end up in an adult ward, but that this must only be in exceptional circumstances where no other reasonable option is available. The Mental Health Commission should be informed if in exceptional circumstances a child is admitted to an adult unit.

The access to, and quality of the service available to children around the country is not even and more needs to be done to improve inadequate services. Detained children should have access to suitable age related facilities and activities (including educational and recreation facilities).

Uncertainty over how a child is brought to an approved centre, particularly if long distances are involved.

Generally seen as unhelpful if there is any confusion between the Child Care and Mental Health Acts.
• Need to ensure that there is greater clarity between the revised Act and section 23(1) of the Non-Fatal Offences against the Person Act 1997 which provides that, in the context of criminal law only, consent to medical treatment by a person aged 16 or 17 years of age has the same status as if he or she was 18 years old, of full age.
• Medication should only be administered with the free and informed consent of the child or young person or, where he/she lacks the capacity to consent.
• Multidisciplinary teams may be better than individual consultants at assessing a child’s mental capacity.
• A video of the services available in approved centres should also be available to children before they are detained.
• There has also been concern about the need to provide additional support for young people in approved centres making the transition to adult units.
• Concern has been expressed that young people aged 18 to 25 may also need special support to deal with their psychological conditions.

4. Voluntary, Involuntary Patients and Capacity

• Although the vast majority of residents of approved centres are voluntary patients, the focus of the 2001 Act is on involuntary patients. As a result most of the provisions and rights provided in the 2001 Act do not apply to voluntary patients.
• The definition of a voluntary patient should be redefined as a person who freely chooses treatment without coercion.
• The Act needs to have positive statements supporting voluntary admission.
• The Act needs to emphasise the principle of the least restrictive alternative.
• Voluntary patients should be informed of the range of common law rights associated with that status including their right to consent to treatment.
• Voluntary patients should be enabled to leave an approved centre when this accords with their will and preferences.
• The 2001 Act should comply with Article 14 (Liberty and Security) of the CRPD.
• Voluntary patients often lack clarity about their rights and should have the right to information on any proposed treatment, the reason for their hospitalisation, likely duration and advocacy support.
• The Act should have a section outlining the rules and regulations as they apply to service users detained on a voluntary basis.
• Voluntary patients should have continuous assessments of their capacity to remain as voluntary patients.
• Voluntary patients should be given independent legal representation funded under the legal aid scheme.
• The absolute right to request a Mental Health Tribunal should be available to voluntary patients.
• There were concerns that voluntary patients may not be readmitted if they discharge themselves against the advice of the consultant.
• The 24 hour detainment period for voluntary patients who decide to leave an approved centre is seen to be causing undue distress at times because those patients recognise that their status can be changed to involuntary in that period.
• Sections 23 and 24 should be deleted and replaced by the same procedure for the initiation of an involuntary admission as pertains when the person is in the community.
• Involuntary admissions should never be allowed or should only take place in exceptional circumstances.
• Incapable compliant patients should be treated as involuntary patients not voluntary patients.
• The “Bournewood gap” as regards incapable compliant patients should be closed.
• The term ‘resident’ should only be used for those receiving social care not for either voluntary or involuntary patients.
• The vast bulk of submissions received stressed the importance of dealing with the issue of capacity. It is seen as a core issue in terms of mental health which needs the backing of strong and modern legislation.
• Strong welcome and support for the proposed Mental Capacity Bill which is expected to deal with the general issue of capacity in a comprehensive manner.
• Acknowledgement that the CRPD requires a presumption of capacity in relation to patients with mental health problems – legislation must be introduced to comply with this.
• Some concern expressed that the proposed Scheme of the Mental Capacity Bill is overly focused on guardianship and regularising substitute decision making rather than on the CRPD’s emphasis on the supporting the patient’s own decision making.
• Need to further examine Mental Capacity Bill on issues such as determination of capacity, supported or assisted decision making and substitute decision making or guardianship.
• Acknowledgement that the proposed Capacity Legislation should also clearly and unequivocally state that inconsistencies and a number of unknowns exist with psychiatric interventions and that regardless of how well designed the legislation may be, ethical problems will remain with practices that are carried out under the auspices of the either the Capacity or the Mental Health Act.
• Issues arising from Court judgements relating to compliant incapacitated need to be examined in context of proposed capacity legislation.
• Call for a multi-disciplinary assessment of capacity which some see as better than an assessment carried out solely by medical professionals.
• Question as to whether capacity assessments should be carried out independently of the approved centre.
• Should capacity be referred to a Tribunal for determination in appropriate cases?
• People who lack capacity should get the same protection as presently available to ‘involuntary’ patients under the Mental Health Act 2001.
• Reminder that capacity in law and capacity in medicine have different frames of reference.

5. Consent to Treatment

• In relation to treatment, free and informed consent should be required from all patients unless they lack capacity and either life saving treatment is needed or the treatment has been reviewed independently.
• Consideration should be given to providing support to people to choose their treatment and to narrow the broad range of exceptions.
• It is unsatisfactory that sections 59 and 60 allow for competent refusals of treatment to be overridden. Informed consent is essential and therefore in sections 59 and 60, the phrase ‘or unwilling’ should be removed.
• Any proposal to use ECT should be independently reviewed, ideally by a Tribunal, before it may proceed. Others suggest that the Mental Health Commission should be more involved in the review of ECT cases.
• Rules on ECT should apply to voluntary patients also per section 69(4).
• Include a subsection that it is an offence not to comply with the rules on ECT similar to the provision in section 69(3).
• Psycho-surgery should be retained to prevent possible future use.
• Where psycho-surgery is proposed as a treatment option, Tribunals should firstly review the capacity of the individual concerned and confirm that it is a treatment of last resort.
• Informed consent and collaboration must be a feature of any treatment plan. Departure from this principle should be subject to independent opinion and multidisciplinary team.
• Continued administration of medicine should be authorised in the form of a medication plan.
• The drafting error in section 61 should be corrected.
• The Recovery model as set out in A Vision for Change should be promoted.
Advocates should be available to advise patients about their treatment.
The rules governing the administration of medication in the initial 24 hour assessment period set down in section 14(2) are not clear.
Risk benefit assessments needed for any suggested interventions.
Easy to understand information should be available regarding any interventions.
The title of the Act should be inclusive of the focus towards community care.
Principle of least restrictive option for patients should be highlighted.
An independent complaints mechanism covering treatment issues should be established.
Advance Directives provide a method of ascertaining a person’s wishes before they lose capacity or during lucid periods.
The Act should distinguish between treatment for mental health and medical conditions.
Treatment should not be given during periods of detention before Tribunals are held.
Counselling, holistic treatment options and community based alternatives should be widely available to patients.
The right to change psychiatrist is not adhered to in practice.
Medication is often over-prescribed and often in cases where it has no beneficial effects.
The term ‘mental disorder’ should be replaced with less stigmatising label.
Dementia and Intellectual disability should be removed from Section 3.
Need to clarify phrases like ‘immediate and serious harm’, ‘serious likelihood’ and ‘material extent’ in section 3.
In subsection 3(1)(b) replace the phrase ‘likely to lead to a serious deterioration in his or her condition ‘ with ‘shall, within a certain period of time benefit or alleviate it’.
The presence of personality disorder, social deviance or addiction to drugs or alcohol should not prevent an individual with a mental disorder from receiving treatment for that disorder (see section 8(2). Also, the meaning of ‘social deviant’ in that section should be clarified.
Each patient should have an individual care/recovery/discharge plan.
Each care/recovery/discharge plan should be regularly reassessed and amended as required.
Discharge plans should include diagnosis, changes/additions to patient medication, relevant community care team and facilities and plans for regular reviews.
Carers and families should be updated about the diagnosis, condition, treatment and discharge of patients.
• Decisions on mechanical restraint and seclusion should be the subject of speedy Tribunal reviews.
• Physical and chemical restraints should be included in this section.
• Rules rather than codes of practice in relation to seclusion and restraints should be introduced.
• Regulations should comply with the minimum standards of the Convention on the Prevention of Torture.
• The Inspector of Mental Health Services should have the power to order the end of seclusion.
• Need to clarify the purpose of Section 26 leave. Others suggest it should be deleted from the Act and that compassionate leave should be dealt with separately.
• Section 26 leave should be more closely linked with individual care plans.
• The Act should specify a maximum leave time and specify any conditions imposed must be necessary and proportionate.
• Introduce a section allowing community treatment orders if required.
• Tribunals are affirming renewal orders while patients are absent on leave in the community. This should be stopped.
• It has been suggested that if a person is well enough for temporary release they should no longer be involuntarily detained.

6. Detention
• What is the status of a person under the Act in the period between a GP’s recommendation that he/she be involuntary admitted and a consultant’s approval of his/her admission?
• Each patient’s individual care plan should be included at the earliest point following admission and should provide a seamless approach towards discharge and support in the community.
• Detained patients (voluntary and involuntary) should be regularly informed of the reasons for their detention, their condition, treatment, rights and care plans.
• The principle of least restrictive and least intrusive option for patients should be highlighted in the legislation.
• Voluntary patients including compliant incapacitated patients do not have the same protections under the 2001 Act as involuntary patients.
• The role of family members in involuntary admissions needs to be reconsidered.
• Carers and family members of detained patients need to be kept informed of the patients’ condition in the approved centres, their treatment, care plans, discharge and subsequent after-care plans.
• A person who seeks to have a person involuntarily detained should be required to explain their reasons.
• The Act should state that detentions should be no longer than necessary.
• The Inspector of MHS should visit each patient at least once a year.
• The examination by a GP referred to in section 10 should be properly defined.
• In order to minimise physical disturbance the examination could take place at the individual’s home. The person could then be admitted directly to the approved centre and he/she would have the status of an involuntary patient during the journey to the approved centre.
• The examination and relevant form should specify clinical signs/symptoms and impairments required for involuntary placement.
• A person should never be allowed to be signed in by their spouse.
• A separate section relating to Gardaí should be included in the Act.
• There should be an independent review of Garda detentions before the patient is brought to an Approved Centre.
• The Gardaí should bring people they have detained directly to approved centres for assessment.
• The Gardaí are concerned that many approved centres require detained persons to go through hospital emergency departments for assessment by a psychiatrist before admission to the Approved Centre.
• The Gardaí who take a person into custody should be obliged to attend a Tribunal and explain the basis on which they formed the opinion that a person was suffering from a mental disorder.
• The Gardaí should have the rights to take the detained person directly to an approved centre.
• Concern that Gardaí have used excessive force when assisting with involuntary admissions.
• The appropriateness of Garda involvement in detentions has been questioned.
• A new position to replace the role of Gardaí in relation to detentions needs to be created.
• Where a patient absconds, the Gardaí should be able to return the patient from the approved centre where he/she is being temporarily detained to their original centre.
• Gardaí are wasting time waiting for results of assessments of patients in approved centres and hospitals.
• Gardaí should have the right to seek a second opinion from a GP if the first GP refuses to make a recommendation for involuntary admission.
• Need to clarify the legal status of a person during the 24 hour assessment period in the approved centre.
• The initial 24 hour period of detention could be shortened.
The rules governing medication during this initial 24 hour period are unclear.
The HSE are seeking to be indemnified against failures and/or mistakes on the part of external agents involved in the involuntary admission process.
Many comments received about the maximum length of renewal orders with either 3 or 6 months being recommended.
Patients should have the right to request, within limits, a review of their detention between the periods of automatic review.
Section 19 should be amended to enable a patient to appeal the decision of the Tribunal on expanded grounds including on procedural grounds.
The burden of proof that a person has a mental disorder should be with the detainer rather than the patient.
Patients should have access to a legal representative after a Tribunal decision in order to help them decide whether to appeal a decision or not.
In the case of long-term orders being made, the period in which to consider making an appeal should be lengthened from 14 days to 28 days.
A separate panel of psychiatrists for appeals may need to be created.
Consideration should be given to abolishing stamp duty on appeals to the Circuit Court.
Section 73 should be repealed. Every person with a disability should have equal access to the law (CRPD).
The status of the person remaining in the centre following discharge needs to be considered.
Tribunals should have the power to vary an order as well as affirm or revoke one.
Regular audits of Tribunals should take place to improve their operation.
Tribunals should have the power to grant conditional discharges similar to community treatment orders in the UK.
Tribunals should only be allowed to waive minor procedural irregularities.
Tribunals should be able to review more procedural sections like section 13 (Removal of Persons to Approved Centres).
Tribunals should take place at the earliest possible opportunity – the 21 day cut off period maybe too long. Suggested that the waiting period between admission and Tribunals should be reduced to 14 days.
Alternatively, time limit of 21 days before the first Tribunal starts is working well and should stand.
Consideration should be given to reducing the 14 day time period allowed for in Section 17(1)(c)(iii) to receive the second consultant’s report
A person’s legal representative should be allowed access to patient records at the outset.
• Instead of the Mental Health Commission acting for Tribunals in appeals and in the High Court, an independent body and separate legal representation should act for the Tribunals.
• Patients should have the right to apply for a Tribunal review of a proposal to administer medication and treatment.
• Patients should have the right to appeal their detention before the time period of their Admission or Renewal order is finished. This is especially important in relation to Renewal Orders which are either 6 or 12 months long.
• Clarification required on whether a Renewal Order only becomes effective after the expiry of the Admission Order or the previous Renewal Order.
• Section 18(2) should be amended so that the 21 day period for the commencement of any review of renewal order only begins to run as of the effective date of the renewal order.
• Enhance power of the Inspector to enable referral of patients to a Tribunal if he/she has reason to doubt detention.
• Gardaí who detain a person under this section 12 should be required to explain their reasons at the Tribunal.
• Tribunals should always investigate the nature of the examinations carried out by GPs.
• Tribunals should be held in public or accounts of Tribunal proceedings should be available to the public, with appropriate safeguards to ensure anonymity.
• In relation to appeals to Courts, the burden of proof should be on the detainer to demonstrate that the individual has a mental disorder.
• Consultant psychiatrists hold the balance of power at Tribunals. Tribunals should not have an ingrained imbalance towards psychiatry and any registered medical doctor, or a mental health professional that is not a psychiatrist, should replace the psychiatrist as one of the designated members.
• Tribunal language should be changed and simplified. The terminology of the Tribunals should also better reflect the benefit of the process to the patient.
• Tribunals could be called Reviews or Review Boards.
• Tribunal members should be more impartial.
• Some relatives have suggested that patients can manipulate the Tribunal boards during Tribunals, leading to inappropriate discharge.
• Families should be notified when Tribunals are taking place with the consent of the patient.
• Patient support in the form of family, friend or peer should be considered at the independent review of detention.
• Any member of the general public who is not a medical practitioner should be the wording for section 48(3)(c).
• The agreement of a patient should be sought and recorded if the Tribunal feels that they should not attend the hearing. The wishes of the patient should take precedence.
• Either additional sections or a set of procedural rules should define the burden and standard of proof in accordance with ECtHR and Irish case law.
• Tribunals should use inquisitorial not adversarial procedures.
• Tribunals should be obliged to try and avoid undermining therapeutic relationships.
• There is a need to review the way the Tribunals deal with the order in which evidence is taken, who attends, the need for advocacy and the rights of family members to attend, particularly if capacity is an issue.

7. **Authorised Officers**

- The definition of authorised officer should be changed to reflect the reality that they are competently trained mental health professionals who are independent of consultant psychiatrists.
- The role of authorised officers needs to be developed.
- The supply of authorised officers and their availability should also be specified.
- Authorised Officer should be the option of choice for involuntary admissions in order to help reduce potential damage to family relationships.
- Authorised Officers should be clearly defined and independent of consultants.
- Care should be taken not to exclude mental health social workers or other members of community mental health teams or hospital multi-disciplinary teams from acting as authorised officers.
- The potential overlap of the Disability Act 2005 sections 8 and 11 concerning assessment officers and liaison officers, should be examined and strengthened where appropriate.
- The HSE welcomes the fact that authorised officers have resulted in a significant reduction in the number of involuntary patients.
- HSE believes that having its mental health professionals employed as authorised officers has been beneficial because they can bring their professional judgment and knowledge of local mental health services to bear on each case.
- The failure to develop the ‘authorised officer’ role can hinder the process of admission. Time delays add to the stress for patient, family and health care professionals especially in after-hour situations where the patient is not known to the GP.