



Mental Health Reform

Promoting Improved Mental Health Services

Medical Council consultation on draft guide to professional conduct and ethics
Submission
14th August 2015

Introduction

Mental Health Reform (MHR) welcomes this opportunity to contribute to the Medical Council's consultation on its draft guide to professional conduct and ethics. As the national coalition promoting improved mental health services and implementation of the mental health policy *A Vision for Change*, Mental Health Reform makes this submission with particular reference to individuals in receipt of mental health care and/or treatment. The recommendations set out by MHR apply to doctors working in both community and inpatient mental health settings.

Mental Health Reform provides input on specific sections of the draft code, as outlined below.

Section 2: professional misconduct

This section of the guide should acknowledge that individuals with a mental health difficulty can make a complaint about the care received from a doctor, where the individual is in receipt of public care, through the HSE complaints process *Your Service, Your Say*. Information about how to make a complaint is published on the HSE website and on healthcomplaints.ie, and posted in all mental health service facilities.

Mental Health Reform considers that information relating to this complaints service should be advertised in all health centres, including in GP practices.

It should also be recognised in this section of the guide that an individual engaged in public mental health care and/or treatment can make a complaint about the care/treatment they received (including care provided by a doctor) to the Ombudsman's Office once they have exhausted all local measures.

The guide should also take account of the fact that the HSE recently appointed a confidential recipient to whom anyone can make a complaint or raise concerns about the care and treatment of any vulnerable person receiving residential care in a HSE or HSE funded facility, including individuals receiving mental health treatment by a doctor in inpatient, outpatient or day centre clinics.

Section 4.3: Professional identity

Mental Health Reform welcomes the guidance in this section that doctors should communicate with individuals who are in receipt of care, including through the provision of information.

In terms of this guidance, MHR recommends that this section also take account of the Expert Group (on the review of the Mental Health Act, 2001) recommendation on the provision of information for individuals in inpatient mental health centres and the national mental health policy's recommendation on communication of information.

A Vision for Change includes a number of recommendations to promote service user and family supporter/carer engagement in mental health services, including ongoing and timely communication of information relating to care options, medications, treatment options and therapies, legal rights and status, availability of services, training, housing, benefits and entitlements.

The Expert Group on the review of the Mental Health Act recommends that on admission to an approved centre, every patient should have a right to information which would include their rights as a voluntary or involuntary patient, their rights regarding consent to or refusal of treatment, the range of services available in the centre, and any additional information as outlined in the Mental Health Commission Code of Practice. In addition, the Expert Group stated that it is imperative to ensure that the patient is made aware of the complaints mechanism in place at the centre and any general complaints mechanisms that exist within the broader mental health service (Section 2.21, p. 64). Mental Health Reform further recommends that voluntary patients be made aware of the rationale for their hospitalization and its likely duration.

The specific communication needs of vulnerable groups of individuals, including the deaf community and people from ethnic minority groups, should be taken into account. Mental Health Reform has been advised through its public meetings and consultation with key stakeholders that there is a lack of appropriate communication between mental health professionals, including doctors, and people who are deaf. The HSE's National Guidelines on Accessible Health and Social Care Services set out guidance for health professionals on caring for people who are deaf. The guidelines provide advice on communicating with people who are deaf and on the provision of interpretation services.

Similarly, people from ethnic minority groups and their representatives have described a range of communication and language barriers with mental health professionals. For example some individuals find it difficult to communicate with their GP, to understand the language used by doctors and to understand the diagnosis they are given and the purpose of medication prescribed.¹

Mental Health Reform recommends that this section advise doctors working with vulnerable groups of individuals to use accessible language about mental health treatment when providing information, drawing on existing HSE guidance.

It is important that doctors are aware that people seeking support should be able to choose between therapies, and be able to discuss medication options with their consultant. In order to make choices, everyone needs good quality, comprehensive and balanced information, including information about the risks and benefits of treatments. However, this has not always been provided, as evidenced by feedback from the National Service User Executive's 'Second Opinions' reports.

Doctors should also recognise that there are many types of expertise, including the expertise that comes from lived experience with a mental health condition. Professionals can continue to value their own clinical knowledge and experience while re-imagining their role to be as facilitators of recovery. Mental Health Reform believes that a new role for all staff working in mental health services as facilitators, 'coaches' or 'guides' working in partnership with the person with mental

¹ Mental Health Reform (2014) *Ethnic Minorities and Mental Health: A Position Paper*, p. 15.

health difficulties to support their recovery is required. Such an approach does not negate the value of clinical expertise, but views such expertise as one of many valued resources. According to Mike Slade, such a facilitator or 'coach' role involves:

- 1) Assuming that the person is or will be competent to manage their life.
- 2) Ensuring that the focus is on facilitating the process of recovery to happen rather than on the person. Coaching is about how the person can live with mental illness [sic] and differs from a clinical focus on treating the mental illness [sic].
- 3) Enabling this self-righting capacity to become active, rather than to fix the problem. This leads to amplification of strengths and natural supports, rather than of deficits.
- 4) Effort in the coaching relationship being directed towards the goals of the coachee, not the coach. The skills of the coach are a resource to be offered. Using these skills is not an end in itself.
- 5) Both participants making an active contribution for the relationship to work.²

Section 4.7: Patient centred care

Mental Health Reform welcomes the commitment to patient-centred care in the Council's guide to ethics and professional conduct. MHR recommends that this section include information on a person's right to Individual Care Planning (ICP) under the Mental Health Commission's Quality Framework and Guidance Document for Individual Care Planning. An individual care plan, as defined by the regulations, is: "a documented set of goals developed, regularly reviewed and updated by the resident's multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation."

The Mental Health Commission has reported that the level of compliance among approved mental health centres with individual care planning (Article 15) fell from 60% in 2013 to 41% in 2014.³

In February 2015, Mental Health Reform's Grassroots Forum members (made up of individuals with self-experience, family members and/or carers) identified some of the barriers to effective individual recovery planning, including inadequate resources to ensure the implementation of ICPs, a lack of recognition of the specific needs of individuals in the design of ICPs and a lack of communication and referral between different agencies and services to ensure that individuals have a choice of mental health supports. Members of the Forum reported that care plans are often filled out just because they have to be and there is often a lack of communication between service users and staff.

It is important that doctors working in mental health services are aware of their responsibilities in terms of Individual Care Planning.

Doctors working in the area of mental health care should also be aware of the potential benefits of involving family members in ICP. There is no national data on the extent of family supporter

² Quoted from Slade, M. (2009), *Op. Cit.*, p.123.

³ Mental Health Commission (2014) Annual Report, p. 7.

involvement in individual recovery planning and legislation does not provide for this. However, family members attending Mental Health Reform's public consultative meetings in the past four years have consistently raised concerns about the barriers to their involvement in their loved one's treatment plans.

Section 5: Partnership

Mental Health Reform welcomes the Council's guidance in this section that doctors should work in collaboration with their patients and with their colleagues; and that this should be based on good communication and advocacy support for the individual accessing care.

In terms of working with the individual, MHR recommends that this section take account of the principles of the recovery ethos that set out what a person should expect from a good quality mental health service. Mental Health Reform has developed, in consultation with its member groups, Grassroots Forum and external expert groups (e.g. Amnesty International's Experts by Experience Group) five key aspects of the recovery ethos that should be adhered to, including, *partnership, hope, listening, choice* and *social inclusion*. A full description of these principles can be found here <https://www.mentalhealthreform.ie/wp-content/uploads/2013/03/MHR-Recovery-paper-final-April-2013.pdf>. In summary, the five principles can be translated as follows:

1. Hope – The hopeful attitude of a mental health worker or family member can make a big difference in helping someone to recover from mental health difficulties. Mental health professionals, including doctors should be encouraging about an individual's future.
2. Listening – People living with mental health conditions come to understand their condition over time and know what works best for them. They are experts by experience. Doctors should listen and respect an individual's preferences, knowledge and aspirations.
3. Partnership – Mental health staff, including doctors, should work in partnership with an individual as a service user and/or a family member. Doctors should provide individuals with the opportunity to play an active role in their recovery. If appropriate, family members should also be included.
4. Choice – People want and need choice in terms of treatment, and there must be a variety of options available that are more than simply medication, including counselling and psychotherapy, occupational therapy and home-based treatment, among others.
5. Social Inclusion – Mental health professionals have an important role to play in supporting individuals with a mental health difficulty to participate in their local community, have social relationships and engage in meaningful activities, including education and employment. Doctors should support individuals to access welfare benefits, housing, education and employment.

It is important that all doctors involved in the mental health care and/or treatment of an individual practise these principles of recovery.

In order to achieve partnership with the individual, doctors should also adhere to the regulations of the Mental Health Commission's guidance on Individual Care Planning, as outlined above.

In an effort to promote consultation and liaison between professionals, particularly among those operating across the different levels of service provision i.e. primary, secondary and tertiary, this section of the guide should refer to the shared care approach (specifically the consultation/liaison model). The objective of the consultation/liaison model is to enable GPs to learn about mental health from specialist doctors, to create clear pathways between primary and secondary care and to reduce referrals to secondary care for mild to moderate mental health difficulties.

The shared care approach is supported by the World Health Organisation and is further endorsed by Ireland's mental health policy, *A Vision for Change*, and the Mental Health Commission. The HSE's Guidance paper on a shared care approach to primary care and mental health services also sets out specific recommendations for its implementation.

The consultation/liaison model has not been implemented on a national basis, though plans are in train for a clinical programme on Early Intervention for Psychosis which was developed in 2013. The programme will detect individuals in the early, at-risk stage of psychosis and also provides multi-disciplinary support and treatment for people with a first episode of psychosis.

It is important that enhanced communication and liaison is developed between doctors and other mental health professionals, across primary, secondary and tertiary services.

Section 7.1, 65 - Training (+ section 23.5.1 on access to training)

The national mental health policy, *A Vision for Change*, recommends that "the education and training of GPs in mental health should be reviewed. GPs should receive mental health training that is appropriate to the provision of mental health services described in this policy".

While there have been some initiatives to increase the capacity of GPs to provide mental health care, including e-learning modules through the Irish College of General Practitioners (ICGP), the Primary Care Resource Pack and a course provided by Dublin City University (in partnership with the ICGP and the HSE), there has not been a national programme to ensure that all GPs have adequate training in mental health in primary care. The HSE in partnership with the ICGP has funded a Mental Health Programme which has developed a range of materials and training programmes to support GPs and General Practice in particular. Approximately 100 primary care professionals took part in the mental health training provided through Dublin City University. As part of MHR's 2011 consultation with service users it was noted that there was a lack of knowledge among GPs about mental health issues and that many GPs are not aware of mental health support services available in the community.⁴

Mental Health Reform recommends that this section of the Code advise doctors of the importance of taking part in mental health training appropriate to their role, including through continuing professional development. For example, it is important that doctors working in primary care have training that includes experience in community-based mental health services, including primary care mental health.

⁴ Mental Health Reform (2013) *Mental Health in Primary Care: A Briefing Paper*, Dublin: Mental Health Reform.

Section 8: Dignity of the Patient

In this section, Mental Health Reforms recommends that the Council refer to the Expert Group's recommendation on the autonomy of the individual engaged in inpatient care.

The Expert Group recommends the elimination of the existing 'principal consideration' of 'best interests' and replacing the limited principles in the 2001 Act with a more human rights based list of guiding principles which would reflect the importance of the person's right to autonomy. (Section 2.1, p. 12) Such principles include:

- Primary importance of autonomy
- Right to make one's own choices
- Elimination of 'best interests' to be replaced by 'dignity'
- Interpretation of 'dignity' in line with Convention of the Rights of Persons with Disabilities (CRPD) principle of will and preferences and of supported decision-making
- Inclusion of 'bodily integrity', 'least restrictive' and 'highest attainable standard of mental health'

Mental Health Reform further recommends that 'insofar as practicable' is not utilised by professionals in relation to the principles.

Section 9: Equality and Diversity

Mental Health Reform recommends that the Council include guidance in this section on the importance of culturally competent mental health services.

Culture influences how we view our health. It influences help-seeking behaviour both in terms of access and treatment. All cultures have beliefs and practices which are unique and which they use to explain and manage ill health and mental or emotional distress. These in turn influence how mental health difficulties are experienced.⁵ Therefore, it is important that mental health professionals, including doctors, are culturally competent.

Under the National Intercultural Strategy 2007-2012, cultural competence was described as: "having the right policies, knowledge and skills to meet the needs and practices of people from different cultural backgrounds."⁶ The *Strategy* recognised that culture includes lifestyle, dress, diet, language and spiritual needs, though religion can cross cultural boundaries.⁷

Internationally, a widely used definition of cultural competence is:

"a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations."⁸

⁵ Morgan (2011), op. cit., p.89.

⁶ HSE (2008), op. cit., p.126.

⁷ Ibid., p.126.

⁸ Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989) *Towards A Culturally Competent System of Care*, Volume I, Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center, cited at <http://www.ncccurrricula.info/culturalcompetence.html>

Both of these definitions identify that staff, including doctors, need both knowledge and skills to be able to provide services that meet the needs of people from different cultural backgrounds.

Cross, et al. argue that cultural competence requires organisations and their personnel to have the capacity to:

- value diversity
- conduct self-assessment
- manage the dynamics of difference
- acquire and institutionalize cultural knowledge
- adapt to the diversity and cultural contexts of the individuals and communities served.⁹

These guidelines use the term ‘cultural competence’ to refer to the attitudes, behaviours, knowledge and skills that mental health professionals need to have in order to deliver culturally responsive mental health services.

It is important that all doctors are aware of and are trained in cultural competency so that they can recognise and appropriately respond to mental health difficulties among individuals from ethnic minority communities. In Mental Health Reform’s report on ethnic minorities and mental health https://www.mentalhealthreform.ie/wp-content/uploads/2014/10/Ethnic-Minorities-and-Mental-Health-A-position-paper_WEB.pdf, individuals consulted with reported difficulties in accessing GP care. Such difficulties included the following:

- The quality of GPs’ response to people from ethnic minority communities varies across the country
- GPs in some areas do not refer people from the Traveller community and other ethnic minorities into mental health services
- Some GPs issue repeat prescriptions to Travellers so that the GP can avoid seeing them
- The absence of interpretation services in GP practices
- Communication problems - some Travellers find it difficult to communicate with their GP, to understand the language used by doctors and to understand the diagnosis they are given and the purpose of medication prescribed
- A group of refugees residing in Ireland expressed that they were not confident they were being understood by their GPs

The Mental Health Commission’s Quality Framework <http://www.mhcirl.ie/File/qframemhc.pdf>, the HSE National Intercultural Health Strategy 2007-2012 http://www.hse.ie/eng/services/Publications/SocialInclusion/National_Intercultural_Health_Strategy_2007_-_2012.pdf, and the National US CLAS standards <https://www.pccpc.org/sites/default/files/resources/A%20Blueprint%20for%20Advancing%20and%20Sustaining%20CLAS%20Policy%20and%20Practice.pdf> are among a number of policies which set out specific measures for staff in achieving cultural competency. Some of these measures include:

⁹ Cross, et al. (1989), op. cit.

- Staff should ensure that individuals understand how to access mental health services, their options for treatment and how to maintain their mental health and follow their individual care plan
- Staff should determine the communication and language assistance needed for individuals with limited English proficiency
- Staff should enquire about and understand any relevant cultural practices that the individual may want to avail of to support their recovery from a mental health difficulty

This section of the guide should recognise the necessary measures which must be undertaken by all doctors in order to achieve cultural competency.

Section: 10 Refusal to treat

Please refer to section 4.7 above on individual care planning.

Section 18 & section 21 (restraint)

Mental Health Reform notes that the draft guide advises doctors that “if patients lack capacity to make a decision about treatment or examination, you may use appropriate physical or chemical restraint where this is in the patient’s best interests, provided it is used for the minimum amount of time necessary, and following the guidance on prescribing in paragraph 36”.

MHR recommends that the Council take account of the recommendations of the Expert Group report on review of the Mental Health Act, in relation to the use of restraint.

The Expert Group recommends the “ongoing need for services to ensure that manual or other forms of seclusion and restraint are used only as a last resort, only where there is no other alternative and always in accordance with the rules drawn down by the Commission”. (Section 2.18, p. 60)

It is important that this section reflect international human rights standards with respect to the use of restraint, including standards on the prohibition of torture and inhuman or degrading treatment or punishment. The Council of Europe Committee for the Prevention of Torture has said that “[a]s a general rule, a patient should only be restrained as a measure of last resort; an extreme action applied in order to prevent imminent injury or to reduce acute agitation and/or violence”. Furthermore the Council of Europe Recommendation 2004 (10) provides that “seclusion or restraint should only be used in appropriate facilities, and in compliance with the principle of least restriction, to prevent imminent harm to the person concerned or others, and in proportion to the risks entailed”. It also calls for staff to receive appropriate training on (i) protecting the dignity, human rights and fundamental freedoms of persons with mental disorder; (ii) understanding, prevention and control of violence; (iii) measures to avoid the use of restraint or seclusion; and (iv) the limited circumstances in which different methods of restraint or seclusion may be justified, taking into account the benefits and risks entailed, and the correct application of such measures.

Mental Health Reform further recommends that where restraint is used it should give rise to an assessment of the person’s status as a voluntary patient, where they reside in an inpatient unit.

Section 30: Physical and Intimate Examinations

Mental Health Reform recommends that this section of the document include guidance to doctors on addressing the physical health needs of people with long term and/or severe mental health difficulties.

A Vision for Change recognised that people with mental health difficulties are at higher risk of physical health problems and vice versa. Considering that people with long-term mental health difficulties live up to 25 years less than the general population, physical health screening could help to improve the health outcomes for this group of individuals.

Doctors should also be aware of the principle of ‘parity of esteem’. The Royal College of Psychiatrists (RCP) in the UK has defined ‘parity of esteem’ as “valuing mental health equally with physical health”.¹⁰

In its report on *Whole Person Care*, 2013, the RCP identifies how parity translates into practice; when compared with physical healthcare, mental health care is characterised by¹¹

- equal access to the most effective and safest care and treatment, including timely access
- equal efforts to improve the quality of care
- equivalent levels of choice for individuals in receipt of care/treatment
- the allocation of time, effort and resources are on a basis commensurate with need
- equal status within education and practice
- equally high aspirations for service users
- tackling the physical health problems of people with mental health difficulties and vice versa (this requires movement away from mental health, physical health and social care ‘silos’)

In Ireland, there has yet to be fulfilment of the principle of parity of esteem for mental health care. It is important that doctors work to this principle. A full briefing note on the parity of esteem can be provided at your request.

Section 31: Continuity of Care

A lack of continuity of care among people with mental health difficulties is of serious concern. At Mental Health Reform’s public consultation meetings in 2015, people described situations in which they waited for extended periods of time to get an appointment with a doctor and never met with the same physician twice.

“I saw a senior house officer every 3 months, which wasn’t enough contact with a doctor. I also had the problem of meeting a different doctor each time so I had to retell my story to a new person over and over again,” said one attendee.

A psychiatrist who took part in one of the meetings discussed why they felt that doctors should deal with service users on an ongoing basis: “Consistency is so important. I get to know the patients, know when they are unwell and I see their progress.”

¹⁰ Whole Person Care, RCPsych, April 2012.

¹¹ Ibid

Given the unique nature of mental health difficulties, in that they can often be quite complex, difficult to assess and sometimes, long term and/or ongoing, it is important that doctors recognise the importance of continuity of care in the treatment of people with mental health difficulties. This should be acknowledged in this section of the draft guide.

Section 36: Prescribing

One of the strongest messages to come out of the consultation that fed into *A Vision for Change* was that people with poor mental health want alternatives to medication, including access to counselling and psychotherapy. This view was reiterated in the Independent Monitoring Group's consultation meetings held in 2012 as well as by the HSE¹² and in Mental Health Reform's consultation meetings conducted in 2011.

Despite an acknowledgement at national level of an over reliance on medication and a lack of alternative therapies, there is evidence that this gap still exists. In 2015, Mental Health Reform sought feedback online from people with experience of mental health difficulties on their experience of mental health supports. A considerable number of people who gave feedback were concerned with what they perceive to be an overemphasis on medication-centred treatment. Many respondents were also concerned that this approach was being used as a result of a lack of resources in other areas of the mental health services and that medication was not a satisfactory long term solution.

A prominent point in relation to medication was that many service users believed that they might benefit from talking therapies but that these were often not available. One participant said: "There's far too much drug therapy for issues such as depression and anxiety, drugs which are only a temporary fix. Behaviour therapy at least gives you skills to manage your mental health."

The Kilkenny Consumer Panel has also cited concerns about the overuse of medication and the lack of choice of treatments for people with mental health difficulties.¹³

The reported lack of knowledge among GPs about mental health, community/local support groups, in addition to alternative therapies (including talking therapies), should be recognised by the Council and guidance should be provided to all doctors on addressing mental health difficulties through alternative means. Medication should not be the only measure relied on.

Section 51: Information for patients

A Vision for Change includes a number of recommendations to promote service user and family supporter/carer engagement in mental health services, including: Ongoing and timely communication of information relating to care options, medications, treatment options and therapies, legal rights and status, availability of services, training, housing, benefits and entitlements

¹² Health Service Executive Primary Care and Mental Health Group (2012) Advancing the Shared Care Approach between Primary Care & Specialist Mental Health Services: A Guidance Paper, Naas: Office of the Assistant National Director Mental Health, HSE, p.11.

¹³ Mental Health Reform (2015) *A Vision for Change Nine Years On: A Coalition Assessment of Progress*, Dublin: Mental Health Reform, p. 6.

and on the provision of information to individuals on how to make a complaint, and on the procedures to be followed.

In 2006, the Expert Group recognised that inadequate information, or an absence of information, contributed to poor experiences for service users and carers, often exacerbating their mental health difficulties.

In December 2013, the Inspectorate of Mental Health Services sought feedback from a number of service users, carers, family representatives, consumer panels and advocacy groups across the country on service user involvement in mental health services. The Inspector concluded that despite significant service user involvement in a small number of areas, “service user involvement is very fragmented and some areas are not interested in service user views.”¹⁴ In 2011, the National Service User Executive found that service users and family members are not receiving enough information.¹⁵ As outlined above, in order to make choices, an individual needs good quality, comprehensive and balanced information, including information about the risks and benefits of treatments.

The Council should also be aware of the Expert Group’s recommendations on the Mental Health Act review, relating to the right of individuals to information, as set out above.

The commitment to provide appropriate information is also included in *A Vision for Change*, as outlined above.

In 2010, the National Disability Authority (NDA) published a report on the strengths and weaknesses of publicly funded Irish health services provided to women with disabilities, including women with mental health difficulties in relation to pregnancy, childbirth and early motherhood. One of the findings of the report was that women often received inconsistent advice regarding medication in pregnancy and in the postnatal period.

As outlined in the National Institute for Health and Care Excellence (NICE) guidelines on antenatal and postnatal mental health, health professionals, including doctors, should provide detailed advice about the possible risks of mental health difficulties and the benefits and harms of treatment in pregnancy and the postnatal period. A detailed list of information that should be provided is set out in the guidelines at <https://www.nice.org.uk/guidance/cg45>. Information should be provided prior to pregnancy, during pregnancy and during the postnatal period.

Furthermore, Mental Health Reform has previously called for the Department of Health to ensure that women of child-bearing age who are prescribed valproate medicines are fully informed of the risks and can make an informed decision about their mental health treatment. Valproate, which is used to treat bipolar disorder, among other conditions, has been linked to birth defects and developmental problems in children of pregnant women who have taken the drug. Under the Mental Health Commission’s Quality Framework people who use mental health services should be empowered regarding their own care and treatment by exercising choice, rights and informed consent. The risks associated with Valproate heighten the need for all health services and professionals in Ireland to ensure they fulfil this standard.

¹⁴ Inspectorate of Mental Health Services (2013) National Overview Meeting: Service Users, Carers, Family Representatives, Consumer Panels and Advocacy Groups, Dublin: Mental Health Commission, p. 5.

¹⁵ National Service User Executive (2011) Second Opinions 2010 available at <http://www.nsue.ie/documents/>.

The FACS (Fetal Anti Convulsant Syndrome) Forum Ireland continue to advocate for better warnings and information from the Department of Health and related agencies on the side effects to expectant mothers of drugs that contain Valproate.

It is important that all doctors take account of the aforementioned recommendations.

Section 50: Capacity to Consent

In terms of the Council's guidance on capacity to consent, this section should take account of the Expert Group's recommendations on capacity in its review of the Mental Health Act. The Expert Group makes the following recommendations on capacity:

1. The Expert Group recommends that the definition of treatment should be expanded to include treatment to all patients admitted to or detained in an approved centre. The Group states that revised legislation should explicitly provide that "all patients (voluntary and involuntary) must give informed consent to treatment and be advised about the support available to them (under proposed capacity legislation) to make informed decisions regarding their treatment". 'Consent' as defined in section 56 should be amended to acknowledge that consent can also include consent given by a patient with the support of a family member, friend or an appointed 'carer', 'advocate' or support decision maker appointed under the proposed capacity legislation. (Section 2.3, p. 18)
2. The Expert Group recommends that "if it is deemed that a person does not have capacity on admission to an inpatient service, and the person has a 'mental illness' they may only be admitted on an involuntary basis provided they satisfy all the criteria for detention. A person who lacks capacity and has a 'mental illness' but does not fulfil the criteria for detention, may in specified circumstances be admitted as an 'intermediate' patient". (Section 2.6, p.27) The Group recommends a new category of patient known as 'intermediate' who will not be detained but will have the review mechanisms and protections of a detained person. Such patients would not have the capacity to consent to admission and equally do not fulfil the criteria for involuntary detention. (Section 2.8, p.33)

Mental Health Reform further recommends that draft legislation clarify that when a person loses capacity to make decisions while a voluntary patient and also does not qualify to be admitted as an involuntary patient, the protections afforded to 'intermediate' patients would apply.

3. The Expert Group recommends that revised legislation should ensure that the definition of capacity should be consistent with the Assisted Decision-Making (Capacity) Bill. The Capacity Bill proposes to change the existing law on capacity from the current 'all or nothing' status approach to a functional one, whereby there is a presumption of capacity and therefore capacity is assessed only in relation to the matter in question and only at the time in question. (Section 2.6, p. 26)
4. The Expert Group also advises that it will be necessary to simultaneously develop recommendations and guidelines for the assessment of capacity of persons who require admission for mental health treatment to an approved centre. Notwithstanding the principle of the presumption of capacity, the Expert Group was very clear on the need for the admitting mental health professional to establish if the person has the capacity to

understand and give his/her informed consent to the proposed admission to an approved centre. If a person has decision making supports in place, the mental health professional should be made aware of such supports but still must make a decision on the capacity of the person to consent to admission at that particular time, thus endorsing the functional approach in the Capacity Bill. Where the admitting mental health professional forms the view that the person may lack capacity to understand and give his/her informed consent to the proposed admission, they must refer the person for formal capacity assessment to be completed within 24 hours. (p. 25)

MHR further recommends that in assessing the capacity of an individual to make decisions under the Mental Health Act, the admitting mental health professional must involve any existing or potential assistive or supportive decision-maker in so far as is practicable.

5. The Expert Group recommends that “if on admission of a patient, the admitting mental health professional forms the view that the person may lack capacity to understand and give his/her informed consent to the proposed admission, they must refer the person for formal capacity assessment to be completed within 24 hours.” (Section 2.6, p.25) The Group also recommends that the Mental Health Commission should develop and publish guidelines in relation to the assessment of capacity. Capacity assessment can be undertaken by mental health professionals with the required competencies and such competencies should be accredited by the respective professional bodies who should provide support and training where required. Capacity should be monitored on an ongoing basis by the treating clinicians.

MHR recommends that capacity assessments incorporate the perspective of at least one non-medical professional.

6. Finally, the Expert Group recommends that, where relevant, information relating to how capacity is assessed and the right of appeal against a decision on their capacity to a Mental Health Review Board should be given to patients. (Section 2.6, p.27)

In terms of the capacity legislation Mental Health Reform has made the following key recommendations that the Council should take into account.

- Ensure that all individuals in approved centres as defined by the Mental Health Act, 2001 can avail of the provisions in the capacity legislation
- Ensure timely review and transition of all persons presently subject to wardship
- Ensure that the legislation protects people who are incapacitated and compliant
- Restrict the scope of informal decision-making, in particular in respect of restraint, to persons who are in mental health services and address concerns regarding potential overuse of medication
- Introduce advance directives and ensure that these are binding on decisions about mental health treatment, except in life-saving emergencies

Section 56: Advance Healthcare Planning

In terms of the Council’s guidance on advance healthcare planning, this section should take account of the Expert Group’s recommendations on advance healthcare directive on review of the Mental Health Act. The Expert Group makes the following recommendations in this area:

The Expert Group recommends the introduction of legislation providing for advance healthcare directives which apply to mental health on an equal basis with general health. The Group recommends that when revised mental health legislation is being framed, it either amends the Assisted Decision-Making (Capacity) Bill, if necessary, or introduces provisions in mental health law to deal in a more complete and comprehensive manner with the operation of advance healthcare directives in the area of mental health in the longer term. In particular, the authority to override a treatment refusal where a person's health as opposed to life is at risk, should be re-visited again when mental health legislation is being framed. (Section 2.25, p. 78 & 79)

The Group also recommends that advance health care directives:

- Should state in clear and unambiguous terms the specific treatments to which it relates and also the particular situations in which the treatment decisions are intended to apply
- Should be recorded in the person's recovery plan
- If an advance healthcare directive is overridden, the Inspector of Mental Health Services should be notified within 3 days and it must be included in the Inspector's report on the approved centre
- Guidelines on advance healthcare directives should also be produced by the Health Information and Quality (HIQA) and the Mental Health Commission with the involvement of the appropriate professional regulatory bodies.

Mental Health Reform further recommends that advance health directives apply to people who are involuntarily detained under the Mental Health Act.

A full copy of Mental Health Reform's submission of on advance healthcare directives can be provided at your request.

About Mental Health Reform

Mental Health Reform is the national coalition working to promote improved mental health services and the implementation of the mental health policy *A Vision for Change*.

Mental Health Reform is available to discuss the above recommendations. Please contact Kate Mitchell, Policy and Research Officer at 01 874 9468 or via email at kmitchell@mentalhealthreform.ie for further information.