Public Consultation on Draft Legislation to Update the Mental Health Act, 2001

09 April 2021

Mental Health **Reform**

Promoting Improved Mental Health Services

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Introduction

Mental Health Reform ('MHR') is Ireland's leading national coalition on mental health. We aim to drive progressive reform of mental health services and supports, with legislative and policy reform being a key focus of that work. Alongside our over 75 member organisations, we focus on demonstrably impacting the system of supports that nurture people's mental health through coordination and policy development, research and innovation, accountability and collective advocacy. By acting as a unifying voice, MHR works daily to bring about an Ireland where everyone can access the support they need in their community, or in a setting as close to their home as possible, to achieve their best possible mental health.

At the outset of this submission, we would like to clearly state our aspiration that this public consultation be a meaningful one. We wish for it to be used to its fullest potential by the Department to shape the forthcoming mental health legislation using the voices and needs of service users and their friends, families, carers, supporters and advocates. We therefore embrace and welcome this opportunity to contribute to the review of the Mental Health Act, 2001.

Mental Health Act, 2001

It is worth noting that at the time of its enactment and commencement, the Mental Health Act, 2001 represented a significant improvement in the protections afforded to people involuntarily detained and treated in the mental health services. This was achieved by introducing a right to review of involuntary detention by an independent tribunal, establishing the Mental Health Commission as the statutory agency that promotes quality mental health services, and providing for the regulation of inpatient services in Ireland. These legislative changes have positively impacted the nature of mental health service delivery when compared with the pre 2001 landscape, for example by reducing the number of involuntary detentions in Ireland.

That said, the international and domestic landscape has shifted dramatically in the intervening 20 years in terms of human rights norms and standards, which Ireland has been out of step with for some time. As a result, the time for legislative reform has been and gone, and the ten years it has taken to get to this point has caused a significant negative impact for those whose lives have been directly affected by the ongoing use of the current Mental Health Act, 2001.

It is our priority to see human rights compliant legislation introduced as a matter of urgency, but also to see that legislation provide sufficiently robust and forward thinking protections and entitlements for service users, their supporters (friends, families, and carers), and clinical staff to ensure that this new legislation lasts the test of time.

This document sets out Mental Health Reform's response to the Report of the Expert Group on the Review of the Mental Health Act, 2001. It is structured according to key issues of concern in the Act, each of which includes Mental Health Reform's recommendation.

MHR Comments and Recommendations

Given the breadth and scope of the Mental Health Act, 2001, we propose to limit our comments and recommendations to the specific aspects of the legislation and Expert Group Report that MHR has been campaigning on since its establishment. **For expediency, it is to be taken that where we do not make comment on a specific aspect of the Expert Group's recommendations, MHR supports inclusion of their recommendations in the new legislation**.

The table of contents above sets out the headings covered.

Human Rights and Mental Health Law Reform

Changes in the law relating to mental health are needed to fulfill the vision set out in Ireland's mental health policy *Sharing the Vision* and to bring about compliance with several key human rights instruments, including the European Convention on Human Rights, and the United Nations Convention on the Rights of Persons with Disabilities. Through this submission, we set out the aspects of the Mental Health Act, 2001 that require reform to achieve those advancements.

We would, however, like to emphasise the need for this legislation to advance the limits of progression towards compliance with current and emerging trends in human rights standards, and trauma oriented, person centered care. This is essential if this lengthy process of reform is to result in a fit for purpose, future proofed, and sufficiently enduring piece of law that protects, affirms, and vindicates the rights and obligations of all stakeholders to the treatment and care of those experiencing mental health difficulties in Ireland. These stakeholders include service providers, clinical and support staff, friends, families, carers, and, most vitally, service users.

The area of human rights and mental health is rapidly evolving, particularly since the United Nations Convention on the Rights of Persons with Disabilities ('UNCRPD') was signed into international human rights framework. By ratifying this landmark convention in 2018, the Irish State committed to acknowledge, respect and vindicate the rights of people living with disabilities, including those with psychosocial disabilities. This commitment must be reflected in any new additions to the statute book that relate to mental health care and treatment, and MHR believes the current review of the Mental Health Act, 2001 presents an ideal opportunity for Ireland to become a leader in the sphere of human rights-led mental health service delivery.

MHR Recommendation:

As a general comment, MHR recommends that the Department look outward to best practice within other states that have and continue to bring mental health service delivery into line with the standards set out in the UNCPRD and beyond. One of the most notable examples in this area is India's Mental Healthcare Act, 2017. This Act both enumerated a right to mental healthcare for that state's 1.3 billion citizens, and brought its legal framework on mental health service delivery into line with the UNCRPD[1].

[1] Duffy, R.M. and Kelly, B.D., 2019. India's Mental Healthcare Act, 2017: content, context, controversy. International Journal of Law and Psychiatry, 62, pp.169-178.

Legal and Policy Coherence

Published in June 2020 *Sharing the Vision* renews the government's mental health policy focus on the principle of partnership. This is intended to ensure that people using mental health services – and their family, friends, carers, advocates, and supporters – are key decision makers in their own recovery planning and play a central role in designing and developing services. It highlights the importance of mental health services adapting to meet the person's wishes and preferences, and recognises that self-determination is a vital part of successful treatment and recovery.

The progressive, partnership approach promoted through *Sharing the Vision* must follow through to any new mental health legislation brought forward by the Department if legal and policy coherence is to be achieved. This includes the aspiration set out in recommendation 92, which states,

> Progress a 'zero restraint, zero seclusion' action plan, which should be developed in partnership with mental health services. Prioritise comprehensive legislation to reform the Mental Health Act, 2001 in line with this policy and in line with international human rights law. In keeping with the evolving understanding of human rights, particularly the UN Convention on the Rights of Persons with Disabilities, ensure that involuntary detention is not used except in a lifesaving emergency. Make available a range of advocacy supports including both peer and representative advocacy as a right for all individuals involved with the mental health services. A range of advocacy supports including both peer and representative advocacy should be available as a right for all individuals involved with the mental health services.

MHR Recommendation:
New mental health legislation must have an embedded human rights focus, with the centrality of the person to the process being a fundamental principle and must progress the aspiration to move to a 'zero restraint, zero seclusion' model of delivery.

Guiding Principles

Mental Health Reform welcomes the principles recommended by the Expert Group, i.e.

- Self-determination
- Autonomy
- Dignity
- Bodily integrity
- Least restrictive care
- Best attainable mental health

However, we are concerned about the suggestion that the phrase 'insofar as practicable' be used to limit the obligations arising out of these guiding principles. Such an insertion appears to fundamentally undermine human rights when it is in conflict with practicality. The human rights principle of progressive realisation recognises that rights may not be fully realisable immediately, but that States have an obligation to move forward over time in the fulfillment of human rights.

MHR Recommendation:
We call for implementation of the Expert Group's recommendation on the guiding principles of the Bill, but for 'insofar as practicable' to be excluded from the proposed legislation.

Definitions and Language

Language matters and the definitions to be used within the forthcoming legislation have the potential to make great impact on the lives of those who are impacted by it. MHR supports the introduction of the following changes to definitions in the Act:

1. **Replacement of 'Mental Disorder'**
   While we support the recommended replacement of 'mental disorder' MHR does not agree with the recommendation of the Expert Group that the term 'mental illness' should be used in its place.

   The reasoning behind this position is that medicalised language does not adequately reflect the full diversity of mental health difficulties and their causes. The combination of origins, contributory factors, manifestations, and impact of mental health difficulties for those who experience them are unique to each individual. While for some a medical diagnosis and focus may be incredibly helpful and useful, that is not the case for everyone and the use of medicalised terminology can be highly exclusionary as a result. Such terminology can have the unintended effect of narrowing how mental health difficulties are understood, responded to, and treated, which can be detrimental to many whose needs and experiences go beyond the realm of the medical.

   MacLachlan et. al. (2021) highlight that the proposed change of language from 'mental disorder' to 'mental illness' is not in line with terminology adopted by the United Nations, the World Health Organisation and the European Commission, and suggest cause neutral terminology be used when referring to mental health difficulties.[2] The 2017 annual report of the United Nations High Commissioner for Human Rights, which dealt solely with the issue of human rights and mental health, uses 'persons with mental health conditions' and 'persons with psychosocial disabilities.[3] The latter is in line with the UNCRPD and is sufficiently specific and well accepted within the international human rights framework to be a reliable alternative to the Expert Group's proposed use of 'mental illness'.

   MHR Recommendation:
   a. Replace 'mental disorder' with 'psychosocial disability' in line with the UNCRPD

   or

[2] https://hrbopenresearch.org/articles/4-28/v1
[3] https://www.un.org/disabilities/documents/reports/ohchr/a_hrc_34_32_mental_health_and_human_rights_2017.pdf

b. Replace ‘mental health difficulties’ in line with language used in Irelands mental health policy ‘sharing the vision

2. **The Term ‘Patient’**
   While it is understood that this legislation governs care and treatment of mental health difficulties in inpatient settings, it would be more in keeping with a person-centered approach if the personhood of the individual rather than their status as a patient be used when referring to them.

   MHR Recommendation: Replace ‘patient’ with ‘person’

3. **Gender Neutral Language**

   MHR Recommendation: It is recommended that the new legislation be written with gender-neutral language. Doing so would constitute a significant advancement in the official acknowledgement of those who do not identify within the bounds of the male and female binary or cis-gendered classifications. Such an approach would be highly beneficial from the perspective of inclusivity, and would have the added benefit of future-proofing the new legislation against the need to retrofit gender-neutral language at a later time.

Criteria for Detention

The Expert Group’s recommendation reflects Mental Health Reform’s recommendation. However, in light of the evolving understanding of the implications of the UNCRPD, MHR is concerned that allowing detention on the basis of ‘risk to health’ treats people with mental health difficulties differently from those with physical illness and, therefore, potentially contravenes the UNCRPD.

“Ultimately the Group were persuaded that, on balance, it is reasonable to allow for a person to be detained in circumstances where their health may deteriorate without the appropriate treatment.” (Section 2,4, p. 21)
However, the Expert Group has also recommended that if the person has capacity, they can refuse treatment and if they refuse all treatment options, must be discharged.

MHR Recommendation:
MHR urges that the new legislation include an unambiguous balancing of the interplay between the admission criteria of ‘risk to health’ and the right to refuse all treatment and thereby be discharged. We further recommend that ‘risk to health’ be replaced with ‘serious risk to health’.

Capacity

The Assisted Decision-Making (Capacity) Act 2015 brought Ireland’s capacity legislation closer into line with internationally accepted human rights standards, MHR albeit

acknowledges that further work is needed to fully comply with the UNCRPD. This is the case, for example, with regard to the continuing use of substitute decision-making practices, which contravene Article 12 of the UNCRPD.

MHR does however welcome the elimination of the principle of 'best interests', the paternalistic interpretation of which undermined the person's ability to play an active and key role in determining the pathway of their care and treatment. We also welcome the,

- Principles of the 2015 Act
- Presumption of capacity it enumerates
- Provision it makes for decision making supports, and
- Emphasis it places on respecting the will and preferences of the person.

All of these elements enable and empower people to be the principal decision-makers in their lives, including in relation to their own mental health care and treatment. We welcome the abolition of 'a person of unsound mind' status and the move away from capacity based on medical diagnosis. MHR further notes that access to supports under the 2015 Act must be a new feature of care. However, we wish to see the new legislation being drafted by the Department move further towards compliance with the UNCRPD with respect to assisted decision-making (for example by eliminating substitute decision-making). All of these elements must be supported or complemented by any new addition to the statute book, as it relates to mental health service delivery.

MHR notes the considerable interaction between the 2001 and 2015 Acts, and urge that the current law reform process be used to resolve existing conflicts and inconsistencies between these two important pieces of legislation. Irish law must provide a coherent legal and policy framework to ensure the effective implementation of the principles of autonomy, empowerment and self-determination, including with regard to individuals' mental health.

MHR Recommendations:
We ask that the new Mental Health Act:

- Aligns fully with and is legislatively coherent with the Assisted Decision Making (Capacity) Act 2015
- That all capacity legislation, supports, and practices be brought fully into line with the UNCRPD
- Ensures parity for people with mental health difficulties, including those who are involuntarily detained and everyone else

Change of Capacity During Treatment

The protections for people who become incapacitated following admission to an Approved Centre are not set out clearly within the Expert Group Report, and this must be addressed in the new legislation. Such individuals should be afforded the protections and review mechanism presently afforded to involuntary patients under the Mental Health Act.

MHR Recommendation:

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 should apply.

Functional Approach to Capacity

The Expert Group's recommendation reflects MHR's recommendation on the use of the functional approach to capacity. However, MHR is concerned about the confusion between the functional approach to capacity and the idea of supported decision-making reflected in the Assisted Decision-Making Act (2015), in that the Expert Group appears to be equating the two. MHR does not conflate the two Acts. We understand the 2015 Act to be about capacity and supporting those with have difficulties with decision making, and the Mental Health Act to be about mental health including the care and treatment of people in approved centres and for those who are involuntarily detained. We do however want parity for all people under the 2015 Act including those who are involuntarily detained.

MHR Recommendation:

- In assessing the capacity of an individual to make decisions under the new 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.
- We also call for a minimum of three mental health professionals to be involved in the assessment of an individual's 'risk to health'. The term 'risk to health' should be narrowed to 'serious risk to health' and the term 'material extent' should be amended to ensure that mental health professionals understand what this term means.
- MHR also proposes that the revised legislation include provisions for the appointment of an adequate number of Authorised Officers and for the removal of Section 9(a) from the Act under Involuntary admission of persons to Approved Centres.

Responsibility for Assessing Capacity

While the Expert Group recommendation reflects MHR's recommendation to some extent, there is no requirement for the involvement of a minimum of three different disciplines in the assessment, as called for by MHR. Furthermore, the assessment of an individual who is also already residing as an inpatient in an inpatient unit is not set out clearly.

MHR Recommendation:
Implement the Expert Group's recommendation but also introduce a requirement that capacity assessments incorporate the perspective of at least one allied mental health professional. Formal capacity assessments should involve the input of multi-disciplinary staff.

Advance Healthcare Directives

Advance Healthcare Directives ('AHD') provide a way for people to articulate their will and preferences for a later date in which their views may become unclear or unknown. However, under the 2015 Act, people who are detained in hospital for mental health treatment are specifically excluded from legally binding AHDs. They have no legal right to have their advance wishes respected, even though they had capacity to make decisions about their mental health care and treatment at the time of making their directive. There is no other group of individuals that are specifically excluded from this legal right; a shortfall which is clearly contrary to international human rights standards, including the UNCRPD.

To make a blanket denial of a person's preferences and concerns when they are detained involuntarily on mental health grounds is simply unjust, particularly at the moment such AHDs become most important. It is essential that AHDs apply equally to people with mental health difficulties, as to others, to promote respect for treatment preferences. They should apply to people who are voluntarily admitted, people who are involuntarily detained, and to individuals engaged with forensic mental health services.

While MHR agrees with the majority of the Expert Group's recommendations under this heading, the Group appears to accept that the recognition of AHDs should not apply to people involuntarily detained.

MHR Recommendation:
AHDs for those experiencing mental health difficulties must be given parity of esteem to those applying to physical health. The recognition of such directives must also apply to people who are involuntarily detained under the Mental Health Act, as per MHR's previous submissions.

Rights of Voluntary Patients

1. **Leaving Inpatient Care**
   The Expert Group recommendation does not go far enough in protecting the right of voluntary patients to leave an Approved Centre. It recommends retaining Section 23 of the Act allowing a voluntary patient to be detained for up to 24 hours before undergoing admission as an involuntary patient. However, the recommendation that an Authorised Officer will be required for all admissions, including in the conversion of voluntary to involuntary status, goes some way to strengthening the oversight in such transfers of status.

   MHR Recommendation: In addition to the implementation of the Expert Group's recommendation, MHR calls for
   - Review Boards to review all conversions of inpatient status
   - Guidelines to be developed for staff on how a section should be used

- Strengthening and clarification of the wording ‘given an assurance’ as recommended by the Expert Group, to precisely define what constitutes an assurance for the purposes of the Act.

2. **Right to Information**
   The Expert Group does not specify that voluntary patients be given information on the rationale for their hospitalisation and likely duration of their admission.

   MHR Recommendation: The Expert Group’s recommendation should be implemented, but the new legislation should ensure the Mental Health Code of Practice includes a requirement that voluntary patients be made aware of the rationale for their hospitalisation and its likely duration. Service users should also be provided information on the broad range of supports available to them.

Right to Advocacy and Supported Decision-Making

People who are in hospital for mental health treatment on a voluntary basis have no right to basic information, including information about their treatment. Under the Mental Health Act, 2001, it is not clear that all individuals are entitled to information about; their rights as a voluntary or involuntary patient, their rights about consent or refusal of treatment, the range of services available in the centre, and any complaints processes available to them.

In addition, there is no right to advocacy under the Mental Health Act, 2001 to ensure that any person voluntarily admitted or involuntarily detained, who needs advocacy support has the legal right to avail of it. It is crucial that children and adults who are in hospital for mental health treatment have direct access to professionals whose role it is to provide independent information about their rights when in hospital, advice and help to make decisions or to voice any concerns they may have. Currently, there are significant gaps in advocacy supports for people with mental health difficulties, including those in hospital. For example, people who are involuntarily detained do not have a legal right to have an advocate present at a review of their detention.

MHR Recommendation:

- All people in inpatient mental health services must be provided with information (on admission) on the treatment that they will receive, the reason why they are in hospital, how long they can expect to be in hospital and who they can contact for advocacy support
- Update the Mental Health Act to include a right to advocacy for all people admitted to approved centres governed by mental health legislation
- Make provision for the establishment or appointment of a publically funded, independent advocacy service for adults and children accessing the mental health services.

Seclusion and Restraint

The significant increase in the use of seclusion and restraint over the last decade, despite guidance on the reduction of coercive practices in mental health settings, is a deep cause of concern. In total there were 7,420 episodes of restrictive practices reported to the Mental Health Commission in 2017 and 7,464 in 2018.[4] When the Commission began reporting on restrictive practices in 2008, there were 4,765 combined episodes of physical restraint and seclusion.

Force and coercion should not be viewed as a method for engaging people with mental health difficulties in care and treatment. The Mental Health Commission published its *Seclusion and Restraint Reduction Strategy* in 2014 setting out a framework for the reduction of restrictive practices in approved centres. Both the policy and practice of this strategy needs to be included in the revised Act to guarantee appropriate implementation in approved centres.

MHR understands that nothing in the 2015 Act authorises treatment where the person's treatment is regulated by Part 4 of the Mental Health Act. With regard to the authorisation of seclusion and restraint practices there is no authority under the 2015 Act for a Decision-Making Representative, or Enduring Power of Attorney to authorise seclusion and restraint practices, except in designated limited circumstances. The limitation of such coercive practices is essential. It is critical for the purposes of equality that people with mental health difficulties and more specifically those who are detained under the 2001 Act, are treated the same as everyone else. In this regard, mental health care professionals should not be afforded the authority to override the decision of a Decision Making Representative, as will be the status quo in all other areas of the health sector. This will ensure parity between all individuals under the legislation.

People who are wards of court and who are detained in mental health inpatient units continue to be a matter of fundamental concern. Of the 479 active cases in 2017, 106 (or 22%) individuals were admitted to wardship due to "psychiatric illness" (Courts Service, 2017). The implementation of the ADM (Capacity) 2015 Act will provide for a review of all wards of court, including people with mental health difficulties in acute or community settings. It will allow for the transition of individuals from wardship to the decision-making structures of the legislation, or full discharge from wardship, as appropriate. There are, however, some inconsistencies between the ADM (Capacity) 2015 Act and the Mental Health Act, 2001. These inconsistencies relate to the provision of evidence, terminology used, and timelines proposed in the review process, and need to be addressed as a matter of priority.

MHR Recommendation:

- Revise the legislation to prohibit the use of seclusion or restraint except in life saving/emergency situations. The Mental Health Commission should ensure its Code of Practice reflects that the use of restraint should give rise to an assessment of the person's status as a voluntary patient.
- Ensure inclusion of the Mental Health Commission Strategy in the new Act., particularly with regard to actions on environment and regulation.

[4] https://www.mhcirl.ie/publications/use-restrictive-practices-approved-centres-activity-report-2017/2018

- An unambiguous definition of seclusion must be included in any new legislation to eliminate the possibility of this practice being used under a different name, for example ‘quiet time’.

Recognising the Role of Friends, Family Members, and Carers

MHR is concerned that the Expert Group did not make any recommendation on amending legislation to include rights for families.

MHR Recommendation:

- The legislation should place a duty on the health service to provide information of a general nature on mental health to the family members of a person with a mental health condition, upon request and with the permission of the service user.
- The legislation should place a duty on the health service to assess the support needs of family members of a person receiving treatment for a mental health condition, upon request of the family member and with the permission of the service user.
- The Act should be amended to place a duty on the Clinical Director to involve the family in discharge planning where the individual concerned is being discharged to the family’s home and the individual has given their permission.
- Where the family members include children or adolescents under the age of 18, there should be a duty on health and social care services to assess the needs of the children and provide appropriate supports.

Independent Complaints Mechanism

Mental Health Reform notes that the Expert Group did not recommend an independent route for making a complaint. The Decision Support Service, a stand alone service located within the Mental Health Commission, will provide support on decision making and investigate complaints on decision making for people with a mental health difficulty under the 2015 Act. However, this narrow remit is solely set to apply to complaints surrounding decision-making, which may limit the scope of the sort of complaints that can and will be investigated on behalf of service users.

MHR Recommendation:
An independent, publicly funded body must either be established or appointed to undertaken the duty of investigating all complaints arising out of the time spent by service users in inpatient settings for mental health care and treatment. This will ensure transparency.

Protection from Abuse

The previous mental health legislation of 1945 included a section (253), which criminalised the ill treatment or neglect of a patient in a psychiatric institution. The current Mental Health Act repealed this section and omitted any replacement. MHR sees no rationale for the repeal of this provision. In light of the history of abuse in various institutions in Ireland, it is important that provision is made in legislation, which emphasises the unacceptability of abusive behaviour. Furthermore, given the widespread presence of users of mental health services in community-based services including day hospitals, day centres and HSE-supervised community residences, such a provision should also be extended to cover all mental health services, whether in acute or community settings.

MHR Recommendation:
Re-introduction of criminal sanctions for ill treatment and neglect of any person being treated in a psychiatric institution.

Reporting on Detention

There is no specific recommendation made in the Expert Group's report on the reporting of a detained individual due to a lack of adequate community based services.

MHR also notes the confusing terminology with reference to 'detention order'. This refers to an order detaining a person who was made a ward of court and is waiting for their review under Part 6, and not an admission or renewal order under the 2001 Act.

MHR Recommendation:
MHR calls for the certification of the least restrictive principle. This should include reporting when a person has been required to be detained due to a lack of adequate community services being available, e.g. lack of a home-based treatment team, lack of a crisis housing, unavailability of service etc. We also call for reporting on individuals who are refused access to inpatient services due to shortages in beds.

Temporary Release Orders

The Expert Group did not make any specific recommendations relating to,

1. The conditions imposed upon a person during a period of absence with leave
2. The need for clarification that a person may not be recalled from leave unless they fulfill the criteria for detention under the Act
3. The need for the Mental Health Commission to be notified of all absences with leave granted.

MHR Recommendation:

- Section 26 should be amended to ensure that its temporary release provisions cannot be used to impose *de facto* community treatment orders, by specifying a maximum time for which such leave provisions may be used, and a requirement to consider whether the patient should be discharged.

- Section 26 should also expressly provide that any conditions imposed upon a person during a period of absence with leave, must be necessary and proportionate in the circumstances and the Code of Practice should provide guidance on what that means in practice.
- In addition, the Act should clarify that a person may not be recalled from leave unless he or she fulfills the criteria for detention under the Act.
- The architects of the new legislation should consider introducing a notification requirement, whereby the Mental Health Commission would be notified of all absences with leave granted (including the length of the period of absence and the conditions imposed, if any).

Conclusion

According to the criteria of Article 17 (1) iv. and Article 18 iii. of Rec (2004) 10 of the UNCRPD, Involuntary placement and involuntary treatment should be implemented when no alternatives are available. Involuntary placement must only be inevitable either because it is not possible to provide the necessary care outside an institution or because alternative means are not available. Likewise, involuntary treatment should only be performed if no less intrusive means would be sufficient [5]. These are important points to note with respect to the Irish mental health landscape, as all too often resource and funding deficiencies have forced reliance on acute care and treatment services where a more appropriate approach would have involved community based or other treatment options.

Whilst this consultation is not concerned directly with resources and funding, human rights compliant and forward looking law reform in this area can only be achieved if all appropriate alternatives to inpatient mental health care and treatment are adequately resourced and supported by government. This includes providing appropriate early interventions at the point of care to ensure the need for acute care is reduced in individual cases and across the system.

MHR, therefore, calls for the Department to make all reasonable efforts to ensure the care and treatment set out in any new mental health legislation is leaned on as a last resort. This will be achieved by providing sufficient planning, finances, staffing, and other supports needed for alternative care and treatment.

With respect to the legislation itself, MHR is of the view that given the lengthy duration of the review to date and the seriousness of the gaps in human rights protections for people receiving inpatient mental health treatment, there is a need for the implementation of the Expert Group recommendations by the Irish Government as a matter of priority.

We welcome the chance to contribute to this important consultation and hope to see the speedy publication of the General Scheme of new legislation after its conclusion.

[5] https://fra.europa.eu/sites/default/files/involuntary-placement-and-involuntary-treatment-of-persons-with-mental-health-problems_en.pdf