

Human Rights Analysis of the Draft Heads of a Bill to Amend the Mental Health Act 2001

Summary of Recommendations

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Mental Health Reform
Promoting Improved Mental Health Services

Introduction

In 2021, Mental Health Reform commissioned Dr Charles O'Mahony and Dr Fiona Morrissey of NUI Galway to develop 'A Human Rights Analysis of the Draft Heads of a Bill to Amend the Mental Health Act 2001'.

This document provides a summary of the authors' recommendations, which are aimed at strengthening respect for the human rights of people receiving mental health treatment and care in approved inpatient facilities.

The Department of Health (DOH) completed a public consultation and engagement process with key stakeholders in April 2021, which informed the Heads of Bill. The finalised Heads of Bill to amend the 2001 Act were approved by the Government in July 2021. They contain over 120 proposed changes to the 2001 Act.

Following the Government decision to approve the Heads of Bill, a formal Bill will be drafted by the Office of the Attorney General, in consultation with the DOH. The Oireachtas will review, debate, and amend the bill before submitting to the President to be signed into law. The authors hope the recommendations for further reform set out below will be given due consideration.

The recommendations contained in this document are to be read in conjunction with the full report "**A Human Rights Analysis of the Draft Heads of a Bill to Amend the Mental Health Act 2001**" available at www.mentalhealthreform.ie. The full report and recommendations will be available online from 30th November, 2021.

1. Language in the Heads of Bill

1.1 Recommendation:

- Replace the terms “mental disorder” and “mental illness” with “psychosocial disability” in the amending legislation in line with the UN Convention on the Rights of Persons with Disabilities (UNCRPD) or with “mental health difficulties” in line with language used in Ireland’s mental health policy “Sharing the Vision”.

2. Provisions Relating to Children & Young Persons

2.1 Summary of Recommendations Relating to Part 8

Based on the forgoing discussion and analysis of the Heads of Bill the authors make the following recommendations:

Guiding Principles Relating to Children and Younger Persons

- Considering the rights contained in the UN Convention on the Rights of the Child (CRC) and the CRPD there is a concern that a paternalistic approach will continue and recognition of the evolving capacity of the child and their right to participate in decision-making will be undermined. To minimise this risk, it would be beneficial to provide a definition of best interests and welfare for the purposes of the Act. This definition should encompass respect of the child’s legal capacity and right of participation in decision-making. The requirement to consult and include children subject to the 2001 Act at all stages of diagnosis and treatment is essential and the term “where practicable” should be replaced with a requirement that consultation must take place. Provisions to support the child in exercising their decision-making should be included in Part 8 of the amended legislation.

Persons Aged 16 and Under

- A procedure should be put in place to ensure that a systematic approach is taken to facilitate the child's right to express their views. In this regard the role of an independent advocate is important in supporting the child in participating meaningfully in the process and ensuring that their views, will and preferences are given due weight.

Children Aged 16 and Older

- To ensure that the legal capacity of children under the Act is respected a definition of “maturity and capacity” that aligns with the relevant international human rights law should be provided for in the legislation.
- There is concern that the Heads of Bill are insufficient in safeguarding the decision-making of persons aged 16 and older. A clear deficit is that the 2015 Act does not apply to children or young people thus creating a deficit for children's rights. This undermines the requirement to respect the evolving capacity of the child as the supported decision-making provisions in the 2015 Act do not apply. The Heads of Bill should provide for detail on the supported decision-making provisions for 16- and 17-year-olds subject to the mental health legislation.

Admission of Children to Adult Units

- The authors have serious concerns that Heads of Bill will not address the ongoing problem with the admission of children to adult units. As such an express provision should be contained in the amending legislation that provides that no child or young person shall be admitted to an adult inpatient unit.

Independent Advocacy for Children under the Mental Health Act 2001

- The authors recommend that a right to independent advocacy be included in the amending legislation to the 2001 Act for children and adults. The provision of this service is key in supporting children and young people in understanding the mental health services, their rights and in exercising their legal capacity.

The Appropriate Form to Review Admission of Children

- The authors are also concerned that s.84(3) only requires that hearings before the District Court under Part 8 should be before a District Family Law Court in so far as is practicable. The authors believe that the District Family Law Court should make the initial decision on admission of children and young people as involuntary for the purposes of the 2001 Act, but that a child friendly/age-appropriate version of the Mental Health Review Board should subsequently review the admission. If it is decided to retain the District Family Law Court as the body responsible of making decisions about the admission of children, there should be an express provision requiring that the District Family Law Court is required to exercise this function.

Review of Detention of Children

- Maximum periods of detention of children and young people under the Act should be provided and apply for the shortest time possible. The Heads of Bill should provide that a child or young person who is subject to a detention order or an advocate would have the right to apply to the Mental Health Review Board to review of their detention during such period on the grounds that they no longer fulfil the criteria for involuntary detention under the Act.

Psychosurgery and Electro-Convulsive Therapy in Respect of Children

- The authors believe that the 2001 Act should be amended to expressly prohibit the administration of ECT to children and young persons as recommended by the WHO. It would be appropriate to provide for an express provision in the amending legislation that prohibits the use of psychosurgery in respect of both adults and children and young person's subject to the mental health legislation.

Information and individual care/recovery planning relating to children and young persons

- To ensure that individual health planning is effective, meaningful and vindicates the rights of children and young person's, independent advocates should be involved in supporting the person in developing the plan with the multidisciplinary team. Human rights training should be provided on the importance of meaningful participation in the care planning process to achieve the cultural shift needed. The authors welcome the requirement in s.92(3) that the consultation by the multi-disciplinary team with the child on the care plan should be done in a manner that is accessible to the child. Each person in receipt of mental health services should also be provided with the opportunity to develop an advance healthcare directive with support if needed as part of the recovery/discharge process. This provision will support children and young persons in vindicating their rights and ensuring that their will and preferences are clearly understood. S.92 should require that as part of the individual care planning process a supported decision-making strategy should be included in circumstances where a person's capacity to make decisions is called into question.

3. Guiding principles in respect of adults in the Heads of Bill

3.1 Recommendation:

- S.4(9) in Head 5 should be deleted as this provision undermines the revised guiding principles underpinning the 2001 Act.

4. Definition of Mental Disorder in the Heads of Bill

4.1 Recommendations:

- The Department of Health clarify the scope of the proposed definition of "mental disorder" in s.3.
- The terms "mental disorder" and "mental illness" and replaced with "psychosocial disability" in the amending legislation in line with the CRPD or with "mental health difficulties" in line with language used in Ireland's mental health policy "Sharing the Vision".
- The term "illness" and "disability" be deleted from the text of s.3.

5. Voluntary Category

Change of status from voluntary to involuntary

5.1 Recommendations:

- The authors are concerned that these provisions are insufficient to address the human rights concerns about the lack of freedom of voluntary persons to leave approved inpatient facilities and refuse treatment. It is recommended that a provision be included in s.79 providing both for an express right to leave an approved inpatient facility at any time and a right to refuse treatment without threat or coercion.
- The powers contained in s.23 should be replaced with an alternative system of supports for the person and should not be used outside of very narrowly defined emergency circumstances where there is an imminent threat to life.
- Emergencies need to be defined in the Heads of Bill to prevent widening of the criteria.

6. Intermediate Category

6.1 Recommendations:

- An independent advocate should be appointed to support a person to articulate their will and preferences and maximise the safeguards surrounding their detention. This can supplement informal support from other trusted persons that the person chooses to be involved.
- S.80 on individual care plan should contain a requirement to develop a supported decision-making strategy as part of the individual care planning. This should be a legal requirement.
- S.80 should include a requirement that the Mental Health Commission (MHC) and the Decision Support Service develop guidelines / a code relating to the intermediate category.

7. Involuntary Admission

7.1 Recommendation:

- A right to community mental health services should be provided for in the amending legislation to the 2001 Act. This will ensure that alternatives to inpatient services are available and will support the State in meeting its obligations to eliminate coercion in mental health services.

Criteria for involuntary admission to approved inpatient facilities

7.2 Recommendation:

- S.8 should be amended to require that detention is to last only for as long as absolutely necessary in emergency circumstances.

Persons who may apply for involuntary admission

7.3 Recommendation:

- To ensure that the application for involuntary admission is indeed a last resort it is recommended that s.9 should be amended to expressly require the Authorised Officer (AO) to take all possible steps to use alternatives to coercion and that the steps taken to use alternatives should be documented.

Making of recommendation for involuntary admission

7.4 Recommendations:

- Considering the issues raised in the relevant case law it is necessary to explicitly include in s.10 the requirement for the examination to take place in person. However, given recent public health restrictions the issue of in person examination needs to be given further consideration.
- S.10 of the Heads of Bill should be further strengthened to ensure that the RMP is independent and has undertaken specialised training in both mental health and the relevant human rights law.

8. Powers of Garda Síochána under the Act & Assisted Admissions & Emergency Departments

8.1 Recommendations:

- To address the human rights concerns relating to provisions in s.12, s.13 and s.13A it is recommended that these codes will be essential in ensuring that the exercise of Garda powers under the 2001 Act and assisted admissions under the Act are carried out in a manner that causes the least amount of distress to the individual concerned.
- Gardaí and independent contractors involved in assisted admissions under the 2001 Act be required to undertake training on human rights and de-escalation techniques and obligated to use alternatives to coercion during the admission.
- Response teams could be created who have expertise in alternatives to coercion and should be involved in the assisted admissions process. It is essential that these teams include persons with lived experience.
- The Inspector be conferred with a statutory power and duty to undertake an annual review of powers exercised under s.12, s.13 and s.13A.
- Trained independent advocates should also be involved in assisted admissions.
- Vehicles used in assisted admissions should be unmarked to avoid long term stigma for persons and respect for their privacy and dignity.
- There should be a requirement that only trained people and trusted supporters are involved, Gardaí and independent contractors are only used in exceptional circumstances.

Section 13B Transfer of persons to emergency department

8.2 Recommendation

- Based on the forgoing discussion the authors would welcome clarification in relation to s.13B as provided for in the Heads of Bill.

9. Mental Health Review Board (MHRB)

International Human Rights Law & the Proposed Amendments on Mental Health Tribunals

9.1 Recommendations:

- An express provision be included in s.16B (powers of review board) conferring a power and duty on the MHRB to review individual care plans and to make recommendations as appropriate. This oversight should include enquiring as to whether the person had meaningful participation in the development of the care plan. The authors are of the view that this is a critical safeguard in ensuring transparency and accountability in the development and delivery of individual care planning. This provision will also mean that MHRBs can respond directly and meaningfully to failures and shortcoming raised by the person, their legal representative or advocate in respect of delivery of care plans. The person should also be automatically offered the opportunity to develop an Advanced Healthcare Directive (AHD) with support as part of the individual care plan. The content of any AHD the person has developed in relation to their mental health treatment and care preferences should also be considered by the MHRB and respected.

- The wording in s.16B does not sufficiently implement the Expert Review Groups' recommendations requiring the attendance of the representative and the responsible treating clinician at MHRB hearings. The text should be amended to provide greater clarity. The authors agree that where a person does not wish for their legal representative to attend this decision should be respected.
- The authors consider that a three-year term is appropriate for the appointment of independent consultant psychiatrist.
- The authors recommend that the MHC be required to publish data on the functioning and decision-making of the independent consultant psychiatrist.
- The authors consider that it would be beneficial to get the report nearer to the tribunal / board date as it is more up to date regarding the person's well-being. In recognition that a person's well-being can change significantly in 3 days the authors recommend that the Responsible Consultant Psychiatrist should be required to submit report at least 3 hours before Tribunal hearing.
- The authors recommend that s.16B(14) should be amended to require information as to whether a decision was a majority or unanimous decision be included when published.
- S.16A(3) should be amended to expressly exclude retired/no longer practicing Medical Practitioners, Nurses or Mental Health Professionals, Barristers or Solicitors from appointment to MHRBs as "community members".
- It is essential that more persons with lived experience are recruited as community members of the MHRBs. There should be a requirement that at least 50% of lay members have lived experience of psychosocial disability.
- The authors recommend that the format of MHRBs ensure that the person is placed at the centre and given precedence to speak before any other person attending the hearing.
- The authors believe that s.16A should be amended to require that a flat rate should apply equally to all members of the MHRB. This is essential to reflect that the views and experiences of all members are given equal weight and recognition in the discharge of their functions under the 2001 Act.
- S.16A(c) should be amended to permit community members to undertake the role of Chairperson.
- The authors recommend that where a person decides not to attend a MHRB hearing they would be entitled to nominate an independent advocate and/or trusted supporter to attend and participate in their absence.
- The authors acknowledge that some persons might prefer a remote hearing. S.16B(13) should be amended to provide that the MHRB should be required to ascertain the persons preference and

to comply with the decision of the person. This is important as face-to-face MHRB hearings with 6 – 8 people in a room can be very intimidating for the person.

10. New Part 4 Requirements for Consent to Treatment

Definition of Consent to Treatment

10.1 Recommendations:

- S.56 should include a requirement to provide support to persons subject to the 2001 when their capacity is called into question.
- S.56 should explicitly provide that a person's advocate and other support persons should be involved in the capacity assessment if the person so wishes.
- The presumption of capacity to consent needs to be strengthened in s.56 in alignment with the 2015 Act. This presumption of capacity should not be displaced until all appropriate supports have been put in place to enable the person to exercise their capacity to consent. There should be a requirement to document supports put in place if depriving a person of their capacity. This should include support persons, independent advocacy, information in a format the person understands, time to consider the information and AHDs.
- Other supports appropriate to the person's needs should be considered on an ongoing basis and put in place to enable them to exercise their capacity. This should include the development of an AHD after discharge.

Treatment Not Requiring Consent

10.2 Recommendations:

- The authors welcome the provision in s.57, which should increase the opportunities for developing AHDs and respect for the will and preferences of persons subject to the legislation. Provision should be made to raise awareness of the 2015 Act and support be provided to persons using mental health services to understand and avail of the supported decision-making provisions in the 2015 Act.
- The amending legislation should place a requirement on mental health professionals to demonstrate what supports they put in place to enable the person to exercise capacity before there is any finding of incapacity. All practical steps to support the person should be exhausted. It should be difficult to rebut the presumption of capacity, and there should be strong evidence to rebut it including the use of all appropriate supports.
- The authors are concerned about the provision in s.57(3) and s.57(6). Treatment should only be given without consent in emergency circumstances where there is an imminent threat to the life of the person or others. All practical supports should be put in place and exhausted before this can occur and should only apply for the shortest period possible.

11. Psycho-surgery

11.1 Recommendation:

- The authors note that in the Heads of Bill the section on psycho-surgery is to be deleted. We consider that it would be more appropriate to include an express provision in the amending legislation prohibiting the use of psychosurgery in respect of both adults and children and young person's subject to the mental health legislation. This prohibition would extend to voluntary, intermediate, and involuntary persons.

12. Electroconvulsive Therapy (ECT)

12.1 Recommendation:

- The Heads of Bill should not permit ECT to be administered where the person is considered unable to consent unless they have specifically consented to it in advance through an AHD or designated healthcare representative, Decision Making Representative or enduring power of attorney. ECT should not be given outside of life-saving emergencies or where the person has expressly consented to it.

13. Administration of Treatment

13.1 Recommendations:

- Treatment without consent should only be used in circumstances where all practicable steps have been taken to support the person to consent, and for the shortest period possible.
- There should be an obligation to identify appropriate supports to enable the person to exercise their capacity to consent within the 21-day period and treatment should not be administered without consent after 21 days outside of emergency circumstances where there is an imminent threat to the life of person or others.
- While multidisciplinary input is to be welcomed, second independent opinions as proposed in s.60(5) of the Heads of Bill provide little safeguard against treatment without consent.

14. Advance Healthcare Directives as they relate to mental health

14.1 Recommendations:

- The Department of Health should clarify the application of AHDs as provided for in the 2015 Act in the context of the 2001 Act.
- The validity of AHDs should apply equally between both general health care and mental health care. The Heads of Bill should explicitly provide the AHD are enforceable in respect of voluntary, intermediate, and involuntary categories. The 2015 Act should be amended accordingly.

- Independent support should be provided for all persons using mental health services to develop an AHD.
- There should be a presumption of capacity for all persons to make an AHD.

15. Coercion, Seclusion and Restraint

15.1 Recommendations:

In order to transition to the abolition of coercive practices in mental health services the authors set out below recommendations adapted from those developed by the COE Parliamentary Assembly and the work of the WHO QualityRights initiative.

- The MHC should be required in the amending legislation to develop a strategy to radically reduce recourse to coercive measures within Irish mental health services. This strategy should cover a 5-year period.
- In order to support the implementation of this strategy the MHC should be provided with additional resources to identify international best practice in ending coercion and develop resources on non-coercive measures.
- Additional funding should also be provided for the development of pilot community-based responses such as peer-led crisis or respite services, and other initiatives identified as international best practice.
- Additional funding should also be dedicated to the development of prevention and early identification of mental health conditions and early, non-coercive intervention, especially for children and young persons. This should be included as a standalone section in Part 7 (Miscellaneous) of the amending legislation.
- There should be a requirement in the amending legislation that key stakeholders should be required to undertake mandatory human rights training that covers both regional and international human rights law, with a focus on the Convention on the Rights of Persons with Disability (CRPD).
- The MHC should be required to fund the delivery of the WHO QualityRights training initiative to reduce the need for coercion and improve quality of care in mental health services. Training should be delivered by WHO QualityRights trainers and people with lived experience of mental health services.
- Gardaí, AOs, MHC staff, Psychiatrists, and all mental health professionals working in inpatient and community services should be required to undertake WHO QualityRights training.
- Persons with lived experience of involuntary detention should be involved in the development and delivery of this human rights training.
- The Heads of Bill should require the *Department of Further and Higher Education, Research, Innovation and Science* to undertake a review of the curricula of Irish higher education institutions (degrees in law, medicine, nursing, occupational therapy, psychology, social care, social work and speech and language therapy) to ensure that content on the United Nations Convention on the Rights of Persons with Disabilities and related human rights law is included.
- Strategies to prevent and avoid seclusion and restraints should be developed. Key strategies include individualised care plans; de-escalation; human rights training helps affect attitudinal change towards use of seclusion and restraint; comfort rooms and response teams.

16. Direct complaints mechanism

16.1 Recommendations:

- The Heads of Bill should provide for an independent direct / specific complaints mechanism for mental health services. This needs to be separate from the existing HSE “Your Service, Your Say” complaints mechanism. Both adults and children should be entitled to avail of this complaints mechanism.
- The Inspector of Mental Health Services should be conferred with a statutory obligation to receive, investigate, and determine individual complaints relating to mental health services.
- Information on the complaints mechanism should be expressly included in the information provided to adults and children admitted to approved inpatient facilities, community residences and community mental health services. The complaints mechanism should be accessible, and information should be provided in a format the person understands.
- Given that persons using mental health services are at increased risk of coercion and restriction of their human rights, a mental health ombudsman for this area should be considered.
- The Optional Protocol to the CRPD should be ratified immediately so that persons subject to the 2001 Act have the option to submit complaints directly to the CRPD Committee.

17. Individual Care Planning

17.1 Recommendations:

- S.80 should provide that independent advocates be involved in supporting persons to develop the individual care plan with the multidisciplinary team.
- There should be a legal requirement that the person supported to meaningfully participate in the development of individual care plan with appropriate independent support if necessary.
- Human rights training should be provided on the importance of meaningful participation in the care planning process to achieve the cultural shift to a human rights led approach.
- S.80 should require that information on care planning be provided in a format that the person understands.
- S.80 on individual care plans should contain a requirement to develop a supported decision-making strategy as part of the individual care planning.
- The individual care plan should also form the basis for the development of an advance healthcare directive. Independent support should be provided to develop the individual care plan and AHD. This may include the involvement of trained independent advocates.

18. Independent Advocacy

18.1 Recommendations:

Based on the forgoing discussion and analysis of the Heads of Bill the authors make the following recommendations:

- The Heads of Bill should put the right to an advocate on a statutory footing for voluntary, intermediate, and involuntary persons.

- The advocacy service should be independent of the HSE, MHC and the Decision Support Service (DSS) and this should be specified in the legislation.
- The advocacy service should be peer led and advocates should have personal experience of using the mental health services.
- Peer advocates should be provided with appropriate supports and reasonable accommodations to undertake this work.
- Advocates should receive ongoing training on human rights, mental health legislation and the capacity legislation.

19. Clinical Trials

19.1 Recommendation

- The proposed change to s.70 should be given further consideration *vis a vis* the 2015 Act and the proposed changes around decision-making in the Heads of Bill.
- When developing AHDs consideration should be given as to whether participation in clinical trials should be included. The person should state their views as to whether they wish to participate in clinical trials related to their future mental health treatment.

20. Review of the Mental Health & Capacity Legislation

20.1 Recommendations

- To minimise the risk of a fragmented approach the review of the mental health legislation provided for in s.75 should coincide with the review of the Assisted Decision Making Capacity Act 2015.
- The coordinated review of the mental health and capacity legislation should take place 3 years after the commencement of both pieces of legislation.



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