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

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List of Abbreviations

2001 Act	Mental Health Act 2001
2015 Act	Assisted Decision-Making (Capacity) Act 2015
2018 Act	Mental Health (Amendment) Act 2018
AHD	Advance Healthcare Directive
AO	Authorised Officer
AVFC	A Vision for Change
COE	Council of Europe
CRC	United Nations Convention on the Rights of the Child
CRC Committee	United Nations Committee on the Rights of the Child
CRPD	United Nations Convention on the Rights of Persons with Disabilities
CRPD Committee	United Nations Committee on the Rights of Persons with Disabilities
DOH	Department of Health
ECHR	European Convention on Human Rights
ECT	Electroconvulsive Therapy
ECtHR	European Court of Human Rights
ERG	Expert Review Group
HSE	Health Service Executive
LRC	Law Reform Commission
MHC	Mental Health Commission
MHRB	Mental Health Review Board
MHT	Mental Health Tribunal
OP	Optional Protocol
RCP	Responsible Consultant Psychiatrist
RMP	Registered Medical Practitioner
WHO	World Health Organization

мΦ LУŕŃŃ2ŘdzŎŕŕλ2Y ϑ . І·Ŏ⌊ƎŃŃ2dzyŘ ŕ2 ŕŕKŜ І ŜІ·Řă 2Ŧ . λŕŕ[m]

[2] KŜY ŕŕKŜ *a ŜyŕŕІ·ŕ І ŜІ·ŕŕK !Ŏŕŕ нллм* óнллм !Ŏŕŕŕ ǿІ·ă Ŏ2YYŜyŎŜŘ λY нллсΣ λŕŕ ŃŜLJŃŜăŜyŕŕŜŘ І· ǿІ·ăŕŕ λYLJŃ2ǿŜYŜyŕŕ 2Y λŕŕă LJŃŜŘŜŎŜăă2ŃΣ ŕŕKŜ *a ŜyŕŕІ·ŕ YŜyŕŕ !Ŏŕŕ мфпрΣ* λY І·Ř2LJŕŕλY3 І· YZŃŜ KdzYІ·Y ŃλƎKŕŕă π ŏІ·ăŜŘ І·LJLJŃ2І·ŎK ŕ2 ăІ·ŦŜƎdzІ·ŃŘλY3 ŕŕKŜ ŃλƎKŕŕă 2Ŧ LJŜŃă2yã λYǿ2ŕdzyŕŕІ·ŃλŕŕŘ ŜŕŕІ·λYŜŘ λY LŃλăK YŜyŕŕІ·ŕ KŜІ·ŕŕK ăŜŃǿλŎŜăǿ ŕKŜ нллм !Ŏŕŕ ǿІ·ă ăŜŜY І·ă ŏŃλY3λY3 LŃλăK YŜyŕŕІ·ŕ KŜІ·ŕŕK ŕІ·ǿ λYŕŕ2 Ŏ2YLJŕІ·yŎŜ ǿλŕŕK λYŕŕŜŃY1·ŕŕλ2Y1·ŕ KdzYІ·Y ŃλƎKŕŕă ŕІ·ǿΣ λY LJІ·ŃŕŕλŎdzŕІ·Ń ŕŕKŜ 9dzŃ2LJŜІ·Y /2YǿŜyŕŕλ2Y 2Y І dzYІ·Y wλƎKŕŕă ó9/ І wúΦ І2ǿŜǿŜŃΣ ăλYŎŜ ŕŕKŜY ŕŕKŜ ŃŜŕŕŜǿІ·yŕŕ λYŕŕŜŃY1·ŕŕλ2Y1·ŕ KdzYІ·Y ŃλƎKŕŕă ŕІ·ǿ KІ·ă ŘŜǿŜŕ2LJŜŘΣ YŜІ·yλY3 ŕŕKІ·ŕ ŕŕKŜ ŕŜƎλăŕІ·ŕŕλ2Y YŜŜŘă ŕ2 ŏŜ ŃŜǿλŜǿŜŘ ŕ2 Ŏ2YLJŕè ǿλŕŕK ŕŕKŜ ¦ b /2YǿŜyŕŕλ2Y 2Y ŕŕKŜ wλƎKŕŕă 2Ŧ tŜŃă2yã ǿλŕŕK 5λăІ·ŏλŕŕŕŕλŜă ó/wt5ŕŕΦ[H]

[2] Ŝ ǿŜŕŕŎ2YŜ ŕŕKŜ 2LJLJ2Ńŕŕdzyλŕŕè ŕ2 Ŏ2YYŜyŕŕ 2Y ŕŕKŜ І ŜІ·Řă 2Ŧ . λŕŕΣ ǿKλŎK LJŃ2LJ2ăŜă ăλƎyλŦŕŎІ·yŕŕ ŎKІ·y ƎŜă ŕ2 ŕŕKŜ нллм !ŎŕŕΦ ¢KŜ f2yƎ ŕλŕŕŕŜ 2Ŧ ŕŕKŜ І ŜІ·Řă 2Ŧ . λŕŕ ŜÈLJŕλŎλŕŕè y2ŕŕŜă ŕŕKІ·ŕ λŕŕ ăŜŜ⌊ă ŕ2 Ŝyãdz ŃŜ ŕŕKŜ І·dzŕ2y2Yè 2Ŧ LJŜŃă2yãΣ І·yŘ ŕŕKІ·ŕ ŕŕKŜ ŕŜƎλăŕІ·ŕλ2Y ŃŜăLJŜŎŕă І·yŘ LJŃ2Y2ŕŕŜă ŕŕKŜ ŃλƎKŕŕă 2Ŧ LJŜŃă2yã ădzō?ŜŎŕŕ ŕ2 ŕŕKŜ ŕŜƎλăŕІ·ŕλ2yΦ . Ŝŕ2ǿ ǿŜ ăŜŕŕ 2dzŕŕ Ŏ2YLJŃŜKŜyãλǿŜŕè ŕŕKŜ ŃŜŕŕŜǿІ·yŕŕ ŃŜƎλ2Y1·ŕ І·yŘ λyŕŕŜŃY1·ŕŕλ2Y1·ŕ KdzYІ·Y ŃλƎKŕŕă ŕІ·ǿΦ ¢Kλă ō2Řè 2Ŧ ŕІ·ǿ ǿλŕŕ ăŜŃǿŜ І·ă І· ŦŃІ·YŜǿ2Ń⌊ Ŧ2Ń І·yІ·ŕèăλY3 ŕŕKŜ І ŜІ·Řă 2Ŧ . λŕŕΦ ¢KŜ І·yІ·ŕèăλă 2Ŧ ŕŕKŜ І ŜІ·Řă 2Ŧ . λŕŕ ǿλŕŕ І·ŘŘŃŜăă ăŜǿŜŃІ·ŕ ⌊Ŝè І·ŃŜІ·ăΦ ¢KŜăŜ І·ŃŜІ·ă λYŎŕdzŘŜ t І·Ńŕŕ y 2Y /KλŕŘŃŜYΣ ŕŕKŜ yŜǿ ƎdzλŘλY3 LJŃλYŎλLJŕŜăΣ ŕŕKŜ ŘŜŦλYλŕŕλ2Y2Ŧ ćY ŜyŕŕІ·ŕ Řλă2ŃŘŜŃéΣ ŕŕKŜ Ø2ŕdzyŕŕІ·Ńè ŎІ·ŕŕŜƎ2ŃèΣ ŕŕKŜ λyŕŕŜŃY ŜŘλІ·ŕŕŜ ŎІ·ŕŕŜƎ2ŃèΣ ŕŕKŜ λyǿ2ŕdzyŕŕІ·Ńè ŎІ·ŕŕŜƎ2ŃèΣ І·yŘ І·ŕŕλŜŘ λăădzŜăΦ ! yдzYōŜŃ 2Ŧ 2ŕŕKŜŃ ⌊Ŝè LJŃ2ǿλăλ2yã ǿλŕŕ ōŜ ŜÈІ·YλyŜŘ ădzŎK І·ă ŜyŘλY3 ŕŕKŜ dzăŜ 2Ŧ Ŏ2ŜŃŎλ2yΣ ŕŕKŜ yŜŜŘ Ŧ2Ń λyŘŜLJŜyŘŜyŕŕ І·Řǿ2ŎІ·Ŏè І·yŘ ŕŕKŜ Ŏ2YLJŕІ·λyŕŕă YŜŎKІ·yλăY Ŧ2Ń LJŜŃă2yã dzyŘŜŃ ŕŕKŜ нллм !Ŏŕŕ . І·ăŜŘ 2Y ŕŕKλă І·yІ·ŕèăλă 2Ŧ ŕŕKŜ І ŜІ·Řă 2Ŧ . λŕŕΣ ŕŕKŜ І·dzŕK2ŃăY І·⌊Ŝ ăŜǿŜŃІ·ŕ ŃŜŎ2YYŜyŘІ·ŕλ2yãΣ ǿKλŎK І·ŃŜ І·λYŜŘ І·ŕ ăŕŕŃŜyƎŕŕKŜyλY3 ŃŜăLJŜŎŕ Ŧ2Ń ŕŕKŜ KdzYІ·Y ŃλƎKŕŕă 2Ŧ LJŜŃă2yã ădzō?ŜŎŕŕ ŕ2 ŕŕKŜ ŕŜƎλăŕІ·ŕλ2yΦ

¢Kλă λă І· ōŃλŜŦ 2ǿŜŃǿλŜǿ 2Ŧ ŕŕKŜ ŕІ·ǿ ŃŜŦ2ŃY LJŃ2ŎŜăă ădzŃŃ2dzyŘλY3 ŕŕKŜ нллм !Ŏŕŕ І·yŘ ŕ2 ōІ·Ŏ⌊ƎŃ2dzyŘ ŕ2 ŕŕKŜ І ŜІ·Řă 2Ŧ . λŕŕΦ ¢KŜ І·dzŕK2ŃăŕŕK2dzƎKŕŕ ŕŕKλă ǿ2dzŕŘ ōŜ dzăŜŦdzŕ ƎλǿŜY ŕŕKŜ LJŃ2ŕŕŃІ·ŎŕŕŜŘ yІ·ŕdzŃŜ 2Ŧ ŕŕKŜ ŃŜǿλŜǿ LJŃ2ŎŜăă 2Ŧ ŕŕKŜ нллм !Ŏŕŕ ¢KŜ 9ÈLJŜŃŕŕ wŜǿλŜǿ DŃ2dzLJ ó9wDú LJdzōŕλăKŜŘ λŕŕă wŜLJ2Ńŕŕ λY нлмрΣ ǿKλŎK YІ·ŘŜ мср ŃŜŎ2YYŜyŘІ·ŕλ2yã 2Y K2ǿ ŕ2 І·YŜyŘ ŕŕKŜ нллм !Ŏŕŕ {K2Ńŕŕè І·ŦŕŜŃ ŕŕKλă ǿІ·ă LJdzōŕλăKŜŘ ŕŕKŜ *!ăăλăŕŕŜŘ 5ŜŎλăλ2yπ a І·⌊λyƎ ó/І·LJІ·Ŏλŕŕèú !Ŏŕŕ нлмр* óнлмр !Ŏŕŕŕ ǿІ·ă ŜyІ·ŎŕŕŜŘΦ[O] {λyŎŜ ŕŕKŜY ŕŕKŜŃŜ KІ·ă ōŜŜY ŕλŕŕŕŕŜ LJŃ2ƎŃŜăă λY λYLJŕŜYŜyŕŕλyƎ ŕŕKŜ 9wD ŃŜŎ2YYŜyŘІ·ŕλ2yã І·yŘ Ŏ2YYŜyŎλyƎ ŕŕKŜ нлмр !Ŏŕŕ ¢KŜ 5ŜLJІ·ŃŕŕYŜyŕŕ 2Ŧ І ŜІ·ŕŕK ó5h І ú Ŏ2YLJŕŜŕŕŜŘ І· LJdzōŕλŎ Ŏ2yãdzŕŕІ·ŕλ2Y І·yŘ ŜyƎІ·ƎŜYŜyŕŕ LJŃ2ŎŜăă ǿλŕŕK ⌊Ŝè ăŕІ·⌊ŜK2ŕŘŜŃă λY ! LJŃλŕ нлнмΣ ǿKλŎK λyŦ2ŃYŜŘ ŕŕKŜ І ŜІ·Řă 2Ŧ . λŕŕΦ[P] ¢KŜ ŦλyІ·ŕλăŜŘ І ŜІ·Řă 2Ŧ . λŕŕ ŕ2 І·YŜyŘ ŕŕKŜ нллм !Ŏŕŕ ǿŜŃŜ І·LJLJŃ2ǿŜŘ ōè ŕŕKŜ D2ǿŜŃyYŜyŕŕ λY Wdzŕè нлнмΦ[P] ¢KŜ aλyŕăŕŕŜŃ Ŧ2Ń І ŜІ·ŕŕKΣ І·yŘ ŕŕKŜ aλyŕăŕŕŜŃ 2Ŧ {ŕІ·ŕŕŜ Ŧ2Ń aŜyŕŕІ·ŕ І ŜІ·ŕŕK І·yŘ hŕŘŜŃ tŜ2LJŕŜ І·yŘ YŜyŕŕІ·ŕ KŜІ·ŕŕK І·ŘǿŎІ·Ŏè ƎŃ2dzLJă ǿŜŕŕŎ2YŜŘ ŕŕKŜ ŘŜŎλăλ2yΦ[C] ¢KŜ І ŜІ·Řă 2Ŧ . λŕŕ Ŏ2yŕŕІ·λY2ǿŜŃ мнл LJŃ2LJ2ăŜŘ ŎKІ·yƎŜă ŕ2 ŕŕKŜ нллм !Ŏŕŕ ¢KŜ aλyŕăŕŕŜŃ Ŧ2Ń І ŜІ·ŕŕKΣ {ŕŕŜLJKŜY 52yYŜŕŕèΣ ăŕІ·ŕŕŜŘ ŕŕKІ·ŕ ŕŕKŜ ōλŕŕ αλŕŕ λă І·Y λYLJ2ŃŕŕІ·yŕŕ ăŕŕŜLJ λY ŜyădzŃλyƎ ŕŕKІ·ŕ ŕŕKŜ ŃλƎKŕŕă 2Ŧ LJŜ2LJŕŜ І·ŎŎŜăăλyƎ ăŜŃǿλŎŜă І·ŃŜ Ŧdzŕŕè ǿλyŘλŎІ·ŕŕŜŘb[Φ][T] ¢KŜ І ŜІ·Řă 2Ŧ . λŕŕ І·ŃŜ ăŕІ·ŕŕŜŘ ŕ2 ōŜ ŕŕKŜ ŃŜdzŕŕŕ 2Ŧ Ŏ2yãdzŕŕІ·ŕλ2YōŜŕŕǿŜŜY ŕŕKŜ 5h І І·yŘ ⌊Ŝè ăŕІ·⌊ŜK2ŕŘŜŃăΣ λyŎŕdzŘλyƎ ŕŕKŜ aŜyŕŕІ·ŕ І ŜІ·ŕŕK /2YYλăăλ2Y ó a І /úΣ ŕŕKŜ І ŜІ·ŕŕK {ŜŃǿλŎŜ 9ÈŜŎdzŕŕλǿŜ ó І {9úΣ ŕŕKŜ ŃλăK /2ŕŕŜƎŜ 2Ŧ tăèŎKλІ·ŕŕŃè І·yŘ ŕŕKŜ Ŏ2yãdzŕŕІ·ŕλ2Y ǿλŕŕK ŕŕKŜ LJdzōŕλŎ І·yŘ LJŜŃă2yã dzăλyƎ YŜyŕŕІ·ŕ KŜІ·ŕŕK ăŜŃǿλŎŜăǿ ¢KŜ 5h І ŃŜǿλŜǿŜŘ І·yŘ ŃŜǿλăŜŘ ŕŕKŜ ŘŃІ·Ŧŕŕ І ŜІ·Řă 2Ŧ . λŕŕ λY

[M] ¢KŜ І·dzŕK2ŃăΦ ǿ2dzŕŘ ŕλ⌊Ŝ ŕ2 ŕŕKІ·y⌊ Cλ2yІ· ! yŘŜŃă2yΣ 5Ń / І·ŕŕλ2yІ· a 2ŕ2yŜè І·yŘ w2ăλŜ [2] λŕă2yŦ2Ń ŕŕKŜŃ Ŏ2YYŜyŕŕă 2Y ŕŕKŜ Ŏ2yŕŕŜyŕŕă 2Ŧ ŕŕKλă ŃŜLJ2ŃŕŕΦ ¢KŜ І·dzŕK2Ńă ŕІ·⌊Ŝ Ŧdzŕŕ ŃŜăLJ2yãλŎλŕŕè Ŧ2Ń І·yè ŜŃŃ2Ńă 2Ń 2Y λăăλ2yã λY ŕŕKλă ŃŜLJ2ŃŕŕΦ

[H] ¢KŜ *a ŜyŕŕІ·ŕ І ŜІ·ŕŕK !Ŏŕŕ нллм* Ŏ2YYŜyŎŜŘ λY b2ǿŜYōŜŃ нллс І·yŘ І·ŦŜǿ Y2yŕŕKă ŕІ·ŕŕŜΣ λY a І·ŃŎK нллтΣ ŕŕKŜ D2ǿŜŃyYŜyŕŕ ăλƎyŜŘ ŕŕKŜ ¦ b ¦ yλŕŕŜŘ bІ·ŕλ2yã /2yǿŜyŕŕλ2Y 2Y ŕŕKŜ wλƎKŕŕă 2Ŧ tŜŃă2yã ǿλŕŕK 5λăІ·ŏλŕŕŕŕλŜă ó/wt5ŕŕΦ

[O] 5ŜLJІ·ŃŕŕYŜyŕŕ 2Ŧ І ŜІ·ŕŕKΣ áwŜLJ2Ńŕŕ 2Ŧ ŕŕKŜ 9ÈLJŜŃŕŕ DŃ2dzLJ 2Y ŕŕKŜ wŜǿλŜǿ 2Ŧ ŕŕKŜ aŜyŕŕІ·ŕ І ŜІ·ŕŕK !Ŏŕŕ нллмé ó5dzōŕλYY нлмрŕŕΦ

[N] ! ă LJІ·Ńŕŕ 2Ŧ ŕŕKІ·ŕ ŃŜǿλŜǿ LJŃ2ŎŜăă ŕŕKŜ 5ŜLJІ·ŃŕŕYŜyŕŕ 2Ŧ І ŜІ·ŕŕK ă2dzƎKŕŕ ŕŕKŜ 2LJλyλ2yã 2Ŧ ⌊Ŝè ăŕІ·⌊ŜK2ŕŘŜŃă 2Y ŕŕKŜ нллм !Ŏŕŕ ŕŕKŃ2dzƎK І· Ŏ2yãdzŕŕІ·ŕλ2Y І·yŘ ŜyƎІ·ƎŜYŜyŕŕ LJŃ2ŎŜăă λY ! LJŃλŕ нлнмΦ CІ·ŎλŕŕŕŕІ·ŕŜŘ ǿ2Ń⌊ăK2LJă ǿŜŃŜ K2ăŕŕŜŘ ōè І {9 aŜyŕŕІ·ŕ І ŜІ·ŕŕK 9yƎІ·ƎŜYŜyŕŕ І·yŘ wŜŎ2ǿŜŃè hŦŕλŎŜ І·yŘ aŜyŕŕІ·ŕ І ŜІ·ŕŕK wŜŦ2ŃY Ŧ2Ń LJІ·ŃŕŕλŎλLJІ·yŕŕă ŕŕ2 ăKІ·ŃŜ ŕŕKŜŃ ŜÈLJŜŃŕŕŜyŎŜ 2Y λYLJ2ŃŕŕІ·yŕŕ λăădzŜă dzăλyƎ ŕŕKŜYŜă 2Ŧ ŕŕKŜ 9wDΦ ! LJdzōŕλŎ Ŏ2yãdzŕŕІ·ŕλ2Y ǿІ·ă І·ŕă2 dzyŘŜŃŕŕІ·⌊ŜY І·ŕŕ ŕŕKλă ŕŕλYŜΦ

[P] 5ŜLJІ·ŃŕŕYŜyŕŕ 2Ŧ І ŜІ·ŕŕKΣ áaλyŕăŕŕŜŃă 52yYŜŕŕè І·yŘ . dzŕŕŜŃ ǿŜŕŎ2YŜ D2ǿŜŃyYŜyŕŕ І·LJLJŃ2ǿІ·ŕ 2Ŧ ŕŕKŜ KŜІ·Řă 2Ŧ ōλŕŕ ŕ2 І·YŜyŘ ŕŕKŜ aŜyŕŕІ·ŕ І ŜІ·ŕŕK !Ŏŕŕé ó5dzōŕλYY tŃŜăă ŃŜŕŕŜІ·ăŜΣ moúK 2Ŧ Wdzŕè нлнмŕŕΦ

[C] /2ŃYІ·Ŏ hΩYŜŜŦŦŜΣ áaŜyŕŕІ·ŕ І ŜІ·ŕŕK DŃ2dzLJă [2] ŜŕŎ2YŜ [2yƎπ ! ǿІ·ŕŕŜŘ ! yŷ2dzyŎŜYŜyŕŕ 2Ŧ bŜǿ [І·ǿăé óLŃăK 9ÈІ·YλyŜŃΣ mпúK Wdzŕè нлнмŕŕΦ

[T] 5ŜLJІ·ŃŕŕYŜyŕŕ 2Ŧ І ŜІ·ŕŕKΣ áaλyŕăŕŕŜŃă 52yYŜŕŕè І·yŘ . dzŕŕŜŃ ǿŜŕŎ2YŜ D2ǿŜŃyYŜyŕŕ І·LJLJŃ2ǿІ·ŕ 2Ŧ ŕŕKŜ KŜІ·Řă 2Ŧ ōλŕŕ ŕ2 І·YŜyŘ ŕŕKŜ aŜyŕŕІ·ŕ І ŜІ·ŕŕK !Ŏŕŕé ó5dzōŕλYY tŃŜăă ŃŜŕŕŜІ·ăŜΣ moúK 2Ŧ Wdzŕè нлнмŕŕΦ

response to the feedback.[8] The Minister for State for Mental Health and Older People (Mary Butler) stated that these submissions were invaluable in finalising the Heads of Bill.[9]

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 Heads of Bill will then be sent to the Joint Oireachtas Committee on Health. The Oireachtas will review, debate, and amend the bill before submitting to the President to be signed into law. The Minister for State for Mental Health and Older People that "the Bill will be a significant step in ensuring parity between mental and physical health, in empowering people to make decisions about their own mental health care and in enhancing protections and safeguards for people accessing the mental health services."[10] The Minister also stated that she is committed to seeing the Bill drafted as quickly as possible so it can be presented to the Oireachtas. Given the delays in implementing the recommendations of the ERG, the amending legislation should be prioritised. The authors hope the recommendations for further reform set out below will be given due consideration.

[8] Ibid.
[9] Ibid.
[10] Ibid.

2. Mental Health Laws & International Human Rights Law

The national and international human rights landscape has changed dramatically since the *Mental Health Act 2001* was commenced in 2006. Since 2006, a range of monumental changes have shifted mental health and capacity law towards a more human rights-based approach under the social model / human rights of disability.[11] One of the most influential drivers of change has been the drafting of the UN Convention on the Rights of Persons with Disabilities (CRPD) in 2006.[12] While the European Convention on Human Rights (ECHR) was the driving force behind the enactment of the 2001 Act, subsequent law reform in Ireland has been largely driven by CRPD ratification. The CRPD is the first internationally binding document, which explicitly applies to disabilities and has been ratified by the European Union (EU) in its own right.[13] It is regarded as the most significant developments in human rights and disability law of the 21st century.

Mental health laws throughout the world have been the subject of debate for many decades. Increased scrutiny through the lens of human rights law has been a significant feature. Of relevance are Articles 12 and 14 of the CRPD, which require mental health laws to be abolished and replaced by consensual practices and services based on a social and human rights model rather than a medical model of disability. The UN Committee on the Rights of Persons with Disabilities (the CRPD Committee) has urged all necessary legislative, administrative and judicial measures to ensure that no one is detained against their will in any kind of mental health facility and to develop de-institutionalisation strategies based on the human rights model of disability. [14] It has stated that all mental health services should be based on free and informed consent with emphasis on community-based outpatient services. The Committee has recommended that states "allocate more financial resources to persons with intellectual and psychosocial disabilities who require a high level of support, in order to ensure that there are sufficient community-based outpatient services to support persons with disabilities."[15]

The 2001 Act is at odds with Ireland's obligations under the CRPD. Since the Expert Review Group (ERG) Report was published in 2015 Ireland ratified the CRPD and the CRPD Committee has clarified the implications of the convention for domestic mental health legislation. It is important to note that State Parties obligations under Article 14 (the right to liberty and security of the person) have been the subject of much debate over the past number of years and have been informing and shaping mental health law reform. The text of Article 14 reiterates the general right to liberty, stating that it cannot be removed unlawfully or arbitrarily. Article 14 specifically provides that "disability shall in no case justify a deprivation of liberty". It was initially thought that Article 14 added little to international human rights law, as disability is not a sole justification for loss of liberty. Rather, the combination of disability with a perception of danger to oneself or to others historically justified deprivation of liberty (subject to legal safeguards as is the case with the 2001 Act). Therefore, it was thought that Article 14 merely required a narrowing of the criteria for loss of liberty. Article 14(2) of the CRPD provides

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[11] Under the social model, disability is caused by socially constructed barriers that serve to exclude the individual. See Anna Lawson & Angharad Beckett "The social and human rights models of disability: towards a complementarity thesis" (The International Journal of Human Rights, 25(2), pages 348-379).

[12] The CRPD, opened for signature on the 30th of March 2007, and entered into force on the 3rd of May 2008.

[13] The EU became the 97th party to the treaty when it ratified it on the 23rd of December 2010.

[14] See CRPD Committee, "Concluding Observations of the Committee on the Rights of Persons with Disabilities Austria" (Geneva: CRPD /c/aut/co/1, 2014), at para 30-31. See also CRPD Committee, "Concluding Observations of the Committee on the Rights of Persons with Disabilities Denmark" (Geneva: PD/C/DN/CO/1, 30th October 2014) and CRPD Committee, "Concluding Observations of the Committee on the Rights of Persons with Disabilities Spain" (Geneva: CRPD/C/ESP/CO/1, 19th October 2011).

[15] CRPD Committee, "Concluding Observations of the Committee on the Rights of Persons with Disabilities Sweden" (Geneva: CRPD/c/SWE/CO/1, 12th May 2014).

that if persons with disabilities are deprived of their liberty through any process, they are entitled to all the due process guarantees available to others under international human rights law and shall be treated in conformity with the objectives and principles of the CRPD. However, it has emerged that the implications of Article 14 are much more significant than the tightening of the criteria upon which loss of liberty can occur. This understanding of the CRPD was not reflected in the ERG's Report nor in the Heads of Bill as published by the DOH.

The CRPD Committee has interpreted Article 14 of the CRPD as a key non-discrimination provision that is particularly relevant for persons with psychosocial disability, who are at increased risk of deprivation of liberty.[16] The Committee, in its guidelines on Article 14, emphatically state that involuntary detention on healthcare grounds violates the absolute ban on deprivation of liberty and the principle of free and informed consent of the person to healthcare under Article 25 of the CRPD. The Committee has consistently stated that States Parties to the CRPD need to repeal provisions that permit the involuntary detention of "persons with disabilities in mental health institutions based on actual or perceived impairments".[17] The Committee has noted that involuntary detention in mental health services results in the denial of legal capacity to make a range of decisions about healthcare, treatment, and admission to a hospital, and as such violates Article 12 (legal capacity / equal recognition before the law) in conjunction with Article 14 (the right to liberty).[18]

Under Article 5 of the European Convention on Human Rights (ECHR), the arbitrary prohibition on the deprivation of liberty is subject to certain exceptions for individuals with mental health conditions.[19] These exceptions include that the condition is of a certain severity, but these exceptions are excluded under the CRPD. It is still not clear how the tensions between the ECHR and the CRPD will be resolved. The EU and most Council of Europe (COE) member states are also signatories to the CRPD. However, it is anticipated that the European Court of Human Rights (ECtHR) jurisprudence in the area of mental health will continue to evolve and in time align with the with the CRPD, as the ECHR is after all a living instrument. Ratification of the CRPD obliges states to develop a coherent national strategy for implementation and guidance on translating the rights contained in the CRPD into domestic law. The prohibition on detention based on disability may be problematic for countries governed by the ECHR and the CRPD. However, the recent opinion of the ECtHR on the Oviedo Protocol suggests a move towards the human rights norms required by the CRPD.[20]

It is important that a greater emphasis is given to the CRPD, and its implications are reflected in the Heads of Bill reforming the 2001 Act. The framework provided by the CRPD provides a pathway to moving away from practices, policies and processes that have violated the human rights of persons who interact with mental health services and a shameful history of institutionalisation in this jurisdiction. It is essential that the Heads of Bill reflects the paradigm shift required by Ireland's ratification of the CRPD and provides an opportunity to leave "behind the legacy of human rights violations in mental health services". [21] The right to the highest attainable standard of health needs to be understood as requiring the cultural shift from paternalism and coercion.

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[16] See CRPD Committee, "Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities" (Geneva: Adopted during the CRPD Committee's 14th session, September 2015).

[17] Ibid, at para.10.

[18] Ibid.

[19] Article 5 (1)(e). European Convention for the Protection of Human Rights and Fundamental Freedoms, opened for signature 4 November 1950, 213 UNTS 222 (entered into force 3 September 1953).

[20] European Court of Human Rights, "Request for an advisory opinion under Article 29 of the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine" (Strasbourg: Grand Chamber Decision, 15 September 2021).

[21] Dainius Pūras, "Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Human Rights Council, June 2017), at page 17.

Ireland signed the CRPD in 2007 and ratified in 2018[22] but deferred ratification of the Optional Protocol (OP), until all relevant legislation has been reviewed and updated.[23] The failure to ratify means that Ireland is an outlier amongst EU Member States (along with the Netherlands and Poland) in not ratifying the OP to the CRPD. The Optional Protocol (OP) is a legal instrument that addresses issues that the parent treaty (the CRPD) does not cover. The OP to the CRPD essentially provides for two procedures to strengthen it, namely the individual communications procedure and the inquiry procedure.[24] The failure to ratify the OP has been criticised by Non-Governmental Organisations, Disabled Persons Organisations and the Irish Human Rights and Equality Commission, as undermining Ireland's commitment to implementing and realising the rights contained in the CRPD. Louise Arbour, the former United Nations High Commissioner for Human Rights highlighted the importance of Optional Protocols to human rights treaties as bolstering "… the current system of treaty monitoring [and] help[ing] to clarify what is – and what is not – required of States, while providing effective remedies to aggrieved individuals".[25] The failure to ratify the OP means that persons subject to the 2001 Act are denied access to the mechanism to make individual complaints directly to the CRPD Committee. The delayed ratification is regrettable as the OP encourages Ireland to implement the CRPD effectively, to address human rights concerns and provide remedies to law and policy that is at odds with the Convention. The failure to ratify means that an essential layer of accountability is absent. As such it is essential that the OP to the CRPD is ratified immediately.

The CRPD differs from other human rights conventions in that people with lived experience of disability including psychosocial[26] disabilities were involved in drafting it. The use of the term "disability"[27] is important in this context because it highlights the significant barriers that hinder the full and effective participation in society of people with actual or perceived impairments and the fact that they are protected under the CRPD. The underlying theme of the CRPD is "Nothing about us without us", a motto that underpinned the drafting of the Convention. It has been embraced widely by the disability movement as the universal standard of human rights for all persons with disabilities, including those with psychosocial disabilities and has taken precedenceover previous instruments. Previous international instruments on disability and mental health started from the premise that

[22] Ireland was the last country in the EU to ratify the CRPD largely due to the delay in reforming outdated capacity legislation (*The Lunacy Regulation (Ireland) Act (*1871)), which does not comply with international human rights standards. This will be replaced by the *Assisted Decision-Making (Capacity) Act 2015*, which is due to commence in mid-2022.

[23] The protocol allows for complaints to be submitted directly to the CRPD Committee, which is a UN body of independent experts which monitors implementation of the CRPD by countries that have become party to it. A person can make a complaint alleging the violation of CRPD rights if the State has ratified the optional protocol.

[24] The ratification of the OP is "optional" in that States are not obliged to become parties to the protocol, even if they are party to the parent treaty (the CRPD).

[25] United Nations, "Chapter Three: Monitoring the Convention and the Optional Protocol" in *From Exclusion to Equality, Realizing the rights of persons with disabilities: Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol* (Geneva: Office of the High Commissioner for Human Rights, 2007).

[26] The term "psychosocial disability" has been adopted by the UN to include people who have lived experience of mental health issues or who self-identify with this term. The terms "cognitive disability" and "intellectual disability" are designed to cover people who have received a diagnosis specifically related to their cognitive or intellectual function including, but not limited to, dementia and autism. The CRPD has clearly stated that the protections and rights set out in it extends to these groups.

[27] The language reflects the evolving conceptualisation of disability and different terms will be used by different people across different contexts over time. Disability is broadly defined in the CRPD to include persons with long-term physical, mental, intellectual, or sensory impairments, which "in interaction with various barriers" may hinder their full participation in society on an equal basis with all others. People must be able to decide on the vocabulary, and descriptions of their experience, situation, or distress. For example, in relation to the field of mental health, some people use terms such as "people with a psychiatric diagnosis", "people with mental disorders" or "mental illnesses", "people with mental health conditions", "service users" or "psychiatric survivors". Others find some or all these terms stigmatising or use different expressions to refer to their emotions, experiences, or distress. It is an individual choice to self-identify with certain expressions or concepts, but human rights still apply to everyone, everywhere.

coercion was justified in certain circumstances.[28] The CRPD, in contrast, prohibits coercion on the basis of disability.[29] It forces us to consider the prejudices perpetuated by the legal system towards persons with psychosocial disabilities and provides much greater depth than other human rights treaties in prohibiting discrimination and achieving equality.[30] It requires us to engage in new approaches to decision-making in mental health law and to develop a range of support strategies. Mental health law has traditionally authorised interventions, which would otherwise be unlawful including loss of liberty and non-consensual treatment. These actions are often justified on the premise that individuals should be required to accept treatment for the protection of themselves or others. Prior to the CRPD, there was little consideration of the lawfulness of mental health laws under international human rights frameworks, outside of ensuring that procedural protections applied.

As mentioned above several articles of the CRPD have placed doubt over current mental health laws in Ireland and other countries including Article 5 (non-discrimination), Article 12 (legal capacity), Article 14 (liberty), Article 17 (physical and mental integrity) and Article 15 (torture or cruel, inhuman, or degrading treatment). The CRPD requires the abolition of policies and legislative provisions that allow or perpetuate forced treatment and substitute decision-making to ensure legal capacity is restored to persons with disabilities on an equal basis with others.[31] Legal capacity allows individuals to make fundamental decisions regarding their lives. It enables individuals to choose and to have those decisions respected including decisions in relation to mental health treatment. The CRPD Committee recognises that persons with psychosocial disabilities have been disproportionately affected by substitute decision-making and denials of legal capacity through laws that permit non-consensual treatment and declarations of incapacity.[32] The right to equal recognition before the law requires that legal capacity is a universal attribute, which applies to all persons with disabilities on an equal basis with others. The CRPD requires the abolition of substitute decision-making regimes to one based on supported decision-making.[33] The approach in Article 12 is a major paradigm shift from traditional approaches, which provide for substitute decision-making. The CRPD requires respect for the legal capacity of all persons, including those detained under mental health legislation. Therefore, the provision of supported decision-making is essential in complying with the CRPD.

The CRPD provides a new benchmark for the development of mental health and capacity law. It requires legislators and policymakers to understand the underlying philosophy and to give tangible effect to the provisions.[34] The provisions challenge how our current mental health laws are conceptualised. State Parties are required to holistically examine all areas of law to ensure that persons with disabilities are not denied their right to legal capacity, forcibly treated, or deprived of their liberty based on their disability. The CRPD requires repeal of legislation, which provides for substitute decision-making or authorises treatment without informed consent.[35] This will create a

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[28] See Article 5 (1)(e) of the ECHR; UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, General Assembly Resolution 46/119 (17 December 1991); UN Declaration on the Rights of Mentally Retarded Persons, GA Res 2856 (XXVI) 26 UN GAOR Supp (No 29) at 93, UN Doc A/8429 (1971).

[29] Article 14 (1). CRPD Committee, "Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities" (Geneva: Adopted during the CRPD Committee's 14th session, September 2015), at para 12.

[30] Michael Perlin, "International Human Rights and Mental Disability Law: When theSilenced are Heard" (Oxford University Press, 2012), at page 36.

[31] CRPD Committee "General Comment No. 1: Equal Recognition Before the Law (article 12)" (Geneva: Eleventh session, 31 March–11 April 2014).

[32] Ibid.

[33] Ibid.

[34] Gerard Quinn, "Statement by Professor Gerard Quinn, Director, Centre for Disability Law& Policy to the Oireachtas Joint Committee on Justice, Defence and Equality, Re: Hearing on the Mental Capacity Bill" (Dublin: 29th February 2012).

[35] CRPD Committee "General Comment No. 1: Equal Recognition Before the Law (article 12)" (Geneva: Eleventh session, 31 March–11 April 2014).

need for support measures, which enable individuals to exercise legal capacity and provide for consent when they may be unable to make decisions.

CRPD based law reform has already begun in Ireland through the enactment of the *Assisted Decision-Making (Capacity) Act 2015* (2015 Act). It is understood that the 2015 Act is due to commence in 2022 after considerable delay. It is essential that the legislation amending the 2001 Act align with the provisions of the 2015 Act. As will be discussed below there are several issues with the Heads of Bill in this respect. Protection of liberty safeguards and procedures are also being drafted for persons whose capacity is in question from being *de facto* detained in other settings outside of the 2001 Act.[36] Currently there is no process of automatic review to determine if persons admitted to residential care settings have consented to be there. The CRPD requires wardship (and similar laws) and mental health laws that deprive individuals of their legal capacity, and provide for substitute decision-making, and forced treatment to be replaced with a system of alternative supports. Decisions which involve physical or mental integrity should only be taken with the free and informed consent of the person.[37]

The framework provided by the CRPD provides a pathway to moving away from practices, policies and processes that have violated the human rights of persons using mental health services. The former UN Special Rapporteur on the Right to Health (Dr. Danius Pūras) consistently reiterated the need to move away from coercion,[38] and all forms of practices, which are inconsistent with human rights-based mental healthcare.[39] In his ground breaking report in 2017, Dr Pūras stated that the world needed nothing short of a revolution in mental health care and called on states to move away from traditional practices to a more rights-based approach.[40] In many countries, coercive practices are no longer confined to involuntary hospital admissions and are becoming increasingly prevalent within community-based care and during "voluntary" admissions to hospital.[41] According to a recent evidence-based review, the need to reduce coercion in mental healthcare is a major challenge, which requires urgent action globally.[42] This will require more than legislative change and will necessitate a fundamental and profound change in culture to make mental healthcare consensual.[43]

The authors acknowledge that it is not the intention of the Heads of Bill to prohibit involuntary detention and coercion. Therefore, in this analysis of the Heads of Bill we make several recommendations, which we believe will better protect the human rights of persons subject to the legislation. The Heads of Bill is a key opportunity to lay a solid foundation to move towards ending coercion in Irish mental health services. The focus on children in the Heads of Bill is to be welcomed. The application of the rights of the child under the UN Convention on the Rights of the Child (CRC) and the UN Convention on the Rights of Persons with Disabilities is considered in greater detail below.

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[36] The Government approved the publication for public consultation purposes of preliminary draft Heads of Bill to form Part 13 of the Assisted Decision-Making (Capacity) Act 2015. These are currently being redrafted. Dept of Health, The Deprivation of Liberty Safeguards Proposals: The Public Consultation (July 2019).

[37] CRPD Committee "General Comment No. 1: Equal Recognition Before the Law (article 12)" (Geneva: Eleventh session, 31 March–11 April 2014).

[38] Dainius Pūras, "Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Human Rights Council, June 2017), at page 21.

[39] SP Sashidharan, Dainius Pūras, Roberto Mezzina "Reducing Coercion in Mental Healthcare" (Epidemiology and Psychiatric Services: 2019 Dec;28(6):605-612).

[40] Dainius Pūras, "Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Human Rights Council, June 2017), at page 21.

[41] Ibid.

[42] Ibid.

[43] Ibid.

3. Language in the Heads of Bill

Language matters and the language used in the mental health legislation is of paramount importance and should reflect the human rights model and not be based on the medical paradigm, which is stigmatising and discriminatory. A number of language changes as provided in the Heads of Bill are to be welcomed. In particular, we welcome the removal of the term "patient" and replacement with "person" throughout the text of the Heads of Bill. We also welcome the deletion of the terms "suffering from a mental illness" and "suffering from a mental disorder" in the Heads of Bill, which represents a move from the medical model to the social / human rights model of disability.

As will be discussed below it is regrettable that the term "mental disorder" has been retained in the Heads of Bill. While the authors supported the recommendation of the ERG to remove the "mental disorder" we did not agree with the ERG's recommendation that the term "mental illness" should be used in its place. The reasoning behind this 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.

The retention of the term "mental disorder" and use of the term "mental illness" is problematical and is not in line with terminology adopted by the United Nation, CRPD Committee, the World Health Organization, and the European Commission. 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".[44] The latter term is in line with the CRPD and is sufficiently specific and well accepted within the international human rights framework to be a reliable alternative to the use of "mental disorder" and "mental illness".

3.1 Recommendation

- Replace the terms "mental disorder" and "mental illness" 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".

[44] Human Rights Council, "Annual report of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commissioner and the Secretary-General: Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development" (A/HRC/34/32, Human Rights Council, Thirty-fourth session, 27 February-24 March 2017).

4. Provisions Relating to Children & Young Persons

On the whole the authors welcome the provisions contained in the Heads of Bill as they relate to children and young persons. In particular, the creation of Part 8 in the Heads of Bill dealing exclusively with the admission of children to approved inpatient facilities under the Act will be a significant improvement. The creation of Part 8 should address the disjointed approach and make the legislation more accessible for children subject to the act, their parents and/or guardians, mental health professionals and other stakeholders. The inclusion of guiding principles in s.84 of the Heads of Bill is also welcomed and will hopefully positively impact the operation and interpretation of the legislation and ensure greater compliance with international human rights standards relating to children. However, there are a number of areas where the rights of the child can be strengthened in the amending legislation. In order to understand the challenges, the following section discusses the relevant human rights law as it relates to children and young persons.

4.1 Children Mental Health and International Human Rights Law

The UN Committee on the Rights of the Child (CRC Committee) have been critical of the lack of comprehensive legislation on children's consent to and refusal of medical treatment, in particular mental health-care services.[45] The provisions regulating the admission and treatment of children have been criticised for failing to safeguard their human rights.[46] On this basis the Committee has recommended that Ireland introduce legislation that explicitly and comprehensively provides for children's consent to and refusal of medical treatment and ensure that the legislation is in line with the objectives of the CRC and encompasses clear recognition of the evolving capacities of children.[47] The Committee has further recommended that Ireland undertake measures to improve the capacity and quality of its mental health-care services for children and adolescents.[48]

The 2001 Act as it currently operates prohibits children from exercising their legal capacity in making decisions around their treatment, vesting the decision-making power instead in adults who act as substitute decision-makers. The authors welcome the inclusion of rights-based principles to guide the interpretation of the 2001 act as they relate to children. The Irish courts have interpreted the principles in the 2001 Act in a paternalistic manner, which has resulted in a failure to comply with regional and international human rights law. General Comment No 1 on Article 12 (legal capacity) of the CRPD Committee states "equality before the law is a basic general principle of human rights protection and is indispensable for the exercise of other human rights".[49] However, children who experience mental health difficulties are at increased risk of having their right to legal capacity denied or restricted by way of substitute decision-making and mental health laws. We acknowledge that the law in the area of mental health and capacity is extremely complex, as the legislation seeks to achieve a number of goals. The situation is even more challenging in respect of children who experience mental health difficulties as they are often regarded as unable to make decisions for themselves.[50]

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[45] CRC Committee, "Concluding observations on the combined third and fourth periodic reports of Ireland"(Geneva: CRC/C/IRL/CO/3-4, 1st pf March 2016), at para 53.

[46] Catriona Moloney, "Time for Change in the Mental Health Act 2001: The Law Must Recognise Children's Capacities to Consent to and Refuse Medical Treatment" (Medico-Legal Journal of Ireland 2017, 23(1), 8-17), Law Reform Commission, "Report on Children and the Law: Medical Treatment" (Dublin: LRC 103–2011); Geoffrey Shannon, "Annual Report of the Special Rapporteur on Child Protection" (Dublin: 2010), at page 51; Children's Mental Health Coalition, "Submission to the Department of Health on the Review of the Mental Health Act 2001" (Dublin: 2011).

[47] CRC Committee, "Concluding observations on the combined third and fourth periodic reports of Ireland"(Geneva: CRC/C/IRL/CO/3-4, 1st of March 2016), at para 54.

[48] Ibid.

[49] CRPD Committee "General Comment No. 1: Equal Recognition Before the Law (article 12)" (Geneva: Eleventh session, 31 March–11 April 2014).

[50] Catriona Moloney, "Time for Change in the Mental Health Act 2001: The Law Must Recognise Children's Capacities to Consent to and Refuse Medical Treatment" (Medico-Legal Journal of Ireland 2017, 23(1), 8-17), at page 9.

In this regard, the CRPD provides useful guidance in Article 12, requiring State Parties to respect the person's right to make legally effective decisions.

As discussed above the CRPD requires State Parties to abolish substitute decision-making processes. The application of this obligation in respect of children necessitates further consideration. In General Comment No 1 the CRPD Committee highlighted that Article 12 was premised on the general principles of the Convention, as outlined in article 3. These principles include respect for inherent dignity, individual autonomy, which includes the freedom to make one's own choices, and independence of persons; non-discrimination; full and effective participation and inclusion in society; respect for difference and acceptance of persons with disabilities as part of human diversity and humanity; equality of opportunity; accessibility; equality between men and women. Article 3 also requires respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

The CRPD Committee in General Comment No 1 acknowledged a difference in the application of Article 12 between children and adults. However, the Committee clarified that Article 12 of the CRPD protects equality before the law for all persons, regardless of age. It noted that Article 7 (children with disabilities) recognises the developing capacities of children which requires that "in all actions concerning children with disabilities, the best interests of the child … be a primary consideration". Article 7 further provides "their views [be] given due weight in accordance with their age and maturity". In its General Comment the CRPD committee concluded that for States to comply with Article 12, they must examine their laws to ensure that the will and preferences of children with disabilities are respected on an equal basis with other children.[51]

Therefore, children unlike adults are not presumed to have capacity. However, regard has to be given to the evolving capacity of the child and focus on the formation and expression of their views.[52] The CRC is instructive in particular in Article 12 (the child's opinion), which provides that the child is a rights holder and a subject of rights with the capacity to influence their own life. Specifically, the CRC at Article 12(1) provides for a substantive right for children to express their views and that their views are given due weight in accordance with their age and maturity. The text in Article 12 of the CRC has been considered to restrict the decision-making of children, for example Article 12(1), refers to "the child who is capable" and their "age and maturity". The Committee on the Rights of the Child have clarified that this text "should not be seen as a limitation, but rather an obligation for State parties to assess the capacity of the child to form an autonomous opinion to the greatest extent possible."[53] This interpretation is complemented by Article 3 (best interests), Article 5 (evolving capacity) and Article 12 (the child's opinion) of the CRC. Therefore, these provisions need to be read holistically as they are inter-related and a decision as to what is in the best interests of the child requires the participation of the child.[54] Children must be supported and facilitated in the expression of their view during a best interests assessment, and their capacity must only be assessed to determine the influence of their views on the outcome of decisions.[55] The difference between children and adults in respect of legal capacity must be understood as requiring the development of mechanisms to support

[51] CRPD Committee "General Comment No. 1: Equal Recognition Before the Law (article 12)" (Geneva: Eleventh session, 31 March–11 April 2014), at para 32.

[52] Catriona Moloney, "Time for Change in the Mental Health Act 2001: The Law Must Recognise Children's Capacities to Consent to and Refuse Medical Treatment" (Medico-Legal Journal of Ireland 2017, 23(1), 8-17), at page 10.

[53] CRC Committee, "General Comment No.12: The right of the child to be heard" (Geneva: CRC/C/GC/12, 20th July 2009), at para. 20.

[54] Catriona Moloney, "Time for Change in the Mental Health Act 2001: The Law Must Recognise Children's Capacities to Consent to and Refuse Medical Treatment" (Medico-Legal Journal of Ireland 2017, 23(1), 8-17), at page 10.

[55] For a detailed guide on the application of the child's right to be heard in Article 12 of the CRC see: CRC Committee, "General Comment No.12: The right of the child to be heard" (Geneva: CRC/C/GC/12, 20th July 2009).

children in exercising their capacity.[56] Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities as required by Article 3 of the CRPD necessitates the inclusion of the will and preferences of the child in considering what is in the best interest of the child. The CRPD must be considered in the context of consent to treatment. The CRPD provides a right to medical treatment based on consent and requires increased recognition of the child's legal capacity.[57]

4.2 A Human Rights Analysis of the Provisions Relating to Children and Young Persons

The explicit references to the provisions of the Child Care Act 1991 in the Heads of Bill are to be welcomed. This development along with the standalone Part of the legislation relating to the admission of children and young people should make the legislation more easily understood. The authors welcome the inclusion in the Heads of Bill the presumption of capacity to consent to and refuse admission and treatment for those aged 16 and 17 years. This recognition has been advocated for by the ERG, the Law Reform Commission and Amnesty International Ireland and when enacted will bring Irish law in this area into greater compliance with international human rights law. There has been a consensus that the current provisions in the 2001 Act that relate to children are wholly inadequate in safeguarding their rights. The admission of a child under Part 4 of the 2001 Act either on a voluntary or involuntary basis will decide what rights apply in respect of the child. However, admission regardless of the status of voluntary or involuntary has no bearing on the child's right to consent or refuse treatment as the legislation as it currently stands does not provide for such a right. The legislation therefore is at odds with Ireland's obligations under international human rights law, specifically the CRC and the CRPD, which as discussed above requires respect for the evolving capacity of the child and their right to participate in decision-making. The current legal position means that children subject to the 2001 Act are not provided with sufficient procedural and due process rights and a failure to provide adequate support for children to exercise their legal capacity.[58] However, the discussion below will highlight a number of areas where the human rights of children and young person's subject to the legislation can be better safeguarded in the amending legislation.

4.3 Analysis of the Guiding Principles Relating to Children and Younger Persons

When implemented it is hoped that the amended guiding principles will serve to embed the paradigm shift in thinking required by the CRPD within mental health services. In particular, it is hoped that the guiding principles will remove the legislative and attitudinal barriers that have curtailed the participation of children in decision-making relating to their treatment. The Heads of Bill needs to ensure that adequate supports are provided to ensure that the child can form and make choices in relation to their treatment. While the CRPD has had a significant impact on both the review of the 2001 Act and in the development of the 2015 Act, it is of concern that the ERG Report in its discussion of children did not reference Article 12 of the CRPD. It is essential that the paradigm shift in thinking around legal capacity is translated into the reform of the 2001 Act as it applies to children.

S.4A of the 2001 Act to be which sets out guiding principles in respect of children has been amended in the Heads of Bill and moved to Part 8 (now s.84).[59] S.84 provides that in making any decision under the Act concerning the care or treatment of a child due regard shall be given to the "guiding principles for children". S.84(a) provides that the best interests and the welfare of the child, will be the primary consideration. S.84(b) provides that every child should have access to health services that have as the

[56] Catriona Moloney, "Time for Change in the Mental Health Act 2001: The Law Must Recognise Children's Capacities to Consent to and Refuse Medical Treatment" (Medico-Legal Journal of Ireland 2017, 23(1), 8-17), at page 10.
[57] Article 25(d) and Aricle.12.
[58] Ibid.
[59] Part 8 of the Act deals solely with the admission of children and young persons to inpatient facilities.

aim of those services, the delivery of the highest attainable standard of mental health for children. Irish mental health law adopts a welfare-oriented approach to decision-making, where the views of mental health professional prevail in an environment where children are perceived as "incompetent and dependent rather than as social actors and agents capable of holding and exercising rights".[60]

In the Heads of Bill, the guiding principles in respect of children are then split into two categories; children aged 16 and over and children aged under 16 years. S.84(1)(c)(i) provides in the case of a child who is aged 16 years or older, it will be assumed that the child has the necessary maturity and capacity to make decisions affecting themselves in relation to their care and treatment. The views and will and preferences of the parents of the child, or either of them, or person or persons acting in *loco parentis* must be recorded.

S.84(1)(c)(ii) provides that in respect of children under 16 years of age, who are deemed to possess the necessary maturity and capacity, the child is able to make decisions affecting themselves in relation to their care and treatment. In respect of a child who is considered to lack the necessary maturity and capacity, but who can form their own views, there is a requirement to consult, "where practicable" with the child at each stage of diagnosis and treatment. This requirement to consult also requires that due weight be given to their views, will and preferences and have regard to the age and maturity of that child with regard also to the views. This also extends to the will and preferences of the parents of the child, or persons acting in *loco parentis*.

S.84(1)(d) provides that in so far as is practicable the provision of care and treatment should be in an age-appropriate environment, near the child's home or family. S.84(1)(d) further provides that the child should receive the least intrusive treatment possible in the least restrictive environment practicable and s.84(1)(f) requires respect for the right of the child to dignity, bodily integrity, privacy, and autonomy. S.84(1)(g) specifies respect for the right of the child to non-discrimination, and S.84(1)(h) provides for respect of the child's right to life, survival, and development. S.84(1)(i) provides that information to the child and their parents, or either of them or persons acting in loco parentis, in an accessible manner at all times. S.84(1)(j) further provides that decisions and actions related to the care and treatment of the child be carried out in a timely manner. S.84(2) provides that in so far as practicable, a child and adolescent consultant psychiatrist should carry out the functions of the consultant psychiatrist under Part 8 of the Act. S.84(3) further provides that in so far as practicable, hearings before the District Court under this Part 8 should be before a District Family Law Court.

As discussed above the creation of Part 8 in the Heads of Bill, which deals exclusively with children and young persons under the Act is to be welcomed. The creation of a dedicated Part of the Act relating to children should address the disjointed approach and make the legislation more accessible for children subject to the act, their parents and/or guardians, mental health professionals and other stakeholders. The inclusion of guiding principles in s.84 of the Heads of Bill is also to be welcomed and will hopefully impact the operation and interpretation of the legislation and ensure greater compliance with human rights standards relating to children.

S.84(1)(a) provides that the most important guiding principle is the best interests and the welfare of the child. The ERG recommended that the best interests of the child must be defined in a way that is informed by the views of the child, bearing in mind that those views should be given due weight in accordance with their age, evolving capacity and maturity and with due regard to their will and preferences. However, a divergent approach has been taken in the Heads of Bill. The DOH explained this approach on the basis that the Office of the Ombudsman for Children recommended that the best

[60] Catriona Moloney, "Time for Change in the Mental Health Act 2001: The Law Must Recognise Children's Capacities to Consent to and Refuse Medical Treatment" (Medico-Legal Journal of Ireland 2017, 23(1), 8-17), at page 13.

interests of the child should be the primary consideration in the guiding principles, in line with Article 3 of the CRC, and Article 7(2) of the CRPD. Considering the discussion above on the rights contained in the CRC and the CRPD there is a concern that an overly paternalistic approach will continue and recognition of the evolving capacity of the child and their right to participate in decision-making will be undermined. In order to minimise this risk, it would be beneficial to provide a definition of best interests and welfare for the purposes of the Act. There is concern that the inclusion of the concept of welfare could undermine the voice and decision-making of children and younger persons. This definition should include respect of the child's legal capacity and right of participation in decision-making.

It is to be welcomed that s.84(1)(c)(ii) requires consultation with children under 16 years of age, who are considered capable of forming their own views to consult at every stage of the diagnosis and treatment. However, principle is limited by the inclusion of the stipulation that this will be done "where practicable". It is further limited by requiring consultation only where the child is considered capable of forming their own view. There is no guidance as to how this is to be determined or detail of support for the child in exercising their decision-making. As discussed above Ireland's obligations under the CRC and CRPD require respect for the evolving capacity of the child and their right to participate 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 amending legislation. S.84(3) provides that in so far as practicable, hearings before the District Court under this Part of the Act should be before a District Family Law Court. The appropriate forum for decisions relating to the admission of children and young persons to inpatient mental health services will be discussed below.

4.4 Persons Aged 16 and Under

While the Heads of Bill recognise the legal capacity to consent to and refuse admission and treatment for young people aged 16 and 17 years the same does not apply for children under 16 years. This approach reflects the view of the ERG that there should be no automatic presumption of capacity for children under the age of 16. Based on the discussion above on the relevant international human rights law there is concern that this approach does not comply with the non-restrictive approach required by Article 12 of the CRC, which extends to the child irrespective of their age. The CRC Committee have been clear that Article 12 requires State Parties "to assess the capacity of the child to form an autonomous opinion to the greatest extent possible."[61]

S.85(1) of the Heads of Bill provides that a child under 16 years of age can be admitted as a voluntary person to an approved inpatient facility in circumstances where a parents, or persons acting in *loco parentis* consent. This provision effectively continues the existing position that parents or guardians make decision as to whether a child under 16 years of age is admitted on voluntary basis. This process for voluntary admission for children aged 16 and younger does not provide any additional safeguards for their views and will and preferences. The provisions in the Heads of Bill do not sufficiently set out the process of ensuring that the voice of the child aged 16 and under and their will and preferences are given sufficient weight. For example, in s.85, which deals with the voluntary admission of a child under 16 years of age it provides that the child can be admitted as a voluntary basis with the consent of either of their parent or a person acting in *loco parentis*. S.85(2) merely requires when a decision to admit a child to an approved inpatient facility that due weight be given to the child's views and their will and preferences. However, there is no reference to the role of an independent advocate or other support to assist the child in this process. A procedure should be put in place to ensure that a

[61] CRC Committee, "General Comment No.12: The right of the child to be heard" (Geneva: CRC/C/GC/12, 20th July 2009), at para. 20.

systematic approach is taken to facilitate the child's right to express their view and will and preferences. 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 and will and preferences are given due weight in practice. The need for independent advocacy services will be discussed in greater detail below.

4.5 Children Aged 16 and Older

As mentioned above the existing definition in the 2001 Act of a child as a person under the age of 18 has been problematical and has resulted in the restriction of the legal capacity of 16- and 17-year-olds whose rights have been curtailed when compared to 16- and 17-year-olds who have been permitted to consent to treatment in general health care. The differential treatment appears to have been justified on the basis that young persons' subject to the 2001 Act have a disability. This position is clearly discriminatory and at odds with Ireland's international human rights obligations. The recognition in s.84 of the Heads of Bill that a person aged 16 or older is assumed to have the necessary maturity and capacity to make decisions affecting their care and treatment is a significant development that should bring the relevant law closer to compliance with international human rights law. This improves upon the current legal position which vests parents and not the child (16 or older) with the right to consent to in-patient mental health care and treatment. The current position while arguably in line with the constitutional rights of parents has failed to give adequate recognition of the evolving capacities of the child and their ability to exercise their legal capacity.[62]

The provision in s.86 on the voluntary admission of a child aged 16 years or older to an approved inpatient facility is to be welcomed. S.86(1) provides that it is presumed that any child aged 16 years or older has capacity to consent to or refuse voluntary admission to an approved inpatient facility. While s.86(2) provides that a child aged 16 years and over that neither consents nor objects to admission cannot have their admission done on a voluntary basis. However, there is a concern that the lack of provision of independent advocacy and support for the young person in making decisions about treatment will undermine the effectiveness of the provisions in practice.

The assessment of capacity in respect of persons aged 16 and older requires careful consideration if the provisions are to be effective in recognising the person's legal capacity and ensuring that decision-making is respected and legally effective. Explicit regulation of the nature and form of the capacity assessments is essential if it is to comply with the proactive and inclusive requirements of Article 12 of the CRPD. Unfortunately, the 2015 Act has yet to be commenced and at any rate only applies to persons aged 18 and over. It is regrettable that the 2015 Act excluded persons aged under 18 to avail of the supports it provides. In particular, the exclusion of 16- and 17-year-olds from the scope of the 2015 Act is of concern as it serves to impede young persons from exercising their legal capacity under the revised mental health legislation. The Heads of Bill provides that the MHC will develop codes of practice on capacity assessments to provide greater guidance and detail before the amending legislation is commenced. It is essential that the MHC adopt a human right informed approach in the development of this guidance.

The Heads of Bill provides in s.2 for a definition of "capacity assessment" in relation to an adult, as meaning an assessment undertaken by a suitably qualified mental healthcare professional, as prescribed by way of Regulations under the legislation, to assess whether a person has the necessary decision-making capacity, construed in accordance with s.3 of the 2015 Act, to decide in relation to their admission or treatment. However, in relation to a child, an assessment is to be undertaken by a suitably qualified mental healthcare professional, as prescribed by way of Regulations, to assess

[62] Catriona Moloney, "Time for Change in the Mental Health Act 2001: The Law Must Recognise Children's Capacities to Consent to and Refuse Medical Treatment" (Medico-Legal Journal of Ireland 2017, 23(1), 8-17), at page 13.

whether a child has the necessary maturity and capacity to decide in relation to their admission or treatment. S.87 in the Heads of Bill relates to a child aged 16 years or older as an intermediate person to an approved inpatient facility. S.87(1) provides that following an examination of a child aged 16 years or older, if the consultant psychiatrist who carried out the examination, considers that the child may lack capacity to consent to or refuse admission, then a capacity assessment should be carried out by the consultant psychiatrist (or the consultant psychiatrist may arrange for another mental healthcare professional to carry out a capacity assessment). The capacity assessment determines whether the child has the necessary capacity to make the decision. S.87(2) further provides that after this assessment where the consultant psychiatrist or other mental healthcare professional is of the view that the child lacks the necessary capacity, another capacity assessment by a second mental healthcare professional not involved in the care and treatment of the child shall be carried out. S.87(3) provides that where the second mental healthcare professional is of the view that the child lacks capacity to consent to or refuse admission, then the child shall be deemed to lack capacity. S.87(4) provides that where the second mental healthcare professional finds that the child does not lack capacity, then the child shall be deemed to have capacity.

S.87 of the Heads of Bill relates to the admission of a child aged 16 or older as an intermediate person to an approved centre. Effectively s.87 provides for a capacity assessment of children aged 16 years and older before an admission order, in circumstances where the consultant psychiatrist who examined the young person reasonably considers they lack capacity. The Heads of Bill have departed from the ERGs recommendation that where a 16 or 17 year old objects to admission the case should be referred to a District Family Law Court to determine whether the child has the necessary maturity or capacity to make an informed decision. [63] The ERG had recommended that if the Court determines that the child has the necessary maturity and capacity, admission may only proceed on an involuntary basis by order of the Court. Where the Court determines that the child does not have the necessary maturity and capacity then voluntary admission may proceed with the consent of the parents or person as required acting in *loco parentis*. The change of approach was adopted based on a recommendation of the Ombudsman for Children that children over 16 years of age who lack capacity should be given similar protections as adult "intermediate persons". Therefore, s.87 subsections (9) to (16) provide safeguards similar to adult intermediate persons, except the District Court reviews the person's admission rather than a Mental Health Review Board.

The authors welcome the proposed provisions in s.87 as the recommendation from the ERG that a child or younger person determined to lack capacity, could nonetheless be admitted by way of parental consent was at odds with international human rights law. It has been argued that parental consent to voluntary admission of a young person who lacks capacity results in a denial of due process safeguards.[64] The authors welcome the provision for of a second capacity assessment in s.87. S.87(10) provides that where a child has been admitted as an intermediate person "all relevant supports shall be provided to the child by the approved inpatient facility to enable the child to make decisions about his or her care and treatment, and the child's status as an intermediate person shall be regularly reviewed". However, there is concern that there is no detail on the support provisions that ought to be provided to the person subject to s.87 in exercising their legal capacity. This undermines the presumption of capacity as provided for in the amending legislation, which is compounded with the failure to provide supported decision-making for children and young person's subject to the mental health legislation.

[63] Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), see recommendation 116.

[64] Catriona Moloney, "Mental Health Act 2001: A Child Rights Assessment of the Current Framework and its Proposed Reform—Part II" (Irish Journal of Family Law 2016, 19(3), 43-48), at page 46.

The definition of capacity as it relates to children under the act and the guiding principles refers to the "maturity and capacity" of the child. S.89(iv) also provides that in the case of a child who lacks the necessary maturity and capacity to consent to his or her admission, following the making of reasonable enquiries by the Health Service Executive, the parents of the child, or either of them, or a person acting in *loco parentis* cannot be found, the HSE can make an application to a court in the district where the child concerned resides, or is located, for an order authorising the detention of the child in an approved inpatient facility. There is concern about the lack of detail regarding the meaning of "maturity and capacity" in the amending legislation. 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 (see the discussion above) 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.

4.6 Admission of Children to Adult Units

There is concern about the continued admission of children to adult units. The MHC in its Annual Report for 2020 noted that there were 27 admissions of children to 9 adult units in 2020.[65] This compares to 54 admission to 15 adult units in 2019.[66] The MHC also reported that there was 0% compliance with its code of practice on the admission of children to approved centres as none of the services provided age-appropriate facilities and programmes of activities to adult units.[67] The Heads of Bill now provides that children should receive care and treatment in an age-appropriate environment in the guiding principles.[68] However, s.108 of Part 8 of the Heads of Bill provides for the continued use of admission of children to adult units. S.108 merely requires that the MHC be notified of the admission, due regard to the guiding principles be taken and that the MHC can make rules in the admission of a child to an adult approved inpatient facility.

The inappropriate admission of children and young people to adult units have been a source of criticism since the commencement of the 2001 Act. The MHC have noted that children and young people should not be admitted to an adult unit except in exceptional circumstances.[69] The justification for such admissions is that there is an immediate risk to the person or to a third party and there is not a CAMHS bed available. As such in crisis situations children and young people are left with an unacceptable choice between an emergency department, general hospital, children's hospital, or an adult inpatient unit. The UN Committee on the Rights if the Child in its concluding observations to Ireland have been highly critical of the admission of children to adult units. Most recently is criticised the admission of children "to adult psychiatric wards owing to inadequate availability of mental health-care facilities for children; and, long waiting lists for access to mental health support and insufficient out-of-hours services for children and adolescents with mental health needs, in particular

[65] Mental Health Commission, "Annual Report 2020 Including Report of Inspector of Mental Health Services" (Dublin: Mental Health Commission, 2020).
[66] Mental Health Commission, "Annual Report 2019 Including Report of Inspector of Mental Health Services" (Dublin: Mental Health Commission, 2019).
[67] Mental Health Commission, "Annual Report 2020 Including Report of Inspector of Mental Health Services" (Dublin: Mental Health Commission, 2020), at page 20.
[68] See s.84(1)(i).
[69] Mental Health Commission, "Annual Report 2020 Including Report of Inspector of Mental Health Services" (Dublin: Mental Health Commission, 2020), at page 29.

eating disorders".[70] Article 37(c) of the CRC provides that every child deprived of liberty shall be separated from adults unless it is considered in the child's best interests not to do so.

The authors do not believe that the Heads of Bill will 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.

4.7 Independent Advocacy for Children under the Mental Health Act 2001

The CRC Committee have been critical of the lack of a child-focused advocacy and information services for children who experience mental health difficulties in Ireland. In its most recent concluding observations to Ireland it recommended that consideration should be given to the creation of a dedicated mental health advocacy and information service for children, which would be accessible and child-friendly.[71] Similarly, the ERG recognised that children and young people detained under the 2001 Act are in a particularly vulnerable situation and that it would be appropriate if they were given every support including advocacy services for both children and young people and their families / guardians.[72]

The Heads of Bill recognises the need for advocacy and provides a definition of an advocate in s.2 as an "individual, acting independently of the approved inpatient facility, on behalf of a person receiving treatment in an approved inpatient facility, with the expressed consent of the person concerned". In Part 8 of the Heads of Bill s.91 provides that children admitted either on a voluntary or involuntary basis should be informed that they are entitled to engage an advocate by themselves or with their parents / person acting in *loco parentis*.[73] S.91(4) also provides that where the child consents, information of a general nature on the care and treatment of the child may be provided to the child's advocate, or another person nominated by the child.

While the Heads of Bill recognises that an advocate can support a child and their family it does not make sufficient provision for independent advocacy services. Both Amnesty International Ireland and the Law Reform Commission have recommended that all children and young people admitted and treated under the 2001 Act should have access to an independent advocate.[74] The availability of professional, independent, and adequately resourced advocacy service will ensure that the voice of children and young people will be heard and will move towards greater compliance with international human rights obligations set out in the CRC and the CRPD.

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.

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[70] CRC Committee, "Concluding observations on the combined third and fourth periodic reports of Ireland"(Geneva: CRC/C/IRL/CO/3-4, 1st pf March 2016), at para 53

[71] Ibid, at para 54

[72] Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), at page 72.

[73] See s.91(1)(f) and s.91(2)(h) of the Heads of Bill.

[74] Amnesty International Ireland, "Mental Health Act 2001: A Review" (Dublin: Amnesty International, 2011), at page 181 & Law Reform Commission, "Consultation Paper: Children and the Law: Medical Treatment" (Dublin: LRC CP59, 2009), at recommendation 7.15.

4.8 The Appropriate Forum to Review Admission of Children

There is concern as to whether the District Court is the appropriate forum to make and review admission decisions in respect of children and young persons. The Law Reform Commission in its work on children and consent to medical treatment considered the appropriate forum to make decisions in relation to admission, concluding that a less formal venue than the District Court would with an age-appropriate focus would be more fitting.[75] As such it recommended that the District Court make the initial decision on admission of children and young people as involuntary for the purposes of the 2001 Act, but that a Mental Health Tribunal (with an age-appropriate focus) rather than the District Court should review admission. This approach would be more effective in ensuring the child had sufficient the opportunity to express their views and give them due weight in accordance with their age and maturity. However, the ERG when considering the issue of circumstances where a 16 or 17 year objected to admission, recommended that the case be referred to a District Family Law Court, which would determine whether the child has the necessary maturity or capacity to make an informed decision. It recommended that where the Court determines that the child has the necessary maturity and capacity, the admission may only proceed on an involuntary basis by order of the Court. Where the Court determines that the child does not have the necessary maturity and capacity then voluntary admission may proceed with the consent of the parents or person as required acting in *loco parentis*. The Heads of Bill have opted for this approach as recommended by the ERG.

The General Comment of the CRC Committee provides useful guidance on the environment for any judicial or administrative proceedings affecting the child or young person.[76] The Committee stated that a child cannot be heard effectively where the environment is intimidating, hostile, insensitive or inappropriate for their age. The Committee also stated that proceedings must be both accessible and appropriate for children and particular attention needs to be paid to the provision and delivery of child-friendly information, adequate support for self-advocacy, appropriately trained staff etc. As such the approach recommended by the LRC better aligns with Ireland's obligations under international human rights law.

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 decision about the admission of children, there should be an express provision requiring that the District Family Law Court is required to exercise this function.

4.9 Review of Detention of Children

The authors are concerned that the time periods in relation to the review of children and young people admitted as involuntary does not comply with the requirements of international human rights law. Article 37(b) of the CRC provides "[n]o child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time".

In the Heads of Bill s.89 will replace the current provision on involuntary admission of a child to an approved inpatient facility in s.25 of the 2001 Act. S.89(6) proposes that where the court is satisfied

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[75] Law Reform Commission, "Report: Children and the Law: Medical Treatment" (Dublin: LRC-103, 2011), at pages 136-137.
[76] CRC Committee, "General Comment No.12: The right of the child to be heard" (Geneva: CRC/C/GC/12, 20th July 2009), at para. 34.

that the child is suffering from a mental disorder and fulfils the criteria for detention as set out in s.88, the court shall make an order that the child be admitted and detained for treatment in a specified approved centre inpatient facility for a period not exceeding 3 months. This provision increases the time period from 21 days under the current provisions to three months.

The authors consider that the provisions in the Heads of Bill are inadequate to safeguard the right to liberty of children and young people subject to the legislation. There are no maximum periods of detention of children and young persons under the Act and the review of detention is less robust than the provisions that apply in respect of adults. Article 37(d) of the CRC provides that every child deprived of their liberty should have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of their liberty before a court or other competent, independent, and impartial authority and to a prompt decision on any such action. *Habeas corpus* or judicial review proceedings are not a sufficient safeguard to vindicate the right to liberty of persons subject to the legislation. 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 independent 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.

4.10 Psychosurgery and Electro-Convulsive Therapy in Respect of Children

The authors note the deletion of psychosurgery in the Heads of Bill. However, we believe that 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. This is discussed further below.

The ERG did not specifically address the use of ECT in respect of children in its Report. However, the World Health Organization has criticised the use of ECT on children and young people and has recommended that the use of ECT should be prohibited by legislation.[77] S.106 in the Heads of Bill contains a specific provision for the administration of ECT to children. It states that a programme of electro-convulsive therapy should not be administered to a child aged 16 years or older unless the child gives their consent in writing to the administration of the programme of therapy. S.106(2) provides that where a child aged 16 years or older has been deemed to lack capacity (as per s.104) or where a child is aged under 16 years of age, or a child in respect of whom an order under s.89 is in force, a programme of ECT should not be administered in any circumstances to the child without the explicit approval of the court. The explanatory notes for s.106 explain that the HSE advised that provision for ECT for children should be retained in the revised Act as it continues to be prescribed occasionally. While s.106(1) aligns with the ERG's recommendation that persons aged 16 years or older should be permitted to consent to treatment, it fails to consider the human rights issues surrounding the administration of ECT. We recommend that the 2001 Act should be amended to expressly prohibit the administration of ECT to children and young persons as recommended by the WHO.

[77] World Health Organization, "WHO Resource Book on Mental Health, Human Rights and Legislation Stop Exclusion: Dare to Care" (Geneva: 2005), at page 64.

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

As will be discussed below in relation to the provisions on adults, individual care plans are a key mechanism by which the person's will and preferences regarding their care and treatment are documented, understood, and respected. The MHC emphasises the importance of individual care planning asserting that the essential dignity, autonomy and right to self-fulfilment of the individual is enshrined most strongly in this area.[78] The 2001 Act regulations require an individual care plan for each resident. Ireland's in-patient mental health services have been consistently non-compliant with the regulatory requirements relating to individual care planning, which underscores the need to make it a legal requirement. The ERG has recommended that individual care/recovery plans be placed on a statutory basis. The MHC Inspectorate is particularly concerned with non-compliance due to lack of resident involvement in the planning process. A 2018 inspectorate report found that more than 40% of approved centres were non-complaint with Regulation 15: Individual Care Plans.[79]

The inclusion of s.92 on individual care plans for children and young persons in Part 8 of the Heads of Bill is to be welcomed. S.92 mirrors the corresponding provision for adults in s.80. S.92 requires that a responsible consultant psychiatrist must ensure that each child under their care and receiving treatment has an individual care plan, within 7 days of the child's admission. The individual care plan has to be made available to the child and/or to their parents, or persons acting in *loco parentis*. The multi-disciplinary team is responsible for the clinical content of the plan and are required to have due regard to the will and preferences of the child concerned.

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 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 is very positive. 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. Individual care plans will be given further consideration below and additional recommendations to strengthen these provisions.

4.12 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 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.

[78] Mental Health Commission, "Annual Report 2018 Including Report of Inspector of Mental Health Services" (Dublin: Mental Health Commission, 2018).
[79] Ibid.

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.

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

The ERG recommendation in respect of the guiding principles reflected the need for a "substantial shift away from the paternalistic interpretation of mental health legislation by the Courts". Additionally, the ECHR and the CRPD require the "best interests" paradigm to be replaced by the "will and preferences" paradigm. As such the authors welcome the inclusion of the revised principles in s.4A of the Heads of Bill as this represents a substantial shift to a human rights approach. These guiding principles should strengthen the protection of the rights of individuals, who receive inpatient mental health treatment and goes some way to aligning the 2001 Act with the 2015 Act.[80] The authors consider that the revised principles have the potential to make progress on Ireland's compliance under international human rights law in conjunction with a cultural shift to a human rights-based approach in Irish mental health services.

One of the most important elements of the guiding principles is their empowering ethos, their usefulness in guiding the courts and others who may be involved in supporting with difficult decisions. They act as benchmarks against which decision-making can be tested. They are also integral to ensuring that persons subject to the act are supported in their decision-making. Importantly they mirror those in the 2015 Act including the presumption of capacity for all adults. Included is an innovative principle embracing two themes, one referring to access to health services which aims to deliver the highest attainable standard of mental health and, the second having due regard to the person's right to their own understanding of his or her mental health. Synergy is important for what will be two closely operated laws making them easier to understand and avoiding many of the difficulties that have occurred in the fragmented English system. The authors are concerned with the inclusion of s.4(9) in Head 5. This section states "[t]he provision of mental health services is subject to the availability of resources". While we acknowledge that mental health services are subject to resources the inclusion of this provision in the guiding principles serves to undermine the principles underpinning the legislation.

5.1 Recommendation

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

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

[80] See Dáil Debates 2nd May 2017 (Second Stage).

6. Definition of Mental Disorder in the Heads of Bill

Head 4 relates to the revised definition of mental disorder. S.3 as it currently stands provides the definition of mental disorder, in conjunction with additional criteria that must be met for a valid admission or renewal order. The conflation of the definition of "mental disorder" with the criteria for involuntary detention has resulted in confusion for persons subject to the legislation, family members, mental health professionals and other stakeholders. The authors consider that the separation of the definition of "mental disorder" from the criteria for involuntary detention is crucial in making the legislation less stigmatising and more easily understood. As such we welcome the separation of the definition of mental disorder and the criteria, which will be contained in s.8 of the revised Act.

However, there is concern with the decision to depart from the recommendation of the EGR to replace the term "mental disorder" with "mental illness". The EGR formed the view that the definition of "mental disorder" needed to be more focused to comply with the requirements with the ECHR and CRPD. In its Report the ERG stated "the legal definition of mental disorder can be complex and are difficult to draft… any revised definition agreed should raise the standard of proof required to conclude that a person is suffering from a 'mental disorder' in an effort to limit the number of involuntary admissions taking place to the greatest extent possible."[81] It was on this basis that the ERG recommended a standalone definition and the criteria should be listed separately with the benefit of making the 2001 Act more easily understood by all the stakeholders. The ERG recommended that mental disorder should no longer be retained and instead a definition of "mental illness" should be included.

"Mental disorder" as currently defined in the legislation is an excessively broad term that encompasses, mental illness, severe dementia, and significant intellectual disability. It is important to note that the use and meaning of "mental disorder" is both contested and controversial in mental health law, as the definition ultimately determines who can be involuntarily detained and forcibly treated. There are significant concerns from a human rights perspective with regards to the current definition of "mental disorder", which encompasses mental illness, severe dementia, and significant intellectual disability. The inclusion of "significant intellectual disability" and "severe dementia" has been criticised by the ERG, the Irish Human Rights and Equality Commission, Amnesty International Ireland, and the European Committee for the Prevention of Torture. It is clearly inappropriate that a person who has an intellectual disability or dementia but who do not have a mental illness could be detained in a psychiatric setting. The authors note that the revised wording of s.3 deleted the term "severe dementia" and "significant intellectual". However, the revised wording in the Heads of Bill will now defines "mental disorder" as meaning "any mental disorder, illness or disability". The revised definition is completely at odds with the recommendations of the ERG in that it appears to expand the definition of mental disorder to encompass "illness" and "disability". The rationale for this approach is not detailed in the Heads of Bill document. The proposed amendment will not raise the standard of proof required to conclude that a person is suffering from a "mental disorder" and has the potential to increase the number of involuntary admissions. Therefore, the wording in the Heads of Bill is at odds with the assertion that the proposed amendments to s.3 are in line with the ERG recommendations.

There is concern that the rationale for the retention of the term "mental disorder" seems to be mainly based upon submissions to the DOH favouring the term on the basis of its use in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the WHO's International Classification of Diseases (ICD-10).[82] The concern about this approach, particularly in light of the criticism, controversary and

[81] Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), at page 16.

[82] See the explanatory notes of the Heads of Bill.

debate relating to the DSM. The removal of "severe dementia" and "significant intellectual disability" from the scope of s.3 necessitates the deletion of the term "mental disorder" and replacement with "mental illness". The continued use of the term "mental disorder" reflects a medical model approach, which is at odds with the recommendations of the ERG and Ireland's obligations under the CRPD. The authors are concerned that the proposed amendments to s.3 do not go far enough to address the human rights concerns as articulated by the ERG. It is important to understand that the recommendations of the ERG in respect of s.3 are informed by the concern that involuntary admission and the resulting loss of liberty must be a measure of last resort, a view strongly supported by the ERG, and it must be accompanied by the required safeguards after less restrictive measures have been considered. The failure to implement less restrictive and coercive measures are the key elements that have undermined mental health services and must be addressed to ensure that involuntary admission is truly a measure of last resort. While the authors welcome the intention to separate the definition of mental illness from the criteria for detention the retention of the terms "mental disorder" and "mental illness", and the proposed wording of the section fails to limit the scope of the legislation as required by the relevant human rights law discussed above.

6.1 Recommendations:

Based on the forgoing discussion and analysis of the Heads of Bill the authors make the following 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 Irelands mental health policy "Sharing the Vision".
- The term "illness" and "disability" be deleted from the text of s.3.

7. Voluntary Category

One of the most significant human rights issues with the 2001 Act as it currently operates relates to persons who fall between the categories of voluntary and involuntary and the lack of safeguards for their right to liberty and lack of support in exercising their legal capacity. The Heads of Bill seeks to address this gap with the creation of a third category of intermediate. It is hoped that the introduction of this new category will address the human rights issues by providing the supports needed to make decisions about treatment and admission etc. The intermediate category as provided for in the Heads of Bill is discussed in detail below.

A significant issue with the 2001 Act as it currently operates is the lack of obligation under s.16 to provide information to voluntary persons on their rights regarding consent or refusal of treatment. The ERG recommended that voluntary persons be fully informed of their rights to consent or refuse any treatment proposals. The importance of informed consent and the need to inform persons who comply with voluntary admission but lack capacity to decide, is emphasised throughout the report of the ERG and it recommended that all voluntary persons should, on admission, be fully informed of their rights relating to proposed treatment and their right to leave the approved centre at any time.[83] The authors welcome the creation of s.79 on the provision of information for persons admitted as voluntary persons to approved inpatient facilities. S.79.(1) provides that where a person is admitted as a voluntary person a consultant psychiatrist (or if a consultant psychiatrist is not available) a relevant mental healthcare professional, is required within 24 hours to ensure that the person is informed of their right to consent to or refuse treatment during the period of admission. It also provides that they are informed of the complaint's procedure in the approved inpatient facility, the entitlement to communicate with the Inspector and informed that they may leave the approved inpatient facility at any time (subject to s.23) and the entitlement to engage an advocate. S.79(2) provides that on admission as a voluntary person must sign a form agreeing to admission. S.79(3) requires that the consent of the person is required if information of a general nature on their care and treatment is to be provided to the person's family, carer, advocate, or another person nominated by them. Importantly, s.79(4) provides that all information provided to the person should be in a form and language that may be understood by them. This is a crucial provision as a person in crisis, may require the support of a trusted support person or an independent advocate. The information should be communicated in a format appropriate to the needs of the person, and they should be given sufficient time to consider it.

The ERG recommended that the definition of voluntary needs to be an active definition of what it is rather than a definition of what it is not. This is important in safeguarding the rights of persons receiving inpatient mental health services.[84] The Heads of Bill proposes to delete s.29 on voluntary admission to approved centres as there is now a definition in Part 1 s.2 of the voluntary category for the purposes of the legislation. The new definition of "voluntary person" proposed in s.2 of the Heads of Bill is as follows:

> "voluntary person" means, in the case of an adult, a person who has capacity (within the meaning of *section 3* of the *Act of 2015*) and has been admitted to an approved inpatient facility and has given consent to his or her admission and to his or her treatment, with the assistance of a decision-making support as defined in the *Act of 2015*, if needed; or in the case of a child aged 16 years or older, the child has given consent to his or her admission and to his or her treatment, or in the case of a child aged under 16 years of age, consent to his or her

[83] Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), at page 30.
[84] Ibid.

admission has been given by the parents of the child, or either of them, or person or persons acting in *loco parentis*;

This new definition of voluntary refers to the need to have capacity and recognises that a person is also entitled to supported decision-making under the 2015 Act (if needed/applicable). The commencement of the 2015 Act will be essential to ensure support for people to make important decisions regarding their care and treatment. S.4(2) in the guiding principles provides that it will "be presumed that every person has capacity to make decisions affecting himself or herself unless the contrary is shown in accordance with the provisions of the *Act of 2015"*. This provision is essential in safeguarding the human rights of persons subject to the legislation.

The European Committee for the Prevention of Torture, in a 2010 report to the Irish Government, expressed concern about the lack freedom to leave or refuse treatment of the voluntary person in the 2001 Act and advocated for reform.[85] In contrast, persons who are formally detained under the 2001 Act have safeguards including independent review of their detention. As mentioned above s.79(1)(e) provides that subject to s.23 a voluntary person should be informed that they may leave the approved inpatient facility at any time. S.79(1) provides that the person be informed of their right to consent to or refuse treatment during the period of his or her admission. 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. We recommend 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.

7.1 Change of status from voluntary to involuntary

The UN Committee Against Torture referred to the lack of clarity regarding the change of status from voluntary to involuntary under the 2001 Act, which fails to comply with international human rights standards.[86] People who use mental health services perceive the powers in s.23 and s.24 as coercive, used to "persuade" them to remain as voluntary and consent to treatment. The Court of Appeal in *PL v St Patricks Hospital* stated that any restriction on liberty would be unlawful under Article 40.4.1 of the Constitution unless there was a legal basis for it.[87] The court affirmed the holding power in s.23 requires that the staff must have the opinion that the person has a "mental disorder". The Court held that voluntary persons cannot be prevented from leaving an approved centre except pursuant to the provisions of s.23.

As discussed above the ERG recommended that all voluntary persons admitted to an approved centre must be fully informed of their rights. This includes their right to leave the approved centre, and this should be the norm. Despite this view the ERG Report recommended retention of s.23 and s.24 but without the need to express a wish to leave, rather that this power should only be used in exceptional circumstances.[88] The Heads of Bill endorsed the ERG's recommendations and proposes to amend s.23 to provide that in future it will no longer be necessary for a voluntary person to express a wish to leave before s.23 can be activated. The authors have serious concerns with this provision, which will be elaborated upon below.

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[85]Council of Europe, "Committee for the Prevention of Torture, Inhuman and Degrading Treatment, Report on Ireland" (Strasbourg: Council of Europe, CPT/Inf, 2011), at para. 117.

[86] Committee against Torture, "Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment"(Geneva: Forty-sixth session, 17th June 2011).

[87] *PL v St Patricks Hospital* [2012] IEHC 15, [2014] 4 IR 385.

[88] Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), at page 55 Rec 73.

The existing provisions s.23 (power to prevent voluntary patient from leaving approved centre) and s.24 (power to detain voluntary patients) are now contained in an expanded s.23 titled "Power to detain voluntary and intermediate persons who may fulfil the criteria for involuntary detention". The amendments to s.23 in the Heads incorporate the ERG's recommendation that a registered medical practitioner who is not a member of staff at the approved inpatient facility should examine the person and consider whether or not to recommend that they be involuntarily admitted and the recommendation that the Commission must be notified every time a voluntary person is detained under s.23.(1). The explanatory notes describe new s.23 as a robust procedure, which is capable of being completed within 24 hours and adopts a multidisciplinary approach, with the added protection of input from a consultant psychiatrist who is independent of the approved inpatient facility. S.23(10)-(15) effectively set out the provisions related to intermediate persons who may fulfil the criteria for detention as set out in s.8.

Sections 23 and 24 have been the subject of much criticism from a human rights perspective and are perceived by many service users, carers and advocates as making many voluntary persons involuntary in all but name.[89] Persons using inpatient mental health services have expressed the view that they do not have any real choice in whether they should be admitted to hospital or not. The threat of coercion and forced treatment caused many voluntary persons to feel they were involuntarily detained in practice.[90] It has been argued that the provisions in s.23 are required in exceptional cases to prevent a voluntary person from leaving an approved centre. However, the reality is that the provisions are commonly used.[91] The authors are concerned that the proposed expansion of the scope of s.23 will further erode the rights of persons subject to the 2001 Act. In addition, the potential use of the provisions looms large, and it is not possible to quantify that impact of these provisions on persons in the voluntary category. As discussed above the amending legislation should expressly provide that voluntary persons have the right to leave at any time.

The authors have significant concerns about the recommendations of the ERG, which have now been incorporated into s.23. The revised provision in s.23 is unlikely to address the human rights concerns with the existing operation of these provisions and have the potential to further erode the right to liberty of persons choosing to receive inpatient mental health services on a voluntary basis. In effect, revised s.23 means that any person admitted to an approved centre is never truly voluntary as they can be detained if they express a wish to leave, and now even where they do not express a wish to leave. This potentially widens the net of coercion even further. 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. The new mental health policy states that involuntary detention should not be used outside of emergency circumstances, but emergencies need to be defined to prevent widening of the criteria.

7.2 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.

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[89] Amnesty International Ireland, "Mental Health Act 2001: A Review" (Dublin: Amnesty International, 2011), at page 65
[90] Ibid.
[91] 513 people were regraded from voluntary to involuntary out of 1,919 involuntary form 6 admissions in 2020. See: https://www.mhcirl.ie/what-we-do/mental-health-tribunals/mental-health-tribunal-statistics

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8. Intermediate Category

The authors are very concerned about the lack of human rights safeguards for persons who are considered voluntary and who have difficulties in decision-making and need support in exercising their legal capacity. This concern is illustrated acutely in the English case of *R v Bournewood Community and Mental Health NHS Trust*, *ex parte L*. [92] While reform of English mental health and capacity law has taken place, the lack of regulation in Ireland is very concerning from a human rights perspective. There is little doubt that the lack of safeguards for voluntary persons who lack mental capacity is in violation of the European Convention on Human Rights. However, the Irish courts have been reluctant to take a human rights-based approach to this matter when the matter has arisen. For example in *EH v Clinical Director of St. Vincent's Hospital* the court found that the lack of any requirement to assess the capacity of the person to give consent to the admission under the 2001 Act was not a violation of the applicant's right to freedom and personal autonomy under the Irish constitution or the ECHR. [93] The person at the centre of the case were initially admitted on an involuntary basis, but remained in the centre as voluntary person when they were no longer liable to be detained, but they were not free to leave.

The ERG spent considerable time considering these issues. In the context of the requirement to ensure the person is truly voluntary but lacks capacity to make the decision regarding admission, the suggested alternative was that the person could be subjected to involuntary admission. However, this is only feasible if the person satisfies the criteria for involuntary admission. Where this situation arises the Review recommends that "where a person is deemed to lack capacity and therefore cannot give informed consent, admission cannot take place on a voluntary basis even if a decision-making representative is appointed under the 2015 Act."[94] This situation exposes a gap in access to in-patient care and treatment for people who fall between the two categories. The Group was unanimous that this gap cannot be permitted, and every person should have a right to all levels of treatment should they require it. The Group proposed a new category of persons to be known as "intermediate" who would not be detained but would have similar review rights and safeguards as detained person. The Review states that detailed guidelines will have to be produced for this category to which the Commission and Head of the Decision Support Service (DSS) under the 2015 Act should contribute. [95]

These safeguards are the subject of drafting at the time of writing and will be known as Protection of Liberty Safeguards. Their objective will be to ensure the rights of the intermediate persons are protected and that their will and preferences, to the greatest degree possible, are respected, as such protections are set out in the 2015 Act. The Minister for State at the DOH at the time, Jim Daly, emphasised that any change regarding the voluntary person in the 2018 Act could not be commenced until other relevant sections of the 2015 Act are introduced "due to the interconnected nature of many of the changes to be made…"[96] The ERG emphasised the importance of having the 2015 Act fully commenced to ensure the appropriate support is available to assist in making these decisions. It is not clear how many people will need assistance with decision-making or will fall outside the new definition.

The ERG proposed that there would be intermediate admission and renewal orders and the renewal orders would have the same time scales that apply for involuntary persons as well as the MHRBs would

[92] *R(L) v Bournewood Community and Mental Health NHS Trust* [1998] UKHL 24, [1998] 3 All E.R.289.
[93] EH [2009] ILRM 149.
[94]Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), at page 31.
[95] Ibid, at page 84.
[96] *Dáil Debates* 14th July 2017 (Report and Final stage).

also apply to intermediate persons.[97] The issue of lack of capacity will be a key issue for the MHRB because of the requirement that the person will not have satisfied the criteria for detention and if the person is found to have capacity they will be discharged from intermediate status and will be able to remain as a voluntary person where appropriate. The Commission would be informed of the initial and continuing admission of this category. When the 2015 Act is fully commenced and a person has a decision-making representative who refuses treatment on their behalf, this decision should be respected. An exception was considered for emergency circumstances involving risk to self and others and where no other safe option is available, then that decision might be overridden. The decision would be subject to review by the MHRB within 3 days to ensure the criteria for emergency circumstances were fulfilled. If emergency circumstances prevailed, then the treatment could continue subject to a second opinion.

S.2 of the Heads of Bill defines "intermediate person" as follows:

> "a person (other than a child) who lacks capacity (withing the meaning of s.3 of the Act of 2015) and does not meet the criteria for involuntary detention in s.8, but requires treatment in an approved inpatient facility; or in the case of a child over 16 years of age, means a child who lacks capacity to consent to his or her admission and has been admitted with the consent of his or her parents, or either of them, or person or persons acting in loco parentis".

As discussed above the CRPD requires the replacement of substitute decision-making regimes with modern capacity legislation and supported decision-making alternatives. The authors recognise that the creation of this new category within the mental health legislation will extend procedural safeguards to persons whose right to liberty and allied human rights are not adequately safeguarded or vindicated. However, there is an obligation on the State under the CRPD to ensure that persons who are considered to lack capacity are supported to develop decision-making skills and exercise their legal capacity. The authors are concerned that if appropriate supports are not resourced and provided an unknown number of persons using mental health services could come under the intermediate category because of lack of supports. In that regard there is a concern that there is insufficient provision in the Heads of Bill to ensure that person in the intermediate category will benefit from supported decision-making. This reform is urgently needed for those more vulnerable people on voluntary admission who have no formal support to make decisions and have no safeguards under the Act. Although the 2015 Act has been enacted, only limited sections have commenced. Deprivation of liberty safeguards which are essential to meet the requirements set out by the ECtHR in the *HL v UK* case. While these provisions are under consideration, they have not been sufficiently progressed. This leaves a continuing gap for people in this situation.

The authors welcome the creation of the new intermediate category as it will provide some level of safeguard for persons *de facto* detained in mental health services. However, the authors have reservations about how these provisions will operate in practice. There is a potential risk that the introduction of this category could widen the net of coercion. Voluntary persons who are considered to lack capacity could alternatively be supported under the 2015 Act and/or through the DOLS processes when/if enacted. It will be important to keep the operation of the new category under review to ensure that the provisions are not used to undermine the rights of persons who use mental health services.

The current framing of the new category of intermediate does not sufficiently correlate with the 2015 Act. Persons detained under this category require support in exercising their decision-making. The creation of a new provision s.80 which relates to individual care planning is to be welcomed in

[97] Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), at pages 32-33.

I·ŘŘNŜăăλyƎ űKŜ Ŏ2Y LJfλI·yŎŜ ŘŜŦλŎλű øλűK űKŜ a I /ă NŜƎdzfI·űλ2yã λy űKλă I·NŜI·Φ Lű λă ŎNdzŎλI·f űKI·ű ădzLJLJ2NűĂ ű2 ŜÈŜNŎλăŜ ŎI·LJI·ŎλűÈ I·NŜ λyŎfdzŘŜŘ λy űKŜ ŎI·NŜ LJfI·y øKŜy ŷŜŜŘŜŘ I·yŘ λű ăK2dzfŘ ōŜ I· fŜƎI·f NŜIjdzλNŜY Ŝyű űKI·ű LJŜNă2y λă ƎλØŜy űKŜ I·LJLJN2LJNλI·űŜ ădzLJLJ2NűĂ ű2 LJI·NűλŎλLJI·űŜ λy ŘŜØŜf2LJY Ŝyű 2Ŧ űKŜλNJ λyŘλØλŘdzI·f ŎI·NŜ LJfI·yΦ ¢KŜ ŎNŜI·űλ2y 2Ŧ I· ăűI·űdzű2Nè 2ōfλƎI·űλ2y 2y űKŜ NŜăLJ2yãλōfŜ Ŏ2yãdzfűI·yű LJăèŎKλI·űNλăű ű2 Ŝyãdz NŜ űKI·ű ŜI·ŎK LJŜNă2y dzyŘŜNJ űKŜλNJ ŎI·NŜ NŜŎŜλØŜă I·y λyŘλØλŘdzI·f ŎI·NŜ LJfI·y øλűKλy τ ŘI·èă 2Ŧ I·ŘY λăăλ2y øλff K2LJŜŦdzffè I·ŘŘNŜăă űKλă Ŏ2yŎŜNyΦ {λY λfI·NfèƵ űKŜ NŜIjdzλNŜY Ŝyű űKI·ű űKŜ Y dzfűλπŘλăŎλLJfλyI·Nè űŜI·Y ōŜ NŜăLJ2yãλōfŜ Ŧ2NJ űKŜ Ŏfλyλŏl·f Ŏ2yűŜyű 2Ŧ űKŜ LJfI·y I·yŘ NŜIjdzλNŜă ŘdzŜ NŜƎI·NŘ Ŧ2NJ űKŜ øλff I·yŘ LJNŜŦŜNŜyŎŜă 2Ŧ űKŜ LJŜNă2y Ŏ2yŎŜNyŜŘ λă I·fă2 ű2 ōŜ øŜfŎ2Y ŜŘΦ ¢KŜ I·dzűK2Nă y2űŜ űKI·ű űKŜ 9wD KI·Ř Ŏ2yãλŘŜNŜŘ űKŜ ø2NŘλyƎ 2Ŧ áŎI·NŜ LJfI·yε ōŜ I·Y ŜyŘŜŘ ű2 áNŜŎ2ØŜNè LJfI·yãε ōdzű ŘŜŎλŘŜŘ I·ƎI·λyãű űKλă Ŧ2ff2øλyƎ Ŏ2yãdzfűI·űλ2y øλűK ʃŜè ăűI·ʃŜK2fŘŜNăΦ DλØŜy űKŜ Ŧ2Ŏdză 2y NŜŎ2ØŜNè øλűKλy Y Ŝyű I·f KŜI·fűK LJ2fλŎè I·yŘ ăŜNØλŎŜ ŘŜfλØŜNè λű ø2dzfŘ ōŜ ŘŜăλNJI·ōfŜ Ŧ2NJ NŜŎ2ØŜNè ű2 ōŜ λyŎfdzŘŜŘ λy űKŜ űŜÈű 2Ŧ ăΦулΦ Ly NŜăLJŜŎű 2Ŧ űKŜ yŜø λyűŜNJY ŜŘλI·űŜ ŎI·űŜƎ2Nè λyŎfdzăλ2y 2Ŧ I· NŜIjdzλNŜY Ŝyű 2y űKŜ Y dzfűλŘλăŎλLJfλyI·Nè űŜI·Y ű2 ădzLJLJ2Nű űKŜ LJŜNă2y λy ŘŜØŜf2LJλyƎ űKŜλNJ ŘŜŎλăλ2yπY I·ʃλyƎ ăK2dzfŘ ōŜ ŜÈLJNŜăăfè LJN2ØλŘŜŘ Ŧ2NJΦ

DλØŜy űKI·ű LJŜNă2yã λy űKŜ λyűŜNJY ŜŘλI·űŜ ŎI·űŜƎ2Nè Ŏ2dzfŘ I·ØI·λf 2Ŧ űKŜ ădzLJLJ2NűŜŘ ŘŜŎλăλ2yπY I·ʃλyƎ ădzLJLJ2NűĂ λy űKŜ нлмр !Ŏű ăΦул yŜŜŘă ű2 λyŎfdzŘŜ I· NŜIjdzλNŜY Ŝyű űKI·ű ō2űK űKŜ a Ŝyű I·f I ŜI·fűK /2Y Y λăăλ2y I·yŘ űKŜ yŜøfè ŎNŜI·űŜŘ 5ŜŎλăλ2y {dzLJLJ2Nű {ŜNØλŎŜ ŘŜØŜf2LJ ƎdzλŘŜfλyŜă κ I· Ŏ2ŘŜ NŜfI·űλyƎ ű2 űKλă ŎI·űŜƎ2NèΦ ¢Kλă λă ŜăăŜyűλI·f λy Ŝyãdz NλyƎ űKI·ű űKŜ LJŜNă2y λă LJN2ØλŘŜŘ øλűK ŜØŜNè 2LJLJ2Nűdzyűè ű2 I·ØI·λf 2Ŧ ădzLJLJ2NűŜŘ ŘŜŎλăλ2yπY I·ʃλyƎ I·yŘ űKŜ ŜÈŜNŎλăŜ 2Ŧ űKŜλNJ fŜƎI·f ŎI·LJI·ŎλűÈΦ

yΦм wŜŎ2Y Y ŜyŘI·űλ2yãY

.I·ăŜŘ 2y űKŜ Ŧ2NƎ2λyƎ ŘλăŎdzăăλ2y I·yŘ I·yI·fèăλă 2Ŧ űKŜ I ŜI·Řă 2Ŧ .λff øŜ Y I·ʃŜ űKŜ Ŧ2ff2øλyƎ NŜŎ2Y Y ŜyŘI·űλ2yãY

- !y λyŘŜLJŜyŘŜyű I·ŘØ2ŎI·űŜ ăK2dzfŘ ōŜ I·LJLJ2λyűŜŘ ű2 ădzLJLJ2Nű I· LJŜNă2y I·NűλŎdzfI·űŜ űKŜλNJ øλff I·yŘ LJNŜŦŜNŜyŎŜă I·yŘ Y I·ÈλY λăŜ űKŜ ăI·ŦŜƎdzI·NŘă ădzNN2dzyŘλyƎ űKŜλNJ ŘŜűŜyűλ2yΦ ¢Kλă ŎI·y ădzLJLJfŜY Ŝyű λyŦ2NJY I·f ădzLJLJ2Nű ŦN2Y 2űKŜNJ űNdzăűŜŘ LJŜNă2yã űKI·ű űKŜ LJŜNă2y ŎK22ăŜă ű2 ōŜ λyØ2fØŜŘΦ
- {Φул 2y λyŘλØλŘdzI·f ŎI·NŜ LJfI·y ăK2dzfŘ Ŏ2yűI·λy I· NŜIjdzλNŜY Ŝyű ű2 ŘŜØŜf2LJ I· ădzLJLJ2NűŜŘ ŘŜŎλăλ2yπY I·ʃλyƎ ăűNJI·űŜƎè I·ă LJI·Nű 2Ŧ űKŜ λyŘλØλŘdzI·f ŎI·NŜ LJfI·yyλyƎΦ ¢Kλă ăK2dzfŘ ōŜ I· fŜƎI·f NŜIjdzλNŜY Ŝyű Φ
- {Φул ăK2dzfŘ λyŎfdzŘŜ I· NŜIjdzλNŜY Ŝyű űKI·ű űKŜ a Ŝyű I·f I ŜI·fűK /2Y Y λăăλ2y I·yŘ űKŜ 5ŜŎλăλ2y {dzLJLJ2Nű {ŜNØλŎŜ ŘŜØŜf2LJ ƎdzλŘŜfλyŜă κ I· Ŏ2ŘŜ NŜfI·űλyƎ ű2 űKŜ λyűŜNJY ŜŘλI·űŜ ŎI·űŜƎ2NèΦ

φφ LyØƒdzyűl·NJè !ŘY˙λăăλƒy˙

¢ŕKŜ нллм !ŏűΣ ǿŕKŜy˙ŏƒY˙Y˙ŜyŏŜŘ LJNJƒØλŘŜŘ ŦƒNJ űŕKŜ ŦλNJăű űλY˙Ŝ dzyŘŜNJ LNJλăK fl·ǿΣ űŕKŜ NJλƎŕKű űƒ l·y˙l·dzűƒY˙l·űλŏ NJŜØλŜǿ ƒŦ l·ŘY˙λăăλƒy˙l·yŘ ŏƒyűλydzŜŘ ŘŜűŜyűλƒy˙ōŜŦƒNJŜ l· Y˙Ŝyűl·f KŜl·fűK űNJλōdzyl·f űƒ LJŜNJăƒyã λyØƒdzyűl·NJλfè l·ŘY˙λűűŜŘφ ² KλfŜ űŕKŜ λyűNJƒŘdzŏűλƒy˙ƒŦ űŕKλă NJŜØλŜǿ LJNJƒŏŜăă ǿl·ă l· ăλƎyλŦλŏl·yű ŘŜØŜf2LJY˙Ŝyű λy˙ăl·ŦŜƎdzl·NJŘλyƎ űŕKŜ NJλƎŕKűă ƒŦ LJŜNJăƒyã űŕKŜ LJNJƒØλăλƒyã yƒ f2yƎŜNJ ŏƒY˙LJfè ǿλűK űŕKŜ NJŜIjdzλNJŜY˙Ŝyű ƒŦ λyűŜNJyl·űλƒyl·f KdzY˙l·y˙ NJλƎŕKűă fl·ǿ l·ă ŘλăŏdzăăŜŘ l·ōƒØŜφ 5ŜăLJλűŜ ăűl·űŜY˙Ŝyűă űƒ űŕKŜ ŏƒyűNJl·NJè űŕKŜ wŜLJƒNJű ƒŦ űŕKŜ 9wD ăűl·űŜă űŕKl·ű Y˙Ŝyűl·f λftfyŜăă ǿλftf ōŜ l· yŜŏŜăăl·NJè ŜfŜY˙Ŝyű ŦƒNJ űŕKŜ ŏNJλűŜNJλl· ŦƒNJ ŘŜűŜyűλƒy˙ǿŕKŜNJŜ λű λă ƒŦ ădzŏK l· ŘŜƎNJŜŜ ƒNJ ăŜØŜNJλűèφ ¢ŕKŜ NJŜŏƒY˙Y˙ŜyŘl·űλƒyã ƒŦ űŕKŜ 9wD ŘλŘ yƒű ădzŦŦλŏλŜyűfè ŏƒyãλŘŜNJ űŕKŜ λY˙LJfλŏl·űλƒyã ƒŦ LNJŜfl·yŘΩă ƒōfλƎl·űλƒyã dzyŘŜNJ űŕKŜ /wt5φ ¢ŕKŜ 9wD NJŜŏƒY˙Y˙ŜyŘŜŘ űŕKl·ű űŕKŜ ŏNJλűŜNJλl· ŦƒNJ ŘŜűŜyűλƒy˙ǿdzfŘ λyŏfdzŘŜ ǿŕKŜNJŜ λű ǿl·ă λY˙Y˙ŜŘλl·űŜfè yŜŏŜăăl·NJè ŦƒNJ űŕKŜ LJNJƒűŜŏűλƒy˙ƒŦ fλŦŜ ƒŦ űŕKŜ LJŜNJăƒyΣ ŦƒNJ LJNJƒűŜŏűλƒy˙ŦNJƒY˙ l· ăŜNJλƒdzăl·yŘ λY˙Y˙λyŜyű űŕKNJŜl·ű űƒ űŕKŜ KŜl·fűK ƒŦ űŕKŜ LJŜNJăƒyΣ ƒNJ ŦƒNJ űŕKŜ LJNJƒűŜŏűλƒy˙ƒŦ ƒűŕKŜNJ LJŜNJăƒyã űŕKl·ű űŕKŜè ăŕKƒdzfŘ NJŜŏŜλØŜ ădzŏK űNJŜl·ű Y˙Ŝyű l·yŘ λű Ŏl·yƴƒ2ű ōŜ LJNJƒØλŘŜŘ dzyfŜăă űŕKŜè l·NJŜ ŘŜűl·λyŜŘ λy˙l·y˙l·LJLJNJƒØŜŘ ŏŜyűNJŜ dzyŘŜNJ űŕKŜ нллм !ŏűφ

¢ŕKŜ ¦b {LJŜŏλl·f wl·LJLJƒNJűŜdzNJ ƒy˙l Ŝl·fűK Kl·ă yƒűŜŘ űŕKl·ű űŕKŜ yƒűλƒy˙ƒŦ ǿŘl·yƎŜNJƒdzăyŜăăέ λă ƒŦűŜy˙ƎNJƒdzyŘŜŘ ƒy˙ǿλyl·LJLJNJƒLJNJλl·űŜ LJNJŜƒdzŘλŏŜΣ NJl·űŕKŜNJ űŕKl·y˙ŜØλŘŜyŏŜέφφу ¢ŕKŜ ¦b {LJŜŏλl·f wl·LJLJƒNJűŜdzNJ l·fă2 λŘŜyűλŦλŜŘ űŕKl·ű űŕKŜ ǿLJNJƒfλŦŜNJl·űλƒy˙ƒŦ LJl·űŜNJyl·fλăűλŏ Y˙Ŝyűl·f KŜl·fűK fŜƎλăfl·űλƒyέ l·yŘ űŕKŜ ŏƒNJNJŜăLJƒyŘλyƎ fl·ŏ˥ ƒŦ l·fűŜNJyl·űλØŜă Kl·ă NJŜădzfűŜŘ λy˙ ǿλŘŜăLJNJŜl·Ř Y˙ŜŘλŏl·f ŏƒŜNJŏλƒyφφφ ¢ŕKŜ ƒdzăűλŦλŏl·űλƒy˙ ƒŦ NJ űŕKŜ dzăŜ ƒŦ ŏƒŜNJŏλƒy˙ λă ƒŦűŜy˙ LJNJŜŘλŏl·ûŜŘ ƒy˙ō2ûK ǿY˙ŜŘλŏl·f yŜŏŜăăλûèέ l·yŘκƒNJ ǿŘl·yƎŜNJƒdzăyŜăăέφмллφφφ ¢ŕKŜăŜ LJNJλyŏλLJfŜă l·NJŜ ădzō?ŜŏûλØŜ l·yŘ ûŕKŜ ¦b {LJŜŏλl·f wl·LJLJƒNJűŜdzNJ yƒűŜă ûŕKl·ű ûŕKŜè l·NJŜ yƒű ădzLJLJƒNJűŜŘ ōè NJŜăŜl·NJŏK l·yŘ ûŕKŜλNJ l·LJLJfλŏl·ûλƒy˙λă ƒLJŜy˙ûƒ ōNJƒl·Ř λyûŜNJLJNJŜûl·ûλƒy˙l·yŘ NJl·λăŜ IjdzŜăûλƒyã l·ă ûƒ ûŕKŜλNJ l·NJōλûNJl·NJλyŜăăφмлмφφφ

¢ŕKŜ ¦b {LJŜŏλl·f wl·LJLJƒNJűŜdzNJ yƒűŜă ûŕKl·ű ûŕKŜ NJλƎŕKű ûƒ KŜl·fűK λă l· LJƒØŜNJŦdzf ƎdzλŘŜ ŦƒNJ {ûl·ûŜă λy˙λY˙LJfŜY˙Ŝyűλy˙ ûŕKŜ ǿLJl·NJl·Řλ˙Y˙ ăKλŦû ûŕKl·ű λă NJŜŏƒØŜNJè l·yŘ ŏƒY˙Y˙dzyλûèπōl·ăŜŘΣ LJNJƒY˙ƒûŜă ăƒŏλl·f λyŏfdzăλƒy˙ l·yŘ ƒŦŦŜNJă l· NJl·yƎŜ ƒŦ NJλƎŕKűăπ ōl·ăŜŘ ûNJŜl·ûY˙Ŝyűă l·yŘ LJăèŏKƒăƒŏλl·f ădzLJLJƒNJű l·ű LJNJλY˙l·NJè l·yŘ ăLJŜŏλl·fλÎŜŘ ŏl·NJŜ fŜØŜfăέφмлнφφφ ¢ŕKŜ l·dzûKƒNJă yƒûŜ ûŕKl·ű ûŕKŜ NJλƎŕKű ûƒ KŜl·fűK λă ƒŦûŜy˙ ŏƒNJNJŜfl·ûŜŘ ǿλûK l·ŏŏŜăă ûƒ ûNJŜl·ûY˙Ŝyű l·yŘ ûŕKλă Kl·ă ōŜŜy˙dzăŜŘ ûƒ ƒdzăûλƒè ŏƒŜNJŏλƒy˙λy˙ LNJŜfl·yŘ ōè Y˙Ŝyűl·f KŜl·fűK LJNJƒŦŜăăλƒyã l·yŘ ƒûŕKŜNJăφ ¢ŕKŜ NJλƎŕKű ûƒ KŜl·fűK ăKƒdzfŘ yƒű ōŜ dzăŜŘ ûƒ ƒdzăûλƒè ŘŜûŜyűλƒy˙ƒNJ λyØƒdzyűl·NJè ûNJŜl·ûY˙Ŝyűφ ! NJλƎŕKű ûƒ ŏƒY˙Y˙dzyλûèY˙Ŝyűl·f KŜl·fűK ăŜNJØλŏŜă ăKƒdzfŘ ōŜ LJNJƒØλŘŜŘ ƒŦNJ λy˙ûŕKŜ l·Y˙ŜyŘλyƎ fŜƎλăfl·ûλƒy˙ûƒ ûŕKŜ нллм !ŏűφ ¢ŕKλă ǿλftf Ŝyăƒdz˙NJŜ ûŕKl·ű l·fűŜNJyl·ûλØŜă ûƒ λyLJl·ûλŜyű ăŜNJØλŏŜă l·NJŜ l·ØI·λfl·ōfŜ l·yŘ ǿλftf ăƒdzLJLJƒNJű ûŕKŜ {ûl·ûŜ λy˙Y˙ŜŜûλyƎă λy˙ƒōfλƎl·ûλƒyã ûƒ ŜfλY˙λyl·ûŜ ŏƒŜNJŏλƒy˙λy˙Y˙Ŝyűl·f KŜl·fűK ăŜNJØλŏŜăφ t l·NJű н ƒŦ ûŕKŜ l Ŝl·Řă ƒŦ .λftf λă yƒǿ ûλûfŜŘ áŏNJλûŜNJλl· ŦƒNJ λyØƒdzyűl·NJè l·ŘY˙λăăλƒy˙ûƒ l·LJLJNJƒØŜŘ λyLJl·ûλŜyű Ŧl·ŏλfλûλŜăέφ ¢ŕKŜ Řλăŏdzăăλƒy˙ōŜƒfƒǿ ǿλftf Ŧƒŏdză ƒy˙ûŕKŜ Y˙l·λy˙ LJNJƒØλăλƒvã λv˙ t l·NJű н ŦNJƒY˙ l· KdzY˙l·v˙NJλƎŕKűă LJŜNJăLJŜŏûλØŜφ

φφм wŜŏƒY˙Y˙ŜyŘl·ûλƒy˙

- ! NJλƎŕKű ûƒ ŏƒY˙Y˙dzyλûèY˙Ŝyűl·f KŜl·fűK ăŜNJØλŏŜă ăKƒdzfŘ ōŜ LJNJƒØλŘŜŘ Ŧƒ λy˙ûŕKŜ l·Y˙ŜyŘλyƎ fŜƎλăfl·ûλƒy˙ûƒ ûŕKŜ нллм !ŏűφ ¢ŕKλă ǿλftf Ŝyăƒdz˙NJŜ ûŕKl·ű l·fűŜNJyl·ûλØŜă ûƒ λyLJl·ûλŜyű ăŜNJØλŏŜă l·NJŜ l·ØI·λfl·ōfŜ l·yŘ ǿλftf ăƒdzLJLJƒNJű ûŕKŜ {ûl·ûŜ λy˙Y˙ŜŜûλyƎă λy˙ƒōfλƎl·ûλƒyã ûƒ ŜfλY˙λyl·ûŜ ŏƒŜNJŏλƒy˙λy˙Y˙Ŝyűl·f KŜl·fűK ăŜNJØλŏŜăφ

φу 5l·λyλdză tnNJl·ă áwŜLJƒNJűŜdzNJ ƒy˙ûŕKŜ {LJŜŏλl·f wl·LJLJƒNJűŜdzNJ ƒy˙ûŕKŜ NJλƎŕKű ƒŦ ŜØŜNJè2yŜ ûƒ ûŕKŜ Ŝy?2èY˙Ŝyűƒ ûŕKŜ KλƎŕKŜăűƒ l·ûûl·λyl·ōfŜ ăűl·yŘl·NJŘ ƒŦ LJKèăλŏl·f l·yŘ Y˙Ŝyűl·f KŜl·fűKέ ó l dzY˙l·y˙wλƎŕKűă /2dzyŏλƒΣ WdzyŜ нлмтú l·ű LJl·ƎŜ мпφ

φφ LōλŘφ

мллφ LōλŘφ

мллφφφ LōλŘφ

млнφφφ LōλŘΣ l·ű LJl·ƎŜ мтφ

9.2 Criteria for involuntary admission to approved inpatient facilities

As discussed above the ERG recommended that a person cannot be detained solely based on having an intellectual disability and after careful consideration recommended that the sole dementia ground should also be removed. This recommendation appears to have been inadvertently omitted from the list of recommendations for exclusion, but it is included in the list of recommendations on mental illness and mental disorder.[103] The Heads of Bill adopted the ERGs recommendations on the revised criteria for involuntary detention, which are now detailed in a revised wording of s.8(1). The ERG recommended that "nature or degree" be used as part of the first criterion for detention. However, in the explanatory notes to the Heads of Bill the submissions from the MHC and the College of Psychiatrists of Ireland, the DOH decided to use the wording "nature and degree". It was noted that significant case law on the term "nature and degree" in "mental disorders" has developed in the United Kingdom, as such it was decided that the term should be used in the amending legislating in order to provide greater clarity.

S.8(1)(b) states that the criteria for detention arises "where such treatment is immediately necessary to protect the life of the person, or to protect the health of the person from the threat of serious harm, or for the protection of other persons". However, it does not state that the detention should only be for as long as absolutely necessary in emergency circumstances in line with the "A Shared Vision". The authors consider that it would be important to amend the text of s.8(2) to place emphasis on this. The other changes set out in s.8(2) reflect recommendations by the ERG to the effect that unless a person fulfils the criteria for involuntary detention in s.8(1), then the admission or renewal order must be revoked, and the person discharged. It also provides additional protections for a voluntary person in the event their order is revoked. S.8(3) provides that nothing in s.8(1) can be construed as authorising the involuntary admission of a person to an approved centre inpatient facility because the person has a mental disorder which does not meet the criteria for detention, has an intellectual disability, or has a personality disorder, or is socially deviant, or is addicted to drugs or intoxicants., or behaves in such a manner, or holds views, that deviates from the prevailing culture, norms, values, or beliefs of society, or requires to reside in a safe environment. S.8(3) implements other recommendations of the ERG. The ERG had recommended that involuntary "detention should only be for as long as absolutely necessary and the person continues to satisfy all the stated criteria".[104] The wording of s.8(2) is as follows "[o]nce a person no longer satisfies the conditions outlined in subsection (1), the admission or renewal order, as the case may be, must be revoked and the person discharged in accordance with section 28."

9.3 Recommendation

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

[103] Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), at page 17.
[104] Ibid, at page 22.

9.4 Persons who may apply for involuntary admission

Extensive recommendations have been made regarding the development of the role of Authorised Officer (AO).[105] The ERG focused on the current role of the AO and recommended that a broader role beyond making the application would result in the AO acting as a resource in the role of a "dedicated and informed mental health specialist."[106] The ERG envisioned that this role would involve a more active role in the context of a potential involuntary admission, that it could lead to more appropriate and a less coercive approach, more focus on the community alternatives and ensure that involuntary admission was truly an action of last resort.[107] Following consultation, where appropriate, with the family or carers, the AO could provide immediate information to a family in a crisis and ultimately, where no other more appropriate service was available, would make the decision to progress an involuntary admission. There is no mention of consultation with the person, the subject of the involuntary admission. The recommendations provide that the AO should be the person to sign all applications for an involuntary admission to an approved centre including inpatient status change from voluntary to involuntary. The intention of the recommendations is to reduce the burden on the family and reduce the involvement of the Gardaí in involuntary admissions.

Other recommendations from the ERG focused on second opinions from AOs or where a previous assessment by an AO existed, the same AO could be asked again to review the circumstances. Where the Gardaí are involved under s.12 the initial assessment by the AO should take place as soon as possible after the person is taken into custody. The maximum period which the person could be held prior to being assessed by the AO or the doctor is set at 24 hours in the ERG's recommendations. The ERG recommended "a second 24-hour timeframe in which both the AO and the doctor must carry out their assessments." The Heads of Bill gives effect to the recommendations of the ERG. S.9(1) now provides that where it is proposed to have a person (other than a child) involuntarily admitted to an inpatient facility, an application for a recommendation that the person be so admitted shall be made to a registered medical practitioner exclusively by an authorised officer. S.9(3) requires that the AO in considering whether or not to make an application must meet with, speak to, and observe the person, and consult where possible and appropriate with the person's family or carer, and must take account of whether the care and treatment can be given other than in an approved inpatient facility, with a view to ensuring an application for involuntary admission is only made as a last resort. When an application is made under s.9(1) the application needs to contain a statement of the reasons why it is so made, and of the circumstances in which the application is made.

In its 2008 Report on the Operation of Part 2 of the Act, the MHC recommended that "the HSE develop crisis response teams and an authorised officer service in line with best practice with the aim of improving patient and carer experiences in the application/ recommendation process".[108] The MHC further recommended that these services should be co-ordinated to form part of the wider development of community services outlined in "A Vision for Change".[109] It is regrettable that 13 years since there has been little progress in the development in the provision of AO function under the 2001 Act. The authors welcome the proposed provision in s.9 enhancing the role of the AO in the admission process. In the explanatory notes it was stated that the HSE would need significant time to train additional AOs so that enough were available throughout the country on a 24/7 basis. However, the authors are concerned about the suggestion that this would require more time and resources to build up the authorised officer service, to the extent that this key new provision would not come into effect until the full service is in place. Given the important role of the AO in reducing coercion it is

[105] Ibid, at pages 36-37.
[106] Ibid, at page 34.
[107] Ibid.
[108] Mental Health Commission, "Report on the operation of Part 2 of the Mental Health Act 2001" (Dublin: Mental Health Commission, 2008), at page 87.
[109] Ibid.

crucial that the commencement of this provision is not delayed and that the HSE immediately begins the process of training the required number of AOs.

S.9(4) adopts the ERGs recommendation that family/carers can request a second authorised officer to look at their case if they are not happy with the recommendations of the first authorised officer. There is a requirement that the refusal by the first authorised officer (if known) shall be disclosed in writing to the second authorised officer and in any subsequent application to a registered medical practitioner. The authors have concerns with this provision from a human rights perspective. Given the requirement of international human rights law it is recommended that s.9(4) should be amended to exclude the possibility of family members being permitted to make a further application for a second AO for involuntary admission. The authors welcome the requirement in s.9(6) that the AO must have met with, spoken to and observed the person the subject of the application within the preceding 24 hours before they make an application. This represents a welcome additional procedural safeguard for persons subject to the legislation compared to the current requirement of 48 hours.

The role of the AO has been continuously raised in the Mental Health Commission's Annual Reports, highlighting the failure to meet the potential of the role, as an alternative to the family having to make the application for admission. Despite this the number of AOs has remained low and inconsistent throughout the country, despite commitments to train and involve greater numbers. In 2018 there were 1,825 involuntary admissions from the community, 14% were applications for admission by AOs compared with 5% in 2009, a miniscule increase.[110] The provision of adequate resourcing for the recruitment and training of AOs is essential. The commencement of these provisions should significantly reduce the pressure on the family and reduce the involvement of the Gardaí in the admissions process. Preparation for the commencement of this provision should be an immediate priority for the HSE to provide a full distribution of AOs throughout the country.

The ERG in its Report emphasised "the need to ensure that the individuals chosen as Authorised Officers must be experienced mental health professionals with a good knowledge of mental health services who also receive appropriate training in terms of the legislation and the proposed expanded regime".[111] However, the authors consider that it is essential that persons with lived experience of mental health services should also be recruited and trained as AOs. We also consider that AOs should be recruited and trained based on their ability to deal with vulnerable persons in a respectful and human rights-based manner and that this competency is more important than prior experience as a mental health professional. This will be key in bringing about the cultural shift needed. The authors consider that the provisions in s.9 have the potential if adequately resourced and supported to manage more effectively the sensitive areas of potential involuntary admission and identify alternative supports in the community.

S.9(3) requires that the AO in considering whether or not to make an application they need to meet with, speak to and observe the person, and consult where possible and appropriate with the person's family or carer, and must take account of whether the care and treatment required by the person can be given other than in an approved inpatient facility, with a view to ensuring an application for involuntary admission is only made as a last resort. In order to ensure that the application for involuntary admission is indeed a last resort the authors believe s.9 should be amended to expressly require the AO to take all possible steps to use alternatives to coercion and that the steps taken to use alternatives should be documented. This will promote transparency in the discharge of the functions of the AO and facilitate review of the effectiveness of this law reform.

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[110] Mental Health Commission, "Annual Report 2018 Including Report of Inspector of Mental Health Services" (Dublin: Mental Health Commission, 2018).

[111] Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), at page 36.

9.5 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 AO to take all possible steps to use alternatives to coercion and that the steps taken to use alternatives should be documented.

9.6 Making of recommendation for involuntary admission

S.10 of the 2001 Act relates to the requirement on the registered medical practitioner (RMP) in relation to the examination and recommendation for involuntary admission to an approved centre. The examination of the person must take place within 24 hours of the application being presented to the doctor. There have been some concerns raised in relation to the operation of s.10. For example, the adequacy of the examination arose in the case of *XY v Adelaide and Clinical Director of St Patricks University Hospital* [112]. The RMP was familiar with the person concerned, observed her from a distance in a car park and combined what he observed along with his previous knowledge of her to make a recommendation for admission. In the subsequent constitutional challenge, the court was influenced by the decision in *Z(M) v Khattak & Tallaght Hospital Board* [113] in making allowances for the circumstances and was satisfied that a proper assessment was carried out at the hospital by the psychiatrist. The court also confirmed that to the extent that the admission order was irregular this failure did not invalidate a subsequent detention order, which was otherwise valid.

In light of the concerns with the operation of s.10 of the 2001 Act the ERG stated that a "greater level of transparency" is required in relation to the personal examination under s.10(2) to be conducted by the RMP and recommended that in future it must be clearly certified how the RMP came to the view that the person has a mental illness and how the criteria for detention are being met.[114] The ERG also recommended a specific disqualification that the RMP cannot be in the role of examining the person concerned if he or she becomes the owner of an approved centre or, an employee or, agent of a centre to which the person is being admitted.

The authors welcome the implementation of the ERGs recommendations in the Heads of Bill. S.10(1) now provides that "[t]he registered medical practitioner shall be required to certify the basis on which he or she is of the opinion that the person satisfies the criteria for detention". The explanatory notes for s.10 state that the definition in s.10(2) was sufficient to ensure that the examination by the RMP would take place in person. S.10(2) provides that "[a]n examination of the person the subject of an application shall be carried out within 24 hours of the receipt of the application by the registered medical practitioner and the registered medical practitioner concerned shall inform the person of the purpose of the examination". As such it was thought unnecessary to include the requirement that the examination had to take place in person. However, in light of the issues raised in the relevant case law the authors consider that it is necessary to explicitly include in s.10 the requirement for the examination to take place in person. Given recent public health restrictions the issue of in person examination needs to be given further consideration. The authors consider that 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.

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[112] [2012] IEHC 224.
[113] [2008] IEHC 262.
[114] Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), at page 36.

9.7 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.

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{⌀мн łă y2ø ŜyűłűfŜŘ ałJ2øŜŃă 2ŧ DI·ŃŘI· {Ń2ŎKłył· ű2 űI·ţŜ I· LJŜŃă2y ōŜfłŜØŜŘ ű2 ŧdzfŧłf ŎŃłűŜŃłI· ŧ2Ń łyØ2fdzyűI·Ńè ŘŜűŜyűł2yłyű2 Ŏdzăű2Řèéφ {⌀мн 2ŧ űKŜ нллм !Ŏű Ŏ2yŧŜŃă LJ2øŜŃă dzLJ2yűKŜ DI·ŃŘI·Ń ű2 űI·ţŜ I· LJŜŃă2y łyű2 Ŏdzăű2Řè øKŜŃŜ űKŜè KI·ØŜ ŃŜI·ă2ył·ōfŜ ƎŃ2dzyŘă ŧ2Ń ōŜfłŜØłyƎ űKI·ű I· LJŜŃă2y KI·ă I· YŜyűI·f Řłă2ŃŘŜŃ I·yŘ űKI·ű ōŜŎI·dzăŜ 2ŧ űKŜ YŜyűI·f Řłă2ŃŘŜŃ űKŜŃŜ łă I· ăŜŃł2dză fłţŜfłK22Ř 2ŧ űKŜ LJŜŃă2yŎI·dzăłyƎ łYYŜŘłI·űŜ I·yŘ ăŜŃł2dză KI·ŃY ű2 űKŜYăŜfØŜă 2Ń ű2 2űKŜŃ LJŜŃă2yã⌀ ¢KŜ 9wD ŃŜŎ2YYŜyŘŜŘ űKI·ű űKŜ !h ăK2dzfŘ ōŜ űKŜ LJŜŃă2y ű2 YI·ţŜ űKŜ I·LJLJfłŎI·űł2y ŧ2Ń łyØ2fdzyűI·Ńè I·ŘYłăăł2y I·yŘ űKŜ DI·ŃŘI·Ń ăK2dzfŘ ăŜŜţ ű2 Ŏ2yűI·Ŏű űKŜ !h łYYŜŘłI·űŜfèφ ¢KŜ 9wD I·fă2 Ŏ2yãłŘŜŃŜŘ øKŜŃŜ I·yłyŘłØłŘdzI·f łă űI·ţŜyłyű2 Ŏdzăű2Řè ōè űKŜ DI·ŃŘI·Ń dzyŘŜŃ ă⌀мнΣ ŘŜűŜyűł2yăK2dzfŘ 2yfè fI·ăű ŧ2Ń I·ă f2yƎ I·ă łă yŜŎŜăăI·Ńè ŧ2Ń űKŜ !h ű2 Ŏ2yãłŘŜŃ űKŜ ŧI·Ŏűă I·yŘ LJ2ăăłōfŜ I·fűŜŃył·űłØŜ űŃŜI·űYŜyű ōŜŧ2ŃŜ űKŜè YI·è ŘŜŎłŘŜ ű2 YI·ţŜ I·y I·LJLJfłŎI·űł2y ŧ2Ń łyØ2fdzyűI·Ńè I·ŘYłăăł2y I·yŘ I·ff2ø ŧ2Ń I· wat ű2 ŜÈI·YłyŜ űKŜ LJŜŃă2y I·yŘ YI·ţŜ I· ŃŜŎ2YYŜyŘI·űł2y ŃŜƎI·ŃŘłyƎ łyØ2fdzyűI·Ńè I·ŘYłăăł2y I·yŘ dzyŘŜŃ ă⌀мнóмú øKŜŃŜ I· YŜYōŜŃ 2ŧ űKŜ DI·ŃŘI· {Ń2ŎKłył· KI·ă ŃŜI·ă2ył·ōfŜ ƎŃ2dzyŘă ŧ2Ń ōŜfłŜØłyƎ űKI·ű I· LJŜŃă2yŧdzfŧłfă űKŜ ŎŃłűŜŃłI· ŧ2Ń ŘŜűŜyűł2y I·ă ăŜű 2dzű ły ă⌀yΣ űKŜ YŜYōŜŃ YI·è ŜłűKŜŃ I·f2yŜ 2Ń øłűK I·yè 2űKŜŃ YŜYōŜŃ 2Ń YŜYōŜŃă 2ŧ űKŜ DI·ŃŘI· {Ń2ŎKłył· ű I·ţŜ űKŜ LJŜŃă2y łyű2 Ŏdzăű2Řè I·ă ă22y I·ă LJŃI·ŎűłŎI·ōfŜΣ ōdzű y2 fI·űŜŃ űKI·y мн K2dzŃă ŧŃ2Y űKŜ űłY Ŝ űKŜ LJŜŃă2y łă ű I·ţŜy łyű2 Ŏdzăű2Řè {⌀мнóмúóI·ú ŃŜűI·łyã űKŜ LJ2øŜŃ ű2 ŜyűŜ ŃΣ łŧ ySŜŘ ōŜΣ ōè ŧ2ŃŎŜ I·yè ØøŜfłyƎ 2Ń 2űKŜŃ LJŃŜYłăŜă 2Ń I·yè LJfI·ŎŜ łŧ űKŜè KI·ØŜ ŃŜI·ă2ył·ōfŜ ƎŃ2dzyŘă ŧ2Ń ōŜfłŜØłyƎ űKI·ű űKŜ LJŜŃă2y łă ű2 ōŜ ŧ2dzyŘ űKŜŃŜ⌀ {⌀мнóнú LJŃ2ØłŘŜă űKI·ű øKŜŃŜ I· DI·ŃŘI· űI·ţŜă I· LJŜŃă2y łyű2 Ŏdzăű2Řè dzyŘŜŃ ă⌀мнóмúΣ űKŜè 2Ń I·yè 2űKŜŃ YŜYōŜŃă ăKI·ff łYYŜŘłI·űŜfè Ŏ2yűI·Ŏű I·y !hΣ øK2 øłff ŃŜØłŜø űKŜ LJŜŃă2y I·yŘ ŘŜŎłŘŜ øKŜűKŜŃ ű2 YI·ţŜ I·y I·LJLJfłŎI·űł2y 2Ń y2ű dzyŘŜŃ ă⌀ф I·yŘ øKŜŃŜ I·y I·LJLJfłŎI·űł2y łă YI·ŘŜ űKŜ !h ăKI·ff űKŜy I·ŃŃI·yƎŜ ŧ2Ń I·wat ű2 ŎI·ŃŃè 2dzű I·yŜÈI·YłyI·űł2y 2ŧ űKŜ LJŜŃă2y øK2 øłff űKŜy ŘŜŎłŘŜ øKŜűKŜŃ ű2 YI·ţŜ I· ŃŜŎ2YYŜyŘI·űł2y 2Ń y2ű dzyŘŜŃ ă⌀мл⌀

{⌀мнóoú y2ø LJŃ2ØłŘŜă űKI·ű øKŜŃŜ űKŜ !h Ř2Ŝă y2ű YI·ţŜ I·y I·LJLJfłŎI·űł2y űKŜ LJŜŃă2y űKŜ ădzō?ŜŎű 2ŧ űKŜ I·LJLJfłŎI·űł2y øłff ōŜ ŃŜfŜI·ăŜŘ ŧŃ2Y Ŏdzăű2Řè łYYŜŘłI·űŜfè⌀ {łYłfI·Ńfè ă⌀мнóпú y2ø LJŃ2ØłŘŜă øKŜŃŜ űKŜ wat Ř2Ŝă y2ű YI·ţŜ I· ŃŜŎ2YYŜyŘI·űł2y ŧ2Ń I·ŘYłăăł2y űKŜ LJŜŃă2y űKŜ ădzō?ŜŎű 2ŧ űKŜ I·LJLJfłŎI·űł2y øłff ōŜ ŃŜfŜI·ăŜŘ ŧŃ2Y Ŏdzăű2Řè łYYŜŘłI·űŜfè⌀ {⌀мнóрú 2ŧ űKŜ ISI·Řă 2ŧ .łff ăűI·űŜă űKI·ű øKŜy I·y I·LJLJfłŎI·űł2y I·yŘ I· ŃŜŎ2YYŜyŘI·űł2y I·ŃŜ YI·ŘŜΣ I·y DI·ŃŘI· {Ń2ŎKłył· ăKI·ff űŃI·yãŧŜŃ űKŜ LJŜŃă2y ű2 űKŜ I·LJLJŃ2ØŜŘ łyLJI·űłŜyű ŧI·ŎłfłűÈ ăLJŜŎłŧłŜŘ ły űKŜ ŃŜŎ2YYŜyŘI·űł2y I·ă ă22y I·ă LJŃI·ŎűłŎI·ōfŜ I·ŧűŜŃ űKŜ Ŏ2YLJfŜűł2y 2ŧ űKŜ ŃŜfŜØI·yű ăűI·űdzű2Ńè ŧ2ŃYă⌀ {⌀мнócú LJŃ2ØłŘŜă űKI·ű I· LJŜŃă2y ű I·ţŜy łyű2 Ŏdzăű2Řè dzyŘŜŃ ă⌀мнóмú 2Ń ły űKŜ ŜÈŜŃŎłăłyƎ 2ŧ I·yè ŧdzyŎűł2yã ƎŃI·yűŜŘ ű2 YŜYōŜŃă 2ŧ űKŜ DI·ŃŘI· {Ń2ŎKłył· dzyŘŜŃ űKŜ fŜƎłăfI·űł2yΣ I·y DI·ŃŘI· {Ń2ŎKłył· ăKI·ff ŜÈŜŃŎłăŜ űK2ăŜ ŧdzyŎűł2yã ły I· YI·yŷŜŃ űKI·ű ŃŜăLJŜŎűă űKŜ ŃłƎKűă 2ŧ űKŜ LJŜŃă2yΣ I·yŘ øłűK ŘdzŜ ŃŜƎI·ŃŘ ű2 űKŜ ƎdzłŘłyƎ LJŃłyŎłLJfŜă ły ă⌀п ół·Řdzfűăú 2Ń ă⌀уп óŎKłfŘŃŜyűφ {⌀мнóтú y2ø ŃŜIjdzŃŜă űKI·ű űKŜ a I / ły Ŏ2yãdzfűI·űł2y øłűK űKŜ DI·ŃŘI· {Ń2ŎKłył· I·yŘ I·yè 2űKŜŃ ŃŜfŜØI·yű ō2ŘèΣ LJŃŜLJI·ŃŜ I· /2ŘŜ 2ŧ tŃI·ŎűłŎŜ 2y űKŜ ŧdzyŎűł2yã 2ŧ űKŜ DI·ŃŘI· {Ń2ŎKłył· dzyŘŜŃ űKŜ нллм !Ŏű⌀

{⌀мо 2ŧ űKŜ нллм I·ă łű ŎdzŃŃŜyűfè 2LJŜŃI·űŜă LJŃ2ØłŘŜă ŧ2Ń űKŜ ŃŜY2ØI·f 2ŧ űKŜ LJŜŃă2y ű2 űKŜ I·LJLJŃ2ØŜŘ ŎŜyűŃŜ łă ű2 ōŜ I·ŃŃI·yƎŜŘ ōè űKŜ I·LJLJfłŎI·yűΣ 2Ń ōè űKŜ ŎfłyłŎl·f ŘłŃŜŎűł2Ń 2Ń Ŏ2yãdzfűI·yű LJăèŎKłI·űŃłăű I·ŎűłyƎ 2y űKŜłŃ ōŜKI·fŧΣ YdzăŭI·ŃŃI·yƎŜ ŧ2Ń űKŜ ŃŜY2ØI·f 2ŧ űKŜ LJŜŃă2y ű2 űKŜ I·LJLJŃ2ØŜŘ ŎŜyűŃŜ ōè YŜYōŜŃă 2ŧ űKŜ ăűI·ŧŧ 2ŧ űKŜ I·LJLJŃ2ØŜŘ ŎŜyűŃŜ 2Ń ōè I·dzűK2ŃłăŜŘ LJŜŃă2y⌀ ² KŜŃŜ űKŜăŜ I·ŃŃI·yƎŜYŜyűă I·ŃŜ y2ű LJ2ăăłōfŜ I·yŘ űKŜŃŜ łă ăŜŃł2dză fłţŜfłK22Ř 2ŧ łYYŜŘłI·űŜ I·yŘ ăŜŃł2dză KI·ŃY ű2 űKŜ LJŜŃă2yΣ 2Ń 2űKŜŃăΣ űKŜ DI·ŃŘI·Ń øłff ōŜ 2ōfłƎŜŘ ű2 I·ăăłăűφ ¢KŜ ŃŜIjdzŜăű ű2 űKŜ DI·ŃŘI·λ łă ōI·ăŜŘ 2y űKŜ 2LJłył2y 2ŧ űKŜ wat I·yŘ űKŜ ŎfłyłŎl·f ŘłŃŜŎűł2Ń 2Ń Ŏ2yãdzfűI·yű LJăèŎKłI·űŃłăű øK2 YI·ţŜa űKŜ ŃŜIjdzŜăűφ ¢KŜ DI·ŃŘI·Ń ŎI·y ŜyűŜŃ I· LJŃŜYłăŜăΣ ōè ŧ2ŃŎŜ łŧ ySŎŜăăI·ŃèΣ I·yŘ I·ŃŜ 2ōfłƎŜŘ ű2 űI·ţŜ I·ff ŃŜI·ă2ył·ōfŜ YŜI·ădzŃŜă ySŎŜăăI·Ńè łyŎfłzŘłyƎ űKŜ ySŎŜăăI·Ńè ŃŜăűŃI·łyű I·yŘ ŘŜűŜyűł2y ŧ2ŧ űKŜ LJŜŃă2y⌀ ¢KŜŃŜ KI·ă ōŜŜy I· fI·Ŏţ ŧ2ŧ Ŏfł·ŃłűÈ I·Ń2dzyŘ űKŜ YŜI·yłyƎ I·yŘ ăŎ2LJŜ ŧ2ŧ űKŜ űŜŃY ał·ăăłăűε ły űKŜ нллм !Ŏű⌀

From an examination of the case law relating to the assisted admission of involuntary persons the authors have concerns about these provisions as they operate in the 2001 Act. The first of three decisions concerning the lawfulness of the removal of the person to the approved centre arose in *RL v Clinical Director of St Brendan's Hospital* [115] where the person had been removed to an approved centre by contractors who were not "staff of the centre" contrary to s.13(2). In the High Court, Feeney J held that non-compliance with s.13 did vitiate the admission order made under s.14 and by comparison with s.18 which required compliance with a number of provisions, s.13 did not. This section concerns the way in which someone is taken to the institution and received there, and the admission is a separate matter. The Court decided that any wrong that might have potentially been done "is cured by the complete and proper implementation of the provisions in relation to an admission order…"[116] Hardiman J in the Supreme Court believed there was on the face of it a breach of s.13(2) but thought it was extraordinary that the removal system could be so limited and not address situations that arose suddenly where no hospital staff might be available. He said the legal question had to be isolated,

> This is, does that breach of s.13 … operate to prevent the making of an admission order under s.14 and if it did that would it logically also prevent the making of further orders under the Act? The court can simply see no reason whatever to believe that an irregularity or a direct breach of s.13 would render what is on the face of a lawful detention on foot of an admission order invalid."[117]

He went on to say, "that is not to say that we excuse or draw a veil over the alleged breaches of s.13. On the contrary, we will say that these breaches, if they occurred are serious matters and that a person in the position of a Clinical Director may be in a very difficult position… L's right in relation to any breach of the law is a right to compensation…"[118]

Members of staff or authorised persons have no specific statutory powers of restraint in these assisted admissions. Where it is believed there are risks associated with the assisted admission the clinical director or consultant psychiatrist can request Garda assistance and the Gardaí are obliged to comply with the request. As discussed above independently, the Gardaí are also empowered to remove a person under s. 12 but the powers granted to the Gardaí in s. 12 are not applicable to approved centre staff and authorised persons.

In *MZ v Khattak and Tallaght Hospital Board* [119] the concerned person's brother was the applicant for the recommendation for admission, but the Gardaí arranged the removal to hospital as he was in custody at the time. Peart J was satisfied it followed s.13 and although the person's brother did not instigate the removal or organise the ambulance, this was of no material significance as he was present in the Garda station. Wrongful removal was raised again in *EF v Clinical Director of St. Ita's Hospital* [120] where allegations of unlawfulness were not being considered, instead the applicant was seeking declarations that the removal was not in accordance with s.13(2) and that the clinical director had acted *ultra vires* of those powers by having her restrained and removed to hospital by persons who were not staff of the hospital. The HSE had engaged a service for assisted admissions by a private company known as Nationwide Health Solutions Limited. The judgment was delivered more than two years from the time of the detention so that the applicant had been discharged. The applicant's description of her forcible removal to hospital following her exit from a restaurant was that she was "man-handled" into a car, suffered bruising and those involved did not identify themselves or explain

[115] RL [2008] IEHC 11.
[116] Ibid, at page 302.
[117] Ibid, at pages 5-6.
[118] Ibid, at pages 8-9.
[119] MZ [2008/9] IEHC 262.
[120] [2009] IEHC 253

where she was going. The issue was whether the assisted admissions team were "staff" of the approved centre as required by the Act. The court held that although "staff' is not defined in the Act it is a question of fact as to whether someone is a member of staff. Also, the corporate entity, Nationwide Health Solutions, was addressed as to whether the corporate entity contracted by the HSE to effect assisted admissions could come within that definition in s.13(2). The Court held that a corporate entity could not be a member of staff and the people provided by that entity were at all material times staff of that entity and not staff of the approved centre. Following this decision s.63 of *the Health (Miscellaneous Provisions) Act 200*9 was enacted to amend s.13(2), to avoid retrospective challenges where these independent contractors were used and inserted a new s.71A into the Act. It provides that the registered proprietor of the approved centre is enabled to enter arrangements with a person for the purposes of arranging for persons, who are the staff of that person, to provide services under s.13 for the removal of persons to the centre and bringing persons back to the centre under s.27. The clinical director may authorise the staff of that person to provide services for up to 12 months, referred to as "authorised persons". Prior to the amendment of s.13(2) to provide for the "authorised persons', apart from the Gardaí, only staff of the approved centre were authorised to do so under s.13(2). The Commission has no apparent supervisory role or standard setting role with "authorised persons" carrying out such sensitive work.

S.13 is now titled transfer of persons to approved inpatient facilities. In the Heads of Bill, the term removal as currently enacted in the 2001 Act is replaced with the term "transfer" as this is seen to be more person-centred. S.13 has also been amended to reflect that only AOs will be eligible to make an application for involuntary admission. The Heads of Bill in s.13(2) now requires that where the AO is unable to arrange for the transfer of the person concerned, they shall contact the clinical director of the approved inpatient facility specified in the recommendation or a consultant psychiatrist acting on their behalf, who will arrange for the transfer of the person to the approved inpatient facility by members of the staff or authorised persons of the approved centre inpatient facility as soon as practicable, but not later than 12 hours after being contacted. In the Heads of Bill s.71A (transfer of persons and bringing back of persons to approved inpatient facilities by authorised persons) is moved from Part 6 and is now numbered as s.13A.

Significant human rights concerns have been raised in respect of the powers conferred on Gardaí and others authorised persons to force persons subject to the 2001 Act to approved centres. Amnesty International Ireland in their research on the 2001 Act reported that the "involvement of Gardaí can add significantly to the distress experienced by the individual, who is already in a vulnerable state".[121] This is evident in circumstances where Gardaí arrive to a person's home in a marked Garda car, or where an admission takes place in public. This statement from a person with lived experience also illustrates the human rights issues involved:

> "When I became unwell … an ambulance, two police and a swarm of psychiatric nurses and ambulance staff arrived at my house, even though I had not endangered my own life or those around me. I was carted off to the local hospital which never would have been my hospital of choice. When I got there, I was made 'voluntary', the Mental Health Commission were not informed of my detention … I was not allowed speak to my boss to try and salvage my job, so I lost my temporary job and (nearly 4 years down the road) I have lost my career … My experience with psychiatry was a very negative one. It nearly destroyed me. I am trying hard to bounce back from the trauma of it all … My mental health has been severely damaged by

[121] Amnesty International Ireland, "Mental Health Act 2001: A Review" (Dublin: Amnesty International, 2011), at pages 95-96

the experience. It was only by meeting or connecting with doctors I can trust that I saw a future."[122]

The lived experience of persons of these provisions are of concern from a human rights perspective as it denies the person's right of the person to dignity, bodily integrity, privacy, and autonomy as provided for in the Guiding Principles in s.4(8)(b) in the Heads of Bill. There is a concern that Gardaí are not sufficiently trained in relation to assisted admissions and there is a lack of transparency around the use of independent contractors in assisted admissions.

Assisted admissions should be handled in a very sensitive manner without force to avoid additional trauma for the person. Everyone involved in the assisted admissions process (including independent contractors) should be required to undertake training in human rights and de-escalation techniques and obligated to use alternatives to coercion during the admission. Trained independent advocates should also be involved. The authors recognise that admission is a very distressing experience for the person, which can cause long term trauma such as PTSD. Vehicles used in assisted admissions should be unmarked to avoid long term stigma for persons. There should be a requirement that only trained people, trusted supporters are involved, and Gardaí and independent contractors are only used in exceptional circumstances. The authors welcome the provision in s.12(7) requiring the creation of Code of Practice on the functions of the Garda Síochána under the 2001 Act. Similarly, we welcome s.13A(6) in the Heads of Bill, stating that the MHC will issue a code of practice in relation to the requirements for assisted admissions to approved inpatient facilities in s.13, s.27 and s.94. We consider 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. We also recommend that Gardaí and independent contractors involved in assisted admissions under the 2001 Act be required to undertake human rights training.

10.1 Recommendations:

Based on the forgoing discussion and analysis of the Heads of Bill we make the following 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, s13 and s13A.
- 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.

[122] Fiona Morrissey "The introduction of a legal framework for advance directives in the UN CRPD era: The views of Irish service users and consultant psychiatrists" (Ethics, Medicine and Public Health Volume 1, Issue 3, July–September 2015, 325-338).

- There should be a requirement that only trained people, trusted supporters are involved, and Gardaí and independent contractors are only used in exceptional circumstances.

10.2 Section 13B Transfer of persons to emergency department

It appears from the explanatory notes in the Heads of Bill that the DOH decided not to implement ERG recommendations 44-47. However, draft text is provided in relation to the transfer of persons subject to the legislation to emergency departments. The authors would welcome clarification in relation to this provision in the Heads of Bill. The authors have concerns about that appropriateness of emergency departments for persons experiencing a mental health crisis. Some experts by experience have advocated for a dedicated emergency department service for persons experiencing mental distress. There is a need for co-ordination between the facilities for mental and physical mental health and the relevant health professionals. It is essential that the views of the person who is experiencing mental distress as to where they would prefer treatment is respected. The person should be offered treatment in an appropriate environment, and there needs to be some automatic review mechanism to ensure that persons in mental distress are not left languishing in emergency departments or other inappropriate facilities, which may be detrimental to their well-being.

10.3 Recommendation

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

11. Mental Health Review Boards

Mental Health Tribunals (MHT) as provided for in the 2001 Act are impartial bodies, have a judicial character and are independent both of the executive and the parties to a particular hearing. They carry out independent reviews of the lawfulness of involuntary detention at specified periods of time as required by the European Convention on Human Rights. One of the supposed benefits of having these powers exercised by this type of body is that they can operate in a less complicated and accessible manner than a court. The decisions made by MHT on admission and renewal orders include the power to affirm or revoke orders in addition to the power to refuse the transfer of a person to the Central Mental Hospital and to review proposals for psychosurgery under the 2001 Act. It is important to note that MHTs do not have any statutory powers relating to the treatment and do not have any oversight of the use of medication or ECT.

From a human rights perspective the role of MHTs is an essential safeguard for persons subject to the 2001 Act, providing an independent process that reviews the legality of the persons loss of liberty. However, a recent systematic review of the international literature has highlighted significant issues with tribunals, indicating that MHTs can further deny human rights, legitimise coercion and restrict access to justice.[123] The systematic review identified that the participatory potential of MHTs can be undermined by medicalised and legal cultural practices, that dictate and dominate their proceedings.[124] There is also a lack of meaningful involvement of the persons in MHT hearings, resulting in a sense of "powerlessness" and "procedural unfairness", which requires a cultural change to ensure MHTs comply with international human rights law.[125] This research reflects the experience of MHTs in Ireland, which will be discussed below.

The ERG was emphatic in its support of the MHTs. However, it identified a number of areas where the provisions in the 2001 Act could be improved to better safeguard the persons rights. The ERGs recommendations relating to title and power, timing, composition, attendance, role of the independent psychiatrist and oversight will be discussed here. There is a further discussion of MHRBs as provided for in the Heads of Bill in light of international human rights law and other considerations. However, the authors are concerned that the amendments provided for in the Heads of Bill are insufficient in safeguarding the rights of persons detained under the 2001 Act.

The ERG recommended that Mental Health Tribunals should be renamed "Mental Health Review Boards".[126] This recommendation was suggested by persons who have lived experience of the mental health legislation who were unhappy with the term MHT. This recommendation has been given effect in the Heads of Bill and s.16A is now titled "Mental Health Review Boards". The ERG acknowledged that respondents to their consultation suggested that the role of the MHTs should be expanded to cover treatment. However, the ERG decided that decision-making about treatment should continue to be vested with the multi-disciplinary mental health team. However, the ERG did recommend that the MHRB should have the authority to establish whether there is an individual care plan in place and if it is compliant with the law.[127] The ERG also recommended that MHRBs should also establish that the views of the person as well as those of the multi-disciplinary team were sought in the development of the care plan.[128] This recommendation do not appear to have been implemented in the Heads of

[123] Aisha Macgregor, Michael Brown & Jill Stavert "Are mental health tribunals operating in accordance with international human rights standards? A systematic review of the international literature" (Health Soc Care Community: 2019, 27, 494–513).
[124] Ibid.
[125] Ibid.
[126] Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), recommendation 50.
[127] Ibid, recommendation 51.
[128] Ibid, recommendation 52.

Bill. The authors recommend that 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. 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 the MHRBs can respond directly and meaningfully to failures and shortcoming raised by the person, their legal representative or advocate in respect of the delivery of care plans.

The ERG recommended that the person's detention must be reviewed by a MHRB no later than 14 days after the making of the admission order or renewal order concerned.[129] S.18 of the Heads of Bill relates to review by a review board of admission orders and renewal orders and intermediate admission and intermediate renewal orders. S.18(3) implements the ERG recommendation in respect of the period of review. It provides that the MHRB will review the detention (admission order or a renewal order or an intermediate admission order or an intermediate renewal order) not later than 14 days after the making of such order.[130] The authors welcome the implementation of this recommendation in the Heads of Bills as it enhances the safeguards in respect of persons subject to the legislation. In the explanatory notes the MHC informed the DOH that the move from 21 days to 14 days will require additional resources with cost implications. It is essential that logistical and resourcing requirements do not impede the implementation of this recommendation. S.16A(6) now provides that persons nominated as members of the Seanad, persons elected to either House of the Oireachtas the European Parliament, or those elected or co-opted as a member of a local authority are not eligible to sit on a MHRB. The authors welcome the inclusion of this provision in the Heads of Bill.

In relation to attendance at hearings the ERG recommended a legal right to have a MHRB deferred for specified periods (2 periods of 14 days) if the person so chooses.[131] Such deferral would have to be sought through the person's legal representative. S.18(5) of the Heads of Bill now provides for this. The authors welcome this amendment and believes that the flexibility that this affords the person is positive in preparing for a MHRB hearing.

The ERG also recommended that both the person's legal representative and the responsible treating clinician must attend a MHRB.[132] S.16B(6)(a) has been amended in the Heads of Bill and now provides that the MHRB will make provision to notify the consultant psychiatrist to attend the review board at the time and date prescribed by the Commission. Similarly, s.16(6)(c) of the Heads of Bill provides that the MHRB make provision to notify that the attendance of the legal representative at the review board, save where the person has specifically requested that the legal representative not attend, or the person has instructed their own private solicitor to attend the MHRB. The authors do not think the wording in s.16B sufficiently implements the ERGs 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 ERG further recommended that the following persons may attend the MHRB: the person who has the right to attend; an advocate if so, invited by the person, the independent psychiatrist who undertook pre MHRB assessment if requested by the Board, the author of the psychosocial report or if they are unable to attend, another member of the multi-disciplinary team may attend on their behalf

[129] Ibid, recommendation 53.
[130] S.18(3)(b) provides that in the case of an application referred to in s.15(3)(b), not later than 14 days after the date on which the Commission received the application.
[131] Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), recommendation 57.
[132] Ibid, recommendation 58.

if requested by the Board.[133] S.17(1)(c) of the Heads of Bill seeks to implement this recommendation. The ERG made recommendations for changes to the provisions governing the role of independent psychiatrist in light of other recommendations such as reducing the period of time for MHRB hearings to take place (14 days). Therefore, the ERG recommended that the person's detention must be subject to an assessment report by an independent Psychiatrist with input (to be officially recorded) from another Mental Health Professional of a different discipline to be carried out within 5-7 days of the Review Board hearing.[134] The ERG also recommended that the 2001 Act be amended to specify a range of mental health professionals that the independent psychiatrist must consult in preparing the assessment under s.17, although the ERG did not specify which professionals should be included.[135] The ERG further recommended that a psychosocial report should also be carried out by a member of the multi-disciplinary team from the approved centre who is registered with the appropriate professional regulatory body (i.e. CORU, Nursing and Midwifery Board or Medical Council) in the same timeframe as the report from the independent psychiatrist and this report should concentrate on the non-medical aspects of the persons circumstances.[136]

S.16A(7) in the Heads of Bill now provides that member of a panel from which a person is appointed to a review board or as an independent consultant psychiatrist shall hold office for such period not exceeding 5 years and on such other terms and conditions as the Commission may determine when appointing them.[137] This increases the term from 3 to 5 years. The authors have concerns about the extension to 5 years. There is concern about the effectiveness of the independent consultant psychiatrist safeguard given the small size of the Irish health system. The authors understand that the independent consultation psychiatrist rarely (if never) disagrees with the responsible consultant psychiatrist (RCP) recommendations in relation to detention. The authors consider that a three-year term is appropriate. The authors recommend that the MHC be required to publish data on the functioning and decision-making of the independent consultant psychiatrist.

S.17(1)(d) provides that the Commission shall direct in writing a member of the panel of consultant psychiatrists to examine the person concerned, interview, either in person, or remotely, the consultant psychiatrist responsible for the care and treatment of the person and one other mental healthcare professional, other than a registered medical practitioner, that is involved in the care and treatment of the person, and review the records relating to the person, in order to determine whether the person fulfils the criteria for detention. They are required to report in writing on the results of the examination, interviews, and review to the review board and to provide a copy of the report to the legal representative of the person. This report must be completed and submitted to the Commission no later than 3 working days prior to the review board hearing. S.17(5) of the Heads of Bill provides that the consultant psychiatrist responsible for the care and treatment of the person may submit a report to the review board and such report shall be submitted to the Commission no later than 3 working days prior to the review board hearing. The authors consider that it would be beneficial to get the report nearer to the Tribunal 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 we recommend that the RCP should be required to submit report at least 3 hours before Tribunal hearing.

In relation to the oversight of the MHRBs the ERG recommended that the revised legislation should provide for the oversight of the integrity of the process of Review Boards by the Mental Health Commission in line with best practice.[138] The ERG envisaged that this oversight would include a

[133] Ibid, recommendation 59.
[134] Ibid, recommendation 61.
[135] Ibid, recommendation 62.
[136] Ibid, recommendation 63.
[137] S.33(3)(b) of the Heads of Bill provides for a panel of consultant psychiatrists to be established.
[138] Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), recommendation 64.

mechanism to allow information in relation to decisions of Review Boards to be published in anonymised form that would ensure confidentiality for the person and would facilitate decisions to be available for the Mental Health Commission and/or the public to view.[139] S.16B(14) of the Heads of Bill now makes provision that the Commission will publish on its website appropriately anonymised versions of the decisions of review boards on a quarterly basis. The authors welcome this amendment and hopes that the data published will increase scrutiny, transparency of the work of MHRBs and facilitate greater assessment of the effectiveness of the work of MHRBs in discharging their statutory obligations. We 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.

In relation to the issue of composition of the MHRBs the ERG did not think it necessary to change the current composition as provided for in the 2001 Act.[140] This is reflected in the Heads of Bill with the current membership retained in s.16A(3). It was recommended that the "other person" appointed to the MHRB should be known as the "community member" and the person appointed to this role should not be or never have been a Medical Practitioner, Nurse or Mental Health Professional, Barrister or Solicitor in the State or in another jurisdiction.[141] The authors believe this provision should be strengthened by expressly excluding 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.

S.16A(4) provides that a sitting of a MHRB, each member of the board shall have a vote and every question shall be determined by way of a majority vote. This provision underscores the equal importance of the perspective and experiences of each member. The authors are concerned that there is scope for a hierarchical dynamic to take place within tribunals/boards given that there is different remuneration offered to different categories. The authors understand that consultant psychiatrists receive a higher fee, followed by practising barristers / solicitors and then by lay members. Amnesty International Ireland in its research on the 2001 Act reported that in respect of tribunals the consultant psychiatrist was seen as holding "the balance of power at tribunals".[142] One participant reported that during training for lay tribunal members, it was made very clear to them that the layperson should prioritise the reports of the consultant psychiatrists.[143]

The authors understand that in deciding whether to affirm or revoke the order, the Tribunal psychiatrist is generally asked for their opinion first. In evidence before the tribunal, the RCP is almost always asked to submit their evidence before the person detained has an opportunity to speak. In some cases, the person wants to speak first, but is told to wait until the RCP gives their evidence. The authors recommend that the format of MHRBs change so that the person is placed at the centre and given precedence to speak before any other persons attending the hearing. Additionally, the authors consider 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(3)(b) provides that the member of the MHRB who works as a practicing solicitor or barrister shall be the Chairperson of the MHRB. The authors have similar concerns that the exclusion of the community member in the legislation from acting as the Chairperson. Given that the MHC provides training for all members of tribunals, the authors do not see any reason why community members cannot be permitted to

[139] Ibid, recommendation 65.
[140] Ibid, recommendation 54.
[141] Ibid, recommendation 56.
[142] Amnesty International Ireland, "Mental Health Act 2001: A Review" (Dublin: Amnesty International, 2011), at page 260.
[143] Ibid.

undertake the role of chairperson of MHRBs. S.16A(c) should be amended to permit community members to undertake the role of Chairperson.

S.16B(9) amends the existing text of the 2001 Act, which provides that sittings of a tribunal for the purposes of an investigation by it under this Act must be held in private. S.36B(9) now provides that the MHRB shall exclude during the sitting of the review board all persons except persons directly concerned in the review board and such other persons (if any) as the board may in its discretion permit to remain. The authors welcome provision in the Act for an advocate to attend MHRB meetings as this is important from an access to justice perspective and maximising the opportunities for the person to engage with this important safeguard in reviewing the legality of their detention.

S.16B(13) provides that a review board may meet remotely with the agreement of the person who is the subject of the review. It further provides that in the case of a person who lacks the capacity necessary to make this decision but has a relevant decision-making support within the meaning of the 2015 Act, then the review board may still meet remotely provided the relevant decision-making support consents. If the person who is the subject of the review lacks both the necessary capacity and a relevant decision-making support, the review board should meet in person. The authors welcome the inclusion of this provision in the Heads of Bill. The recent public health measures have meant that MHTs have been able to undertake their work remotely and that tribunal members and persons subject to the 2001 Act have been able to participate effectively in the virtual forum. We 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.

The 2001 Act provides the right to legal representation for all persons in relation to MHT hearings. However, it was not clear if the role was broader than solely representation at MHTs. The Court referred to this role in *EJW v Clinical Director of St. Senan's Psychiatric Hospital & Mental Health Commission* and held "the patient has legal representation from the moment that the Commission appoints the legal representative and that the patient's legal representative is acting on behalf of that patient, not simply in relation to the hearing of the review which could be more than two weeks away but generally in order to protect the patient's interests".[144] S.16C contains a new provision on the provision of information to legal representatives. S.16C(1) provides that the legal representative assigned to represent a person, or as the case may be the legal representative otherwise engaged by a person, on either a Review Board or on an appeal to the Circuit Court, is entitled to access to the person's records, provided the person gives their consent. S.16C(2) provides that where persons have been assessed not to have capacity to consent, the provisions of the 2015 Act will apply. The authors welcome this inclusion in the Heads of Bill in bringing greater clarity to the issues raised in the *EJW* case.

S.16B(6)(e) of the Heads of Bill provides that the MHRB ensure that a person is aware that they are not obliged to attend a MHRB. The existing provisions on the powers of tribunals in s.49(11) of the 2001 Act, states that a person shall not be required to attend before a tribunal if, in the opinion of the tribunal, such attendance might be prejudicial to their mental health, well-being or emotional condition. The authors have serious concerns about s.49(11) of the 2001 Act as it currently operates. The authors welcome the deletion of s.49(11) in the Heads of Bill. S.16B(6)(d) requires an approved inpatient facility and/or MHRB to ensure all relevant supports are provided to a person to enable their attendance at the relevant sitting of the review board. This includes the attendance of the person's advocate if they have engaged one and if they so request. It also enables the person to present their case to the review board in person or through a legal representative. The authors welcome recognition of an advocate to attend the MHRB if the person so wishes. However, we are concerned

[144] EJW [2008] IEHC 462, at page 26.

about the inadequacy of independent advocacy for persons subject to the 2001 Act as provided for in the Heads of Bill. This will be discussed in greater detail below. The authors recommend that where a person decided not to attend the hearing, they would be entitled to nominate an independent advocate and/or trusted supporter to attend and participate in their absence.

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

As discussed above we welcomed many of the ERG's recommendations on reform of MHTs as they relate to the title and power, timing, composition, attendance, role of the independent psychiatrist and oversight. However, the recommended reforms do not go far enough in supporting and safeguarding the rights of persons subject to the mental health legislation. These recommendations are insufficient to make the current tribunals effective in vindicating the rights of persons subject to the 2001 Act.

The current MHT process does not adequately protect the human rights of persons admitted under the 2001 Act. Less than 12% of admission orders are revoked at hearing.[145] Tribunal composition is heavily weighted towards the medical model and professional opinion with little or no multi-disciplinary or advocacy input. The Tribunal decision is highly deferent to the evidence of the responsible consultant psychiatrist, the report of the independent consultant psychiatrist and the opinion of the tribunal consultant psychiatrist. The opinion of the independent consultant psychiatrist or tribunal consultant psychiatrist rarely deviates from that of the treating responsible consultant psychiatrist and does not provide meaningful independent input. The "will and preferences" of the person have little bearing on Tribunal members decision in affirming or revoking the admission or renewal order, and presumptions of incapacity are common. The remit of the Tribunal is limited to considering whether the person meets the definition for mental disorder as set out in the legislation. The Tribunal remit needs to be expanded to consider issues such as the "will and preferences" of the person in relation to their admission, detention, care, and treatment. If a person wishes to be treated on a voluntary basis without coercion, this wish should be respected, and a system of supports should be put in place to enable a person to be treated in a less restrictive manner regardless of capacity or insight. In Scotland, the tribunal must consider the content of the person's AHD when making decisions. The person should have access to the support of an independent advocate (outside of legal representation). While it is welcome that the Heads of Bill proposed to permit an advocate to attend hearings, the provision for independent advocacy services is not sufficiently provided for in the Heads of Bill (this is discussed in greater detail below). The composition of the Tribunals should be reviewed to include more multidisciplinary, and advocacy input and to place the "will and preferences" of the person rather than medical evidence at the centre of the process. All tribunal members should receive training and education on human rights under the CRPD to provide a greater understanding of the impact of coercion, and the need to move towards an alternative system of supports, which places the "will and preferences" of the person at the centre of all MHRB decisions.

The qualitative research exploring service user's experiences of mental health tribunals indicates the need for greater support.[146] Service users have described their experiences as follows:

> "a deficit in emotional support at perceived critical time points, including their initial transfer to hospital and before, during, and after their tribunal. In particular, participants who were physically restrained … during their transfer to the hospital recalled that the absence of a

[145] Mental Health Commission, Mental Health Tribunal Statistics. Available at: https://www.mhcirl.ie/what-we-do/mental-health-tribunals/mental-health-tribunal-statistics/mental-health-tribunal

[146] "Service users' experiences of mental health tribunals in Ireland: a qualitative analysis" (Irish Journal of Psychological Medicine, 2017, 34(4):1-10.

familiar person was extremely disconcerting and frightening at this time... A small number of participants … also described feeling scared and anxious about their upcoming mental health tribunal and its potential outcome and described feeling like they had no one to talk to or support them at this time... Whilst this was not the experience of all participants, these participants spoke of the need to have someone to explain the process, help them feel part of the process and someone to talk to about the tribunal process".[147]

11.2 Recommendations:

Based on the forgoing discussion and analysis of the Heads of Bill the authors make the following 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 the 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 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 ERGs 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 RCP 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.

[147] Ibid.

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12. New Part 4 Requirements for Consent to Treatment

The authors note that a number of the recommendations of the ERG have been partially implemented by way of the *Mental Health (Amendment) Act 2015*, which is to be welcomed. However, significant additional changes are needed to the 2001 Act to bring it into compliance with international human rights law. Part 4 of the Heads of Bill provides in s.56 a definition for consent, s.57 details the circumstances where treatment not requiring consent is permitted, s.58 on psycho-surgery is to be deleted, s.59. sets out the regulation of the use of electro-convulsive therapy, s.60 regulates the administration of treatment and s.61 treatment of children has been moved to Part 8 of the Heads of Bill. The discussion below will consider the proposed amendments to Part 4 as contained in the Heads of Bill. The DOH's general comments on Part 4 of the Heads of Bill indicate that s.56, s.57 and s.57A are to be divided into 4 categories.[148] However, the Heads of Bill document does not contain a section numbered s.57A. The general comments also note the intention of the Heads of Bill to ensure that a consultant psychiatrist cannot override the decision of a Decision-Making Representative, Attorney or Designated Healthcare Representative where they have relevant power to decide. We will now discuss these provisions in the Heads of Bill and provide context as to the operation of these provisions under the 2001 Act.

12.1 Definition of Consent to Treatment

Part 4 of the Act contains provisions relating to consent to treatment. The provisions relating to consent to treatment in mental health services are amongst the most controversial in mental health legislation. S.56 in the 2001 Act as currently enacted outlines the definition of consent to treatment. It is linked with s.4, in particular s.4(3). As the legislation currently stands s.4(3) provides that in deciding under the 2001 Act about the care or treatment of a person, due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy, and autonomy. Dignity, bodily integrity, privacy, and autonomy are constitutional rights that also apply to persons subject to the 2001 Act. However, the provisions currently set out in Part 4 are insufficient in safeguarding the rights of persons subject to the legislation.

Consent must be obtained freely without threats, or inducements and the consultant psychiatrist responsible for the person must be satisfied that the person understands the nature, purpose, and likely effects of the treatment. In addition, the consultant psychiatrist is required to give the person adequate information in a form and language that they understand the nature, purpose, and likely effects of the proposed treatment. This section imposes a statutory obligation on the consultant psychiatrist to ensure the person understands the issues involved with the proposed treatment.

The available research has reported difficulties with the provision in information to persons detained under the 2001 Act. A qualitative study of service users' views across the entire trajectory of their involuntary detention under the 2001 Act identified a number of factors that require action to reduce the negative impact of involuntary admission on the person subject to the legislation.[149] The qualitative data identified a number of themes in the experience of service users, which included "feeling trapped and coerced", a "lack of emotional and informational support", and "admission induced trauma".[150] The researchers concluded that to address the issues identified there was a need

[148] See the Heads of Bill document, at page 160.

[149] See Rebecca Murphy R, David McGuiness Emma Bainbridge, Heike Felzmann, Liz Brosnan, Mary Keys, Kathy Murphy, Brian Hallahan, Colm McDonald, Agnes Higgins "Service users' experiences of involuntary hospital admission under the Mental Health Act 2001 in the Republic of Ireland: highlighting the need for person-centred care" (Psychiatric Services in Advance: 2017 Nov 1;68(11):1127-1135).

[150] Ibid. The analysis of the data resulted in the following themes: "Feeling trapped and coerced", "lack of emotional and informational support", "admission induced trauma" and "person-centred encounters".

for a "multi-faceted strategy inclusive of ongoing education and training of all stakeholders in the principles and practices of person-centred care, the provision of repeated and accessible information and emotional support to service users during distinct stages of involuntary admission, as well as a shift in culture to one that minimises the traumatic impact of forced detention on peoples' psychological well-being". [151] The MHC's Code of Practice emphasises the importance of the "active involvement" from "admission to discharge of a resident and their family/carer or chosen advocate, where appropriate (with the consent of the person) including the provision of adequate information".[152]

S.56 when enacted was considered positive as it marked a significant contrast with the 1945 Act which did not include the word "consent" in the legislation. Before the 2001 Act it was presumed that treatment could be given legally under the common law doctrine of necessity. One of the significant issues with s.56 is that there is no test of capacity to consent included, which is unfortunate it has been argued that this could have served to safeguard the person's rights in respect of treatment administered under the 2001 Act. This has been addressed in the Heads of Bill and will be discussed below. In the absence of a statutory definition the relevant case law on consent to medical treatment is important in informing this Part of the 2001 Act. As such the courts have been called upon to address this gap.[153]

As discussed above s.3 of the 2015 Act provides that a person's capacity is to be construed functionally. S.3(1) explains that this involves "a person's capacity shall be assessed on the basis of his or her ability to understand, at the time that a decision is to be made, the nature and consequences of the decision to be made by him or her in the context of the available choices at that time".[154] As discussed above the Heads of Bill has sought to align the approach in the 2015 Act with the amending legislation. The approach to assessing capacity to consent in the 2015 Act places an emphasis on supporting the person to make decisions and to safeguard a person's decision-making. S.3(3) of the 2015 Act provides that a person cannot be regarded as unable to understand the information relevant to a decision if they are merely unable to understand an explanation of it and the use of clear language, visual aids or any other means of communication is required. S.3(4) provides that if the person can retain the information relevant to a decision for a short period only, this does not prevent them from being regarded as having the capacity to make the decision. S.3(5) provides that where a person lacks capacity in respect of a decision on a particular matter at a particular time, this does not prevent them from being regarded as having capacity to make decisions on the same matter at another time. S.3(6) provides that where a person lacks capacity in respect of a decision on a particular matter, this does not prevent them from being regarded as having capacity to make decisions on other matters. S.3(7) provides that information relevant to a decision shall be construed as including information about the reasonably foreseeable consequences of each of the available choices at the time the decision is made or failing to make the decision. Therefore, s.3 of the 2015 Act effectively seeks to provide a more robust process aimed at supporting the decision-making of persons who come under the scope of the legislation.

However, the issue of consent of persons subject to the 2001 Act has remained regulated by Part 4 of the 2001 Act. S.136(1) of the 2015 Act provides that nothing in that legislation authorises a person to give treatment for mental disorder, or to consent to being given treatment for mental disorder, if, at the time when it is proposed to treat the person, their treatment is regulated by Part 4 of the 2001

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[151] Ibid.

[152] "Mental Health Commission Code of Practice: Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, Issued Pursuant to Section 33(3)(e) of the Mental Health Act, 2001" (Dublin: Mental Health Commission, September 2009).

[153] In a case called *Fitzpatrick v FK (No. 2)* [2008] IEHC 104 Laffoy J in this case developed a test to be used in determining whether a person had the capacity to consent or refuse medical treatment (this case did not relate to the 2001 Act).

[154] See s.3(1) of the *Assisted Decision-making (Capacity) Act 2015*.

Act. The Report of ERG recommended that autonomy and self-determination should be included in the set of guiding principles in revised mental health legislation.[155] The ERG considered that these were key principles to inform the interpretation of s.56 and s.57 of the 2001 Act relating to consent to treatment. As discussed above consent under Part 4 applies only to involuntary persons. The consent of a voluntary person is dealt with under the relevant common law rules on consent as they apply to other types of medical treatment. Under the relevant common law, a voluntary person has an unqualified right to refuse treatment. However, as the ERG noted "this is not always clearly understood by or clearly articulated to mental health service users on admission".[156] To address the lack of clarity the ERG recommended that the 2001 Act be amended specifically to provide for the right of voluntary persons to refuse treatment.[157] In addition, the ERG recommended that any such revised legislation should explicitly provide that all persons (voluntary and involuntary) must give informed consent to treatment and be advised about the support available to them under the new capacity legislation to make informed decisions regarding their treatment. The ERG also recommended that consent as defined in s.56 should be amended to acknowledge that consent can also include consent given by a person with the support of a family member, friend or an appointed "carer", "advocate" or support decision maker appointed under what has now become the 2015 Act.

In the Heads of Bill Part 4 of the Act has been retitled "requirements for consent to treatment". The authors welcome the change in the title of this part of the legislation as it highlights that requirements need to be met before treatment can be administered. S.56 appears to have been renamed "definition" and seeks to align the 2001 Act with the 2015 Act. S.56(1) provides that consent must be obtained by a mental healthcare professional before commencing any treatment for a person, save where expressly provided for in the legislation. S.56(2) provides that in order for a person to "consent" to any treatment the following criteria must apply:

(a) a person must have capacity as defined in s.3 of the 2015 Act,
(b) all relevant information in relation to the treatment must be provided to the person in accordance with s.3 of the 2015 Act, and
(c) consent for any treatment must be voluntary.

S.56(3) provides that a person may withdraw their consent to any treatment at any time. S.56(4) states that it shall be presumed that every person has capacity to give their consent to, or to refuse, treatment unless the contrary is shown in accordance with the provisions of s.3 and s.8 of the 2015 Act. S.58(5) provides that where the responsible consultant psychiatrist reasonably considers that a person may lack capacity to consent to or refuse treatment, then a capacity assessment shall be carried out by the consultant psychiatrist responsible for the persons care and treatment, or they can arrange for another mental healthcare professional on the multi-disciplinary team to carry out the assessment, and the details recorded in the person's clinical file.

S.56(6) provides that where the consultant psychiatrist responsible for the care and treatment of the person, or other mental healthcare professional, concludes that the person lacks capacity to consent to, or to refuse, treatment, then they must arrange for the person to be examined by a second mental healthcare professional, who is not involved in the care and treatment of the person concerned, and who is not a spouse or relative of the person. S.56(7) further provides that if both mental healthcare professionals are of the view that the person lacks capacity to consent to or refuse treatment, then the person shall be deemed to lack capacity. S.56(8) provides that where the second mental healthcare professional finds that the person does not lack capacity, then the person shall be deemed

[155] Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), at page 56.
[156] Ibid.
[157] Ibid, at page 59.

to have capacity. S.56(9) requires that capacity assessments carried out under s.56(5) and (6) subsections (5) should be recorded in the person's clinical file. S.56(10) states that the person or a person nominated by them are entitled to copies of all of the assessment carried out in relation to their capacity. S.56(11) further provides that a person in deciding on their treatment, can consult with a person or persons of their choosing prior to making the decision, including family, carers, or their advocate. Finally, s.56(12) provides that the MHC will prepare and publish a Code to govern capacity assessments.

The authors welcome the amendments to s.56 of the 2001 Act as provided for in the Heads of Bill. The lack of a definition as discussed above has been problematical in practice. However, the authors are concerned that while s.56 seeks to align the 2001 with the 2015 Act, the current text will not be sufficient to deliver upon the requirements of the CRPD as discussed above. The text of s.56 is focused upon the process for assessing whether a person has mental capacity with insufficient detail on how the person should be supported in the exercise of their legal capacity. S.56 should include a requirement to provide support to persons subject to the 2001 when their capacity is called into question. 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 in 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.

As discussed above s.56(11) provides that a person in deciding about their treatment under this Act, can consult with a person or persons of their choosing prior to making the decision, including family, carers, or their advocate. However, the authors recognise that family and carers may not be appropriate supporters in some situations. It is important that person include a nominated designated healthcare representative in their AHD. We do not consider this provision sufficient in supporting persons whose capacity to make decisions has been questioned. A right to independent advocacy will be discussed below, the provision of which is an essential support for the person in making decisions about treatment and engaging with an assessment of their capacity. The authors consider that it is essential that s.56 explicitly provides that a person's advocate and other support persons should be involved in the capacity assessment if the person so wishes.

12.2 Recommendations:

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

12.3 Treatment Not Requiring Consent

S.56 of the 2001 Act sets out the definition for "consent" while s.57 of the 2001 Act details the circumstances where treatment can be given to a person without their consent. As things currently stand where the consultant psychiatrist believes it is necessary to save the life of the person, or to restore health, alleviate the condition, relieve suffering, and the person is incapable of consenting due to the mental disorder, then treatment can be given without consent. This provision in s.57 is broad in scope and is certainly broader than the common law doctrine of necessity. This provision vests significant responsibility and power with the relevant consultant psychiatrist in deciding whether a person has capacity to consent to treatment. Additionally, the consultant psychiatrist effectively acts as a substitute decision-maker for the person following their determination that they lack the capacity to decide about their treatment. S.57 has been criticised for inadequately protecting the rights of persons subject to the 2001 Act.[158]

The inadequacy of s.57 has been highlighted in the case law on the 2001 Act. In *M.X. v HSE*[159] the applicant a person involuntarily detained under the 2001 Act argued that her treatment under s.57 of the 2001 Act and this provision was repugnant to the Constitution, incompatible with the European Convention on Human Rights and failed to have due regard for the provisions of CRPD. However, the High Court in this case decided that s.57 did not apply in relation to forms of treatment specified in s.60 of the 2001 Act. S.60, which will be discussed below deals with a position where it is necessary to administer medicine for a continuous period of time. MacMenamin J concluded that the provisions of s. 57(1) were not engaged in this case.[160]

As mentioned above s.57 of the 2001 Act effectively provides that in certain circumstances the right of involuntary persons to refuse treatment can be overridden by a relevant consultant psychiatrist. It is important to note that a person who is involuntarily detained has the same right to refuse treatment as individuals admitted on a voluntary basis unless they are found to lack capacity to consent. The difficulty is that most people admitted on a voluntary basis are found to lack capacity to consent, so their treatment refusal is overridden. The ERG was critical of s.57, acknowledging several difficulties with its operation from a human rights perspective, mainly in that the consultant psychiatrist who makes treatment decisions is also the person who decides if the person has the capacity required to give or refuse consent to proposed treatment in the first instance. The ERG considered this conflict in s.57 as "unsatisfactory as currently constructed".[161] The ERG also acknowledged that since Part 4 of the 2001 Act was commenced the "examination" of a person to determine their capacity has been "less transparent than it should be and that any such consideration of capacity effectively has always been subject to the Consultant Psychiatrist's right to make a decision on treatment where the person lacks capacity".[162]

S.56 and s.57 now sharply contrast with the corresponding provisions on capacity as contained in the 2015 Act. Under the 2015 Act the presumption of capacity to make decisions regarding treatment and care are clearly expressed as a guiding principle underpinning the legislation. As such the authors welcome the amended text in the Heads of Bill and the intention to align the 2001 Act with the 2015 Act and the revised principles in s.4 of the Heads of Bill. These provisions in the Heads of Bill are important as they better comply with Ireland's obligations under the relevant regional and international sources of human rights law as discussed above. However, it is essential that the presumption of capacity to make treatment/care decisions is realised in practice. There is concern

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[158] Amnesty International Ireland, "Mental Health Act 2001: A Review" (Dublin: Amnesty International, 2011), at page 138.
[159] [2012] IEHC 491.
[160] *M.X. v HSE* [2012] IEHC 491 at para 26.
[161] Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), at page 57.
[162] Ibid, at page 57.

that the provisions in the Heads of Bill might not be effective in ensuring that all persons admitted to approved centres on either a voluntary, intermediate, or involuntary basis will have their decisions about treatment respected.

The authors welcome the inclusion of the human rights informed principles as contained in s.4 of the Heads of Bill. It is essential that these principles are respected in the application of s.57 (treatment without consent). S.4(2) requires that a person shall not be considered as unable to make decisions affecting themselves unless all practicable steps have been taken, without success, to help support them. S.4(4) recognised that a person shall not be considered as unable to decide merely by reason of making, having made, or being likely to make, an unwise decision and s.4(5) provides that where a person lacks capacity in respect of a decision then the provisions of the 2015 Act apply. The perceived rationality of a decision along with "lack of insight" are commonly used to deprive people of their liberty and capacity to make treatment decisions in the mental health context, even though the research suggests that the vast majority of persons who receive inpatient services have the capacity to make these decisions.[163] A recent Irish study suggested 98% of persons receiving mental health inpatient treatment had either full capacity (47.4%) or partial capacity (50.7%) to make treatment decisions, compared to 73% of medical inpatients.[164]

However, the ERG noted that in practice most existing involuntary persons are deemed to lack capacity to consent to treatment and that it is rare that a person deemed to have a mental disorder as defined in the s.3 of the 2001 Act and also be deemed to have capacity to make decisions on treatment. This observation by the ERG is troubling given the research citied above, reports that a high percentage of persons receiving inpatient treatment have full or partial capacity. The fact that the majority of involuntary persons are deemed to lack capacity to consent to treatment needs to be closely monitored. This indicates that the statutory requirement that the persons consent for treatment in an approved centre is effectively side-stepped by clinicians. With these concerns informing its thinking the ERG acknowledged "a clear need to strengthen and separate out the current process of assessing the capacity of the individual to establish if he/she is in a position to give their informed consent to treatment options recommended".[165] It is also essential that supports should be put in place in all approved centres where the person needs assistance to exercise capacity.

The ERG recommended that regardless of the presumption of capacity at common law, a formal capacity assessment should be undertaken if at the time of admission, the admitting mental health professional forms the view that the person may lack the capacity to understand and give their informed consent to the proposed admission.[166] The ERG also recommended that if the person disagrees with the mental health professional's decision relating to their capacity, the person can have that decision reviewed by the MHRB when reviewing the detention of the person.[167]

It is useful to set out here the main recommendations made by the ERG to reform the provisions relating to s.57. The ERG recommended that s.57 should be amended so that the informed consent of a voluntary person is required for all treatment. The ERG recommended that informed consent should also be required from involuntary persons who are deemed capable of giving consent. Additionally, it recommended that a Consultant Psychiatrist, after consultation (which needs to be officially recorded) with at least one other mental health professional of a different discipline involved in the treatment of the person, may administer treatment to a detained person who is considered to

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[163] Aoife Curley, Brendan Kelly et al, "Concordance of Mental Capacity Assessments based on Legal and Clinical Criteria: A Cross-Sectional Study of Psychiatry Inpatients" (Psychiatry Research: (2019) 276, 160-166).
[164] Ibid.
[165] Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), at page 57.
[166] Ibid, at page 27.
[167] Ibid, at pages 27-28.

lack capacity, where the person does not have a decision making representative and the consultant psychiatrist considers it immediately necessary for the protection of life of the person, for protection from a serious and imminent threat to the health of the person, or for the protection of other persons that they should receive such treatment and there is no safe and effective alternative available. It was also recommended that where a person is considered to lack capacity but has a decision-making representative appointed under the 2015 Act, the decision-making representative can accept or refuse treatment for the person. However, the ERG also recommended that the consultant psychiatrist can override the decision of a decision-making representative to refuse treatment on behalf of an involuntary person in emergency circumstances where they form the view that the treatment is necessary, the person is injurious to themself, or others and no other safe option is available. The ERG further recommended that a MHRB would be required to meet within 3 days to determine that the treatment was given in the appropriate emergency circumstances. In circumstances where the MHRB agrees that the circumstances were of an emergency nature, then the treatment authorised by the consultant psychiatrist can continue for as long as the emergency circumstances continue but will be subject to other provisions relating to second opinions etc.

S.57 of the Heads of Bill retitles this provision "treatment not requiring consent" and implements many of the ERG's recommendations. S.57(1) reiterates that the consent of a person shall be required for treatment, however this is subject to subsections (2), (3), (4) and (5) of s.57. S.57(2) provides that where following a capacity assessments in s.56, the person is found to lack capacity, then treatment may be administered in the following circumstances:

> (a) the person has an attorney (as defined in the 2015 Act) who has been authorised by the person to make healthcare decisions in accordance with the 2015 Act, which include decisions refusing treatment, or
> (b) the person has a Decision-Making Representative (as defined in the 2015 Act) who has been authorised by the Court to make healthcare decisions in accordance with the 2015 Act, which include decisions refusing treatment, or
> (c) the person has a Designated Healthcare Representative on whom they have conferred power under their Advance Healthcare Directive to consent to, or to refuse, treatment based on the known will and preferences of the person in accordance with their Advance Healthcare Directive, or
> (d) the person has an Advance Healthcare Directive, as defined in Part 8 of the 2015 Act, which includes a provision, or provisions, on the specific treatment proposed, and (e) the parties referred to in (a), (b), (c) or (d) consent to the treatment so authorised.

T.57(3) provides that where, following the capacity assessments in s.56, the person is found to lack capacity but the person does not have at the time the treatment is required— (a) a decision-making representative or attorney or a designated healthcare representative, or (b) a decision-making representative or an attorney or a designated healthcare representative who has the requisite authority to take healthcare decisions on the person's behalf, or (c) there is no provision relating to the specific treatment proposed in the advance healthcare directive or enduring power of attorney, then an application shall be made to the Court pursuant to Part 5 of the 2015 Act. S.57(4) provides that where a decision on an application made to the court under s.57(3) is awaited, treatment may be given to the person concerned if it is immediately necessary for the protection of life of the person, for protection from an immediate and serious threat to the health of the person, or for the protection of other persons that they should receive such treatment and there is no safe and effective alternative available, except treatment given under s.59 (ECT). S.57(5) seems to provide for the disposal of consent that where medicine is being administered to a person subject to s.60(1). The authors are concerned about the provision in s.57(3) that treatment may be given to the person concerned if it is immediately necessary for the protection of life of the person, for protection from an immediate and

serious threat to the health of the person. 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.

S.57(6) provides for treatment without consent prior to the making of an admission order or intermediate admission order under s.14, s.14A or s.23, can only be given if it is immediately necessary for the protection of life of the person, for protection from an immediate and serious threat to the health of the person, or for the protection of other persons that they should receive such treatment and there is no safe and effective alternative available, except treatment given under s.59. Again, there is concern with the language in s.57(6) regarding serious threat to health of person. The authors consider this wording too wide and provides opportunity to give treatment in circumstances where there is no immediate threat to life of person or others.

S.57(7) provides that voluntary persons must give informed consent to any proposed treatment, including treatment set out in s.59 (ECT) and s.60 (administration of medicine), and a voluntary person may withdraw their consent or refuse treatment at any time. The inclusion of these provisions in the Heads of Bill are very important and better safeguard the legal capacity of voluntary persons. Finally, s.57(8) requires that where treatment is given without consent under s.57(4) or s.57(6), it is to be noted on the person's clinical file, the MHC needs to be informed in writing within 24 hours of the treatment being administered, and if the person concerned so wishes, a member of the person's multi-disciplinary team will notify their family, or another person nominated by them.

The authors welcome the amendments to s.56 and s.57 as they can be seen as strengthening the rights of persons admitted on a voluntary, intermediate, and involuntary basis under the 2001 Act. Importantly the revised provisions are linked to the presumption of capacity now recognised in s.4 (guiding principles) of the Heads of Bill. As mentioned above the research suggests that the majority of persons receiving inpatient mental health services in Ireland have either full capacity or partial capacity to make treatment decisions.[168] There is concern that assessment of capacity can be subjective, and people are often found to lack capacity to consent when disagreeing with the treatment proposed. The authors welcome the provisions in s.57 which recognise the rights of the person to consent and refuse treatment. In particular, we welcome the rejection of the ERG's recommendation that a valid and applicable advance healthcare directive could be overridden if at the time when it is proposed to treat the person, they are suffering from a mental illness and their detention and treatment is regulated by Part 4 of the 2001 Act. This is a welcome development that aligns with Ireland's obligations under international human rights law as discussed above. It is essential that there should no exclusion in relation to the applicability of AHDs in relation to mental health treatment and they should apply equally in all healthcare contexts.

S.57(3) provides that following the capacity assessments where the person is found to lack capacity but the person does not have at the time the treatment is required a decision-making representative or attorney or a designated healthcare representative, a decision-making representative or an attorney or a designated healthcare representative, or advance healthcare directive or enduring power of attorney as provided for by the 2015 Act an application can be made to the court in line with Part 5 of the 2015 Act. The authors consider that it is essential to develop an awareness raising strategy around the supports and advance planning provisions in the 2015 Act. It is vital that everyone admitted to an approved centre is automatically given the opportunity to develop an AHD as part of discharge planning and independent support is provided to do this to avoid the need for treatment without consent and substitute decision-making. This is crucial to ensure that the will and preferences

[168] Aoife Curley, Brendan Kelly et al, 'Concordance of Mental Capacity Assessments based on Legal and Clinical Criteria: A Cross-Sectional Study of Psychiatry Inpatients' (2019) 276 Psychiatry Research 160-166.

of the person are respected and that substitute decision-making *via* the court is avoided. This will also minimise the administration of treatment in emergency situations as provided for in s.57(4).

12.4 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.

13. Psycho-surgery

S.58 of the 2001 Act outlines the requirements for consent to psycho-surgery and provides that it must not be performed on a person unless two conditions are met. The first is that the person gives consent in writing, and the psychosurgery is authorised by a tribunal. The second is that the person's consultant psychiatrist must notify the Commission of the proposed psychosurgery and the Commission is obliged to refer the matter to the tribunal. The tribunal will sanction the treatment only where it is satisfied that it is in the best interests of the health of the person, otherwise it will refuse to authorise it. The provisions regarding the tribunal and the right of appeal to the Circuit Court apply to this aspect of treatment. S.58 provides that treatment must not be administered until the time for an appeal has lapsed, or the matter has been determined. In respect of children detained under the 2001 Act, psycho-surgery is only permitted where it is approved by the District Court.[169] Psychosurgery is defined as any surgical operation that destroys brain tissue for the purposes of ameliorating a mental disorder.

The MHC has not developed a code of practice on the use of psychosurgery, reflecting that this provision is not used. However. the MHC developed Form 15 to deal with applications relating to psycho-surgery, although never used.[170] A Private Members Bill titled the *Mental Health (Involuntary Procedures) (Amendment) Bill 2008* had proposed to delete s.58 of the 2001 Act.[171] However, this provision was dropped when the Bill was finally enacted as the *Mental Health (Amendment) Act 2015*.[172] The rationale for not moving forward with the provision to repeal s.58 was discussed as part of the Seanad debate on the general principles of the Bill. The Minister of State John Moloney argued that the repeal of s.58 would mean that there would be no legislative protection for persons in respect of psychosurgery, namely the requirement of obtaining the persons consent.[173] Therefore, he contended that the repeal would reduce the safeguards for persons subject to the 2001 Act.

The ERG did not consider s.58 in its Report. The only reference to psychosurgery is in the context of a discussion of the functions of the MHT under the Act.[174] It is regrettable that the ERG did not consider the significant human rights issues involved in the provision for psycho-surgery under the 2001 Act. Amnesty International Ireland identified in its analysis of the 2001 Act, that s.58 does not sufficiently safeguard persons subject to the 2001 Act in line with Ireland's obligations under international human rights law. In the 2018 Annual Report the United Nations High Commissioner for Human Rights expressed concern about the use of psycho-surgery from an international human rights perspective.[175] In Amnesty International Ireland's review it identified major questions as to the efficacy of psychosurgery as a form of treatment for mental health problems, noting that psycho-surgery is no longer performed in Ireland.[176] Therefore, Amnesty International identified two law reform options in respect of s.58. The first was to prohibit psychosurgery under Irish law; the second was to subject psychosurgery to more rigorous procedural safeguards, which they also recommended in respect of the use of ECT under the 2001 Act.[177]

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[169] S.25(12) of the 2001 Act.

[170] See "Form 15 Proposal to Perform Psychosurgery Involuntary Patient (Adult)". (Dublin: Mental Health Commission, Revised August 13th, 2013).

[171] *Mental Health (Involuntary Procedures) (Amendment) Bill 2008*.

[172] *Mental Health (Amendment) Act 2015*.

[173] See 190 Seanad Debates 490 (25th June 2008). The provision on repealing s.59 was dropped when the Bill was passed by the Seanad on the 24th of March 2011.

[174] Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), at page 42.

[175] "Mental health and human rights: Report of the United Nations High Commissioner for Human Rights" (Geneva: Annual report of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commissioner and the Secretary-General, 2018, A/HRC/39/36) at page 14.

[176] Amnesty International Ireland, "Mental Health Act 2001: A Review" (Dublin: Amnesty International, 2011), at page 153.

[177] Ibid.

As discussed above the 2001 Act is at odds with Ireland's obligations under the CRPD. Ireland's ratification of the CRPD necessities a rigorous review of the 2001 Act considering our evolving understanding of the relevant human rights obligations. Article 17 of the CRPD affirms that persons who experience mental health difficulties have the same right as anyone else to respect for their physical and mental integrity. Article 17 seeks to prohibit coercive treatment in psychiatry and is closely related to Article 12 (legal capacity / equal recognition before the law) & Article 14 (the right to liberty) and Article 15 (freedom from torture or cruel, inhuman, or degrading treatment or punishment). 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.

13.1 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.

14. Electroconvulsive Therapy (ECT)

The provisions relating to the use of electroconvulsive therapy (ECT) have been amongst the most controversial provisions in the 2001 Act and raise significant human rights issues. As discussed above the CRPD Committee have been clear "… involuntary treatment, including forced sterilization and surgical castration; the use of physical, chemical or mechanical restraints, solitary confinement, corporal punishment, the practice of electroconvulsive therapy …[and] the excessive use of force" may amount to torture or cruel, inhuman or degrading treatment.[178] As such the Committee has been unequivocal in requiring State Parties to the CRPD to prohibit practices such as ECT. The World Health Organization (WHO) has similar concerns about the use of electro-convulsive therapy in mental health services.[179] WHO Standard 4.2 in its QualityRights Tool Kit provides "[e]lectroconvulsive therapy, psychosurgery and other medical procedures that may have permanent or irreversible effects, whether performed at the facility or referred to another facility, must not be abused and can be administered only with the free and informed consent of the service user".[180] The WHO specifically state that ECT should not be given without the free and informed consent of service users. As such s.59 is at odds with the relevant human rights law and WHO standards and criteria for the use of ECT.

S.59 of the 2001 Act places an obligation on the MHC to make rules regulating the use of ECT. The term "patient" is defined in the 2001 Act and as construed in s.14 means a person who is subject to an admission or renewal order. One of the main safeguards provided in s.59 against the use of ECT is that it can only be administered to a person when they provide their written consent. However, where the person is unable to give consent, ECT must be approved by the consultant psychiatrist who has responsibility for the care and treatment of the person and another consultant psychiatrist following a referral of the matter to them by the first consultant psychiatrist. There is no requirement prohibiting the use of ECT until such time as the admission order has been affirmed by the MHT. This means under the 2001 Act as it currently operates a person could be involuntarily detained and forcibly given ECT before the Tribunal considers the admission order.

S.59 as it was enacted provided an exemption to the rule that a person must consent to ECT, in that the term "unwilling" was included in the original text of s.59. This meant that a programme of ECT could be administered for a period over 3 months where the person was unwilling to consent. This meant that a person who was considered to have capacity to consent to or refuse treatment could be forced to have ECT regardless of their competent refusal. Following significant human rights advocacy for the reform of s.59, the provision was eventually amended by the *Mental Health (Amendment) Act 2015*. This legislation removed the word "unwilling" from the text of s.59. While the term "unwilling" to consent to the administration of ECT was deleted (s. 59 (1) (b)), the reality is that, under the 2001 Act, people can still be administered ECT without their permission once their treating psychiatrist and another psychiatrist deem, they are "unable" to consent.[181] S.59 does require that a second consultant psychiatrist approve of the course of treatment. However, there is no requirement that that they be independent of the treating psychiatrist.

The MHC first prepared Rules on the use of ECT that came into force on 1st of November 2006. Subsequently an independent review of the Rules was carried out between September and December

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[178] See Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities (Geneva: Committee on the Rights of Persons with Disabilities, adopted during the Committee's 14th session, held in September 2015).

[179] See "WHO QualityRights Tool Kit: Assessing and improving quality and human rights in mental health and social care facilities" (Geneva: World Health Organization, 2012).

[180] Ibid, at page 83.

[181] See Fiona Morrissey, "Electroconvulsive therapy is still given to patients who don't want it" (Irish Examiner, 20th January 2016). Available at: https://www.irishexaminer.com/opinion/columnists/arid-20377065.html

2008, which involved stakeholder consultation.[182] The Rules were then revised to take account of the recommendations arising from this review and the amended Rules subsequently came into force on the 1st of January 2010. As a result of the enactment of the *Mental Health (Amendment) Act 2015*, the Mental Health Commission produced a third version of the rules governing ECT, which came into effect on the 15th of February 2016. As mentioned above prior to the commencement of the 2015 Act, it was possible for the administration of ECT to persons who were unwilling to consent to the treatment. The position is now that ECT cannot be administered to a person who is unwilling to give consent. Therefore, since the commencement of the *Mental Health (Amendment) Act 2015* ECT can only be administered to a person without consent in circumstances where it has been determined that the person is unable to give consent to the treatment. The Rules provide detailed guidance for persons working in approved centres, specifically for staff involved in the delivery of ECT therapy to persons in approved centres.

The provisions permitting and regulating the use of ECT have been the subject of intense debate since the 2001 Act was commenced. As mentioned above s.59 of the 2001 Act requires the written consent of a person where ECT is to be administered. However, s.59 permits the disposal of consent in respect of involuntary persons who are considered unable to give consent. The ERG was in clear agreement that the principles recommended in s.57 whereby persons must give informed consent to treatment should equally apply to ECT. In this regard, the ERG recommended that the authority to give ECT without consent in any circumstance where the person is considered to have the capacity to give consent but unwilling to do so should be removed. This recommendation was no doubt was instrumental is the removal of the term "unwilling" from s.59 in 2015.[183] However, given that many persons admitted under the 2001 Act are determined to lack capacity, it is uncertain as to whether this amendment to the 2001 Act has provided a more robust protection for persons subject to the 2001 Act or brings about any substantive change in practice to the use of ECT.

The ERG was cognisant of the decision-making supports that were to be introduced in the 2015 Act. The ERG agreed that in circumstances where a person is unable to give consent, but a decision-making representative appointed under the 2015 Act for the person, gives consent on the person's behalf to ECT, then ECT may proceed. The scenario where a person does not have capacity and a Decision-Making Representative does not consent to ECT was discussed and deliberated upon at length by the ERG. The ERG accepted the need to allow for refusal of ECT by a decision-making representative to be over-ruled in limited circumstances. They recommended that decisions should be subject to a robust review mechanism in the form of a MHRB, which must convene within 3 days of any such decision being taken. It would then be a matter for the MHRB as to whether, based on the facts presented, the administration of ECT should proceed.

S.59 has been amended in the Heads of Bill to reflect changes required as a result of amendments to s.56 (definition) and s.57 (treatment not requiring consent). S.59(1) provides that a programme of electro-convulsive therapy shall not be administered to a person unless the person gives their consent in writing to the administration of the programme of therapy. However, this requirement is negated by s.59(2) that provides that following a capacity assessments in s.56 where a person is found to lack capacity, then the provisions in s.57 (treatment not requiring consent) apply. S.59(3) provided that the MHC will make rules providing for the use of ECT and a programme of ECT cannot be administered to a person except in accordance with these rules.

[182] See "Mental Health Commission Rules: Rules Governing the Use of Electro-Convulsive Therapy" (Dublin: Mental Health Commission, Version 3, February 2016).

[183] The Group recommended that the first possible opportunity should be taken to effect this change in the context of any future miscellaneous health bill.

The authors are deeply concerned about the provision for ECT in the Heads of Bill. The ERG made recommendations that sought to provide some additional procedural safeguards around the use of ECT. The reasons for not implementing fully the recommendations of the ERG were not explained in the Heads of Bill document. Regardless, the recommendations of the ERG were insufficient to safeguard the human rights of persons subject to the 2001 Act. In light of the significant human rights issues discussed above the authors recommend that ECT be prohibited without the express free and informed consent of the person subject to the 2001 Act.

14.1 Recommendations:

- 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.

15. Administration of Treatment

As with the provisions on ECT the forced medication of persons subject to the 2001 Act has come under greater scrutiny from a human rights perspective. S.60 permits medicine to be given to a person without their consent for a period of three months. After the three months administration, the consent of the person must be obtained in writing and for each further period of three months. If the person is considered unable to consent, then their consultant psychiatrist must seek the approval of a second consultant psychiatrist. The initial period of approval is for 3 months and for periods of 3 months thereafter.

S.60 as it was enacted provided an exemption to the rule that a person must consent to a course of medication, in that the term "unwilling" was included in the original text of s.60. This meant that medication could be administered for a period over 3 months where the person was unwilling to consent to this. This meant that a person who was considered to have capacity to consent to or refuse treatment could be forced to have medication regardless of their competent refusal.

As discussed above the inclusion of the term "unwilling" in s.59 and s.60 was very problematical and led to significant human rights advocacy for the reform. Both sections were ultimately amended by the *Mental Health (Amendment) Act 2015*. The *Mental Health (Amendment) Act 2015* removed the word "unwilling" from the text of s.60. However, given the evidence that many person's admitted under the 2001 Act are found to lack capacity, the practical impact is minimal. S.60 does require that a second consultant psychiatrist approve of the course of treatment. However, there is no requirement that that they be independent of the treating psychiatrist.

M.X. v HSE is an important judgment that considered the constitutionality of s.60 of 2001 Act.[184] In this case the applicant was subject to an involuntary admission order at an approved centre. Following her involuntary detention, the applicant was required to undergo a course of treatment prescribed by her psychiatrist and carried out pursuant to s.60 of the 2001 Act. The evidence presented in court was that the applicant was not capable of fully understanding the nature, purpose, and the likely risks of the proposed treatment. In this case MacMenamin J in the High Court examined the practices, procedures and safeguards surrounding the implementation of the regime provided in s.60 of the 2001 Act. He assessed s.60 considering the person's rights under the Irish Constitution and as informed by the CRPD and the ECHR.

It was also argued on her behalf that she was being treated under s.57 of the 2001 Act, and that this provision was repugnant to the Constitution, incompatible with the ECHR and failed to have due regard for the provisions of the CRPD.[185] One of the interesting aspects of this judgment was the Court's consideration as to whether the CRPD had the force of law in this jurisdiction even though Ireland had not ratified the Convention at that point but the EU had. The Court found that the CRPD did not as the EU has not assumed any large or appreciable jurisdiction over the law relating to mental capacity. While the High Court determined that the CRPD cannot be seen as a rule in the interpretation of an application of ECHR jurisprudence it did however state that the Convention could be used as a "… guiding principle in the identification of standards of care and review of persons" such as the applicant.[186]

In addressing the substance of the applicant's case, the Court held that an assessment of the mechanism provided by s.60 of the 2001 Act had important Constitutional dimensions. The invasive

[184] [2012] IEHC 491.
[185] The CRPD had been signed but not yet ratified when the case was heard. It was argued that the CRPD was directly effective in Ireland under European Union law, the EU having become a party to the Convention in 2009.
[186] *M.X. v HSE* [2012] IEHC 491 at para 45.

nature of the treatment to which the applicant was being subjected resulted in a loss of bodily integrity and dignity. As such this engaged a range of values, referred to as "personal capacity rights", such as self- determination, bodily integrity, privacy, autonomy, and dignity which are all unenumerated but protected by the Constitution under Article 40.3. MacMenamin J considered case law of the European Court of Human Rights on Articles 5 and 8 of the ECHR and Article 13 of the UNCRPD. The Court then engaged with the broader range of Constitutional "personal capacity rights" as informed by the CRPD as well as the principles set out in the relevant jurisprudence of the European Court of Human Rights.[187] MacMenamin J decided that the constitutional protections must act as an appropriate counterweight to the nature of the incursion into these fundamental Constitutional rights and that this requires that when treating staff deem it necessary to invoke s.60 of the Act, the person should have their voice heard. He concluded that where a person lacks capacity, the person should where necessary be assisted in expressing their view as part of the decision-making process.[188]

The court considered that the applicant did not have capacity to make decisions and that it was for the Court to examine whether the choices made by the treating doctors were the least restrictive and involved the minimum practical incursion into her rights. MacMenamin J noted that the applicant had the decision to administer treatment under s.60 reviewed by a court and she therefore had not been denied an independent assessment of the decision. He concluded that the procedure under s.60 was properly administered, was capable of being interpreted in a manner in line with the protection provided by the Constitution the Court refused to make a declaration of incompatibility with the ECHR. MacMenamin J held that any treatment which is ancillary to principal "treatment" administered pursuant to s.60 of the Act must benefit from the same protections and prescriptions as that principal treatment.[189] Therefore, taking a paternalistic approach he concluded that a medical procedure which, albeit invasive, is ancillary to, and part of the procedures necessary to remedy and ameliorate her mental illness or its consequences. The ERG in light of this judgment recommended that treatment should include ancillary tests required for the purposes of safeguarding life, ameliorating the condition, restoring health, or relieving suffering and that the definition of treatment should be expanded to include treatment to all persons admitted to or detained in an approved centre.[190]

Amnesty International Ireland identified that much of the focus in the review process surrounding the 2001 Act was on the provisions on the use of ECT. However, serious human rights concerns in respect of s.60 of the 2001 Act, required consideration.[191] The removal of the term "unwilling" from section 60 by way of the *Mental Health (Amendment) Act 2015* was a direct result of the unequivocal view of the ERG that the term needed to be deleted. The ERG was clear that this term was inconsistent with s.57 which as discussed above provides that a person with capacity can refuse treatment. The ERG argued that there was no justification as to why the administration of medicine before or after a review period should be treated differently with respect to the capacity of the person.[192] S.60 as it was constituted before the *Mental Health (Amendment) Act 2015* essentially undermined the autonomy and self-determination of persons subject to the 2001 Act. The rationale for the ERG's recommendation for the removal of the word "unwilling" from s.60 was "to ensure that where a

[187] See the discussion of *X v Finland* (Decision of the European Court of Human Rights: Application no.34806/04, 3 July 2012).
[188] *M.X. v HSE* [2012] IEHC 491, at para 73.
[189] Ibid, at para 26.
[190] Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), at page 18.
[191] Amnesty International Ireland, "Mental Health Act 2001: A Review" (Dublin: Amnesty International, 2011), at page 158.
[192] The Expert Group recommended that the first possible opportunity should be taken to effect this change in the context of any future miscellaneous Health Bill. See Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), at page 63.

person has the capacity to make his/her decision, any such refusal to accept medicine will be respected".[193]

The ERG also expressed concern with the length of the initial review period of 3 months. They considered that 3 months was excessive and therefore recommended that detained persons who were considered not to have the capacity to give consent, medicine should only be administered for the purpose of ameliorating their condition for a period that would not exceed 21 days.[194] The ERG recommended that if medicine is to be continued after this initial period of 21 days, the adoption of the multi-disciplinary approach would be necessary. That would involve the treating consultant psychiatrist consulting with another mental health professional of a different discipline who is involved in the treatment of the person and this consultation would need to be officially recorded. Additionally, it was recommended that any decision to extend the administration of medicine beyond 21 days would require the authorisation of a second consultant psychiatrist from outside of the approved centre.[195] A number of submissions had suggested that medicine was being used to control persons rather than support their recovery. As such a further safeguard around the administration of medicine was recommended, namely that a requirement to ensure that the continued administration of medicine "must be of therapeutic material benefit to the patient" and that s.60 should be amended to explicitly require this.[196]

The ERG also recommended that further reviews of treatment should be undertaken every three months. When the first review is taking place, it was recommended that a person should be permitted to request that this review take place at an earlier stage.[197] The ERG also recommended that where it is decided to continue the administration of medicine this must be made by the treating consultant psychiatrist who must also consult with another mental health professional of a different discipline involved in the treatment of the person and this must be officially recorded. The recommendation to extend the administration of medicine every three months must also be authorised by a second consultant psychiatrist from outside the centre. The ERG further recommended that where psychotropic medication is proposed, the views of the person should be recorded and, if appropriate, consultation held with their family or advocate and that this would also to be recorded. The other recommendation was that the functions of the Inspector of Mental Health Services could be extended in this area to provide oversight when these recommendations were introduced.[198]

The Heads of Bill essentially introduces amendments to s.60 as required by the amendments to s.56 and s.57, which are discussed above. The changes also reduce the time period from 3 months to 21 days as recommended by the ERG. However, treatment should be given without consent for any period of time outside of emergencies where there is an imminent threat to the life of the person or others, and this should be for shortest period possible. Supports should be put in place to enable a person to consent or refuse treatment outside of these circumstances. Other amendments include a change of title from the 'Administration of medicine' to 'Administration of treatment'. According to the explanatory notes this change reflects that treatment besides medication may be required following the making of an admission or intermediate admission order, such as life- saving nasogastric feeding for persons with acute mental health conditions.

A number of submissions received by the DOH during the March 2021 public consultation criticised the current practice of persons who require nasogastric feeding having to be made wards of court *via*

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[193] Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), at page 62.
[194] Ibid, at page 63.
[195] Ibid, at page 63.
[196] Ibid, at page 63.
[197] Ibid, at page 63.
[198] Ibid, at page 64.

an application to the High Court instead of being accommodated under the 2001 Act. The DOH wrote to the MHC, who in response, said it would support the accommodation of nasogastric feeding in amending legislation. The MHC considered that persons with serious eating disorders would come under the revised criteria for detention in s.8, and the provision of nasogastric feeding would come under the revised definition of treatment in s.2. This raises significant legal and ethical issues. The authors consider that nasogastric feeding should only be administered without the person's consent where there is an imminent risk to the life of the person. A person with a physical or terminal illness can refuse artificial nutrition and hydration in their AHD, and this decision must be respected. This raises the question as to why the legislation is distinguishing between mental health and physical health. Supports should be put in place to enable the person to exercise capacity even in these circumstances, through an AHD, decision-making representative or supported decision-maker. Independent advocacy and other supports should also be available.

S.60(5) and s.60(7) have been included as additional safeguards for the administration of treatment under this section. This is particularly important with regards the administration of treatments, such as nasogastric feeding and the administration of some medicines, to ensure there is a regular review mechanism in place and that there is a second opinion given. S.60(1) now provides that where treatment, as defined in s.2 has been administered to a person who lacks the necessary capacity to consent for a continuous period of up to 21 days following the making of an admission order, or an intermediate admission order, the administration of that medicine shall not be continued unless the person gives their consent in writing to the continued administration of that treatment. S.60(2) provides that if a person does not consent to treatment after the initial 21 days, then the treatment shall not continue. S.60(3) provides that following the initial 21-day period, where the responsible consultant psychiatrist reasonably considers that a person may lack capacity to consent to or refuse treatment, then a further capacity assessment or assessments shall be carried out in accordance with s.56 and if the person is found to lack capacity the provisions in s.57 shall apply. S.60(4) provides for the continued administration of treatment shall be allowed until the capacity assessment or assessments in s.56 have been completed and in any event for no longer than 48 hours after the expiry of the initial 21-day period. The authors are concerned that the provisions here are too focused on the second opinion of a psychiatrist as a safeguard against the denial of the persons legal capacity. There needs to be a robust requirement for the provision of support. Treatment without consent should only be used in circumstances where all practicable steps have been taken to support the person to consent, and for shortest period possible.

S.60(5) provides that the administration of treatment under s.60(1) should be regularly reviewed by the person's multidisciplinary team, and in cases where treatment is being administered for seven continuous days, the consultant psychiatrist responsible for the care and treatment of the person concerned shall arrange for another consultant psychiatrist not involved in the care and treatment of the person concerned to assess the person and review the person's file. S.60(5)(i) & (ii) provide that where the second consultant psychiatrist agrees that the administration of treatment should continue, such treatment may continue for an additional seven days, or until the end of the 21 day period set out in s.60(1) whichever of the two is sooner or where the second consultant psychiatrist does not agree that the administration of treatment should continue, the specific treatment should not continue without the consent of the person concerned. S.60(6) provides that all of a person's treatment under s.60 shall be notified and discussed with the person and recorded in the person's clinical file. S.60(7) provides that treatment under this s.60 does not include treatment provided for under s.59 (ECT).

15.1 Recommendations:

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

16. Advance Healthcare Directives as they relate to mental health

Advance Healthcare Directives ('AHD') are essential in supporting persons to articulate their will and preferences in mental health treatment decision-making. This is essential when a person's views may become unclear or unknown. The authors have expressed their concern that under the 2015 Act, people who are detained in hospital for mental health treatment are specifically excluded from legally binding AHDs. As such 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 AHD. 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, in particular the CRPD. Essentially AHDs as provided for in the 2015 Act cover decisions regarding future healthcare treatment in the event the person is unable to communicate or make such decisions. This includes decisions regarding future mental health treatment. AHDs are considered a critical support to enable people to exercise their capacity in treatment/care decisions and avoid the need for coercion and non-consensual treatment, which is prohibited under the CRPD. The research suggests the process of developing an AHD confers recovery and capacity building benefits for the person.[199] An international systematic review reported that AHDs reduced involuntary admissions by 23%.[200] AHDs are also associated with a reduced need for readmission into hospital,[201] and enhanced recovery.[202] This is particularly relevant in the Irish mental health system where 60% of admissions are readmissions.[203]

It is proposed in the Heads of Bill to amend s.57 of the 2001 Act to provide for "designated healthcare representatives" as per s.88(1)(b)(ii) of the 2015 Act. The explanatory note that accompanies s.57 states that this amendment seeks to introduce "designated healthcare representatives' as per subsection 88(1)(b)(ii)" of the 2015 Act. It notes that s.85(7) and s.136 of the 2015 Act will need to be amended to ensure these provisions can operate and will ensure parity of treatment for those with mental health issues. Therefore, the intention in the Heads of Bill is to provide parity in terms of the application of AHD in respect of both voluntary and involuntary categories. The authors strongly endorse this approach.

However, the issue of consent of persons subject to the 2001 Act will remain regulated by Part 4 of the 2001 Act. S.136(1) of the 2015 Act provides that nothing in that legislation authorises a person to give a person treatment for mental disorder, or to consent to a person being given treatment for mental disorder, if at the time when it is proposed to treat the person, their treatment is regulated by Part 4 of the 2001 Act. The functional approach to assessing and supporting persons to consent should inform the ongoing review of the 2001 Act and the approaches aligned. It is important to recognise that the functional approach is problematic in itself and leads to findings of incapacity. There focus should be on supports to exercise capacity, and a presumption of capacity. S.85 of the 2015 Act details the validity and applicability of AHDs as provided for in the Act. However, s.85(7)(a)

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[199] Marvin Swartz & Jeffrey Swanson, 'Commentary: Psychiatric Advance Directives and Recovery-Oriented Care' (2007) 58 Psychiatric Services 1164.

[200] Mark de Jong and others, "Interventions to Reduce Compulsory Psychiatric Admissions: A Systematic Review and Meta-analysis" (*JAMA Psychiatry:* (2016) 73 (7) *657).*

[201] Claire Henderson and others, "Effect of Joint Crises Plans on Use of Compulsory Treatment in Psychiatry: Single Blind Randomised Controlled Trial" (British Medical Journal, (2004) 329, 13); Chris Flood and others, "Joint Crisis Plans for People with Psychosis: Economic Evaluation of a Randomised Controlled Trial" (British Medical Journal: (2006) 333. 729).

[202] Marvin Swartz & Jeffrey Swanson, "Commentary: Psychiatric Advance Directives and Recovery-Oriented Care" (Psychiatric Services: (2007) 58, 1164).

[203] There were 16,710 admissions to Irish psychiatric units and hospitals in 2019. 60 per cent of these were readmissions and 14 per cent were involuntary. Health Research Board, "National Inpatient Reporting System Bulletin"), (Dublin: Health Research Board, 2020).

provides that an advance healthcare directive shall be complied with unless, at the time when it is proposed to treat the directive-maker, his or her treatment is regulated by Part 4 of the 2001 Act.

While AHDs can be made for mental health treatment/care decisions, under Part 8 of the 2015 Act, they are not legally enforceable for persons involuntarily detained under the 2001 Act. An AHD can be taken into consideration, but it is not legally enforceable in these circumstances. The exclusion of persons detained under the 2001 Act would violate the CRPD as it discriminates on the grounds of disability. Similar legislative provisions were litigated as discriminatory under the American with Disabilities Act in the US in 2003.[204] The *Assisted Decision-Making (Capacity) Amend Bill 2019* proposed to remove this exclusion from the 2015 Act. The Bill reached Seanad stage but lapsed with the dissolution of the Dáil in March 2020. This discriminatory exclusion urgently needs to be removed from the 2015 Act. Equal access to AHDs should be provided for in both the 2015 Act and in the legislation amending the 2001 Act. AHDs are a critical support measure which should be made equally available to everyone, particularly those who are involuntarily detained under mental health legislation. The research exploring this area in Ireland suggests that the group who need AHDs the most to increase trust and respect are excluded from the legislation.[205] Therefore, it is essential that AHDs should be provided for all persons on an equal basis with others in both the legislation amending the 2001 Act and the 2015 Act.

The ERG recommended that the legislation amending the 2001 Act should address in a comprehensive manner the operation of AHDs in the area of mental health. The ERG also recommended that the legislation providing for AHDs should apply to mental health on an equal basis with general health. AHDs should be stated 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 and that directives should be recorded in the person's recovery plan.

However, there is concern about the ERGs recommendation that a valid and applicable AHD can be overridden if at the time when it is proposed to treat the person, they are suffering from a mental illness and are detained Part 4 of the 2001 Act and/or by the *Criminal Law (Insanity) Act 2006*. The blanket denial of a person's will and preferences and concerns when they are detained involuntarily on mental health grounds is unjust, particularly at the moment such AHDs become most important. Therefore, the authors welcome the approach in the Heads of Bill. 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.

16.1 Recommendations:

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

[204] *Hargrave v State of Vermont*, No.2: 99-CV 128 (2001); Hargrave v State of Vermont, 340 F 3d 27 (2nd Cir 2003).
[205] Fiona Morrissey, "The Introduction of a Legal Framework for Advance Directives in the UN CRPD Era: The Views of Irish Service Users and Consultant Psychiatrists" (Ethics, Medicine and Public Health: (2015) (1) 325).

- 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.

17. Coercion, Seclusion and Restraint

The use of seclusion and restraint in mental health services raises serious human rights issues. The UN Committee on the Rights of Persons with Disabilities has called on States Parties to the CRPD to protect the security and personal integrity of persons with disabilities who are deprived of their liberty, including by eliminating the use of seclusion and various methods of restraint in medical facilities, including physical, chemical and mechanic restrains.[206] The Committee has found that these practices are not consistent with the prohibition of torture and other cruel, inhumane or degrading treatment or punishment against persons with disabilities pursuant to article 15 of the CRPD. As such the 2001 Act should be amended to prohibit the use of seclusion and restraint for both voluntary, intermediate, and involuntary persons and this should include a prohibition on other forms of restraint also.

S.69(1) of the 2001 Act currently provides that a person should not be placed in seclusion or have mechanical means of bodily restraint applied unless such seclusion or restraint is in accordance with the Rules made by the MHC under s.69(2) to be necessary for the purposes of treatment or to prevent the person from injuring themselves or others and unless the seclusion or restraint complies with these rules. S.69(4) defines the person as both involuntary and voluntary person and children. Given the serious human rights issues involved in secluding and restraining persons s.69(3) creates a criminal offence for persons who do not comply with the provision. The scope of s.69 is limited to mechanical restraint and does encompass non-mechanical restraint. As such the MHC has developed "Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint"[207] and a separate "Code of Practice on the Use of Physical Restraint in Approved Centres".[208]

S.69 only applies to mechanical restraint. As such the MHC does not have the statutory power to make rules regulating the use of other forms of restraint that is not mechanical in nature. However, the Commission has developed a Code of Practice.[209] The regulation of the use of restraint by way of a code of practice is problematical for a number of reasons. Primarily because the 2001 Act does not impose a legal duty on persons working in the mental health services to comply with Codes of Practice and therefore diminishes the effectives of the code in regulating the use of other forms of restraint in approved centres.[210] However, the Commission notes that best practice requires that codes of practice be followed to ensure the 2001 Act is implemented consistently by persons working in the mental health services. The Commission also noted that failure to implement or follow the Code of Practice on Restraint could be referred to during the course of legal proceedings.[211]

The ERG Report did not provide a substantive analysis of s.69. However, the ERG recommended that the provisions contained in s.69 of the 2001 Act would be more appropriately included in Part 4 of the Act.[212] In addition, it was recommended that the section on restraint should be expanded to encompass all forms of restraint including manual or other forms of seclusion or restraint, and appropriate guidelines should be developed by the MHC. The ERG further recommended that the revised mental health legislation should make it explicitly clear that this provision applies to persons

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[206] See Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities (Geneva: Committee on the Rights of Persons with Disabilities, adopted during the Committee's 14th session, held in September 2015), at para 12.

[207] "Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint". (Dublin: Mental Health Commission, 2009).

[208] "Code of Practice on the Use of Physical Restraint in Approved Centres" (Dublin: Mental Health Commission, 2009).

[209] Ibid.

[210] Ibid, at page 14.

[211] Ibid.

[212] Department of Health, "Report of the Expert Group on the Review of the Mental Health Act 2001" (Dublin: 2015), at page 59.

detained in the Central Mental Hospital. The ERG emphasised in their Report that restraint and seclusion must only be used in rare and exceptional circumstances and only in the best interests of the person when they pose an immediate threat of serious harm to self or others. They also stated that mental health services needed to demonstrate that they are attempting to reduce the use of seclusion and restraint and that their use was a last resort, where there is no other alternative and always in accordance with the rules drawn up by the Commission. However, no practical recommendations were made that would have required services to evidence this commitment.

Part 6 of the Heads of Bill now contains all of the provisions relating to seclusion and restraint, which is titled restrictive practices. S.69 sets out the provisions relating to seclusion, s.69A contains the provisions on mechanical restraint, s.69B deals with physical restraint and s.69C contains new provisions on chemical restraint. The provisions in s.69 (seclusion), s69A (mechanical restraint) s.69B(physical restraint) and s.69C(chemical restraint) all mirror each other and provide additional safeguards for persons subject to the 2001 Act. Effectively the provisions mean that a person should not be secluded, mechanically restrained, physically restrained, or chemically restrained subject to the following requirements:

- the restriction is determined, in accordance with the rules made under the different sections to prevent the person from injuring themselves or others,
- the MHC shall make rules providing for the use of each restrictive practice,
- restrictive practices should be used only in exceptional circumstances,
- registers for the use of restrictive practices need to document each use and retain it on the person's clinical file,
- these provisions apply explicitly to intermediate and involuntary persons and persons detained in the Central Mental Hospital,
- failure to comply with the different sections in Part 6 or the rules developed by the MHC.

The authors welcome the creation of a dedicated Part in the Heads of Bill regulating restrictive practices. We welcome the additional safeguards contained in the Heads of Bill specifically that all restrictive practices will be subject to the creation of rules by the MHC and that the legislation specifies that the use of coercion can only be used in exceptional circumstances. The provisions in Part 6 also specify that their scope does not extend to voluntary persons. We believe it would be appropriate for each section to specify that the restrictive practice cannot be used in respect of voluntary persons.

As discussed above international human rights law requires Ireland to end coercion in mental health services. There is concern that the provisions as contained in the Heads of Bill are insufficient in moving towards compliance and the cultural change needed within mental health services. The urgency in embedding a human rights-based approach was underscored by the Council of Europe (COE), Parliamentary Assembly's Resolution "Ending coercion in mental health: the need for a human rights- based approach" in 2019.[213] The Parliamentary Assembly acknowledged that a growing number of people with psychosocial disabilities are subject to coercive measures such as involuntary detention and treatment and the inadequacy of mental health laws in restricting coercion. The Assembly identified that the use of involuntary measures in mental health settings mainly results from a culture of confinement that is reliant upon coercion to "control" and "treat" persons who are considered potentially "dangerous" to themselves or others.[214] The Parliamentary Assembly's Resolution states "[r]eliance on such coercive measures not only leads to arbitrary deprivations of liberty but, being unjustified differential treatment, it also violates the prohibition of

[213] Council of Europe, "Ending coercion in mental health: the need for a human rights- based approach" Strasbourg: Council of Europe, Parliamentary Assembly Resolution 2291 (2019)1).
[214] Ibid.

discrimination".[215] It was also identified that coercion results in people avoiding or delaying "…contact with the health-care system for fear of losing their dignity and autonomy, which ultimately leads to negative health outcomes, including intense life-threatening distress and crisis situations, which in turn lead to more coercion".[216] As such it recommended that mental health systems across Europe should be reformed to adopt a human rights-based approach that is compatible with the CRPD, and the right to free and informed consent in making healthcare decisions. The Assembly endorsed "hospital-based strategies, community-based responses, such as peer-led crisis or respite services, and other initiatives, such as advance planning" in preventing and reducing recourse to coercive practices. The authors agree that the use of coercion should be considered unacceptable and must be abandoned.

Similarly, the WHO recognises that individuals with mental health conditions experience stigma and discrimination, restrictions on their civil and political rights and ability to participate in society.[217] Recent statements from the WHO have highlighted the importance of legal capacity and participation in decision-making and refer to the CRPD and the obligation on States to provide support to individuals who require assistance to make decisions.[218] WHO QualityRights is a new global initiative, which aims to promote human rights and quality of care in mental health, and related services internationally. The training initiative has been developed over a five-year period with extensive input from persons with lived experience of psychosocial disability, and human rights experts internationally. The UN Special Rapporteur on the Right to Health has recommended the use of the initiative to implement CRPD rights-based policies and practices to affect cultural change in mental health and related services.[219] An evaluation of attitudinal changes achieved through the delivery of the QualityRights training initiative suggest it is an important tool in achieving attitudinal change towards CRPD based human rights relating to coercion, and legal capacity in mental health services.[220] The evaluation suggest that the training initiative may also help affect the attitudinal and cultural shift needed when implementing CRPD based capacity and supported decision-making legislation. The evaluation along with the systematic review of the initiative in practice,[221] strengthens the evidence base for delivery of the QualityRights training initiative by countries seeking to implement attitudinal and cultural change under the CRPD in mental health, and disability related services

17.1 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.

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[215] Ibid.
[216] Ibid
[217] World Health Organisation, "Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group" (WHO 2010), at page xxv.
[218] World Health Organisation Europe, 'User Empowerment in Mental Health-A Statementby the WHO Regional Office for Europe'. Available at: <www.euro.who.int/ data/assets/pdf_file/0020/113834/E93430.pdf
[219] Dainius Pūras, "Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Human Rights Council, June 2017), at page 21.
[220] Fiona Morrissey, 'An Evaluation of Attitudinal Change towards CRPD Rights in following Delivery of the WHO QualityRights Training Programme' (2020) 13 Ethics, Medicine and Public Health Journal
[221] Pathare S, Funk M, Drew Bold N, Chauhan A, Kalha J, Krishnamoorthy S, et al. Systematic evaluation of the QualityRights programme in public mental health facilities in Gujarat, India. Br J Psychiatry 2019:1—8.

- 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 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, Authorised Officers, Mental Health Commission staff, Psychiatrists, and all mental health professionals working in inpatient and community services should be required to undertake WHO QualityRights.
- 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 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.

18. Direct complaints mechanism

The ERG recommended that on admission to an approved centre, every person should have a right to information which would include their rights as a voluntary or involuntary person, 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 MHC Code of Practice. The ERG also noted the obligation to ensure that the person is made aware of the complaint's mechanisms in place at the centre and any general complaints mechanisms that exist within the service generally. While the ERG noted that it is mandatory for the Inspector of Mental Health Services to meet a person who has made a complaint when they subsequently inspect the approved centre, and all persons must be informed of this right on admission to an approved centre and on the process for contacting the MHC. However, it decided not to recommend the creation of a separate Mental Health Ombudsman but suggested that the matter should be considered as part of future reviews.

It is disappointing that the Heads of Bill does not contain any provisions that will support persons subject to the legislation raising issues/issues/complaints based on their lived experiences of mental health services. A major deficit from a human rights perspective is that the 2001 Act does not provide for a dedicated independent direct complaints mechanism. In the absence of a specific complaint's mechanism persons using mental health have to lodge complaints regarding mental health services to the HSE's internal complaints mechanism, which was created under the *Health Act 2004*. If the complainant is dissatisfied with the outcome of a complaint to the "Your Service, Your Say" mechanism the matter may then be referred to the Ombudsman. S.16 of the Act provides that a person must be notified of their entitlement to communicate with the Inspector and during their annual inspection of approved centres, the Inspector is required to see every person who has made a request. However, this measure is far from adequate as the Inspector does not investigate individual complaints *per se* and there is often a significant delay between the time the complaint is made and the next inspection. In addition, the inspectorate team can only look at matters in terms of the service provided to the person and in line with its obligation to review the provisions of the 2001 Act and the 2006 Regulations. It cannot consider the clinical decisions of care and therefore is a very limited oversight mechanism for the individual.

Similarly, s.55 of the 2001 Act provides that the Commission may, and shall if so, requested by the Minister, cause the Inspector of Mental Health Services or such other person as may be specified by the Commission, to inquire into the care and treatment provided to a specified person or a specified voluntary person by the Commission. However, there is no separate complaints mechanism specific to complaints about a tribunal or a tribunal member. The authors advocate that the provision of an of effective complaints mechanism is essential in safeguarding the human rights of persons receiving mental health services.

As discussed above Ireland signed the CRPD in 2007 and ratified in 2018 but deferred ratification of the Optional Protocol (OP). The failure to ratify means that Ireland is an outlier amongst EU Member States (along with the Netherlands and Poland) in not ratifying the OP to the CRPD. The failure to ratify the OP has been criticised by Non-Governmental Organisations, Disabled Persons Organisations and the Irish Human Rights and Equality Commission, as undermining Ireland's commitment to implementing and realising the rights contained in the CRPD. The failure to ratify the OP means that persons subject to the 2001 Act are denied access to the mechanism to make individual complaints directly to the CRPD Committee. This further disadvantages persons subject to the 2001 Act from raising human rights issues based on their lived experiences of involuntary detention and treatment. The delayed ratification is regrettable as the OP encourages Ireland to implement the CRPD effectively, to address human rights concerns and provide remedies to law and policy that is at odds

with the Convention. The failure to ratify means that an essential layer of accountability is absent, and it is essential that the OP to the CRPD is ratified immediately.

18.1 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 complaint's 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 complaint's mechanism should be expressly included in the information provide 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 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.

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- ¢KŜNŜ äK2dzfŘ ōŜ I· fŜ∃I·f NŜIjdzλNŜYŜyŭ ŭKI·ŭ ŭKŜ LJŜNä2y˜ädzLJLJ2NŭŜŘ ŭ2 YŜI·yλy∃Ŧdzffè LJI·NŭλŎλLJI·ŭŜ λy˜ ŭKŜ ŘŜØŜf2LJYŜyŭ 2Ŧ λyŘλØλŘdzI·f ŎI·NŜ LJfI·y˜øλŭK I·LJLJN2LJNλI·ŭŜ λyŘŜLJŜyŘŜyŭ ädzLJLJ2NŭŭλŦ yŜŎŜääI·N è φ

[нннн] aŜyŭI·f IŜI·fŭK /2YYλääλ2yΣ ά!yŷdzI·f wŜLJ2Nŭ нлму LyŎfdzŘλy∃ wŜLJ2Nŭ 2Ŧ LyäLJŜŎŭ2N 2Ŧ aŜyŭI·f IŜI·fŭK {ŜNØλŎŜäέ ó5dzōfλyY aŜyŭI·f IŜI·fŭK /2YYλääλ2yΣ нлмyúφ

- 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.

20. Independent Advocacy

As discussed throughout this report the 2001 Act does not currently provide a right to advocacy services for persons using inpatient mental health services. The need to provide advocacy services has been a policy goal for many years. "A Vision for Change" (AVFC) acknowledged that where a person is experiencing a period of severe emotional distress, they may not be resourced to advocate for themselves. As such it stated, "advocacy should be available as a right to all service users in all mental health services i.e., including hospitals, day centres, training centres, clinics, or elsewhere in all parts of the country".[223] AVFC further recommended that the advocate should be a peer who has personal experience of using the mental health services and has received recognised advocacy training. The Mental Health Engagement and Recovery Office consultation on the 2001 Act identified a number of key concepts which participants wished to see included in the amending legislation and delivery of mental health services.[224] These included a human rights-based approach; autonomy of persons regarding their own care, treatment and recovery; co-production and shared decision-making; range of services to meet diverse needs, preferences and choices; role of supporters and an independent complaints mechanism.[225] The need for increased advocacy supports both in the community and in services was also highlighted in the consultation.

The provision of advocacy is required by the CRPD. Article 12 as discussed above requires State Parties to "take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity". This is key for persons who come under the scope of the intermediate and involuntary categories. The inclusion of a right to independent advocacy would signal a clear commitment to providing persons subject to the act with the supported needed to exercise their legal capacity. An example of best international practice is the *Mental Health (Care and Treatment) (Scotland) Act 2003*, which provides a right of access to an independent advocate. The Scottish legislation provides a legal right to independent advocacy for persons who have a mental health issue, a learning disability, autism, or dementia. The Heads of Bill should provide for a statutory right to an advocate for voluntary, intermediate, and involuntary persons. The authors note that the National Advocacy Service for People with Disabilities (NAS) provides an existing framework for a professional representative advocacy service. NAS is funded and supported by the Citizens Information Board, which has a mandate under the *Citizens Information Act 2007* and the *Comhairle Act 2000* to provide advocacy for persons with disabilities. The remit of the NAS could be expanded to fulfil the role and align with international best practice.

22.1 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 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.

[223] "A Vision for Change" (Dublin: Stationery Office, 2006), at page 26.
[224] Mental Health Engagement and Recovery Office, "Transcript of Discussion Points from Consultation on the 2001 Act" (Dublin: 16th April 2021).
[225] Ibid.

- Advocates should receive ongoing training on human rights, mental health legislation and the capacity legislation.

нмφ /fłyłŏl·f ¢NJłl·fă

{φтл 2Ŧ ŭKŜ нллм l·ă łŭ łă ŏdzNJNJŜyŭfè ŦNJl·YŜŘ LJNJ2ØłŘŜă ŭKl·ŭ 2yfè ŘŜŭl·łyŜŘ LJŜNJă2yã øłff ōŜ ŜÈŏfdzŘŜŘ ŦNJ2Y LJl·NJŭłŏłLJl·ŭł2y˜ły˜ŏfłyłŏl·f ŭNJłl·fãφ ¢KŜ ŏl·LJl·ŏłŭè 2Ŧ l· LJŜNJă2y˜ŭ2 LJl·NJŭłŏłLJl·ŭŜ łă l·y˜łY˜LJ2NJŭl·yŭ łăădzŜ l·yŘ 2yŜ ŭKl·ŭ łă ŘŜl·fŭ øłŭK ły˜ŭKŜ /2yŭNJ2f 2Ŧ /fłyłŏl·f ¢NJłl·f !ŏŭă мфутпмффлφ {łyŏŜ ŭKŜ нллм !ŏŭ Kl·ă ŏ2YYŜyŏŜŘ ŭKŜ łăădzŜ 2Ŧ ŏ2yãŜyŭ ły˜ŏfłyłŏl·f ŭNJłl·fã łă y2ø ∃2ØŜNJyŜŘ ōè ŭKŜ 9dzNJ2LJŜl·y˜/2YYdzyłŭłŜă ó/fłyłŏl·f ¢NJłl·fã 2y˜ a ŜŘłŏłyl·f tNJ2Řdzŏŭă Ŧ2NJ l dzYl·y˜¦ăŜú wŜ∃dzfl·ŭł2yãΣ нллпφHHC ¢KŜăŜ wŜ∃dzfl·ŭł2yã ŭNJl·yãLJ2ăŜŘ łyŭ2 LNJăK fl·ø ŭKŜ LJNJ2Øłăł2yã 2Ŧ /2dzyŏłf 5łNJŜŏŭłØŜ нллмкнлк9/φ {ŏKŜŘdzfŜ м tl·NJŭ o 2Ŧ ŭKŜ нллп wŜ∃dzfl·ŭł2yã LJNJ2ØłŘŜ ŭKl·ŭ l· LJŜNJă2y˜Ydzăŭ ōŜ ŏ2yãłŘŜNJŜŘ ál·ōfŜ ŭ2 ŏ2yãŜyŭ£φ ¢KŜ LJŜNJă2y˜yŜŜŘă ŭ2 LJNJ2ØłŘŜ łyŦ2NJYŜŘ ŏ2yãŜyŭ ły˜2NJŘŜNJ ŭ2 LJl·NJŭłŏłLJl·ŭŜ ły˜ŭKŜ ŭNJłl·fφ {ŏKŜŘdzfŜ м tl·NJŭ p 2Ŧ ŭKŜ wŜ∃dzfl·ŭł2yã ăŜŭă 2dzŭ ŭKŜ NJŜljdzłNJŜYŜyŭă Ŧ2NJ ŭKŜ LJl·NJŭłŏłLJl·ŭł2y˜2Ŧ l· LJŜNJă2y˜ŏ2yãłŘŜNJŜŘ ŭ2 ōŜ łyŏl·LJl·ŏłŭl·ŭŜŘφ ! yŜø /fłyłŏl·f ¢NJłl·f wŜ∃dzfl·ŭł2y˜ó9¦ú b2 роскнлмп øl·ă l·Ř2LJŭŜŘ 2y˜мс !LJNJłf нлмпφ l2øŜØŜNJΣ ŭKłă wŜ∃dzfl·ŭł2y˜Kl·ă èŜŭ ŭ2 YŜ łYLJfŜYŜyŭŜŘφ LYLJfŜYŜyŭl·ŭł2y˜łă LJfl·yŷŜŘ ŭ2 ŭl·¦Ŝ LJfl·ŏŜ ły˜нлнн l·yŘ øKŜy˜łYLJfŜYŜyŭŜŘΣ 5łNJŜŏŭłØŜ нллмкнлк9/ l·yŘ l·ăă2ŏłl·ŭŜŘ fl·øă øłff ōŜ NJŜLJŜl·fŜŘφ ¢KŜ yŜø wŜ∃dzfl·ŭł2y˜ăŜŜ¦ă ŭ2 Kl·NJY2yłăŜ ŭKŜ l·ăăŜăăYŜyŭ l·yŘ ădzLJŜNJØłăł2y˜LJNJ2ŏŜăăŜă Ŧ2NJ ŏfłyłŏl·f ŭNJłl·fã ŭKNJ2dz∃K2dzŭ ŭKŜ 9¦ ŭKNJ2dz∃K ŭKŜ ŘŜØŜf2LJYŜyŭ 2Ŧ l· /fłyłŏl·f ¢NJłl·fã Ly˜Ŧ2NJYl·ŭł2y˜{èăŭŜY˜φ ¢Kłă äèăŭŜY˜ øłff ŏ2yŭl·ły˜ŭKŜ ŏŜyŭNJl·fłăŜŘ 9¦ LJ2NJŭl·f l·yŘ Řl·ŭl·ōl·ăŜ Ŧ2NJ ŏfłyłŏl·f ŭNJłl·fãφ ¢KŜ 9dzNJ2LJŜl·y˜ a ŜŘłŏłyŜă !∃Ŝyŏè łă ŭKŜ ō2Řè ŏKl·NJ∃ŜŘ øłŭK Ŝăŭl·ōfłăKły∃ l·yŘ Yl·łyŭl·łyły∃ ŭKłă äèăŭŜY˜ ły˜ ŏ2ffl·ō2NJl·ŭł2y˜øłŭK ŭKŜ a ŜY˜ōŜNJ {ŭl·ŭŜă l·yŘ ŭKŜ 9dzNJ2LJŜl·y˜/2YYłăăł2yφ

/fłyłŏl·f ŭNJłl·fã Ŧ2NJ y2yπYŜŘłŏły1·f LJNJ2Řdzŏŭă l·NJŜ NJŜ∃dzfl·ŭŜŘ ōè ăφφ 2Ŧ ŭKŜ /2yŭNJ2f 2Ŧ /fłyłŏl·f ¢NJłl·fã !ŏŭ мфутφ {φφ 2Ŧ ŭKŜ мфут !ŏŭ ŜŦŦŜŏŭłØŜfè LJNJ2ØłŘŜă Ŧ2NJ LJNJ2Èè ŏ2yãŜyŭ ōè l· ŭKłNJŘ LJŜNJă2y˜øK2 ły˜ŭKŜ ØłŜø 2Ŧ ŭKŜ NJŜfŜØl·yŭ ŜŭKłŏă ŏ2YYłŭŭŜŜ łă ŏ2YLJŜŭŜyŭ ŭ2 ŘŜŏłŘŜ 2y˜ŭKŜ LJŜNJă2yã LJl·NJŭłŏłLJl·ŭł2y˜ły˜ŭKŜ ŭNJłl·fφ ¢KŜ l·dzŭK2NJă y2ŭŜ ŭKl·ŭ ŭKŜ l Ŝl·Řă 2Ŧ .łff LJNJ2LJ2ăŜă ŭ2 l·YŜyŘ ăφтл ŭ2 l·ff2ø LJŜNJă2yã NJŜŏŜłØły∃ ŭNJŜl·ŭYŜyŭ ły˜l·y˜ l·LJLJNJ2ØŜŘ łyŦLJl·ŭłŜyŭ Ŧl·ŏłfłŭèΣ øK2 Kl·øŜ ŭKŜ ŏl·LJl·ŏłŭè ŭ2 ∃łØŜ łyŦ2NJYŜŘ ŏ2yãŜyŭ ŭ2 LJl·NJŭłŏłLJl·ŭŜ ły˜ŏfłyłŏl·f ŭNJłl·fãφ

¢KŜ l·dzŭK2NJă y2ŭŜ ŭKl·ŭ ŭKŜ 9wD łłŘ y2ŭ łyŏfdzŘŜ l·yl·fèăłă 2Ŧ ŭKłă ăŜŏŭł2y˜ły˜łŭă NJŜLJ2NJŭφ CdzNJŭKŜNJ łłăŏdzăăł2y˜ l·yŘ l·yl·fèăłă 2Ŧ ăφтл ø2dzfŘ ōŜ øŜfŏ2YŜφ ¢KŜ ŜÈŏfdzăł2y˜2Ŧ LJŜNJă2yã l·ŘYłŭŭŜŘ ŭ2 l·LJLJNJ2ØŜŘ ŏŜyŭNJŜă ŦNJ2Y ŏfłyłŏl·f ŭNJłl·fã ŏl·y˜ōŜ ŏ2yãłŘŜNJŜŘ łłăŏNJYłyl·ŭ2NJè φ l2øŜØŜNJΣ łŭ łă ŜăăŜyŭłl·f ŭKl·ŭ LJŜNJă2yã ădzō?Ŝŏŭ ŭ2 ŭKŜ !ŏŭ NJŜŏŜłØŜ ădzLJLJ2NJŭ łŦ yŜŜŘŜŘ ły˜YYl·¦łyły∃ łŘŜŏłăł2yã NJŜ∃l·NJŘłyły∃ LJl·NJŭłŏłLJl·ŭł2y˜ły˜ŏfłyłŏl·f ŭNJłl·fãφ ¢Kłă LJNJ2Øłăł2y˜ ăK2dzfŘ ōŜ ∃łØŜy˜ŦdzNJŭKŜNJ ŏ2yãłŘŜNJl·ŭł2y˜øłă l· øłă ŭKŜ нлмр !ŏŭ l·yŘ ŭKŜ LJNJ2LJ2ăŜŘ ŏKl·y∃Ŝă l·NJ2dzyŘ łłŘŜŏłăł2yπYl·¦łyły∃ ły˜ŭKŜ l Ŝl·Řă 2Ŧ .łffφHHT

нмφм wŜŏ2YYŜyŘl·ŭł2ys

.l·ăŜŘ 2y˜ŭKŜ Ŧ2NJ∃2ły∃ łłăŏdzăăł2y˜l·yŘ l·yl·fèăłă 2Ŧ ŭKŜ l Ŝl·Řă 2Ŧ .łff ŭKŜ l·dzŭK2NJă Yl·¦łŜ ŭKŜ Ŧ2ff2øły∃ NJŜŏ2YYŜyŘl·ŭł2yãY

- ¢KŜ LJNJ2LJ2ăŜŘ ŏKl·y∃Ŝ ŭ2 ăφтл ăK2dzfŘ ōŜ ∃łØŜy˜ŦdzNJŭKŜNJ ŏ2yãłŘŜNJl·ŭł2y˜øłă l· øłă ŭKŜ нлмр !ŏŭ l·yŘ ŭKŜ LJNJ2LJ2ăŜŘ ŏKl·y∃Ŝă l·NJ2dzyŘ łłŘŜŏłăł2yπYl·¦łyły∃ ły˜ŭKŜ l Ŝl·Řă 2Ŧ .łffφ
- ² KŜy˜łŘŜØŜf2LJłyły∃ !łØl·yŏŜ l Ŝl·fŭKŏl·NJŜ 5łNJŜŏŭłØŜă ŏ2yãłŘŜNJl·ŭł2y˜ăK2dzfŘ ōŜ ∃łØŜy˜l·ă ŭ2 øKŜŭKŜNJ LJl·NJŭłŏłLJl·ŭł2y˜ły˜ŏfłyłŏl·f ŭNJłl·fã ăK2dzfŘ ōŜ łyŏfdzŘŜŘφ ¢KŜ LJŜNJă2y˜ăK2dzfŘ ăŭl·ŭŜ ŭKŜłNJ øłŜøă l·ă ŭ2 øKŜŭKŜNJ ŭKŜè øłăK ŭ2 LJl·NJŭłŏłLJl·ŭŜ ły˜ ŏfłyłŏl·f ŭNJłl·fã NJŜfl·ŭŜŘ ŭ2 ŭKŜłNJ ŦdzŭdzNJŜ YŜyŭl·f KŜl·fŭK ŭNJŜl·ŭYŜyŭφ

HHC {L b2 мфл 2Ŧ нллпφ

HHT ¢KŜ нлмр !ŏŭ łłŘ y2ŭ l·YŜyŘ l·yè LJNJ2Øłăł2yã 2Ŧ ŭKŜ /2yŭNJ2f 2Ŧ /fłyłŏl·f ¢NJłl·fã !ŏŭ мфутφ

22. Review of the Mental Health & Capacity Legislation

Persons subject to the 2001 Act, NGOs, mental health professionals and a range of other stakeholders have been frustrated with the delays in reviewing and subsequent implementation of proposed reforms to the legislation. The delays are regrettable given the need to urgently address serious deficits in safeguarding the human rights of persons subject to the legislation. The authors note that in 2011, the then Minister for Health, James Reilly, and the then Minister of State with responsibility for Mental Health, Kathleen Lynch, established a Steering Group on the Review of the 2001 Act.[228] This was to give effect to the commitment in the Programme for Government to review the 2001 Act.[229] The ERG was subsequently appointed to make final recommendations on the reform of the 2001 Act. The work of the ERG published in 2015 was informed by the recommendations from the Steering Group, which published its report in 2012. It is disappointing that it took 6 years before the Heads of Bill were published earlier this year (July 2021). S.75 in the Heads of Bill provides that the Minister for Health will undertake a review of the amending mental health legislation not later than 5 years after its commencement. S.75 provides that the review will assess the effectiveness of the changes introduced and the Minister is required to make a report to each House of the Oireachtas of their findings and conclusions resulting from the review. The authors are similarly concerned with the delays in the commencement of the 2015 Act. S.93 of the 2015 Act commits to a review of Part 8 on AHDs before the 5th anniversary of its commencement, while s.146 provides that the Minister for Justice in consultation with the Minister for Health will review the functioning of the 2015 Act (other than *Part 8*) before the 5th anniversary of the date of enactment of this Act.

The authors are concerned that detached reviews along separate timelines across two government departments runs the risk of a fragmented approach. To minimise this risk, it is proposed that the review of the mental health legislation should coincide with the review of the 2015 Act. This will minimise the risk of a fragmented approach and ensure that policy makers undertake a meaningful and holistic review of the mental health and capacity laws. Given the delays in the commencement of the 2015 Act and the implementation of the ERG recommendations it would be desirable for these reviews to take place 3 years after the commencement of both pieces of legislation. At that point Ireland should have completed the first cycle of reporting to the UN Committee on the Rights of Persons with Disabilities on how the rights enshrined in the CRPD are being implemented. This review process will be essential in responding to the Committee's Concluding Observations and recommendations and in preparation for the second cycle of reporting.[230] A timely, holistic, and co-ordinated approach to review of the mental health and capacity legislation is essential.

22.1 Recommendations

Based on the forgoing discussion the authors make the following 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 2015 Act.
- The coordinated review of the mental health and capacity legislation should take place 3 years after the commencement of both pieces of legislation.

[228] See Department of Health, "Interim Report of the Steering Group on the Review of the Mental Health Act 2001" (Dublin: Department of Health, 2012).
[229] Ibid, at page 4.
[230] States must report initially within two years of ratifying the Convention and, thereafter, every four years. The Committee examines each report and makes suggestions and general recommendations on the report.

Appendix 1: Biographies of Authors

Dr Fiona Morrissey is a graduate of the doctoral programme at the Centre for Disability Law & Policy, School of Law at NUI Galway, where she is now an Adjunct Lecturer in law. Dr Morrissey is a Disability Law Research/Training Consultant who has worked with the World Health Organisation on the development and delivery of the QualityRights training and e-learning programme. This UN programme supports countries to develop and implement human rights-based capacity, supported decision-making and mental health laws, policies, and practices in line with UN Convention on the Rights of Persons with Disabilities. Fiona has extensive knowledge of and expertise in Irish mental health law and has been appointed as a Lay Member of the Mental Health Tribunals by the Mental Health Commission. She is a member of the Ministerial working group charged with drafting codes of practice for advance healthcare directives under the Assisted Decision-Making (Capacity) Act 2015.

Dr Charles O'Mahony is a lecturer in the School of Law at NUI Galway. He was Head of the School of Law from 2017-2021. He completed a PhD at the Centre for Disability Law and Policy, NUI Galway entitled "Diversion: A Comparative Study of Law and Policy Relating to Defendants and Offenders with Mental Health Problems and Intellectual Disability". Charles was elected as President of the Irish Association of Law Teachers (IALT) from 2014-2016. He previously worked as Amnesty International Ireland's Legal Officer on its mental health campaign and as a legal researcher for the Law Reform Commission of Ireland. He was awarded a LLM from University College London and a LLM in Public Law, a BA in Law and History and a LLB degree by NUI Galway.

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