



REPORT OF THE EXPERT GROUP ON THE REVIEW OF THE MENTAL HEALTH ACT 2001

PREFACE

As Chair of the Expert Group established to review the Mental Health Act 2001, it gives me great pleasure to present the Minister for Primary Care, Social Care (Disabilities and Older People) and Mental Health, Ms Kathleen Lynch T.D. with the Group's Report. I believe that the work of the Group provides the foundation on which important and progressive changes can be introduced to our existing mental health legislation.

Our work began at the request of the Minister who asked the members of the Group to examine the Report of the Steering Group which conducted an initial review of the Act. The Group members went about their task with great dedication and enthusiasm with the aim of recommending changes that would both reform our legislation and also ensure that it delivers to the greatest extent possible for all those who, from time to time, may require mental health services, treatment or care in the community or in-patient services in approved centres, whether on a voluntary or involuntary basis.

The Group recognises that the existing Act has served us well and that a review in little over a decade of its operation would likely focus on refining rather than rewriting the 2001 Act.

The Group approached the task recognising that detention and treatment without consent of individuals with mental illness can have a very profound effect on such individuals, their families and carers. We were determined to bring about a perhaps subtle but significant shift of balance from a situation where others decide what is in a person's best interests to one where insofar as is possible the individual has the final say in what he/she deems to be his/her best interests and receives the best possible quality of service that they require to attain the highest standard of mental health.

We believe that the recommendations we have made provide a practical and realistic way forward which can ensure that the safeguards necessary for mental health legislation are robust and fully compliant with international best practice as well as ensuring that those vulnerable people who need care and treatment get it when required.

As Chair I accept that some may find the recommendations to be far-reaching whereas others may feel that we have not gone far enough. The fact is that the issues considered by the

Group whereby a balance must be achieved between a person's right to autonomy and the need for protective measures to be enforced are complex and not easily agreed and certainly not always resolved to the full satisfaction of all sides.

The members of our Group, appointed by the Minister, are a highly motivated team of experts who were determined to ensure that the complex and intertwining issues we examined should be given full consideration. In this regard, I would point out that the Group's report does not fully reflect the breadth of discussions and contemplation that took place over a two year period into all facets of our review but rather it focuses on the outcome and conclusion of those discussions.

I am fortunate to have chaired a group whose members were fully committed to modernising our mental health legislation in a manner that put the person at its core. The knowledge and experience of the membership and their attention to detail were invaluable in reaching the conclusions and recommendations of this Report. Accordingly, I would like to record my sincere gratitude to each member of the Expert Group for their unstinting efforts during the course of the review.

Finally, I hope that the recommendations we have made will be seen as outlining the important next steps required to reshape and update our mental health legislation for many years to come.

LUKE MULLIGAN
CHAIR OF THE EXPERT GROUP
08 December 2014

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	Page(s)
1 Introduction	
1.1 Mental Health Legislation in Ireland	6
1.2 Commitment to review the 2001 Act	6-7
1.3 Changes since the 2001 Act was Introduced	7
1.4 Programme for Government	7
1.5 Structure of Overall Review of the 2001 Act	8
1.6 Establishment of and terms of reference for Expert Group	8-9
1.7 Number of meetings	9-10
1.8 Legislation and Policy	10-11
2 Issues Considered by the Expert Group	
2.1 Guiding Principles	12-15
2.2 Mental Disorder / Mental Illness	15-17
2.3 Definition of Treatment	17-18
2.4 Criteria for Detention	19-22
2.5 Exclusions	23
2.6 Capacity	23-28
2.7 Voluntary Patient	28-30
2.8 New Category of Patient	30-33
2.9 Authorised Officers	33-37
2.10 Procedure for Involuntary Admission to an Approved Centre	37-39
2.11 Patient Firstly Requiring Medical Treatment	40-41
2.12 Treatment Prior to Detention	41
2.13 Mental Health Tribunals	42-49
2.14 Renewal Orders	49-51
2.15 Absence With Leave	51
2.16 Grounds for Appeal	52-53
2.17 Change of Status from Voluntary to Involuntary	53-56
2.18 Consent to Treatment	56-60
2.19 Electro-Convulsive Therapy (ECT)	60-61
2.20 Administration of Medicine	62-64
2.21 Provision of Information on admission to Approved Centres and Complaints Mechanisms	64-65
2.22 Care Plans and Discharge Planning	65-67
2.23 Children	67-74

2.24	Inspections of Approved Centres and Community Services	74-76
2.25	Advance Healthcare Directives	76-79
2.26	Contact with Families and Doctor / Patient Confidentiality	79-81
2.27	Approved Clinician	81-82
2.28	Miscellaneous	82-86
2.29	Conclusion	86-87
3	Complete List of Recommendations	88-105

1 Introduction

1.1 Mental Health Legislation in Ireland

Mental health legislation is common throughout the world. Historically, this kind of legislation served a range of purposes. However, the purpose of modern mental health legislation is to ensure that the rights of a vulnerable section of our population are protected and that people with a mental illness who require treatment may have access to this treatment in an appropriate environment.

Individuals who suffer from mental illness can still face stigma, discrimination and marginalisation in all societies with a likelihood that their human rights can be violated. Legislation has an important role to play in promoting positive mental health and preventing mental disorders. A mental health legal framework can address critical issues such as the provision of high quality care, the regulation of and safeguards for compulsory admission in addition to the protection of human rights.

The Mental Treatment Act 1945 was the first significant piece of mental health legislation in this country in the twentieth century and it repealed a number of lunacy laws still on the statute books at that time. Given the less than ideal conditions for in-patients at the time, there was a warm welcome for the introduction of this legislation which introduced new admission procedures in addition to a range of measures designed to improve practices and standards in mental health care in Ireland.

However, while the 1945 Act improved standards, it wasn't until the introduction of the 2001 Mental Health Act that we saw real and substantial reform in how we dealt with those individuals suffering from mental disorders that require detention and treatment in mental health facilities. The 2001 Act removed indefinite detention orders while bringing in new involuntary admission procedures, independent reviews of detention, free legal representation, independent psychiatric opinions and establishment of the Mental Health Commission to oversee standards of care and protect patients' interests. These were very significant changes in the context of international developments in mental health legislation at the time.

1.2 Commitment to Review the 2001 Act

A 'Review of the Operation of the Mental Health Act 2001 – Findings and Conclusions' was published in May 2007 in line with the commitment in Section 75 of the 2001 Act to carry out a review of the operation of the Act not later than 5 years after the establishment day – 5th April 2002.

The Mental Health Commission produced its 'Report on the Operation of Part 2 of the Mental Health Act 2001' and this was published in April 2008 as required under section

42(4) of the Act. This report commented on the operation of Part 2 of the Act which commenced on 1st November 2006.

As the original five year review was published only months after Part 2 of the Act commenced and was therefore quite limited in scope, it was accepted that a further more substantial review should take place after that key part of the Act had been in operation for a number of years.

1.3 Changes since the 2001 Act was Introduced

The Mental Health Act 2001 was signed into law in July 2001, five years before the publication of *A Vision for Change* and it was only fully implemented in 2006, the same year as publication of *A Vision for Change*. Accordingly, the Act does not reflect the significant changes in thinking about the delivery of mental health services that have taken place in the last ten years, such as the shift to community based services, the adoption of a recovery approach in every aspect of service delivery and the involvement of service users as partners in their own care and in the development of the service.

In the European Convention on Human Rights Act 2003, the European Convention on Human Rights (ECHR) was incorporated into Irish law and Irish Courts must now interpret Irish law in a way which gives effect to the State's obligations under the ECHR. The period since the enactment of the Mental Health Act 2001 has seen substantial developments in the jurisprudence of the European Court of Human Rights (ECtHR) in the context of mental health legislation and the implications of this requires consideration.

Moreover, the Government signed the Convention on the Rights of Persons with Disabilities (CRPD) on March 30th 2007 and is committed to its ratification as quickly as possible. The Convention provides for a rights based approach to disability and in this context, the potential implications of some of the Articles of the Convention for our mental health legislation require further consideration.

1.4 Programme for Government

The Programme for Government contains a commitment to review the Mental Health Act 2001, informed by human rights standards and in consultation with service users, carers and other stakeholders. Progressing this commitment was a key priority in early 2011 for the Minister of State with responsibility for Mental Health, Ms Kathleen Lynch T.D. On that basis, Minister Lynch announced in July 2011 that a review of the Act would commence immediately.

1.5 Structure of Overall Review of the 2001 Act

Minister Lynch announced that the review of the Act would begin with the setting up of an initial Steering Group made up of Department officials and a representative from both the Mental Health Commission and the Health Service Executive (HSE).

The initial Steering Group review was a scoping exercise to identify the key areas of the Act to be examined in more detail under the second and substantial phase of the review. The Steering Group conducted a public consultation exercise as part of its work in order to seek the views of the public and relevant interested groups/parties on what changes should be introduced to improve the operation of the Act. Over 100 submissions were received as part of this consultation. The Group followed this up with a series of meetings with key stakeholders including the HSE, Mental Health Commission, professional representative bodies and service user groups. Analysis of the main issues raised through the consultation process and meetings, along with a review of issues raised by key documentation identified by the Steering Group formed the basis of the initial review.

The Steering Group's report was accepted by Minister Lynch and published in June 2012. The report is available on the Department's website at:

<http://health.gov.ie/blog/publications/interim-report-of-the-steering-group-on-the-review-of-the-mental-health-act-2001/>. The report received a broad welcome from key stakeholders and interested parties at the time.

The Steering Group acknowledged that it was not possible in preparing the Interim Report to be exhaustive or definitive about the vast array of issues and sometimes contradictory viewpoints on those issues that were raised with the Group as part of the review. The detail of this was left for further consideration by the Expert Group established by Minister Lynch in August 2012. Minister Lynch said at the time, "It was always my intention that the Interim Report would be subsequently referred to an Expert Group for the second and substantive phase of the review which would be principally tasked with fleshing out the Steering Group recommendations. In considering membership of the group, I have consulted with key stakeholder organisations and beyond to ensure there is a broad range of relevant expertise available for the work ahead."

1.6 Establishment of and Terms of Reference for Expert Group

The Terms of Reference for the Expert Group as agreed by Minister Lynch are as follows:

1. To examine each of the recommendations of the Interim Review of the Mental Health Act 2001, and
 - a. propose which recommendations can be agreed without further assessment or modification,
 - b. establish which recommendations require further analysis before being finalised, and

- c. make decisions on those areas where the Steering Group had offered choices rather than specific recommendations.
2. To consider Departmental proposals for amending the Mental Health Act which pre-dated the Steering Group report and recommend a course of action in respect of them.
3. To examine any further specific issues which may be referred to the Expert Group by the Minister.
4. To ensure that the recommendations of the Expert Group take account of any Capacity legislation published in the meantime and be consistent with such legislation and existing criminal law insanity legislation, which is also under review at this time.
5. To conclude its deliberations and submit final report to the Minister by end March 2013.

The individuals appointed to membership of the Expert Group are as follows:

Dr. Pat Bracken	Consultant Psychiatrist
Caitriona Browne	Mental Health Nurse Manager
Lisa Corrigan	Occupational Therapy Manager
Dr Mary Donnelly	Senior Lecturer, Faculty of Law, UCC
Dr Rita Doyle *	General Practitioner
Patricia Gilheaney	CEO, Mental Health Commission
Dr. Des Hogan	Acting CEO, Irish Human Rights Commission
Áine Hynes	Solicitor and Chair of the Irish Mental Lawyers Association
Prof Brendan Kelly	Consultant Psychiatrist
Tony Leahy	National Mental Health Planning Specialist, HSE
Luke Mulligan (Chair)	Department of Health
Dr. Edmond O'Dea	Principal Clinical Psychologist
John Redican **	National Service Users Executive
Joan Regan ***	Department of Health
Gerry Steadman	Department of Health
Martin Woods	Department of Health acted as Secretary to the Group

* Due to the pressure of other work Dr Doyle had to step down from the Expert Group in July 2013 and was not replaced by another GP.

** John Redican of NSUE was replaced by John Kidney in August 2013.

*** Joan Regan moved to different duties within the Department and stood down from the Group in January, 2013.

1.7 Number of Meetings

The Group first met on 18 September 2012 and has held 13 meetings with the final meeting taking place on 16 September 2014. While it had been anticipated that the Group would report in 2013 that timescale was pushed out principally for two key reasons. Firstly, the

Group members wanted time to consider the implications of the Assisted Decision-Making (Capacity) Bill which was only published in July 2013 and has yet to be considered at Committee stage in the Oireachtas where a number of significant changes are likely to be made. This review requires members to consider a number of issues relating to capacity in the area of mental health. Secondly, the matters for consideration seeking to balance human rights issues for individuals with the requirements for public health and safety gave rise to a number of detailed discussions which required careful analysis of the various options suggested.

Members were satisfied that the work involved should be given the time required and believe that the time taken to review these complicated matters was appropriate in the circumstances. For her part, Minister Lynch agreed that it would be unwise to rush through a report to satisfy a time requirement when legislation arising from the Group's review is likely to stand for many years into the future. The Minister was also clear that the Group members were free to consider any aspect or issue that they felt was necessary to be considered in the context of the review.

1.8 Legislation and Policy

Health services are shaped by legislation and policy and while there is often a crossover between the two, the two strands tend to be quite separate where mental health is concerned with legislation traditionally focusing on protections, safeguards and procedures relating to those who are involuntarily detained while mental health policy obviously deals with the broad range of mental health services available. Increasingly policy is focusing more and more on the roll out of much needed community mental health services.

One of the requirements of the Group's terms of reference acknowledges that as the Mental Health Act was enacted in 2001, any review of this legislation must take greater account of the vision set out in *A Vision for Change* which is to create a mental health system that addresses the needs of the population through a focus on the requirements of the individual.

Firstly, the Group want to make it clear that members fully agree with and accept the principles behind *A Vision for Change* and the need to bring about a cultural shift in how mental health services are delivered, in particular, by moving from professional dominance towards a person-centred, partnership approach to service delivery. However, while the importance of having our mental health legislation and our national mental health policy aligned is appreciated, it is also recognised by Group members that it would not be practicable or desirable to legislate for how specific services should be delivered or indeed to provide a right for individuals to services. Therefore, while keen to ensure that legislation has due regard for the vision of our mental health services as espoused in *A Vision for Change*, and the principle of recovery in particular, the Group members were constrained by the limitations of how far legislation can go in terms of actual promotion and delivery of mental health services.

There is no single agreed source of authority in the area of mental health and the Group believes that it is important that the often contested view of mental illness should be something both Mental Health Professionals and others such as the Court services should have to take account of. In this regard for example, while it was agreed that it would not be feasible to include recovery as a guiding principle for future mental health legislation, respect for a person's own understanding of their condition and mental health in the context of their own life experience should be included (*see section 2.1 on Guiding Principles*).

Members would emphasise that the importance of recovery was a recurring theme in discussions and they accepted the view that recovery has a much broader definition in the context of mental health than it does in relation to the traditional view of recovery in the area of physical illness. While there are similarities between physical illness and mental illness, there are also important differences. The mind is not simply another organ of the body and mental health expertise is deeply contested.

Members are also conscious of the ongoing need to have a 'parity approach' to delivering our health services where mental health is given equal priority to physical health to ensure a holistic approach is taken to address each person's overall health needs.

Finally, while the Group accepts that separate mental health legislation remains necessary at this time, members recognise that a single legislative framework with a fusion of mental health and mental capacity statutes may be more appropriate in the future.

2 Issues considered by the Expert Group

2.1 Guiding Principles

Throughout its discussions, the Expert Group was conscious that, while there have been some positive changes in general society attitudes over time, people with mental illness still suffer discrimination and stigmatisation. The Group acknowledged the fundamental importance of working towards the removal of all elements of stigma in the field of mental health and this important tenet was a key part of the Group's thinking in looking at the issue of guiding principles.

The Mental Health Act 2001 contains principles which are intended as a guide to the interpretation of the Act in relation to people admitted for mental health care and treatment. They aim to set the tone of the Act and as a general rule, anyone who takes any action under the Act has to take account of the principles. Section 4 of the Act (*Best interests, etc., of person*) can be summarised as follows:

- Best interests of the person must be the principal consideration balanced against other interests;
- Individuals are entitled to notification about certain decisions and to respond in relation to admission and treatment decisions as far as is practicable;
- In all decisions regard must be had to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy.

While the right of the person to having dignity, bodily integrity, privacy and autonomy respected is clearly stated in the Act, the fact that the term 'best interests' is listed as a 'principal consideration' along with the generally 'purposive interpretation' of the Act has led the Courts over the years to interpret these principles in a paternalistic manner as was often the position in case law prior to the introduction of the 2001 Act.

The Expert Group was clear from its first meeting that a substantial shift away from the often paternalistic interpretation of mental health legislation by the Courts is required in order to comply with the European Convention on Human Rights (ECHR) and the United Nations Convention on the Rights of Persons with Disabilities (CRPD). Members agreed that the paternalistic approach is at odds with the person centred ethos of *A Vision for Change* and that it could be considered that best interests as it has been interpreted and applied, is at the opposite end of the scale from autonomy. In that regard, the first action to begin this re-balancing process was identified as the need to ensure that the move from paternalism as highlighted in the current 2001 Act to revised legislation focused on the autonomy of the individual, should be specifically included in the long title to any proposed amending mental health legislation. This significant change in how revised mental health legislation should be interpreted would be reflected in the text of such legislation by the proposed elimination of the existing 'principal consideration' of 'best interests' and replacing the limited principles in the 2001 Act with a more human rights based list of guiding principles which would reflect the importance of the person's right to autonomy. The right of people to make their own

choices and the principle of a presumption of capacity as set out in the Assisted Decision-Making (Capacity) Bill, with the provision of support if necessary, must be respected. This is the case even if it is ‘our view’ that those decisions are ‘wrong’ or not the decisions others might favour.

Some discussion took place on whether in drawing up a list of the most important guiding principles, a hierarchy of these principles should be identified and put in place. Following consideration of the possible effects of identifying a hierarchy and whilst acknowledging the importance of enjoying the highest attainable standard of mental health, and autonomy, it was agreed that the list of guiding principles should not place a greater emphasis on one rather than another principle.

As the list of guiding principles under examination is being framed specifically in the context of mental health legislation, the members agreed that the enjoyment of the highest attainable standard of mental health must be included and that this should be in the context of the person’s own understanding of his or her mental health being given due respect.

There was strong appreciation among Group members that the CRPD has a sharp focus on the need to recognise the ‘will and preferences’ of people as opposed to decisions being made by others on their behalf with their ‘best interests’ in mind. On this basis, autonomy and self determination were seen as warranting inclusion in any list of guiding principles which would inform new mental health legislation. Personal recovery principles, determined and owned by the individual, are a key component of the recovery approach, placing an emphasis on the unique value of the person and their own understanding of their illness and their leadership role in the recovery journey. This balancing of the roles of service users and Mental Health Professionals must be reflected in the guiding principles of revised mental health legislation.

The College of Psychiatrists of Ireland indicated that it is in favour of retaining best interests, though it believed that it should be incorporated not as a single over-arching principle, but as one of a list of principles which should be considered and weighed up together. The Group members were concerned that even with a revised and updated definition of best interests, there might still be a tendency to over use it as a paternalistic measure. While many members agreed that in circumstances where a person’s wishes simply could not be ascertained, it would not be unreasonable to apply a best interests principle, nonetheless the phrase ‘best interests’ itself was not favoured by members. The Group noted General Comment No 1 of the Committee on the Rights of Persons with Disabilities (2014) which states at {21} that “the ‘best interests’ principle is not a safeguard which complies with article 12 in relation to adults. The “will and preferences” paradigm must replace the “best interests” paradigm to ensure that persons with disabilities enjoy the right to legal capacity on an equal basis with others.”

Following further consideration of the matter, the Group agreed that the positive aspects associated with best interests could be captured if the term ‘dignity’ is included as a guiding principle. While it is acknowledged that dignity (which features very prominently in the

CRPD but is not defined in it) is not necessarily an easy principle to define, the Group is satisfied that it should be included as a guiding principle.

In an attempt to add clarity to what is meant by dignity it is important to state that there should be a presumption that the patient is the person best placed to determine what promotes/compromises his or her own dignity.

The Group also believes that wording from the current Assisted Decision-Making (Capacity) Bill along the following lines would be helpful:

‘The word “dignity” is to be interpreted according to the following principles. There is a presumption that the patient is the person best placed to determine what promotes or compromises his or her own dignity. If that presumption cannot be met, other considerations are relevant and these should include, in this order:

- The known or ascertainable will and preferences of the person; the past and present wishes and feelings of the person; the beliefs and values of the person (in particular those expressed in written form) relevant to the matter concerned to which the intervention relates, and other factors which the person would be likely to consider if he or she were able to do so;
- The person being permitted and encouraged, in so far as is practicable to participate, or to improve his or her ability to participate, as fully as possible, in the intervention;
- Consideration of the views of anyone named by the person as a person to be consulted on the matter concerned or any similar matter;
- Consideration of all other circumstances of which the person assisting with the decision is aware and which it would be reasonable to regard as relevant;
- Consideration of the views of anyone engaged in caring for the person, anyone who has a bona fide interest in the dignity and welfare of the person, and/or relevant Healthcare Professionals.’

Finally, it was agreed that bodily integrity and least restrictive care should also be included as guiding principles. While there were many other possibilities discussed for inclusion, it was deemed appropriate that it would be best and more practicable to limit the list of principles to five/six.

Some concern was raised that in granting people greater autonomy and self determination, it may have an unintended consequence of certain people ending up in the criminal justice system rather than seeking or accepting treatment. Group members believe that if it is deemed that an individual needs treatment for mental illness members of the multi-disciplinary team should clearly explain the need to the individual and outline the options for treatment available to the individual. However while it may appear to the individual that there is an inherent (and understandable) view from Mental Health Professionals that treatment is always in the individual’s best interests, nonetheless it must be accepted that the individual with capacity has the right to articulate what he or she believes is in his or her own

best interests even if that is a refusal of treatment or an objection to admission to an approved centre.

Ultimately, the Group members believe that individuals with mental illness and with capacity have the right to make what others may consider to be unwise decisions.

Finally, while mental health legislation is intended to cover interventions that are aimed at achieving the highest attainable level of mental health for the patient, the Group would re-iterate that ‘mental health’ is itself a contested concept and there is no single agreed source of authority in this area. The Group would stress that interventions by Mental Health Professionals and others such as the Court services should take account of the contested nature of mental illness and must, at all times, give due respect to the person’s own understanding of his or her mental health.

Recommendations:

- 1. Insofar as practicable, a rights based approach should be adopted throughout any revised mental health legislation.**
- 2. The following list of Guiding Principles of equal importance should be specified in the new law:**
 - a. The enjoyment of the highest attainable standard of mental health, with the person’s own understanding of his or her mental health being given due respect**
 - b. Autonomy and self determination**
 - c. Dignity (there should be a presumption that the patient is the person best placed to determine what promotes/compromises his or her own dignity)**
 - d. Bodily integrity**
 - e. Least restrictive care.**

2.2 Mental Disorder / Mental Illness

Under section 3(1) of the Mental Health Act 2001, the term ‘mental disorder’ is defined in the context of the criteria for detention. In order to make a determination of mental disorder as defined in the Act, there must, in the first instance be the presence of a mental illness, severe dementia or significant intellectual disability. However the presence alone of any of the above does not meet the threshold for mental disorder and as a consequence involuntary detention. In addition to the presence of any of the three conditions outlined, there must be a serious likelihood of the person causing immediate and serious harm to himself, herself or others. If there is no ‘harm’ component the threshold for mental disorder may still be reached if the severity of the condition (mental illness, severe dementia or significant intellectual disability) is such that the person’s judgement is so impaired that if he/she was not admitted their condition would seriously deteriorate, or it would prevent the administration of treatment that could only be given if the person was admitted to the approved centre and the treatment of the person would be likely to benefit them to a material extent.

The Group members agreed that there is a need for greater clarity about whether and how it is determined that the severity of an individual's mental disorder is such as to warrant consideration of involuntary admission and treatment. Increasing the threshold for what could be deemed to be a mental disorder for the purposes of the Act was seen as being an important step forward. In addition, while it is recognised that legal definitions of mental disorder can be complex and are difficult to draft, it was emphasised that 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.

In considering a revised definition it was agreed that in the first instance it should be a stand-alone definition and the criteria for detention should be listed separately. Quite a few of the submissions made to the original Steering Group were advocating such a separation. This would have the advantage of making the Act more easily understood by Healthcare Professionals, service users, carers and stakeholders, who at times may equate the term 'mental disorder' with a condition rather than part of the criteria for involuntary detention.

There was a consensus within the Group that in order for the definition to be compliant with the ECHR and CRPD, it needed to be more focused. In particular it was agreed that specific inclusion of 'significant intellectual disability' could not continue. The detention of persons with an intellectual disability but who do not have a mental illness in psychiatric institutions is inappropriate and has been criticised on a number of occasions by the European Committee for the Prevention of Torture (CPT).

A more detailed discussion took place about whether 'severe dementia' should remain or also be removed and while it may be argued that there was more reason to include 'severe dementia' as opposed to 'intellectual disability', ultimately the Group members decided that it too should be removed from the definition as it is already captured in the classification of a mental illness. This does not preclude the involuntary admission of persons with intellectual disabilities or severe dementia to approved centres because of mental illness and where they also meet the criteria for detention.

With those two sub-categories removed, the remaining sub-category is mental illness. On this basis, it was agreed that rather than providing a definition of 'mental disorder', which reflects a strongly medical model approach to mental illness, and with just one sub-category of mental illness remaining, it was reasonable to simply define the term 'mental illness' for the purposes of the Act and to drop the reference to 'mental disorder'¹ altogether.

In attempting to set out a revised definition of the term 'mental illness', the Group was keen to acknowledge the fact that mental illness is increasingly recognised as a complex and changeable condition. Members agreed that this important recognition must be included in

¹ Throughout the rest of the report, we will use the term 'mental illness' rather than 'mental disorder' and will only use the latter where we are specifically referring to what is already contained in the 2001 Act.

the definition to remind those who are required to use it to be aware that no one person or profession has a monopoly of wisdom when it comes to making important decisions with regard to a person's possible detention and treatment in those circumstances.

The Group looked at definitions of mental disorder used in other countries but ultimately decided that the existing definition of mental illness in the 2001 Act, slightly amended, would still be relevant and appropriate for the years ahead. The definition agreed is:

Mental illness means a complex and changeable condition where the state of mind of a person affects the person's thinking, perceiving, emotion or judgment and seriously impairs the mental function of the person to the extent that he or she requires treatment.

Recommendations:

- 3. Mental disorder should no longer be defined in mental health legislation but instead the revised Act should include a definition of mental illness.**
- 4. The definition of mental illness should be separated from the criteria for detention (see section 2.4 of this report re criteria for detention).**
- 5. The reference to 'significant intellectual disability' and 'severe dementia' in existing legislation should be removed.**
- 6. The definition of mental illness should be: 'mental illness means a complex and changeable condition where the state of mind of a person affects the person's thinking, perceiving, emotion or judgment and seriously impairs the mental function of the person to the extent that he or she requires treatment.'**

2.3 Definition of Treatment

In the 2001 Act, treatment, in relation to a patient, 'includes the administration of physical, psychological and other remedies relating to the care and rehabilitation of a patient under medical supervision, intended for the purposes of ameliorating a mental disorder'.

The Steering Group in its Interim Report recommended that the definition of treatment should be expanded to include ancillary tests required for the purposes of safeguarding life, ameliorating the condition, restoring health or relieving suffering. This additional element was recommended as a result of the High Court Judgment in the case of *HSE v M.X.* (2012). In the judgment in this case, the High Court indicated that treatment 'should allow for 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 Expert Group was satisfied that the recommendation of the Steering Group should be adopted. In addition, it was agreed that the definition of treatment in this context should be further expanded to include treatment to all patients admitted to or detained in an approved centre. The Group also agreed that treatment should be clearly defined in revised mental

health legislation and clinical guidelines should be further developed on forms of treatment. While traditionally the focus of treatment was on the administration of medication, the Group would like to make it clear that treatment includes a range of psychological and other remedies and where treatment is specifically mentioned in this report, it should be interpreted in its wider sense and not viewed simply as the administration of medication.

During the course of discussions, some members felt that in certain circumstances, the definition of treatment should be expanded to allow for the removal of the person from perhaps a difficult environment to a safe caring one even if no physical, psychological or other ‘treatments’ are being administered. Some members consider that such a place of refuge is, for some individuals, enough to allow recovery to take place. This can be particularly important to service users who do not wish to be medicated and see a place of refuge as being enough for them to regain their health.

On the other hand, caution was expressed by other members who stressed the huge significance of depriving a person of their liberty and voiced their concern that providing for refuge without treatment in legislation could have the effect of allowing for detention without appropriate interventions on a wider scale.

The Group was agreed that including refuge in the definition of treatment may inadvertently allow for the long term detention of a person including a person with dementia even though they could be managed in less restrictive settings. To ensure that this does not occur, it was suggested that an additional sentence in relation to the definition of treatment should be added to state that ‘The provision of safety and/or a safe environment alone does not constitute treatment’. It was acknowledged that this inclusion will impact on the wider mental health population but overall it was felt by the Group that the provision of a safe environment alone cannot justify detention.

Recommendations:

- 7. Treatment should include ancillary tests required for the purposes of safeguarding life, ameliorating the condition, restoring health or relieving suffering.**
- 8. The definition of treatment should be expanded to include treatment to all patients admitted to or detained in an approved centre.**
- 9. Treatment should be clearly defined in revised mental health legislation and clinical guidelines should be further developed for the administration of various forms of treatment.**
- 10. Traditionally the focus of treatment was on the administration of medication, the Group would like to make it clear that treatment includes a range of psychological and other remedies and where treatment is specifically mentioned in this report, it should be interpreted in its wider sense and not viewed simply as the administration of medication.**
- 11. The provision of safety and/or a safe environment alone does not constitute treatment.**

2.4 Criteria for Detention

The right to liberty is a fundamental right and is protected by Article 40.4 of Bunreacht na hEireann and Article 5 of the European Convention on Human Rights (ECHR). Although Article 5 permits deprivation of liberty on the grounds that a person is “of unsound mind”, Article 5(1) states that “No one shall be deprived of his liberty save ...in accordance with a procedure prescribed by law”. Moreover, Article 5(4) states that “Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.”

In *Winterwerp v the Netherlands* [1979] ECHR 4, the European Court of Human Rights [ECtHR] found that, in order for the detention of a person of unsound mind to be lawful the following minimum criteria must be satisfied:

- Except in emergency cases, no one can be deprived of liberty unless he or she can be reliably shown to be of unsound mind on the basis of objective medical expertise;
- The mental disorder must be of a kind or degree warranting compulsory confinement;
- The validity of continued confinement depends on the persistence of the disorder.

Moreover, in *Stanev v Bulgaria* (2012) ECHR 46, the ECtHR recognised a further requirement to consider alternatives to admission and to show that the admission is ‘necessary in the circumstances’.

ECtHR jurisprudence in respect of Article 5(4) has confirmed the importance of an appropriate and accessible review of detention. It is clear that the possibility of judicial review and *habeas corpus* proceedings are not sufficient to meet the requirements under Article 5(4): see *HL v United Kingdom* (2005) 40 EHRR 32 and that the possibility of initiating a review of detention through a family member is insufficient: *Shtukaturv Russia* [2008] ECHR 44009/05.

While section 8 of the 2001 Act provides the authority to involuntarily admit and detain a person to an approved centre on the grounds that he or she is suffering from a mental disorder, it is section 3 of the Act which sets out the definition of mental disorder and which effectively sets out the current criteria for detention. As mentioned in section 2.2 of this report, the Group is agreed that revised legislation should refer to mental illness rather than mental disorder in addition to separating out revised criteria for detention.

It is recognised and accepted that involuntary admission and detention of a person is a *de facto* interference with that person’s right to liberty. However, it was also accepted that the right to liberty is not an absolute right and that there are circumstances where limits may be placed on a person’s liberty provided those limits are deemed to be necessary, proportionate and are carried out in accordance with a procedure set out in law.

The Group members would also unequivocally state that detention of a person with a mental illness cannot be permitted simply by virtue of the fact that the person may have such an illness or indeed because his or her views or behaviour deviate from the norms of the prevailing society.

Detention should only take place where the person is diagnosed with a mental illness and where specific criteria about the potential consequences of a person's mental illness are met in accordance with procedures laid down in law. Detention in these circumstances can never be seen as punitive in nature and detention along with the administration of treatment without consent must always be accompanied by procedures to protect the rights of the person concerned.

Detention is a serious and significant matter for any person and therefore should only be considered where other less restrictive measures have been considered and found to be insufficient to provide the necessary care and/or treatment for the person in addition to providing the appropriate safeguards for the person.

On this basis, the Group recommended the following as detention criteria (a): *The individual is suffering from mental illness of a nature or degree of severity which makes it necessary for him or her to receive treatment in an approved centre which cannot be given in the community.*

In considering therefore whether detention is necessary for a person, the Group focused on four key features which are central to most detention regimes around the world:

- the risk to the person's life;
- the risk to the person's health;
- the risk of harm to other people; and
- the need for treatment.

The current wording of section 3 of the 2001 Act relating to mental disorder reads as follows:

‘3.—(1) In this Act "mental disorder" means mental illness, severe dementia or significant intellectual disability where—

(a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or

(b) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and

(ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.’

The Group is satisfied that revised legislation must provide for involuntary detention where the person concerned is diagnosed with a mental illness and it is required for the protection of his/her life or for the protection of other persons that he or she should receive treatment while detained.

There was considerable discussion within the Group over whether the risk to a person's health or the likelihood of his/her condition deteriorating should be included as a criterion for detention. Some viewed this as a choice that people should have and that with autonomy as one of our proposed guiding principles, it would be wrong to take this choice away from people in circumstances where lives were not at risk. It was also suggested that if this criterion was to be included, some people would see this as a threat which could be held over them and would be likely to discourage some individuals from seeking treatment on a voluntary basis.

The opposing view was that it is enormously difficult for Mental Health Professionals, including Consultant Psychiatrists, to accurately assess risk and that the difference between risk to life and risk to health can be very subjective. It was also considered that if a person's mental illness is severe enough to warrant detention where lives are at risk, it is equally valid that the same severity of mental illness would provide the justification required to allow 'risk to health' to be included as a criterion for detention. Ultimately the Group was persuaded by the latter view that, on balance, it is reasonable to allow for a person to be detained in circumstances where their health may deteriorate without the appropriate treatment.

The Group recommended the following as detention criterion (b): *It is 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 he or she should receive such treatment and it cannot be provided unless he or she is detained under the Act.*

The question of inpatient treatment of a person with a mental illness and the principle of reciprocity also featured heavily in Group discussions in this area. As previously indicated, detention in these circumstances is not intended to be punitive in nature but rather is a means to ensure that where a person's mental illness is severe, then the person can receive appropriate treatment for his/her condition. The Group accepts that the principle of reciprocity demands if someone's liberty is taken away, there is a parallel duty on the health services to provide appropriate treatment for the person's mental illness. In addition, that treatment must be likely to benefit the condition of that person to a material extent and it must be deemed that such treatment cannot be provided otherwise unless he/she is detained in an approved centre under the Act. The Group therefore recommends that if a person with capacity refuses every treatment option, the basis for detaining such a person can no longer be held to be valid and he/she should be discharged (*see also section 2.18 on consent to treatment*).

This brings about a significant change to the existing legislation as under section 3(1)(a) of the Act detention is provided for where in addition to the presence of mental illness, severe

dementia or significant intellectual disability, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, but significantly there is no mention of treatment being required for the person concerned which would be likely to benefit or alleviate the condition of that person to a material extent. This reference to treatment is included in section 3(1)(b) which deals with the possible deterioration in the person's condition. The Group now recommends that the principle of reciprocity should apply in all scenarios where a person is being detained under the Act and that if all treatment is refused by a person with capacity (see also the section on Advance Healthcare Directives in this regard) then the person should be discharged.

The Group therefore recommends the following as detention criterion (c): *the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit the condition of that person to a material extent.*

The Group recommends that detention should only continue for as long as absolutely necessary and the person concerned satisfies all the stated criteria. Immediately a person no longer satisfies any of these criteria, the admission or renewal order must be revoked and if the person chooses not to remain in the approved centre on a voluntary basis, the required services should be provided in the community.

Recommendations:

- 12. Detention of a person with a mental illness cannot be permitted simply by virtue of the fact that the person may have such an illness or because his or her views or behaviour deviate from the norms of the prevailing society.**
- 13. The recommended new criteria for detention are:**
 - a. the individual is suffering from mental illness of a nature or degree of severity which makes it necessary for him or her to receive treatment in an approved centre which cannot be given in the community; and**
 - b. it is 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 he or she should receive such treatment and it cannot be provided unless he or she is detained in an approved centre under the Act; and**
 - c. the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit the condition of that person to a material extent.**
- 14. Detention should only be for as long as absolutely necessary and the person continues to satisfy all the stated criteria.**
- 15. Immediately a person no longer satisfies any one of these criteria, the admission or renewal order must be revoked. In those circumstances, the person may only remain in the approved centre on a voluntary basis or receive the required services which are provided in the community.**

2.5 Exclusions

The Mental Health Act 2001 (*section 8(2)*) details three categories of patient who cannot be involuntarily admitted to an approved centre on the sole basis that the person is suffering from the condition mentioned i.e.

- (a) is suffering from a personality disorder
- (b) is socially deviant, or
- (c) is addicted to drugs or intoxicants.

These categories of persons may only be admitted involuntarily once they fulfil all the criteria for detention detailed in section 2.4 (*Criteria for Detention*).

The Expert Group considered the matter and whether there should be any amendments to the existing stated exclusions. Following the discussion in section 2.2 (*Mental Disorder / Mental Illness*), it was agreed to specifically include a recommendation that a person cannot be detained under the Act solely on the basis of having an intellectual disability, otherwise the Group recommended no change to these existing exclusions, and they should remain in place.

Recommendations:

16. The involuntary admission of a person to an approved centre cannot be authorised by reason only of the fact that the person –

- (a) is suffering from a personality disorder,**
- (b) is socially deviant,**
- (c) is addicted to drugs or intoxicants, or**
- (d) has an intellectual disability.**

2.6 Capacity

Throughout the review of the Mental Health Act 2001, the Expert Group was cognisant of the need to ensure that proposals made by the Group were consistent with, and interacted in an appropriate manner with the review of capacity legislation which is being carried out by the Department of Justice and Equality. The Assisted Decision-Making (Capacity) Bill 2013 was published on 17th July, 2013 and at the time of writing this report, the proposed Bill is being considered by the Oireachtas. It would be anticipated that any new mental health legislation arising from the proposals recommended in the review of the Mental Health Act 2001 would be able to take account of the agreed finalised legislative provisions of the Capacity Bill.

Section 104 of Part 11 of the Capacity Bill seeks to ensure that there is no conflict between the Bill and the 2001 Act with respect to the treatment of a patient with a mental disorder (*which the Group will recommend should now be termed mental illness, section 2.2*). Section 104 provides that '*nothing in this Act authorises a person (a) to give a patient treatment for*

mental disorder, or (b) to consent to a patient being given treatment for mental disorder, if at the time when it is proposed to treat the patient, his or her treatment is regulated by Part 4 of the Act of 2001’.

The Capacity Bill has been framed to meet Ireland’s obligations under the UN Convention on the Rights of Persons with Disabilities and a specified aim was to ‘reform the law on mental capacity to ensure the greatest degree of autonomy for people with intellectual disabilities or suffering with mental illness’. This aim is in keeping with the recommendations of the Expert Group throughout this report and ensuring that the informed consent of a person is sought for important issues such as admission to and treatment in an approved centre. The Capacity Bill proposes to change the existing law on capacity from the current all or nothing status approach to a functional one, whereby there is a presumption of capacity and therefore capacity is assessed only in relation to the matter in question and only at the time in question. The Bill proposes three types of decision making support options to respond to the range of support needs that people may have in relation to decision making capacity:

- **Assisted Decision-Making:** a person may appoint a decision-making assistant – typically a family member or carer to support him or her access information or to understand, make and express decisions. Decision-making responsibility remains with the person.
- **Co-Decision-Making:** a person can appoint a trusted family member or friend as a co-decision-maker to make decisions jointly with him or her. A co-decision-maker will help to access and explain information relevant to a decision and will help the person to make and express a decision. A co-decision-maker cannot oppose a decision made by the person where it is reasonable and will not cause harm to another person.
- **Decision-Making Representative:** for the small minority of people who are not able to make decisions even with help, the Bill provides for the Circuit Court to appoint a decision-making representative. A decision-making representative will make decisions on behalf of the person but must abide by the guiding principles set out in the Bill and must reflect the person’s will and preferences where possible.

The Expert Group looked at the interaction of these decision-making supports proposed in the Bill and the provisions of the Mental Health Act 2001. The Group in its recommendations for voluntary patients (*section 2.7*) recommended that a voluntary patient should be defined as a person who has the capacity (with support if required) to make a decision regarding admission to an approved centre and who, where the person retains capacity, formally gives his/her informed consent to such admission, and subsequent continuation of voluntary inpatient status and treatment on an ongoing basis as required. Thus the Group was clear from this recommended definition that a person who has appointed a decision-making assistant or a co-decision-maker can be admitted on a voluntary basis to an approved centre and can consent to treatment. The position for a person whom the Circuit Court has declared to be unable to exercise his or her capacity and has been assigned a decision-making representative will be elaborated further in *section 2.8 (New Category of Patient)*. The recommendations in

section 2.8 address the situation where a person without capacity but with a decision-making representative requires inpatient services for mental illness but does not meet the criteria for detention and therefore cannot be admitted on an involuntary basis. As such a person also cannot be admitted on a voluntary basis as set out above, recommendations are proposed in section 2.8 to deal with this situation.

The Group acknowledges that changes to the Assisted Decision-Making (Capacity) Bill are likely as the Bill proceeds through the Houses of the Oireachtas. Clearly the Group would be in a better position to make more precise recommendations on capacity related issues specifically in the area of mental health if the Capacity Bill had been passed into law. The Group believes that when revised mental health legislation is being framed a further look at the final proposals in the Capacity Bill will be required.

While the new proposals of the Assisted Decision-Making (Capacity) Bill have been welcomed by the Group, and the adoption of a functional approach to capacity marks a significant advance in this area, it was also acknowledged that it will be necessary to simultaneously develop recommendations and guidelines for the assessment of capacity of persons who require admission for mental health treatment to an approved centre. Notwithstanding the principle of the presumption of capacity, the Expert Group was very clear on the need for the admitting Mental Health Professional to establish if the person has the capacity to understand and give his/her informed consent to the proposed admission to an approved centre. If a person has decision maker supports in place, the Mental Health Professional should be made aware of such supports but still must make a decision on the capacity of the person to consent to admission at that particular time, thus endorsing the functional approach in the Capacity Bill. Where the admitting Mental Health Professional forms the view that the person may lack capacity to understand and give his/her informed consent to the proposed admission, they must refer the person for formal capacity assessment to be completed within 24 hours.

Given the time periods involved, the Group agreed that it would not be feasible to refer people who required formal capacity assessments to the system proposed by the Assisted Decision-Making (Capacity) Bill, instead the Group recommended that the capacity assessment can be undertaken by Mental Health Professionals with the required competencies and such competencies should be accredited by the respective professional bodies who should provide support and training where required. Where a patient objects to the Mental Health Professional's decision in relation to the patient's capacity, this should be referred to the Tribunal (Mental Health Review Board)² to be set up to review the detention of the patient concerned. In addition, it was recommended that the Mental Health Commission should develop and publish guidelines in relation to the assessment of capacity.

If following the capacity assessment, it is deemed that a person has capacity to admit themselves, a voluntary admission may proceed. If it is deemed that they need support to understand, to make or to convey their decision, that support must be provided to assist in the

² Section 2.13 will detail the Group's recommendations to amend the term 'Mental Health Tribunal' or 'Tribunal' to 'Mental Health Review Board'.

voluntary admission process. It will be important that any support required is provided on a timely basis. In this context, it will be necessary to take note of any similar provisions that may emerge when the Assisted Decision-Making (Capacity) Bill is enacted. It may be that provisions in the Capacity Bill will put general procedures in place to deal with this. However, this is a level of detail that will require closer examination when revised mental health legislation is being drawn up in light of what the Capacity Bill proposes in due course.

If it is deemed that a person lacks capacity but has a mental illness and fulfils the criteria for detention, he or she may only be admitted on an involuntary basis. A person who lacks capacity and has a mental illness but does not fulfil the criteria for detention, could not be admitted as an involuntary patient but may be admitted under the new category of ‘intermediate patient’ as outlined in section 2.8. It will also be necessary for the Mental Health Professionals to monitor the capacity of the person on an ongoing basis.

The Group agreed on the need to ensure that the definition of capacity should be consistent with the Assisted Decision-Making (Capacity) Bill. Section 3 of the Capacity Bill (Person’s capacity to be construed functionally) sets out the circumstances in which a person may be unable to make a decision and therefore lacks capacity. The Group members are satisfied with this wording which is set out hereunder:

- ‘(1) A person lacks the capacity to make a decision if he or she is unable—
 - (a) to understand the information relevant to the decision,
 - (b) to retain that information,
 - (c) to use or weigh that information as part of the process of making the decision, or
 - (d) to communicate his or her decision (whether by talking, writing, using sign language, assisted technology, or any other means) or, if the implementation of the decision requires the act of a third party, to communicate by any means with that third party.
- (2) A person is not to be regarded as unable to understand the information relevant to a decision if he or she is able to understand an explanation of it given to him or her in a way that is appropriate to his or her circumstances (whether using simple language, visual aids or any other means).
- (3) The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him or her from being regarded as having the capacity to make the decision.
- (4) For the purposes of this section, information relevant to a decision shall be construed as including information about the reasonably foreseeable consequences of—
 - (a) each of the available choices at the time the decision is made, or
 - (b) failing to make the decision.
- (5) Any question as to whether a person lacks capacity shall be decided on the balance of probabilities.’

All references to capacity in this report should be interpreted accordingly.

The Group also raised concerns relating to what could be described as ‘institutional influence’. This arises where some patients when faced with choices regarding their mental

health care and treatment go along with a proposal put to them not necessarily because they actively agree to it but in part because they are over-awed by Mental Health Professionals or intimidated by a stay in an approved centre. Members cited examples of individuals who seemed to want to ask a question or choose an alternative proposal but instead simply opted to agree to a proposal put to them. The Group believes that the possibility of 'institutional influence' having a bearing on an individual's decision-making should be borne in mind by those carrying out capacity assessments and those seeking consent to treatment options. In addition, the Group suggests that guidelines to be developed by the Mental Health Commission in relation to capacity assessment should also draw attention to the possibility that external factors such as 'institutional influence' can have a bearing on how people react to proposals put to them.

The Group also acknowledged that while the process surrounding involuntary admission including the question of capacity is already explained to individuals when they are being admitted, nonetheless with the increased and welcome focus on capacity, the Group believes that it would be appropriate and beneficial for individuals being admitted if they were given information relating to how capacity is assessed and their right of appeal against a decision on their capacity to a Mental Health Review Board. In addition they, and their family or carers if appropriate, should also be given information relating to the supports that may be available to the individual under the proposed capacity legislation.

Recommendations:

- 17. If on admission of a patient, the admitting Mental Health Professional forms the view that the person may lack capacity to understand and give his/her informed consent to the proposed admission, they must refer the person for formal capacity assessment to be completed within 24 hours. The patient will be required to remain in the approved centre until such time as a capacity assessment is carried out.**
- 18. The Mental Health Commission should develop and publish guidelines in relation to the assessment of capacity. Capacity assessment can be undertaken by Mental Health Professionals with the required competencies and such competencies should be accredited by the respective professional bodies who should provide support and training where required. The guidelines should also draw attention to the possibility that external factors such as 'institutional influence' can have a bearing on how people react to proposals or questions put to them.**
- 19. Capacity should be monitored on an ongoing basis by the treating clinicians.**
- 20. If following the capacity assessment, it is deemed that a person has capacity to admit themselves, a voluntary admission may proceed. If it is deemed that they need support to understand, to make, or to convey their decision, that support must be provided to assist in the voluntary admission process. If it is deemed that they do not have capacity in relation to this decision, and the person has a mental illness they may only be admitted on an involuntary basis provided they satisfy**

all the criteria for detention. A person who lacks capacity and has a mental illness but does not fulfil the criteria for detention, may in specified circumstances be admitted as an ‘intermediate’ patient.

- 21. Where relevant, information relating to how capacity is assessed and the right of appeal against a decision on their capacity to a Mental Health Review Board should be given to patients. In addition they, and their family or carers if appropriate, should also be given information relating to the supports that may be available to the individual under the proposed capacity legislation.**

2.7 Voluntary Patient

In *HL v United Kingdom* (2005) 40 EHRR 32, the European Court of Human Rights found that the admission of a man who clearly lacked capacity to a psychiatric facility without any provision for review was a breach of his right to liberty under Article 5 of the European Convention on Human Rights notwithstanding that the man had not objected to admission. The ECtHR found that the admission had clearly deprived the man of his liberty and that the “right to liberty is too important in a democratic society for a person to lose the benefit of Convention protection for the single reason that he may have given himself up to be taken into detention ... especially when it is not disputed that that person is legally incapable of consenting to, or disagreeing with, the proposed action.”

While the Mental Health Act 2001 provides significant protections and safeguards for involuntary patients, the provisions relating to voluntary patients have been often criticised as being unclear and inadequate. Such provisions deal mainly with the circumstances in which voluntary patients can be detained (*sections 23 and 24*). Indeed, a number of submissions to the original Steering Group argued that the 2001 Act actually provides less protection for voluntary patients than the 1945 Act.

Under the 2001 Act, a voluntary patient is defined as ‘a person receiving care and treatment in an approved centre who is not the subject of an admission order or renewal order’ (*section 2(1)*). This definition which is simply a catch all definition describing what a patient is not, does not refer in any way to either capacity or consent. Critically, it does not distinguish between patients who have capacity to consent to their admission and those patients who do not. In some cases it is clear that patients are considered to be voluntary not because they consented to be admitted but rather because they are not detained under the 2001 Act and did not specifically object to such admission. Patients who lack capacity and are admitted to approved centres as voluntary patients are known as ‘incapacitated compliant patients’ and a separate section on the provisions recommended for these patients can be found in the report at 2.8. (*New Category of Patient*).

The definition of a voluntary patient has also been considered in the High and Supreme Courts in the case of *EH –v- St Vincent’s Hospital and Others*. In this case, the Supreme Court held that the meaning given to the term ‘voluntary patient’ by Section 2 of the 2001 Act does not require that the patient be a person who ‘freely and voluntarily gives consent to

an admission order’ and that in the context of the paternalistic approach to be adopted in the interpretation of the provisions of the Act, the lack of any requirement to assess the capacity of the patient to give consent to the admission order was not a violation of the applicant’s right to freedom and personal autonomy, either at constitutional or at a Convention level.

A number of organisations including the Irish Human Rights Commission have expressed concern at the nature of the current definition of voluntary patient citing the fact that in particular neither capacity nor consent are mentioned, both of which the Commission considers to be key features in determining the status of a patient. In addition, they make the valid point that the definition is out of line with international human rights standards and obligations.

The Expert Group is agreed that the definition of a voluntary patient needs to be an active definition of what it is rather than a definition of what it is not as is currently the case. The Group also recognises that any new definition of voluntary patient must explicitly refer to both the need for the person to have the capacity (with support if required) to make decisions and also to convey his/her consent when and where required. The Group therefore recommends that a voluntary patient should be defined as a person who has the capacity (with support if required) to make a decision regarding admission to an approved centre and who, where the person retains capacity, formally gives his/her informed consent to such admission, and subsequent continuation of voluntary inpatient status and treatment on an ongoing basis as required. This provision should also apply equally to children and their parents or persons as required acting in loco parentis (*see section 2.23 on Children*).

The Group acknowledges the importance of having the Assisted Decision-Making (Capacity) Bill enacted to ensure that those who need support to make important decisions relating to their care and treatment for mental health problems get that support. The Bill as currently drafted sets out very clearly the roles and responsibilities to be given to and exercised by persons appointed to support individuals in making decisions and the Expert Group is generally satisfied with those provisions.

There is a clear consensus in the Group that in line with the principle of ‘legal presumption of capacity’ set out in the Assisted Decision-Making (Capacity) Bill, each and every decision relating to the patient should only be made with the patient’s informed consent. Multi-disciplinary teams treating detained patients however must also take into account that some of these patients will have been assessed on admission as lacking capacity. While patients may lack capacity on admission, it is important not to automatically presume that each person continues to lack capacity where treatment decisions are concerned and further decisions relating to the patient’s treatment should be discussed with and put to the patient as when each decision is being made it is possible that the patient may have regained capacity.

As previously stated in section 2.6 (*Capacity*), the Group also believes that where a person is deemed to lack capacity and therefore cannot give informed consent, then admission cannot take place on a voluntary basis even if a substitute decision maker (decision-making

representative) has been appointed under the proposed Assisted Decision-Making (Capacity) Bill.

While section 16 of the 2001 Act contains specific requirements for information to be given to a person who has been involuntarily detained about the reasons for their detention and their rights, no similar provision exists at present in the Act for ensuring that voluntary patients are fully informed of their rights, including their rights regarding consent or refusal of treatment. The Group recommends that all voluntary patients on admission to an approved centre should be fully informed of their rights as voluntary patients to include information relating to their proposed treatment and their right to leave the approved centre at any time. *(This latter point is elaborated further in section 2.17 relating to the Change of Patient's legal status from Voluntary to Involuntary).*

Recommendations:

- 22. A voluntary patient should be defined as a person who has the capacity (with support if required) to make a decision regarding admission to an approved centre and who, where the person retains capacity, formally gives his/her informed consent to such admission, and subsequent continuation of voluntary inpatient status and treatment on an ongoing basis as required. This provision should also apply equally to children and their parents or persons as required acting in loco parentis. (See also section 2.23 Children)**
- 23. Lack of capacity on admission does not mean that further decisions relating to the patient's treatment should not be discussed with and put to the patient as and when each decision is required. It is important not to automatically presume that each person continues to lack capacity when decisions are required.**
- 24. Where a person is deemed to lack capacity and therefore cannot give informed consent, then admission cannot take place on a voluntary basis even if a substitute decision maker (decision-making representative) has been appointed under the proposed Assisted Decision-Making (Capacity) Bill.**
- 25. All voluntary patients on admission to an approved centre should be fully informed of their rights, including information relating to their proposed treatment as well as their rights regarding consent or refusal of treatment and their right to leave the approved centre at any time.**

2.8 New Category of Patient

Throughout this report, the importance of obtaining a person's informed consent for issues such as admission and treatment has been highlighted and recommended by the Expert Group. The Group has acknowledged the importance of having the proposed Assisted Decision-Making (Capacity) Bill enacted to ensure those who need support to make important decisions relating to their care and treatment for mental health issues get that support. It has been recommended by the Group that a person with a decision-making assistant or co-decision-maker appointed under the Capacity Bill can be admitted as a

voluntary patient. In addition, the Group has also recommended that on admission to an approved centre and notwithstanding the presumption of capacity proposed in the Capacity Bill, if the admitting Mental Health Professional forms the view that the person may lack the capacity to consent to his or her admission, they must be referred for formal capacity assessment.

These measures proposed by the Group will ensure that there should be no more patients who will fall into the compliant incapacitated category (patients who lack capacity to consent but do not object to admission or treatment). In future, a person can only be admitted on a voluntary basis if they have the capacity (with support if required) to make a decision regarding admission to an approved centre and they give their informed consent to such admission.

Group members discussed over a number of meetings the appropriate categorisation of persons who lack the capacity to consent to admission and treatment but who have a decision-making representative appointed under the proposed Assisted Decision-Making (Capacity) Bill. In cases where such individuals require in-patient treatment the question was raised as to whether such a person could be considered a voluntary patient if they themselves could not give consent. While some members thought that it would be reasonable to consider such individuals as voluntary patients if a Court had given authority to the person's decision-making representative to make health related decisions for the individual, nonetheless others felt that because of the particular sensitivities surrounding admission to or detention in an approved centre, such admissions require safeguards and review which would not be available if admission were to proceed on a voluntary basis.

Ultimately therefore the Group 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 has been appointed under the proposed Assisted Decision-Making (Capacity) Bill.

While all of the measures proposed by the Group will provide a significant advance in respecting and strengthening of the autonomy of a person, the Group in formulating its recommendations was also aware of certain categories of patient who may need inpatient treatment but cannot avail of it due to the new measures being recommended. Such patients would not have the capacity to consent to admission, thus can only be admitted on an involuntary basis but equally may not fulfil the criteria for detention. Such a scenario might also arise where a person has a decision-making representative appointed by the Circuit Court under the Assisted Decision-Making (Capacity) Bill. Again under the proposals recommended by the Group, such a person cannot be admitted on a voluntary basis but yet if they do not fulfil the new criteria for detention, they equally cannot be admitted on an involuntary basis. The Group was unanimous that such a scenario cannot be permitted to occur and that every person should have a right to all levels of treatment should they require it.

In order to address the issue of individuals who do not have capacity and don't satisfy the criteria for detention but who nonetheless require in-patient treatment, the Group proposes introducing a new category of patient to be known as 'intermediate' who will not be detained but will have the review mechanisms and protections of a detained person. The Group acknowledges that a detailed set of guidelines would need to be produced for this category of patient and the Mental Health Commission and the Office of Public Guardian to be established under the proposals contained in the Assisted Decision-Making (Capacity) Bill should have a role in this regard.

Where it is decided to proceed with an in-patient admission in these circumstances, an appropriate 'intermediate admission or renewal order' must be completed each time the patient's admission is being determined or extended as the case may be. Renewal orders should cover the same time periods as are recommended for involuntary patients in section 2.14.

Once the course of treatment is finished, or is no longer of any benefit to the person and no alternative in-patient treatment is proposed the individual admitted on an 'intermediate basis' must be discharged. It is important that the Mental Health Commission would be informed of the initial and ongoing admission of this category of patient.

The same timeframe as recommended for Mental Health Review Boards in section 2.13 for involuntary patients should also apply to intermediate patients. The role of the Review Board for this cohort of patient must focus on the question of capacity as, by definition, intermediate patients will not fulfil the clinical criteria for detention. The Review Board can determine if the patient has or lacks capacity and can ensure that the correct procedures were followed in confirming the person as an intermediate patient. If the patient is deemed to lack capacity then he or she may remain as an intermediate patient. If the patient is deemed to have capacity then he or she can decide if they wish to remain on in the approved centre as a voluntary patient or whether they wish to be discharged.

The Group also discussed the circumstances in which it might be appropriate for a Consultant Psychiatrist to override a refusal of treatment by a decision-making representative. It is accepted that decisions made by a validly appointed decision-making representative who has been given the authority by the Courts to make healthcare related decisions on behalf of an individual should be respected. The one exception considered by the Group is where a decision-making representative might refuse treatment in what amounts to emergency circumstances, and the Group is recommending that it would only be appropriate to override a decision-making representative in such emergency circumstances where treatment is deemed necessary and the person's actual behaviour is injurious to self or others and no other safe option is available. Any such decision would be subject to review by a Mental Health Review Board which would convene within 3 days and would decide if the situation presenting to the Consultant Psychiatrist fulfils the criteria for emergency circumstances. If the Review Board agrees that the circumstances were of an emergency nature, then the treatment authorised by the Consultant Psychiatrist may continue for as long as the emergency circumstances prevail subject to other provisions relating to second opinions etc.

It was also agreed that advance healthcare directives should apply for this category of patient on the same basis as that proposed for voluntary patients (*see section 2.25 Advance Healthcare Directives*).

Recommendations:

- 26. The Group recommends a new category of patient known as ‘intermediate’ who will not be detained but will have the review mechanisms and protections of a detained person. Such patients would not have the capacity to consent to admission and equally do not fulfil the criteria for involuntary detention.**
- 27. The Mental Health Commission must be informed of the initial and ongoing admission of this category of patient.**
- 28. The same timeframe recommended for Mental Health Review Boards for involuntary patients should also apply for intermediate patients.**
- 29. The role of the Review Board for this cohort of patient must focus on the question of capacity as, by definition intermediate patients will not fulfil the criteria for detention.**
- 30. A detailed set of guidelines should be produced for this category of patient and the Mental Health Commission and the Office of Public Guardian should have a role in this regard.**
- 31. The Group recommends that it would be appropriate for a Consultant Psychiatrist to have the authority to override a refusal of treatment by a decision-making representative in emergency circumstances where treatment is deemed necessary and the person’s actual behaviour is injurious to self or others and no other safe option is available.**
- 32. A decision to override a refusal of treatment by a decision making representative should be subject to review by a Mental Health Review Board which would convene within 3 days to decide if the situation presenting to the Consultant Psychiatrist fulfils the criteria for emergency circumstances. If the Review Board agrees that the circumstances were of an emergency nature, then the treatment authorised by the Consultant Psychiatrist may continue for as long as the emergency circumstances prevail subject to other provisions relating to second opinions etc.**
- 33. Advance healthcare directives should apply for this category of patient on the same basis as that proposed for voluntary patients.**

2.9 Authorised Officers

Under section 9 of the Mental Health Act 2001 (as amended), an Authorised Officer is one of the categories of applicant who may apply for a recommendation to a Registered Medical Practitioner for the involuntary admission of a person (other than a child) to an approved centre. The Act defines an Authorised Officer as ‘an officer of a health board (*Health Service Executive*) who is of a prescribed rank or grade and who is authorised by the chief executive officer to exercise the powers conferred on Authorised Officers by this section’

(Section 9(8)). The prescribed rank and grade of Authorised Officer is set out in S.I. 550/2006 as ‘Local Health Manager, General Manager, Grade VIII, Psychiatric Nurse, Occupational Therapist, Psychologist or Social Worker’.

It was initially envisaged that a full Authorised Officer service would be introduced over time which would provide an accessible 7 days a week service. Unfortunately, the service has not developed as quickly as originally planned and it is acknowledged that the number of Authorised Officers nationally to date has been inadequate. The number of applications made by Authorised Officers relating to the involuntary admission of a person under section 9 has remained consistently low with only 8% of all applications for involuntary admission in 2013³ being made by an Authorised Officer, a slight rise from the 2007 figure of 7%. However, the HSE has advised that 60 additional Authorised Officers were trained and commissioned in 2013, which when added to the existing number means that there are now over 100 such officers in place nationally.

The Expert Group in its deliberations was in agreement that there should be a more expanded and active role for the Authorised Officer. It was suggested by some Group members that having an Authorised Officer as the applicant, is likely to bring about a reduction in detention levels. The Group felt that an increased Authorised Officer role would have a number of benefits including reducing the sometimes unnecessary burden on families, particularly where they are the ones making the application for detention against the individual’s expressed wishes at the time. The expanded role would also see Authorised Officers acting as a resource not just for the individual who may be the subject of an application but also for the family/carer at a time when all involved may be vulnerable and in need of positive support from a dedicated and informed mental health specialist. The Group members also agreed that it would assist in reducing the involvement of Gardaí in the admission process.

The Group believes that by giving the Authorised Officer a more specialised and central role in relation to the process of all involuntary admissions it can lead to more appropriate and least restrictive treatment for individuals in community or other mental health settings and also bring a greater focus on involuntary admission being a treatment of last resort. Authorised Officers, who are mental health specialists working in services other than staff of the approved centre, should be aware of all treatment services available in a catchment area as well as the potential supports available within the person’s social environment, and in weighing up both the individual’s overall and immediate care and treatment needs along with the views and needs of family/carers, they can establish whether a suitable referral to an appropriate community or other mental health service, rather than go down the route of possible involuntary admission, would be more appropriate. In all admissions, but particularly ones being considered in a crisis situation, a fully functioning Authorised Officer service can also provide an immediate information source for distressed family/carers who may be dealing with such difficult circumstances for the first time. Where, having considered the individual’s needs it is decided that no alternative care and treatment options are available, then it would

³ Mental Health Commission Annual Report 2013

be the decision of the Authorised Officer, rather than the family/carers, to make or not make the application for involuntary admission.

The Group acknowledges that there are practical and resource implications to be considered if a fully functioning Authorised Officer service is to be put in place. Significant issues such as having enough people trained, delegated and geographically placed must be considered in addition to the necessary on call arrangements and 24 hour cover of staff. A system would need to be put in place where a second person would always be on call in the event that the first named Authorised Officer is unavailable. All of this requires investment. Further thought will have to be given to the development of an appropriate and adequate model that would be fit for purpose.

Notwithstanding the challenges to be overcome in rolling out such a model, the Group strongly believes that the process of involuntary admission will be improved if an Authorised Officer is directly involved. It is recommended that the Authorised Officer be the one to sign all applications for involuntary admission (this also includes change of patient status in an approved centre from voluntary to involuntary – see section 2.17 on Change of Status for details). The Authorised Officer should also have the authority under the Act to request the assistance of the Gardaí who must provide such assistance if required and requested. The circumstances in which such Garda assistance can be required should be detailed in regulations under revised mental health legislation.

The Group also recognised that a second option must be open to family/carers in the event that they do not agree with the recommendations of an Authorised Officer. In these circumstances, family/carers can ask a second Authorised Officer to look at their case but this should be limited to a second Authorised Officer. It was also acknowledged that the circumstances of a person may change after a period of time, after being assessed by an Authorised Officer. In this instance, the original Authorised Officer can be asked to look again at the case.

It was also agreed that the timeframe relating to the making of an application needs to be clear and that within a 24 hour period, an Authorised Officer must see the person and after consideration of treatment alternatives, make an application for involuntary admission if he/she thinks it appropriate, and in addition a Registered Medical Practitioner must examine the person and make a recommendation regarding involuntary admission. The Group considers that the sequencing of whether the Authorised Officer or the Registered Medical Practitioner sees the patient first is not relevant once they are undertaken independently. However the Group was clear that when it comes to the signing of the appropriate documentation for involuntary admission, the application from the Authorised Officer must come first followed by the recommendation from the Registered Medical Practitioner. An application for involuntary admission of a person on this basis shall remain in force for 7 days from the time of the first application.

It was acknowledged by the Group that it should be open to an Authorised Officer or family/carers to seek the opinion of more than one Registered Medical Practitioner if they are

not happy with the recommendations of the first Registered Medical Practitioner in relation to the involuntary admission of a person. However, the Authorised Officer must make any additional Registered Medical Practitioners aware of the previous recommendations sought.

Section 12 of the current Act provides the authority to Gardaí to take a person into custody where they have reasonable grounds for believing that a person is suffering from a mental disorder and that because of the mental disorder there is a serious likelihood of the person causing immediate and serious harm to himself or herself or to other persons. In such circumstances, the Group also agrees that the Authorised Officer must still be the one to make the application for involuntary admission and the Gardaí should seek to contact the Authorised Officer immediately the person is taken into custody. In addition, revised mental health legislation should provide that where an individual is taken into custody by the Gardaí under section 12, detention should only last for as long as is necessary for the Authorised Officer to consider the facts and possible alternative treatment before he/she may decide to make an application for involuntary admission and also allow for a Registered Medical Practitioner to examine the person and make a recommendation regarding involuntary admission. The initial assessment, whether that is by the Authorised Officer or the Registered Medical Practitioner, should take place as soon as possible after the person is taken into custody. The maximum period which the person can be held prior to being assessed by the Authorised Officer or Registered Medical Practitioner should be 24 hours. A second 24 hour timeframe in which both the Authorised Officer and the Registered Medical Practitioner must carry out their assessments commences once the first such assessment is initiated. If either the Authorised Officer decides not to make an application or the Registered Medical Practitioner declines to make a recommendation that the person be involuntarily admitted, the person must be released from custody.

The Group 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 now being recommended. The Group acknowledges that a detailed costing of the proposal would need to be completed by the HSE and that the possibility of commencing any new legislation on an incremental basis could be considered in due course to allow time for the new service to develop.

Recommendations:

- 34. The Group recommends that there should be a more expanded and active role for Authorised Officers where involuntary admissions to an approved centre are being considered. This new role can lead to more appropriate and least restrictive treatment for individuals in community or other mental health settings and bring a greater focus on involuntary admission being a treatment of last resort.**

35. The Authorised Officer must, after consultation with family/carers where possible and appropriate, make the decision on whether or not an application for involuntary admission of the person should be made.
36. The Group recommends that an Authorised Officer should be the person to sign all applications for involuntary admission to an approved centre (this also includes change of patient status in an approved centre from voluntary to involuntary – see section 2.17 on Change of Status for details). This will have the effect of reducing the burden on families/carers in these difficult circumstances and reducing the involvement of Gardaí in the admission process.
37. An application by an Authorised Officer to involuntarily admit a person to an approved centre shall remain in force for 7 days from the time of the first application.
38. The Group considers that the sequencing of whether the Authorised Officer or the Registered Medical Practitioner sees the patient first is not relevant once they are undertaken independently. However, as regards completing and signing the appropriate documentation, the application for involuntary admission by the Authorised Officer must come first followed by the recommendation from the Registered Medical Practitioner.
39. 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. If some time has elapsed since an Authorised Officer previously assessed a particular individual for involuntary detention, the same Authorised Officer can be asked to look again at the case.
40. Where an Authorised Officer or family/carer seeks the opinion of a different Registered Medical Practitioner, they must disclose the facts relating to the previous application sought.
41. Where a person is taken into custody by the Gardaí under section 12 of the Act, the initial assessment, whether that is by the Authorised Officer or the Registered Medical Practitioner, should take place as soon as possible after the person is taken into custody. The maximum period which the person can be held prior to being assessed by the Authorised Officer or Registered Medical Practitioner should be 24 hours. A second 24 hour timeframe in which both the Authorised Officer and the Registered Medical Practitioner must carry out their assessments commences once the first such assessment is initiated.

2.10 Procedure for Involuntary Admission to an Approved Centre

The Health Research Board states in their ‘Activities of Irish Psychiatric Units and Hospitals 2013’ report that in 2013, there were a total of 18,457 admissions to Irish Psychiatric Units and Hospitals. The majority of these admissions were on a voluntary basis (16,418) and section 2.7 (*Voluntary Patient*) of this report includes specific recommendations that the Group proposes for this category of patient.

There were 2,132 admissions on an involuntary basis (*Mental Health Commission 2013 Annual Report*) which is a rate of 46.67 per 100,000 total population in 2013 and this compares favourably with other jurisdictions e.g. England had a rate of 53.8 per 100,000 (Health and Social Care Information Centre 2013).

Section 10 of the Mental Health Act 2001 details the procedure for making a recommendation for involuntary admission by a Registered Medical Practitioner while section 14 details the procedures that must be followed by the Clinical Director of an approved centre once a recommendation for admission is received from a Registered Medical Practitioner.

The previous section of this report (2.9) relating to Authorised Officers sets out in detail the Group's recommendations for the initial steps in the involuntary admission of a person to an approved centre, including a 24 hour period for the Authorised Officer and Registered Medical Practitioner to make an application and a recommendation for involuntary admission.

At present, under section 10 of the 2001 Act, in order for a recommendation to involuntarily admit a person to an approved centre to proceed, a Registered Medical Practitioner must satisfy him/herself that 'following an examination of the person the subject of the application', the person is suffering from a mental disorder. Group members agreed that a greater level of transparency is required in relation to the nature of the personal examination to be conducted by the Registered Medical Practitioner. It was agreed that in future, the Registered Medical Practitioner recommending detention must clearly certify how he/she came to the view that the person is suffering from a mental illness and also how the criteria for detention were being met. The Group also re-iterated that the Registered Medical Practitioner cannot play this role if he or she becomes the owner of an approved centre or an employee or agent of such centre, to which the person is to be admitted.

Section 14 of the Act provides that once an application from an Authorised Officer and a recommendation from a Registered Medical Practitioner are received by the Clinical Director of an approved centre, a Consultant Psychiatrist on the staff of this approved centre must, within 24 hours of the arrival of the person at the approved centre, examine the person and be satisfied that he or she is suffering from a mental illness and meets the criteria for detention and if they are satisfied, they may then make an admission order.

In the past the Consultant Psychiatrist was seen as the person who had the sole responsibility in relation to decision making, but in the modern mental health service the Consultant Psychiatrist, while he/she continues to provide the clinical leadership required, does so in tandem with other professionals (Nurses, a range of Health and Social Care Professionals working in mental health, Care Assistants, Peer Support Workers etc.) to make sure that the person's needs are met in a more comprehensive and holistic manner through times of ill-health and into recovery.

The Group believes that with multi-disciplinary teams playing an increasingly prominent role in the delivery of all mental health services, this positive change should also be reflected more fully in mental health legislation.

A more multi-disciplinary approach to the process of admission would also have the effect of reducing the burden on the Consultant Psychiatrist and providing the appropriate professional support to make important decisions regarding the admission and detention of a person.

Where following examination of the individual, the Consultant Psychiatrist is satisfied that the individual is suffering from a mental illness and meets the criteria for detention, and therefore wishes to make an order for his/her reception, detention and treatment in the approved centre, the Group now recommends that at that time the Consultant must also consult with at least one other Mental Health Professional of a different discipline who is or will be involved in the treatment of the person in the approved centre. The assessment and opinion of that other professional would also need to be officially recorded. The recording of this opinion is particularly important where there is a difference of opinion about detention of the individual. Ultimately that decision remains in the hands of the Consultant Psychiatrist but the Group believes that a more direct involvement of professions other than just the medical profession and a broader view of an individual's circumstances, both medical and social, is very much in the interest of all involved.

The Group did discuss and consider whether 'Approved Clinicians' as provided for in England and Wales mental health legislation could play a more central role in our legislation. Such a move would further enhance the important role played by multi-disciplinary teams and would allow increasing responsibilities in the area of admission and detention to be played by nominated 'Approved Clinicians'. Ultimately the Group decided not to proceed with this proposal and section 2.27 of the report will elaborate on this issue in more detail.

Recommendations:

- 42. The Registered Medical Practitioner must personally examine the person and in recommending detention must clearly certify how he/she came to the view that the person is suffering from a mental illness and also satisfies the criteria for detention. The Registered Medical Practitioner cannot play this role if he or she becomes the owner of an approved centre or an employee or agent of such centre, to which the person is to be admitted.**
- 43. Admission must be certified by a Consultant Psychiatrist after examination of the patient and following consultation with at least one other Mental Health Professional of a different discipline that is and or will be involved in the treatment of the person in the approved centre. The opinion of that other Mental Health Professional should be officially recorded.**

2.11 Patient Firstly Requiring Medical Treatment

The Expert Group recognises that in certain circumstances an individual who is to be admitted involuntarily to an approved centre under the Mental Health Act may firstly need urgent medical treatment for a physical condition at an emergency department, hospital or clinic. Under Section 13 of the 2001 Act, a person who is the subject of a recommendation for involuntary admission must be brought to the approved centre specified in the recommendation even if such medical treatment for a physical condition is required. The Group felt it would be important to set out in revised legislation the precise procedures to be followed where a patient firstly requires medical treatment in an emergency department, hospital or clinic.

The Group is of the view that it should be the responsibility of either the Registered Medical Practitioner who recommended the involuntary admission of the person, the Clinical Director of the approved centre or a Consultant Psychiatrist acting on his or her behalf to decide that the patient first requires medical treatment for the physical condition and where this occurs, the patient may first be removed to an emergency department, hospital or clinic for such treatment.

It is important to specify that the stay at the emergency department, hospital or clinic should be for the shortest time possible and there will also be an obligation to notify the Mental Health Commission.

This report has already detailed that the process for admission to an approved centre must be completed within 24 hours (*section 2.10 Procedure for Involuntary Admission to an Approved Centre*). The Group felt that the same timeframe for the admission process to be completed should equally apply in these circumstances and the process must commence on arrival at the emergency department, hospital or clinic as though it was the approved centre. The appropriate assessment and the making of an order should be undertaken within that timeframe by a Consultant Psychiatrist who must consult with at least one other Mental Health Professional of a different discipline involved in the treatment of the person at the approved centre, which must be officially recorded. In terms of the existing legislation, section 13 (*Removal of persons to approved centres*) should be amended to accommodate these new measures.

The Group is also agreed that throughout the period when the patient is at the emergency department, hospital or clinic, the responsibility for the mental health treatment of the person should remain with the Clinical Director of the approved centre to which the patient is being admitted.

Recommendations:

- 44. Where either the Registered Medical Practitioner who recommended the involuntary admission of the person, a Clinical Director of the approved centre or a Consultant Psychiatrist on the staff of the approved centre, is of the view**

that the patient first requires medical treatment for a physical condition, the patient may first be treated in an emergency department, hospital or clinic.

45. The stay at the emergency department, hospital or clinic should be for the shortest time possible and the Mental Health Commission should be notified.
46. The 24 hour timeframe for the admission process to the approved centre should commence on arrival at the emergency department, hospital or clinic as though it was the approved centre named in the application and the appropriate assessment and the making of an order should be done within that timeframe by the Clinical Director of the approved centre or by a Consultant Psychiatrist on the staff of the approved centre after consultation with a Mental Health Professional of another discipline.
47. Throughout this period when the patient is at the emergency department, hospital or clinic, responsibility for the mental health treatment of the person should remain with the Clinical Director of the approved centre to which the patient is being admitted.

2.12 Treatment prior to Detention

In some exceptional circumstances, a person may require treatment without consent for their mental illness in the approved centre prior to the admission order being completed. The Expert Group was clear in its view that this should only occur in emergency circumstances. The Group agreed that it would be necessary to define the term ‘emergency’ and the circumstances in which it would apply. It was recommended that emergency in these circumstances means that the treatment is deemed immediately necessary, that the person’s actual behaviour is injurious to self or others and no other safe option is available.

The Group would like revised legislation to state clearly that in normal circumstances treatment should not be provided without consent prior to an admission order being completed. However, in the specified emergency circumstances, if the Consultant Psychiatrist after consultation with another Health Care Professional who has assessed the person concerned (which will be recorded) is of the opinion that it is immediately necessary, such treatment may occur.

Recommendations:

48. Treatment should not be provided to a patient without consent prior to an admission order being completed unless the Consultant Psychiatrist after consultation (to be officially recorded) with another Health Care Professional is of the opinion that it is necessary in emergency circumstances.
49. Emergency in this situation means that the treatment is deemed immediately necessary, that the person’s actual behaviour is injurious to self or others and no other safe option is available.

2.13 Mental Health Tribunals

Mental Health Tribunals are impartial, have a judicial character and are independent both of the executive and the parties to the case. They carry out independent reviews of the lawfulness of involuntary admission/detention at regular and reasonable intervals while adopting procedures that tend to be less complicated and more informal than those typically associated with the Courts. The Mental Health Commission Annual Report 2013 states that 1,893 hearings took place in 2013:

(http://www.mhcirl.ie/Mental_Health_Tribunals/Involuntary_Admission_Activity/Activity-Statistics-2013/).

Tribunals make binding decisions on such matters as admission and renewal orders, or re-grading, affirming or revoking orders, as well as authorising or refusing to authorise the transfer of patients to the Central Mental Hospital and proposals to perform psychosurgery. Under the current Act, Tribunals do not have any role in relation to treatment or medication decisions.

The fundamental value of the Tribunal system and the absolute need to give detained patients access to an effective review mechanism where their loss of liberty can be independently evaluated is not in question and is fully accepted by members of the Group. A number of detailed discussions on this key topic over several meetings clearly signalled the importance which members attach to the role of Tribunals and the need as they see it to improve how they operate particularly for the benefit of detained patients and to review the existing powers of Tribunals with a view to determining if legislative change may be required.

While there were many different aspects relating to our discussions on Tribunals, they could be broadly summarised under the following headings:

- Title and Power
- Timing
- Composition
- Attendance
- Role of the Independent Psychiatrist
- Oversight

Title and Power

Mental Health Tribunal is the title given in the 2001 Act to the independent body charged with reviewing a patient's detention. Group members were of the view that the use of the word 'Tribunal', which has come to greater prominence in recent years with a more pronounced link to the notion of 'committees of inquiry', is associated with examining whether certain actions and behaviours of a person may be open to question. Service users have increasingly indicated their dissatisfaction with this term and have suggested that a more appropriate term should be included in any revised mental health legislation.

The Group was agreeable to change the terminology currently used and it was decided that the term ‘Mental Health Review Board’⁴ should be used in future legislation. This is similar in name to the Mental Health (Criminal Law) Review Board set up by the Criminal Law (Insanity) Act 2006, and is a term also used internationally e.g. in Victoria South East Australia – ‘A new Mental Health Act for Victoria, summary of proposed reforms’.

Inevitably, when a Tribunal meets to review a patient’s detention and decides whether to affirm or revoke the relevant admission or renewal order, issues relating to treatment of the patient may be discussed. The Consultant Psychiatrist treating the patient can be asked about the treatment regime being used and the patient’s response to it. In addition, the report of the independent Consultant Psychiatrist on the patient will be examined by the members of the Tribunal. This information is discussed to ensure that the Tribunal members have all the necessary information available to them to determine if the patient is or is not, as the case may be, suffering from a mental disorder and has been correctly detained in accordance with the law.

There was some discussion at Group meetings about whether Mental Health Review Boards should go further in terms of reaching conclusions and making judgements about treatment. In this context the Group looked specifically at other jurisdictions which operate systems similar to Ireland i.e. England, Scotland, Victoria and New South Wales. Ultimately it was agreed that Review Board powers could not be extended in this area to the degree that clinical decision-making relating to treatment would be subject to direction by members of a Review Board. A Review Board can however look at the circumstances in which treatment was administered to ensure the correct procedures and guidelines were followed such as the provision outlined in section 2.8 (*New Category of Patient*) and 2.18 (*Consent to Treatment*) where treatment is provided in emergency circumstances when a Decision Making Representative has refused such treatment on behalf of the person concerned.

The Group strongly believes that the Mental Health Review Board can play a useful role in relation to individual care plans to which members attach great importance. The Group therefore recommends that, while decisions about the nature and content of treatment remain within the remit of the multi-disciplinary mental health team, the Review Board should have the authority to establish whether there is an individual care plan in place and if it is compliant with the law. The Group sees this new function as an important step on behalf of detained patients to ensure, for example, that the Review Board can establish that the views of the patient as well as those of the multi-disciplinary team were sought in the development of the care plan. The need to have the appropriate multi-disciplinary team in place in all cases was emphasised.

The introduction of advance healthcare directives will enable individuals to express preferences and plan for their future care in the event that they may be unable to speak for

⁴ Throughout the rest of the report we will use the term ‘Mental Health Review Board’ rather than ‘Mental Health Tribunal or Tribunal’ and will only use the latter where we are specifically referring to what is already contained in the 2001 Act.

themselves (*see section 2.25 for further details*). The need to ensure that an individual's valid advance healthcare directive is fully complied with by the multi-disciplinary team is recognised and the Group therefore recommends that where such a directive is overridden, the decision to do so should also be reviewed by a Review Board.

The Group decided not to recommend extending Review Board powers to ordering conditional discharges.

Timing

In setting down the timeframes for when Review Boards must be held, it has long been recognised that a proper balance must be struck between the need to review promptly the serious decision to detain a person on an involuntary basis with the need to allow time for all the necessary procedures and communications to take place to ensure the Review Board is as effective as it can be in the circumstances.

Section 18 of the 2001 Act provides that 'the Tribunal shall review the detention of the patient concerned' and that a decision of the Tribunal must be made as soon as may be but not later than 21 days after the making of the admission order or renewal order concerned'.

The Group members considered that given the lessons learned in operating this part of the Act to date, there is scope now to look critically at the 21 day timeframe with a view to reducing it. The members acknowledged that there is a strong call from service users to ensure Review Boards are carried out as promptly as possible in order to comply to the greatest extent possible with Article 5(4) of the European Convention on Human Rights which states that the review takes place 'speedily'.

On that basis and with due regard to the fact that from a practical point of view there needs to be sufficient time identified for the administration of matters related to Review Board hearings, the Group members recommend that the current 21 day timeframe should be reduced to no more than 14 days.

The current Act allows a Tribunal, of its own accord or at the request of the patient, to extend the 21 day period in which a Tribunal hearing must be held for a further period of 14 days if it is satisfied that it is in the interest of the patient. This period may again be extended by a further period of 14 days by the Tribunal on the application of the patient. The Tribunal may allow such extensions if it is satisfied that it is in the interest of the patient. The Group members acknowledge that this flexibility can be in the interests of patients and recommends that, rather than have this as a discretionary power for Review Boards, a patient through his/her legal representative should be able to apply to the Review Board for an automatic deferral of the Review Board by 14 days. As is currently the case, this period may be extended by a further period of 14 days by the Review Board on the application of the patient and/or his/her legal representative. The Group is also satisfied that the Review Board of its own accord should retain the existing authority to extend the period in which a Review Board must be held if it is in the interest of the patient.

Composition

The Group members considered at length the nature and composition of Review Boards. At present, the 2001 Act prescribes that each Tribunal must have three members: a lawyer who acts as Chairperson, a Consultant Psychiatrist and another person who is not any one of the following – a Psychiatrist, a Lawyer qualified to act as Chairperson, a Registered Medical Practitioner or a Registered Nurse.

While recognising that the most common international practice is for a three person Review Board comprising a Psychiatrist, a person with legal qualifications and what is generally regarded as a community/lay member, the Group members opted to look for evidence of the operation of a one person Review Board elsewhere. Other jurisdictions specifically reviewed include England, Scotland, Victoria and New South Wales.

The suggestion put forward to the Group members was that a single person Review Board with a high level legal qualification who perhaps would operate on a full-time basis might not just offer an alternative structure to the current one in operation, but would allow the sole person to develop particular ‘judicial’ expertise in this field while still having a medical report prepared for him/her by an independent Consultant Psychiatrist. While members saw certain merits in this proposal, the fact that the State of Victoria in Australia seems to be the only jurisdiction which has operated a one person Review Board system did not offer high hopes that this was the way of the future. Victoria, in fact, has recently decided to return to a three person model (*A New Mental Health for Victoria, Summary of Proposed Reforms*).

On that basis and in the absence of any compelling reasons for change the Group recommends that there should be no change in the current composition of Review Boards at this time. However, this question should be re-examined in any future review of the mental health legislation. The Review Board members must continue to be clearly separate from the original decision-maker and those conducting the independent multi-disciplinary assessment for the Review Board. The Group recommends that the ‘other person’ appointed to the Review Board should be known as the ‘community member’.

With a Consultant Psychiatrist and a Legal Professional already part of a three member Review Board, the Group would like to see the ‘community member’ bring something different to the Review Board and therefore recommends that to be eligible to be appointed to this role, the person 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. The criteria for choosing the ‘community member’ should be specified in regulations and the selection process would be based on applications in a similar manner to other members of the Review Board. An understanding of mental health, personal experience with mental illness or caring for a person with mental illness would be an advantage for the ‘community member’.

Attendance

Those members of the Group with experience of attending Tribunals attested to the fact that for patients the process can sometimes be uncomfortable particularly depending on where they are in their recovery. In that context there was a general acceptance that the number of individuals who may attend Tribunals has increased over time and while each individual may have a particular reason to be there, the overall increase in numbers may at times add to the stress that a patient may feel.

There was broad agreement therefore that the Group should look at and comment on those individuals who play a key role at Review Boards and perhaps draw a distinction between those whose attendance is seen as essential for an effective Review Board and those whose presence could be determined in each individual case.

It was agreed that the legal representative of the patient and the responsible treating clinician must attend Review Board hearings while the patient, the patient's advocate who may attend to support the patient, the independent Psychiatrist charged with carrying out the independent assessment of the patient and the author of the psychosocial report (*see next section for further details on this*) on the patient prior to the Review Board hearing, may attend. In the event that the author of the psychosocial report is unable to attend when requested, another member of the multi-disciplinary team may attend on their behalf. In relation to the patient's advocate, the Group agreed that the person subject to detention has the right to nominate another person, who may be a peer advocate, family member, carer or friend, to support them in all matters concerned with the review of their detention. This is in addition to the provision of a legal representative. It should be a matter for the Review Board to decide who should attend the Review Board hearing, however the patient should always have the right to attend and to nominate an advocate to attend with them as well as their legal representative.

Role of the Independent Psychiatrist

Section 17 of the 2001 Act sets out the role of the independent Psychiatrist which is 'to determine in the interest of the patient whether the patient is suffering from a mental disorder'. Having examined the patient, the Psychiatrist provides a report to the Mental Health Commission to assist the Tribunal in their role of affirming or revoking the admission or renewal order. This report is required to be submitted to the Commission within 14 days. The Group members acknowledged that it is less than ideal that currently a Tribunal may make its determination anywhere between 1 and 20 days after receiving the independent Psychiatrist's report.

In recommending that Review Boards take place no more than 14 days after the making of the admission order or renewal order concerned, it is recognised that there is now a more compact period in which an independent assessment must take place. In order to allow as much time as possible for the appropriate assessment to take place and with a view to minimising the time between the assessment and the Review Board hearing, the Group recommends that the examination of the patient takes place within 5-7 days prior to the Review Board hearing and that the independent Psychiatrist's report be submitted to the

Review Board to which the matter has been referred to arrive no later than 24 hours before the Review Board hearing. The Group further recommends that in completing the assessment the independent Psychiatrist must also consult with the treating Psychiatrist and another Mental Health Professional of a different discipline on the treating team whose views must be officially recorded in the assessment report to be furnished to the Review Board. The range of Mental Health Professionals that a Psychiatrist can consult with should be specified.

The Group recognises that in setting out the above, there is a role for the treating Psychiatrist, the independent Psychiatrist and the Psychiatrist member of the Review Board. The need for greater involvement of non-medical members of the multi-disciplinary team at this stage is something that the Group considers is important. The Group has already recommended that in addition to consulting with the treating Psychiatrist, the independent Psychiatrist must also consult with another Mental Health Professional of a different discipline on the treating team. There is, the Group also believes, a need to take account of the patient's wider social circumstances which would focus less on his/her medical needs and more on the patient's self-care abilities, supports that may be needed and/or are available on discharge and his/her living circumstances. This information should be prepared for and presented to a Review Board to ensure that, as well as considering the independent medical report on the patient, sufficient weight is also given to the non-medical aspects of the patient's circumstances in determining the adequacy of the care plan for the patient. This psychosocial report should be carried out by a member of the multi-disciplinary team from the approved centre who is registered with the appropriate regulatory professional body (i.e. CORU, Nursing and Midwifery Board of Ireland or Medical Council) in the same timeframe as that recommended above for the independent Psychiatrist report.

Oversight

The Group members believe that it would be beneficial to allow for information in relation to decisions of Review Boards to be published in anonymised form. This would have to be carried out in a manner which would obviously not compromise patient confidentiality. It is hoped that such an oversight mechanism would contribute to validating the integrity of the Review Board process and ultimately assist both members of Review Boards and the Mental Health Commission to advance the operation of Review Boards in line with best practice.

Recommendations:

Title and Power

- 50. Mental Health Tribunals should in future be renamed 'Mental Health Review Boards'.**
- 51. While decisions about the nature and content of treatment remain within the remit of the multi-disciplinary mental health team, Review Boards should have the authority to establish whether there is an individual care plan in place and if it is compliant with the law.**
- 52. Review Boards should also establish that the views of the patient as well as those of the multi-disciplinary team were sought in the development of the care plan.**

Timing

53. The patient's detention must be reviewed by a Review Board no later than 14 days after the making of the admission order or renewal order concerned.

Composition

54. There should be no change in the current make up of Review Boards at this stage. The question of having a one person Review Boards should be re-examined in any future review of the mental health legislation.
55. The Review Board members must continue to be clearly separate from the original decision-maker and those conducting the independent multi-disciplinary assessment for the Review Board.
56. The 'other person' appointed to the Review Board 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.

Attendance

57. A patient should have a legal right to have a Review Board deferred for specified periods (2 periods of 14 days) if that is his/her wish. The deferral would have to be sought through the patient's legal representative.
58. The following individuals must attend a Review Board:
- Legal representative of the patient
 - Responsible treating clinician
59. The following individuals may attend a Review Board:
- Patient, who must always have a right to attend the Review Board
 - Advocate at the invitation of the patient exercising his/her right to such support
 - Independent Psychiatrist who undertook pre Review Board assessment if the Review Board so requests
 - 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 if the Review Board so requests.
60. It should be a matter for the Review Board to decide which additional persons should attend the Review Board hearing other than the absolute right of the patient to attend, their legal representative and their advocate if the patient so requests.

Role of the Independent Psychiatrist

61. The patient'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.
62. The range of Mental Health Professionals that the independent Psychiatrist must consult with for a Section 17 assessment should be specified.

- 63. 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 that recommended for the independent Psychiatrist report. This report should concentrate on the non-medical aspects of the patient's circumstances.**

Oversight

- 64. 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.**
- 65. This would include a mechanism to allow information in relation to decisions of Review Boards to be published in anonymised form which will ensure patient confidentiality. This will allow such decisions to be available for the Mental Health Commission and/or the public to view.**

2.14 Renewal Orders

Section 15(1) of the Mental Health Act 2001 authorises the making of an admission order for the reception, detention and treatment of a patient for a period of 21 days. The order may subsequently be extended for periods no longer than 3 months, then up to six months and thereafter periods of up to 12 months. A number of submissions to the original Steering Group felt that the third time period of 12 months was too long and it was subsequently recommended by the Steering Group to reduce the 12 month period to a period not exceeding 9 months. The Expert Group re-examined the time periods for renewal orders and after some deliberation, it was felt that there was merit in limiting the maximum time period for which renewal orders can be made to 6 months.

Further strengthening of the safeguarding procedures involved in issuing renewal orders were discussed by the Group and it was recommended that the multi-disciplinary approach recommended throughout the report should be replicated here i.e. the Consultant Psychiatrist must consult with at least one other Mental Health Professional of a different discipline involved in the treatment of the person at the approved centre prior to certifying the renewal order and the opinion of the other Mental Health Professional must also be officially recorded.

The Group further recommended that section 15(2) of the 2001 Act be amended to clarify that a renewal order only becomes effective after the expiry of the previous admission order or renewal order. This issue was addressed in two court cases: MD –v- St. Brendan's Hospital, MHC and MHT [2007] and AMC –v- St. Luke's Hospital Clonmel [2007].

The Group was also made aware of a recent court case P.D. -v- Clinical Director Department of Psychiatry Connolly Hospital [2014], in which the Court considered whether errors on a renewal order form completed under the 2001 Act were such as to render a woman's

detention invalid. In conclusion, the Judge said that the errors on the face of the renewal order were too significant to admit of any conclusion other than that the order was bad on its face and the Court had no alternative but to hold that the woman's detention under the Act was not in accordance with the law. The Judge indicated that the Oireachtas might well consider amending the Act so as to enable "obvious clerical errors of this kind" to be corrected by means of a 'slip-rule procedure', accompanied by safeguards and external supervision of any changes to the relevant document.

In this regard, it should be noted that there is a 'curing provision' in section 18(1)(a)(ii) of the 2001 Act. As currently drafted the question for Tribunals (and for the High Court on an Article 40) is whether a failure to comply with the provisions of sections 9, 10, 12, 14, 15 and 16 "*does not affect the substance of the order and does not cause an injustice*". The Group is aware that there is some divergence in the High Court authorities as to what exactly constitutes an error/failure affecting the substance of the order. See for example the contrasting approaches taken by Mr. Justice Charleton in *TOD [2007] 3 IR 689* and Mr. Justice O'Neill in *WQ [2007] 3 IR 755*. There is no Supreme Court decision to date which squarely addresses the scope of Section 18(1). However, even if a comprehensive Supreme Court decision on this issue was to be delivered, it could not address every set of circumstances which might arise before a Mental Health Review Board.

In considering this issue and whether, in particular, a 'slip-rule procedure' should be added, a concern expressed was that this might allow Review Boards to overlook virtually any error in procedure with the exception perhaps of bad faith (*mala fides*). Conversely, if the Review Board had no jurisdiction to cure errors in procedure and was obliged to revoke an order no matter how small the error, the admission process would have to start again. Questions were raised about the proportionality of this where very small technical errors were made in completing orders.

On the basis of the above concerns, one option put to the Group was to leave section 18(1)(a)(ii) as it is, while an alternative approach mooted was to include a provision similar to section 15 of the UK Mental Health Act 1983 (as amended in 2007) which permits rectification of errors within 14 days of admission - this applies to applications and recommendations that are in any respect incorrect or defective, the Group ultimately decided that it would be best to leave matters as they stand.

Recommendations:

- 66. Renewal orders must be certified by a Consultant Psychiatrist after consultation (to be officially recorded) with at least one other Mental Health Professional of a different discipline involved in the treatment of the person at the approved centre.**
- 67. Renewal orders at present can be for up to 3 months, 6 months or a year. The Group believes that the 3rd renewal order of up to 12 months is too long and should be reduced to a period not exceeding 6 months.**

- 68. Section 15(2) should be amended by adding ‘and such renewal order shall only come into effect on the expiration of the time period provided for in the previous order be it an admission or renewal order’.**
- 69. The Group agreed that there was no need for a ‘slip-rule’ procedure and it was best to leave section 18(1)(a)(ii) as it stands.**

2.15 Absence With Leave

Section 26 of the Mental Health Act 2001 authorises the Consultant Psychiatrist responsible for the care and treatment of a patient to grant permission in writing to a patient to be absent from the approved centre. The original intention of this provision sought to allow patients to gradually re-integrate into the community on a planned basis facilitating appropriate discharge.

The Interim Report of the Steering Group on the review of the Mental Health Act 2001 highlighted concerns that, over time, this provision has allowed for some patients to be absent on a continued basis from approved centres through the ongoing renewal of detention orders, thus facilitating a kind of de facto community detention. The Steering Group was silent on the introduction of community treatment orders and the majority of the Expert Group having looked at this again agreed that the evidence is not convincing that community treatment orders are effective. In any event, if community treatment orders were to be recommended, they would need to be provided for with appropriate safeguards and oversight separately to the provisions currently available under section 26 of the 2001 Act.

The Expert Group agrees that a leave of absence can be an important part of a patient’s care plan and believes that the existing powers under section 26 should remain in place as the granting of leave to patients is appropriate in certain circumstances. However, in keeping with the original purpose of this section, such leave should be clearly subject to a specified time limit which the Group agreed should be at a maximum of 14 days. In addition, the Group would like it to be made clear that the provisions of this section should not be used as quasi-community treatment orders. The Group also recommends that greater clarification on the precise circumstances in which such provisions can be used should be provided in a Code of Practice to be developed by the Mental Health Commission.

Recommendations:

- 70. The provisions of Section 26 regarding permission to be absent from an approved centre for a specified period should be retained with greater clarification being provided in a Code of Practice (to be developed by the Mental Health Commission) which would outline the precise circumstances in which such provisions can be used. The time limit for such absences should be a maximum of 14 days and they should not be used as quasi-community treatment orders.**

2.16 Grounds for Appeal

Section 19 of the Mental Health Act 2001 provides that a patient may appeal to the Circuit Court against a decision of a Mental Health Tribunal to affirm an order for detention made in respect of him or her. The scope of the appeal is limited to the question of whether the patient is suffering from a ‘mental disorder’ within the meaning of the Act. The burden of proof rests with the patient and this in effect means that they must prove that they are not suffering from a mental disorder. The Steering Group report highlighted the fact that the current legislation provides very limited grounds for appeal of Tribunal decisions and recommended that the grounds for appeal should be amended such that the onus of proof as to the existence of a mental illness does not fall on the patient.

The Expert Group acknowledged that the current system in relation to grounds for appeal could be improved and was concerned with the fact that to date, only one appeal to the Circuit Court has been upheld. As a consequence, the Group looked at systems in other jurisdictions to see if a better alternative elsewhere might be more appropriate here. In particular, the Upper Tribunal system which operates in the UK was examined. However it was felt that due to the elaborate structures associated with Upper Tribunals which apply across a range of areas and the fact that it is a superior court of record which gives it equal status to the High Court in the UK, it was not something which should be introduced solely for the area of mental health and was not recommended.

The Expert Group accepted that the current system with the burden of proof resting with the patient was no longer appropriate and it was agreed that as recommended in the Steering Group report this should be amended to ensure that it does not fall on the patient but rather the onus would be on the approved centre to prove that the person is suffering from a mental illness. The Group felt that this amendment would increase and enhance patient trust in the system.

The Group discussed a procedural issue whereby the respondent in Circuit Court appeals is the Mental Health Tribunal while the approved centre concerned who is the detainer of the person is often a notice party. The current procedure is outlined in S.I. 11/2007, Circuit Court Rules (Mental Health) 2007 which outlines ‘The patient shall be the appellant and the Tribunal concerned shall be the respondent’. The S.I. also makes it clear that a copy of notice of appeal shall be served on, inter alia, the Clinical Director of the approved centre, hence the approved centre’s potential involvement as a notice party but not as respondent. It was felt by the Group that as the Courts have made it clear that the only matter under appeal is the question of whether the patient is suffering from a mental disorder on the date of the hearing and the central evidence is that of the patient and his/her Consultant Psychiatrist, by definition the Tribunal has no role to play in these proceedings. Consequently it was agreed by the Group that as the approved centre is the detainer of the person concerned, S.I. 11/2007 should be amended to reflect the fact that the approved centre should be the respondent in future cases brought before the Court and the Mental Health Commission’s (not the Mental Health Review Board) potential involvement should be as a Notice Party.

Recommendations:

- 71. Grounds for appeal to the Circuit Court should be amended such that the onus of proof as to the existence or otherwise of a mental illness that meets all the criteria for detention falls on the approved centre rather than the patient as is currently the case.**
- 72. S.I. 11/2007, Circuit Court Rules (Mental Health) should be amended to reflect the fact that the approved centre should be the respondent in cases brought before the Court and the Mental Health Commission's potential involvement should be as a Notice Party.**

2.17 Change of Status from Voluntary to Involuntary

As mentioned earlier [*section 2.7 Voluntary Patient*] all voluntary patients on admission to an approved centre should be fully informed of their rights as voluntary patients. This would include an explanation of their rights regarding consent to or refusal of treatment and their right to leave the approved centre at any time.

The need to include a provision in legislation stating expressly that a voluntary patient has the right to leave the approved centre was mentioned in a number of submissions to the original Steering Group. While that right exists in common law, there is broad agreement including among members of the Expert Group that including such a provision in revised mental health legislation is important to ensure that voluntary patients who may be in a vulnerable and difficult situation are given an assurance that they have the right to leave at any time. This provision would also emphasise that it should be the norm that voluntary patients who express a wish to leave an approved centre should have that right upheld.

Notwithstanding the fact that the Act should expressly state that voluntary patients have the right to leave the approved centre at any time, the Expert Group believes that the existing powers under sections 23 and 24 of the Act to initially detain a voluntary patient and to allow for a change of status from voluntary to involuntary must remain.

Section 23 of the Act allows for a voluntary patient to be prevented from leaving an approved centre and detained for a period not exceeding 24 hours where a member of the medical or nursing staff present believes that the patient is suffering from a mental disorder. Section 24 provides for an examination of the patient by a second Consultant Psychiatrist and where, following such an examination, the second Consultant Psychiatrist is satisfied that the person is suffering from a mental disorder, he or she shall issue a certificate to that effect which in turn shall result in the making of an admission order for the reception, detention and treatment of the person in the approved centre.

In recommending that the power to change the status of a voluntary patient to involuntary should continue to be included in revised mental health legislation, the Group recognises that

this power should, insofar as is possible, only be used in very exceptional cases. The Group notes that the UN Committee against Torture in 2011 drew particular attention to the lack of clarity on the reclassification of individuals from voluntary to involuntary status and recommended that the Act be reviewed to ensure it complies with international standards.

Given that voluntary patients do not have the same safeguards and protections prescribed under the Act as involuntary patients, it is important firstly that voluntary status be truly genuine and secondly that voluntary status is not used to bypass the involuntary review process or is revoked unjustifiably once the patient exercises their voluntary rights.

The Group was mindful of the view some stakeholders expressed that where this power is exercised, from a medical point of view, there may be a tendency to take a more cautious approach than if the person was being examined in the community.

The perception among many service users offers a very different insight on the powers set out in sections 23 and 24. Many service users see these powers as a tool used against them in an effort to coerce them to remain as voluntary patients and co-operate with treatment. Some believe that their freedom of choice can be limited in circumstances where they feel that if they were to express a wish to leave, it would immediately lead to their involuntary detention under sections 23 and 24 of the Act. They tend to view such actions, or threats of action, as being designed to compel them to behave in a manner contrary to their own wishes. It is important, therefore, from a service user point of view we put in place the greatest level of protection possible for voluntary patients.

In this regard, the Group would recommend that where a Consultant Psychiatrist who has the clinical responsibility for the treatment of a patient, a Registered Medical Practitioner, Registered Psychiatric Nurse or Mental Health Professional (registered with CORU in the case of the latter) considers that a voluntary patient would satisfy the criteria for detention, they may detain such patient for a maximum period of 24 hours initially during which time an Authorised Officer should be called. He/she should attend the approved centre to consult with the patient and staff and make a determination as to whether or not to make an application for involuntary admission. The Authorised Officer will consider the alternatives available, offer advice and mobilise support for the service user and the family where necessary. Where the officer believes that the person satisfies all the criteria for detention and there is no alternative to detention, the officer should make an application for an involuntary admission in the normal way (this application must be made within the initial 24 hours referred to above and then be subject to the time restrictions for completion of the process as though it was initiated in the community). A Registered Medical Practitioner who is not the owner of an approved centre or an employee or agent of such centre to which the person is to be admitted, should examine the patient within 24 hours of the application being made by the Authorised Officer and determine if there is a need to make a recommendation for admission.

The Group also agrees that it should no longer be a requirement that a patient must first indicate a wish to leave the approved centre before the detention process is initiated. The Act

should also be amended to specifically allow that process to be initiated in such cases in the approved centre in line with the recent High Court ruling on this matter (*Judgement of KC v Clinical Director of St. Loman's Hospital*). Where an application and recommendation for detention are made, these should be referred to the admitting Consultant Psychiatrist at the approved centre for consideration through the normal process.

While there is a requirement under section 24 to notify the Mental Health Commission every time a patient is re-graded from voluntary to involuntary status there is no such notification requirement where section 23 is used to initially detain a voluntary patient. The Group would recommend that every time section 23 is used in this way, (even if section 24 is not subsequently used to further detain the person) the Mental Health Commission should also be notified. In addition, the Group also recommends that section 24 should be amended to clearly state that the involuntary admission procedure to be followed under this section is similar to the procedure set out in Sections 9, 10, 11 and 14, with any necessary modifications.

Recommendations:

- 73. The Group recommends that the existing powers of the Act to initially detain a voluntary patient and to allow for a change of status from voluntary to involuntary must remain. These powers insofar as possible, should only be used in very exceptional circumstances.**
- 74. A Consultant Psychiatrist who has the clinical responsibility for the treatment of a patient, a Registered Medical Practitioner, Registered Psychiatric Nurse or a Mental Health Professional (registered with CORU in the case of the latter) who considers that a voluntary patient would satisfy the criteria for detention may detain such patient for a maximum period of 24 hours initially.**
- 75. The Group recommends that during the initial detention period of 24 hours, an Authorised Officer should be called to attend the approved centre to consult with the patient and staff and make a determination as to whether or not to make an application for involuntary admission.**
- 76. The Authorised Officer must consider the alternatives available, offer advice and mobilise support for the service user and the family where necessary.**
- 77. Where the officer believes that the person satisfies all the criteria for detention and there is no alternative to detention, the officer should make an application for an involuntary admission in the normal way (this application must be made within the initial 24 hours referred to above and then be subject to the time restrictions for completion of the process as though it was initiated in the community).**
- 78. A Registered Medical Practitioner who is not the owner of an approved centre or an employee or agent of such centre, to which the person is to be admitted, should examine the patient within 24 hours of the application being made by the Authorised Officer and determine if there is a need to make a recommendation for admission.**

- 79. The Group also agrees that it should no longer be a requirement that a patient must first indicate a wish to leave the approved centre before the involuntary admission process is initiated. The Act should also be amended to specifically allow that process to be initiated in such cases in the approved centre in line with the recent High Court ruling on this matter (*Judgement of KC v Clinical Director of St. Loman's Hospital*).**
- 80. The Group recommends that every time section 23 is used to initially detain a patient (even if section 24 is not subsequently used to detain the person) the Mental Health Commission should be notified.**
- 81. The Group also recommends that section 24 should be amended to state clearly that the involuntary admission procedure to be followed under this section is similar to the procedure set out in Sections 9, 10, 11 and 14, with any necessary modifications.**

2.18 Consent to Treatment

The inclusion of autonomy and self determination in the set of guiding principles which will inform new mental health legislation has been discussed previously in the report in section 2.1 (*Guiding Principles*). These key principles were to the fore when the Group came to consider the provisions contained in sections 56 and 57 of Part 4 of the 2001 Act relating to consent to treatment. Section 56 sets out the definition for 'consent' while section 57 of the Act details the circumstances where treatment can be given to a patient without their consent.

It should be noted that the consent to treatment provisions under Part 4 of the Mental Health Act 2001 only apply to involuntary patients. The voluntary patient is covered by common law rules regarding consent in the same way as it applies to other types of medical treatment. Under common law a voluntary patient has an unqualified right to refuse treatment though this is not always clearly understood by or clearly articulated to mental health service users on admission. This right should be specifically stated in revised mental health legislation.

In addition, the Group was clear that any such revised legislation should explicitly provide that all patients (voluntary and involuntary) must give informed consent to treatment and be advised about the support available to them (under proposed capacity legislation) to make informed decisions regarding their treatment. 'Consent' as defined in section 56 should be amended to acknowledge that consent can also include consent given by a patient with the support of a family member, friend or an appointed 'carer', 'advocate' or support decision maker appointed under the proposed capacity legislation.

As indicated above, section 57 of the Act details the particular circumstances where the right of involuntary patients to refuse treatment can be over-ruled by a Consultant Psychiatrist. Section 57(1) of the 2001 Act reads as follows:

'The consent of a patient shall be required for treatment except where, in the opinion of the Consultant Psychiatrist responsible for the care and treatment of the patient,

the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.'

The Group recognises a difficulty with the operation of section 57 from a patient's perspective in that the Consultant Psychiatrist who makes treatment decisions is also the person who decides if the patient has the capacity required to give consent. This is unsatisfactory as currently constructed. It seems to be the case that since Part 4 of the 2001 Act was commenced the 'examination' of a patient to determine if he/she has 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 patient lacks capacity. The Group has been informed that in practice the vast majority of existing involuntary patients are deemed to lack capacity to consent to treatment and that it is rare that a patient will be deemed to be suffering from a mental disorder (as defined in the current section 3) and yet also deemed to have capacity to make decisions on treatment.

With the promise of capacity legislation, the Group recognises that there is 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.

As detailed in section 2.6 (*Capacity*) of this report notwithstanding the presumption of capacity, the Group has recommended that a formal capacity assessment be undertaken if on admission, the admitting Mental Health Professional forms the view that the person may lack capacity to understand and give his/her informed consent to the proposed admission. We have also previously recommended that if a patient disagrees with the Mental Health Professional's decision on his or her capacity, the patient may have that decision reviewed by the Mental Health Review Board set up to review the detention of the patient concerned.

In light of the increased and welcome focus on capacity with the proposed capacity legislation, it is likely that with a formal capacity assessment in place, some patients who are deemed to require in-patient treatment on an involuntary basis but who retain capacity, can decide to refuse treatment. Under our revised criteria for detention, if no treatment is being administered, the person can no longer be detained. This will be in clear contrast to the generally accepted current position where in practice practically all patients with a mental disorder are deemed to lack capacity and therefore the decision to treat the patient is a matter for the treating consultant.

It was recognised that in its current form, section 57 does not authorise treatment where there is a competent refusal from a detained person. However, while allowing for that right, it seems, as mentioned earlier, that practically all patients with a mental disorder are deemed to lack capacity, therefore the issue of a competent refusal doesn't arise.

The new criteria for detention recommended by the Group proposes that detention must cease if no treatment is or can be administered even if it is considered necessary for the protection of the person or the protection of others. While the Group recognises that this presents mental health staff with a serious dilemma, ultimately the Group was unanimous that it would be a regressive step to remove this existing right particularly in view of the significance attached to capacity and the right of a person to make their own decisions as set down in the proposed capacity legislation and in the guiding principles recommended for this legislation. The Group therefore agreed that the right of the capable patient to refuse treatment should remain. Ideally it is hoped that patients would not refuse all treatment but while clearly articulating what treatment they wish to refuse, would also agree to other treatment options that may be put to them during the period of detention.

It is important that detained patients, who by reason of their mental illness are not capable of giving consent to treatment, can receive the treatment they need and the Group accepts that it is necessary and appropriate that the Consultant Psychiatrist has the authority under law to administer treatment in these circumstances. However the Group would like to see a clearer definition of the specific circumstances in which such decisions can be taken.

New criteria for detention are recommended in section 2.4 (*Criteria for Detention*), and taking this into account the Group believes that the circumstances in which treatment can be administered without consent to detained patients must be consistent with the criteria for detention. On that basis, the Group recommends that treatment without consent should be administered if it is considered that it is 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 the patient should receive such treatment. With a view to emphasising the need to adopt a more multi-disciplinary approach to consideration of all treatment options the Group proposes that in making treatment decisions in relation to the forced administration of medication where all other alternatives have been considered and ruled out, the Consultant Psychiatrist must consult with a least one other Mental Health Professional from a different discipline and that this consultation must be officially recorded.

As outlined in section 2.6 (*Capacity*), a person without capacity may have a Decision Making Representative (DMR) appointed under the Assisted Decision-Making (Capacity) Bill and in section 2.8 (*New Category of Patient*) we outlined that a DMR if given the authority by the Court, may grant or refuse consent to the carrying out or continuation of treatment for an individual. The only limitation on this is where a DMR refuses treatment for the individual in emergency circumstances, in which case a Consultant Psychiatrist may override the decision of the DMR subject to a Mental Health Review Board convening within three days.

Similarly, where an individual is admitted as an involuntary patient and is deemed to lack capacity but does have a DMR as outlined above, treatment can be administered with the consent of the DMR. The Group also recommends that as has been recommended for intermediate patients, where a DMR refuses treatment on behalf of an involuntary patient, a Consultant Psychiatrist can override that refusal and treat the patient if he or she believes it to be an emergency situation (i.e. where treatment is deemed necessary and the person's actual

behaviour is injurious to self or others and no other safe option is available). As with intermediate patients such a decision would be referred to a Mental Health Review Board within three days who would decide if the situation presenting to the Consultant Psychiatrist fulfils the criteria for emergency circumstances. If the Review Board agrees that the circumstances were of an emergency nature, then the treatment authorised by the Consultant Psychiatrist may continue for as long as the emergency circumstances prevail subject to other provisions relating to second opinions etc.

The close linkages and synergies between Section 57 and the introduction of advance healthcare directives which respect the right of a person to refuse treatment were discussed in detail by the Group. Section 2.25 (*Advance Healthcare Directives*) of the report elaborates further on the proposals for advance healthcare directives which are being formulated as part of the Assisted Decision-Making (Capacity) Bill. In particular, the provisions proposed for advance healthcare directives were examined in detail to ensure no conflict or dichotomy existed between these proposals and the recommendations of the Group for Section 57.

Section 69 of the Act provides for the use of seclusion and restraint ‘for the purposes of treatment or to prevent the patient from injuring himself or herself’ and requires any such measures to be carried out under rules drawn up by the Mental Health Commission. Rules in this regard were published in 2009. These rules make it clear that patients must be respected and that a culture of respect must be fostered with regard to the use of seclusion and restraint. These interventions must only be used in rare and exceptional circumstances and only in the best interests of the patient when he or she poses an immediate threat of serious harm to self or others. In addition it is important that services also demonstrate that they are attempting to reduce the use of seclusion and restraint, where applicable. The Group would emphasise the ongoing need for services to ensure that seclusion and restraint are used only as a last resort, only where there is no other alternative and always in accordance with the rules drawn up by the Commission. The Group believes it would be more appropriate for the section of the Act (69) dealing with seclusion and restraint to be included in Part 4 of the Act which deals with consent to treatment. The Group also recommends that the section should be broadened to include all forms of manual or other forms of seclusion or restraint and appropriate guidelines should be developed by the Mental Health Commission. It should also be made clear that this section applies to patients in the Central Mental Hospital.

Recommendations:

- 82. The right of voluntary patients to refuse treatment should be explicitly stated.**
- 83. All patients should be supported to make informed decisions regarding their treatment and ‘consent’ as defined in Section 56 relating to consent to treatment should include consent given by a patient with the support of a family member, friend or an appointed ‘carer’, ‘advocate’ or a support decision maker appointed under the proposed capacity legislation.**
- 84. Section 57 should be amended so that the informed consent of a voluntary patient is required for all treatment.**

85. Informed consent is also required from involuntary patients who are deemed capable of giving such consent.
86. A Consultant Psychiatrist, after consultation (to be officially recorded) with at least one other Mental Health Professional of a different discipline involved in the treatment of the patient, may administer treatment to a detained patient who lacks capacity where the patient does not have a DMR 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 he or she should receive such treatment and there is no safe and effective alternative available. Where a patient lacks capacity but has a DMR appointed under the capacity legislation, the DMR may accept or refuse treatment for the patient.
87. A Consultant Psychiatrist can override the decision of a DMR to refuse treatment on behalf of an involuntary patient in emergency circumstances where the treatment is deemed necessary, the patient is injurious to self or others and no other safe option is available. A Mental Health Review Board must meet within 3 days to determine that the treatment was given in the appropriate emergency circumstances. If the Review Board agrees that the circumstances were of an emergency nature, then the treatment authorised by the Consultant Psychiatrist may continue for as long as the emergency circumstances prevail subject to other provisions relating to second opinions etc.
88. The Group would emphasise the ongoing need for services to ensure that manual or other forms of seclusion and restraint are used only as a last resort, only where there is no other alternative and always in accordance with the rules drawn up by the Commission.
89. The Group believes it would be more appropriate for the section of the Act (69) dealing with seclusion and restraint to be included in Part 4 of the Act which deals with consent to treatment. The Group also recommends that the section should be broadened to include all forms of restraint including manual or other forms of seclusion or restraint, and appropriate guidelines should be produced by the Mental Health Commission. In addition, it should be made clear that this section applies to patients in the Central Mental Hospital.

2.19 Electro-Convulsive Therapy (ECT)

Under Section 59 of the Mental Health Act 2001, the written consent of a patient is required where a programme of ECT is to be administered. However, where an involuntary patient is *unable* or *unwilling* to give consent, the programme may be administered if it has been approved by the Consultant Psychiatrist responsible for the care and treatment of the patient and also authorised by another Consultant Psychiatrist. The Mental Health Commission has published rules regarding the administration of ECT and adherence to these rules is monitored on an annual basis by the Inspector of Mental Health Services.

There are diverging views both within and outside the psychiatric profession on the necessity and/or efficacy of ECT, on one hand the perception is that ECT is a high risk, low-benefit procedure, while on the other hand it remains a recognised treatment for severe mental illness which is regarded as effective and safe, and particularly useful for severe, treatment resistant depression and in some cases can be a lifesaving treatment.

The Expert Group was in clear agreement that the principles recommended in section 57 whereby patients must give informed consent to treatment should equally apply to ECT. In this regard, the authority to give ECT without consent in any circumstance where the patient is capable of giving consent but unwilling to do so should be removed. 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 Group was cognisant of the decision making supports available in the Assisted Decision-Making (Capacity) Bill and was in agreement that in circumstances where a patient is unable to give consent but a decision-making representative appointed legally under the Assisted Decision-Making (Capacity) legislation for the person gives that consent on the patient's behalf, 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 Group. In normal circumstances such a decision must be respected, however it was also acknowledged that situations can arise where ECT is required as a life-saving treatment, for a patient or where the patient's condition is otherwise treatment resistant. The Group accepted the need to allow for refusal of ECT by a decision-making representative to be over-ruled in these limited circumstances. Such decisions should be subject to a robust review mechanism in the form of a Mental Health Review Board which must convene within 3 days of any such decision being taken. It would then be a matter for the Review Board as to whether, on the basis of the facts presented, the administration of ECT should proceed.

Recommendations:

- 90. Section 59 should be amended to remove the authority to give ECT without consent in any circumstance where the patient is capable of giving consent but unwilling to do so. The Group recommended that the first possible opportunity should be taken to effect this change in the context of any future miscellaneous health bill. Where the patient is unable to give consent but a decision-making representative appointed legally under capacity legislation for the person gives that consent on the patient's behalf, then ECT may proceed.**
- 91. Where a patient does not have capacity and a decision-making representative does not give consent to ECT, such treatment may only take place where it is required as a life-saving treatment, for a patient where there is a threat to the lives of others or where the condition is otherwise treatment resistant, and such ECT may then only be administered subject to approval by a Mental Health Review Board which must convene within 3 days of the decision being taken.**

2.20 Administration of Medicine

Section 60 of the Mental Health Act 2001 provides that where medicine has been administered to a patient for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless the patient gives consent in writing or where the patient is unable or unwilling to give such consent the continued administration of that medicine is approved by the Consultant Psychiatrist responsible for the care and treatment of the patient and the continued administration of that medicine is authorised by another Consultant Psychiatrist following referral by the treating Consultant. The initial approval period is 3 months and thereafter for periods of 3 months.

The Expert Group was unequivocal from the outset that the recommendation of the Steering Group to remove the word ‘unwilling’ from section 60 should be carried through. This particular provision is inconsistent with the current section 57 which allows a person with capacity to refuse treatment. There is no reason why the administration of medicine before or after a review period should be treated differently insofar as the capacity of the patient is concerned. 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 report of the Expert Group has outlined previously the importance of respecting the autonomy and self-determination of the person and in making the recommendation to remove the word ‘unwilling’ from section 60, the Group wanted to ensure that where a person has the capacity to make his/her decision, any such refusal to accept medicine will be respected.

The initial review period of 3 months was felt by the Group to be too long and it was recommended that for detained patients who were deemed to be incapable of giving consent medicine should only be administered for the purpose of ameliorating their condition for a period not exceeding 21 days. If the medicine is to be continued after this initial time period, the Group again recommended the adoption of the multi-disciplinary approach agreed throughout the report that the treating Consultant must consult with another Mental Health Professional of a different discipline involved in the treatment of the patient and this must be officially recorded. In addition, any decision to extend the administration of medicine beyond 21 days must also be authorised by a second Consultant Psychiatrist from outside the approved centre.

In addition, the Group recommends that the requirement to ensure that the continued administration of the medicine concerned will be of therapeutic material benefit to the patient should be included in a revised section 60. It was felt that this provision will alleviate concerns raised in a number of submissions to the Steering Group that in some cases medicine was being used to control patients rather than aid their recovery.

While the Group agrees that it is reasonable to allow further reviews of the ongoing administration of medicine to take place every three months, members recommended that the patient may request that the first such review take place at an earlier stage.

The Expert Group also discussed measures which should be put in place for the administration of psychotropic medication to ensure that patients do not feel that they do not have control regarding the administration of such medication. In this regard, the Group recommends that the views of the patient should be sought and recorded and if appropriate consultation should be held with the patient's family or advocate which will also be recorded. The Group recommends that the duties of the Inspector of Mental Health Services could be extended in this area with he/she being given responsibility for overseeing these safeguards. Appropriate guidance could be provided by the Mental Health Commission.

Recommendations:

- 92. The reference to 'unwilling' should be removed from Section 60, and where any patient who has the capacity to make a decision refuses to take medicine, this decision will be respected. The Group recommended that the first possible opportunity should be taken to effect this change in the context of any future miscellaneous Health Bill.**
- 93. Section 60 should also be amended so that medicine may be administered to a detained patient without capacity for the purpose of ameliorating his or her condition for a period not exceeding 21 days. The recommendation to continue the administration of medicine beyond 21 days must be made by the treating Consultant who must also consult with another Mental Health Professional of a different discipline involved in the treatment of the patient and this must be officially recorded. The recommendation to extend the administration of medicine beyond 21 days must also be authorised by a second Consultant Psychiatrist from outside the approved centre.**
- 94. Section 60 should be amended to reflect the fact that the continued administration of the medicine concerned must be of therapeutic material benefit to the patient.**
- 95. Further reviews of treatment should be undertaken every three months, and in the case of the first such review, a patient may request that this review take place at an earlier stage.**
- 96. The recommendation to continue the administration of medicine every three months must be made by the treating Consultant who must also consult with another Mental Health Professional of a different discipline involved in the treatment of the patient 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.**
- 97. Where psychotropic medication is proposed, the views of the patient should be recorded and, if appropriate, consultation held with the patient's family or**

advocate, also to be recorded. The functions of the Inspector of Mental Health Services could be extended in this area.

2.21 Provision of Information on Admission to Approved Centres and Complaints Mechanisms

This Expert Group report has made recommendations in section 2.7 that all voluntary patients on admission should be fully informed of their rights as voluntary patients and this would include an explanation of their rights regarding consent to, or refusal of, treatment and their right to leave the approved centre at any time. Section 16(2)(c) of the Mental Health Act 2001 provides that when a person is admitted as an involuntary patient to an approved centre, then he or she will be given a general description of the proposed treatment to be administered to him or her during the period of his or her detention. The Mental Health Commission in its Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre outlines in detail the range of information that should be made available to a patient once they are admitted to an approved centre. The Expert Group felt that all these provisions should be combined to ensure that the revised legislation expressly states that on admission to an approved centre, every patient should have a right to information which would include their rights as a voluntary or involuntary patient, their rights regarding consent to or refusal of treatment, the range of services available in the approved centre and any additional information as outlined in the Mental Health Commission Code of Practice. In addition, the Group believes that it is also imperative to ensure that the patient is made aware of the complaints mechanisms in place at the centre and any general complaints mechanisms that exist within the broader mental health service.

Members of the Expert Group looked at the complaints procedures that currently exist within the service and examined a suggestion of providing for a separate Mental Health Ombudsman. The Health Service Executive has a comprehensive complaints mechanism in place which is entitled ‘Your Service, Your Say’, which encourages both positive and negative feedback across all the services it provides and respects the right of HSE service users to comment, compliment or complain about any of the services provided by the HSE. A person with a complaint would go through this process first and if they were subsequently not satisfied, then they can access the existing Office of the Ombudsman. It was felt by the Group that as complaints about mental health services already have access to the existing Office of the Ombudsman and the fact that a separate complaints system for mental health patients could be seen as discriminatory, it would be premature to recommend a Mental Health Ombudsman at this juncture, however it was recommended that it should be re-examined as part of the suggested five to ten year review of any new Act.

Section 52(a) of the Mental Health Act 2001 provides that during the annual inspection of approved centres, the Inspector of Mental Health Services shall see every patient whom he or she has been requested to examine by the resident himself or herself or by any other person. While the Inspector of Mental Health Services does not investigate individual complaints which have been directly received by the Mental Health Commission, they take note of them

and can make enquires of the relevant approved centre on subsequent inspection. The Group wanted to re-iterate the existing obligation on the Inspector of Mental Health Services to meet a complainant when on an inspection and the wording of this section should be re-enforced to reflect this point. The Group again recommended all patients should be informed of this obligation on admission to an approved centre and on the process for contacting the Mental Health Commission.

Recommendations:

- 98. On admission to an approved centre, every patient should have a right to information which would include their rights as a voluntary or involuntary patient, their rights regarding consent to or refusal of treatment, the range of services available in the centre, and any additional information as outlined in the Mental Health Commission Code of Practice.**
- 99. There is also an obligation to ensure that the patient is made aware of the complaints mechanisms in place at the centre and any general complaints mechanisms that exist within the service generally.**
- 100. The Group re-iterates that it is mandatory for the Inspector of Mental Health Services to meet a patient who has made a complaint when he/she is subsequently inspecting that approved centre and all patients must be informed of this right on admission to an approved centre and on the process for contacting the Mental Health Commission.**
- 101. The Expert Group is not recommending a separate Mental Health Ombudsman at this juncture, however it should be re-examined as part of future reviews of any new Act.**

2.22 Care Plans and Discharge Planning

Section 66(2)(g) of the Mental Health Act 2001 provides for the making of regulations '*as to the drawing up and carrying out by centres, so far as practicable in consultation with each resident, of an individual care plan for that resident, including the setting of appropriate goals*'. The regulations which govern care plans are contained in SI 551/2006 Mental Health Act 2001 (Approved Centres) Regulations 2006 of which section 15 provides that '*The registered proprietor shall ensure that each resident has an individual care plan*'. A number of submissions to the original Steering Group highlighted the fact that the Inspector of Mental Health Services found that compliance with this aspect of the regulations has been poor in addition to the fact that the 2001 Act contains no review mechanism regarding how the care plan is drawn up.

The Expert Group was cognisant of the importance of care plans, the role they should play in deciding on treatment plans for patients, and how they must provide a seamless recovery based approach towards discharge and support in the community. The Group recommended that care plans should be reviewed on a regular basis, however the timing of such reviews which will differ from person to person should be decided based on the individual's needs. In

addition, care plans should acknowledge the need for reciprocity by outlining that the patient is being treated with a view to improving his or her health. Evaluation and feedback should also form part of the review of a care plan and there will be a need to show evidence of the undertaking of a review of the care plan. The Group discussed a practical issue where in some cases patients refused to sign their care plans, and it was agreed that all patients must be offered the opportunity to sign their care plan and where it is refused, this must be recorded accordingly. It was also recommended by the Group that for the revised legislation, care plans should be renamed as ‘recovery plans’⁵ and such plans should refer to the person rather than the patient.

Section 2.13 has outlined the recommendations from the Expert Group on the increased powers that Mental Health Review Boards should have in relation to recovery plans and how they should have the authority to establish whether there is an individual recovery plan in place and if it is compliant with the law. In addition, it was recommended that the Review Board can establish that the views of the patient as well as those of the multi-disciplinary team were sought in the development of the recovery plan. The Group was also aware of an issue that arises under the current regulations (SI 551/2006) whereby it is the responsibility of the registered proprietor to ensure that each resident has an individual care plan and consequently they would have to appear before the Review Board on this issue. The Group was in agreement that the responsibility for the clinical content of recovery plans rests with the multi-disciplinary mental health team not the proprietor and the wording of the legislation would need to be amended to reflect this fact.

The importance of discharge planning was also recognised by the Expert Group and the Group highlighted the need to ensure it is specifically included as part of every individual recovery plan. It was acknowledged that the 2001 Act and articles 3 and 15 of SI 551/2006 do not make any reference to discharge planning, however the Mental Health Commission’s *‘Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre’* recommends that discharge planning for the patient should commence as soon as possible following admission to an approved centre so that the patient’s journey towards recovery is optimised from the outset. The Group was made aware of meetings held with representatives of family and carers groups who emphasised the importance of discharge plans and the need for revised legislation to require that discharge planning meetings should take place and involve families. The Expert Group was in agreement on the benefits of discharge planning meetings and reiterated its view that they should where possible take place, however it was also acknowledged that it may not always be possible in practice to arrange such meetings. Discharge planning meetings should provide key discharge related information to families who would be made aware of any potential risks following the discharge of the patient. However, this must be carried out respecting the patient’s right to confidentiality. Ideally, the meeting should be attended by the patient, members of his/her family, carer or chosen advocate (with the consent of the patient), members of the multi-disciplinary team and his/her

⁵ Throughout the rest of the report, we will use the term ‘recovery plan’ rather than ‘care plan’ and will only use the latter where we are specifically referring to what is already contained in the 2001 Act.

key worker. It was also recommended that there should be robust codes of practice produced on the implementation of discharge planning.

Section 66 of the Mental Health Act 2001 provides that regulations may be drawn up in relation to approved centres and the Group was of the view that this section should be strengthened further to specifically ensure that community based services are included in such regulations.

Recommendations:

- 102. Care planning function should be strengthened and extended to all persons in receipt of mental health services and provide a seamless recovery based approach towards discharge and support in the community.**
- 103. Recovery plans should be reviewed on a regular basis and the timing of the reviews should be decided based on the patient's individual needs.**
- 104. Patients must be offered the opportunity to sign off on their recovery plans and this must be recorded.**
- 105. Evaluation and feedback should form part of the review of a recovery plan and there should be a need to show evidence of the undertaking of a review.**
- 106. Wording of the legislation should be amended to ensure that it is the multi-disciplinary team that has responsibility for the clinical content of recovery plans rather than the proprietor.**
- 107. Care plans should be renamed as recovery plans and should refer to the person rather than the patient.**
- 108. Discharge plans must form part of a person's individual recovery plan.**
- 109. It is desirable that discharge planning meetings should take place with family members, carers or chosen advocate (with the consent of the patient) and there should be robust codes of practice produced on their implementation.**
- 110. Section 66 should be strengthened further to cover community based services.**

2.23 Children

It is acknowledged that children of any age can suffer from a mental illness or mental health difficulties, but adolescence is a typical time for the development of such problems with very often long term implications.

While the vast bulk of children with such problems are and will increasingly be dealt with in the community, nonetheless there is an ongoing requirement for child and adolescent in-patient services to be available. In 2013, there were 408 admissions of 332 children i.e. persons under 18 years of age, to adult and dedicated child and adolescent services. This is a decline in admissions of over 6% since 2012. More than three-quarters of all admissions for children in 2013 were to dedicated child and adolescent units. 3.4% of all admissions in 2013 were on an involuntary basis under the Mental Health Act 2001 (*Mental Health Commission Annual Report 2013 p 32-33*). Admissions of children to adult units has continued to decline

over the past number of years and in the last six years this has decreased by almost 65% – from 247 in 2008 to a figure of 91 in 2013. There are 51 child and adolescent beds operational nationally and it is expected that this operational capacity will increase to 60 beds in 2014. While it is acknowledged that there have been advances in recent years, that is not to say that more can't be done and done more quickly. Progress needs to continue to drive down admissions of children to adult units and to drive down waiting lists and waiting times for certain child and adolescent mental health services.

Since 2012, an additional €125 million has been ring-fenced for the reform of the mental health services with the approval for the provision of over 1,000 posts primarily to strengthen community mental health teams for both adults and children. This significant improvement in community services will offer a more appropriate and local treatment for children who need access to mental health services. It should also help to further drive down the number of children that need to be admitted to approved centres.

In July 2011, the Law Reform Commission (LRC) published their Report *Children and the Law: Medical Treatment*, chapter 3 of which deals with mental health. The Commission made a number of recommendations regarding the amendment of the 2001 Act and these recommendations have informed the Expert Group in the context of this review.

The Mental Health Act 2001, including the categories of voluntary and involuntary admission, applies to both adults and children. The provisions relating to children are spread out across different sections of the Act and because of this, there has been a lack of clarity over whether certain sections of the Act encompass children or not. In addition, the 2001 Act has also incorporated various aspects of the Children Act 2001 and, while these are referred to specifically in section 25(14) the detailed provisions are not quoted, meaning that users of the Act often have a difficult job in trying to reference and interpret two statutes simultaneously. It is for these reasons that submissions to the original Steering Group all recommended that the provisions of the 2001 Act relating to children be included in a standalone section of any future mental health legislation. The Expert Group is also satisfied that a separate section of the Act for children which should expressly include, rather than cross-reference, any provisions of relevant child care legislation would be more user friendly and should be included in any future mental health legislation.

The definition of a child under the Mental Health Act 2001 is 'a person under the age of 18 years other than a person who is or has been married'. This is the definition used in the Child Care Act 1991. The Group agreed that the definition should now be brought into line with the Children Act 2001 which defines a child as 'a person under the age of 18 years'.

Having recommended a standalone section of the Act specifically for children, the Group believes that this would also facilitate the setting out of child appropriate guiding principles which should underpin those provisions of the Act relating to children.

In considering the particular principles which must be taken into account where children are concerned, members began by examining the *Convention on the Rights of the Child* (CRC) (to which Ireland is a party), in addition to the ECHR and the CRPD, both of which rely on the CRC to interpret their provisions. Article 7 of the CRPD provides:

‘Article 7 - Children with disabilities

1. States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.
2. In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration.
3. States Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realise that right.’

Article 7 of the CRPD reflects the provisions under Articles 2, 3, 5, 6, 12 and 23 of the CRC - to ensure ‘the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children’ as required by the CRPD which requires that children with disabilities benefit from all the rights in the CRC, be treated equally with others and are protected from all forms of discrimination (Article 2 CRC and Article 5 CRPD) including on the grounds of their disability.

As with the guiding principles for adults, the need to achieve the highest attainable standard of mental health and the right to respect the autonomy and self-determination of a child are considered essential for inclusion in the list of child appropriate guiding principles.

Article 12 of the CRC, which members saw as particularly important, provides:

‘Article 12

- 1 States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.
- 2 For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.’

The Group accepts the need to reflect the key tenets of Article 12 in child appropriate guiding principles to ensure that the child can express a view and have such views given due weight in addition to providing the child with the opportunity to be heard. Such provisions are not currently reflected in our mental health legislation either in relation to voluntary or involuntary admission.

Article 37(c) of the CRC provides “...In particular, 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 Group fully endorses that statement and acknowledges that the HSE’s Child and Adolescent

Mental Health Service (CAMHS) has expanded in recent years to ensure that children are, where possible, treated in an age appropriate manner. In that context the Group notes and welcomes the HSE protocol '*Access Protocols for 16 and 17 year olds to Mental Health Services*' which provides that from 1st January 2014, CAMHS will accept referrals of all new cases of children up to age 18. While progress continues to be made in this regard the Group would like to see this policy implemented at a much faster rate.

The Group also emphasised that in addition to being age appropriate, such services should be provided in close proximity to family and/or carers wherever possible. Children should also receive the least intrusive treatment possible in the least restrictive environment possible.

Finally, the Group also recognises that where children are concerned there is a need to refer to best interests and notes that paragraph 1 of Article 3 of the CRC provides that 'In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.'

The following is the list of child appropriate guiding principles recommended by the Group:

- a) Every child should have access to health services that aim to deliver the highest attainable standard of child mental health.
- b) The autonomy and self-determination of the child should be respected insofar as practicable in conjunction with parents or persons as required acting in loco parentis.
- c) There must be consultation with the child at each and every stage of diagnosis and treatment with due weight given to his/her views consistent with his/her age, evolving capacity and maturity and with due regard to his/her will and preferences.
- d) Services should be provided in an age-appropriate environment wherever possible.
- e) Services should be provided in close proximity to family and/or carers wherever possible.
- f) The child must receive the least intrusive treatment possible in the least restrictive environment possible.
- g) Where there is an intervention on behalf of the child, his/her best interests must be taken into account, and 'best interests' 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 his/her age, evolving capacity and maturity and with due regard to his/her will and preferences.

In addition to the above guiding principles, the Group believes it important to state that each child should have an individual care plan and all necessary information relating to admission, detention and treatment should be provided as appropriate.

The Expert Group members acknowledge that section 23 of the Non-Fatal Offences Against the Person Act 1997 states that 'The consent of a minor who has attained the age of 16 years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his or her person, shall be as effective as it would be if he or she were

of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his or her parent or guardian.’

It has long been unclear, however, how this Act interacts with the provisions of the Mental Health Act 2001. The apparent inconsistency between the two Acts has led to confusion over the status of consent or refusal given by adolescents.

It is the Group’s view that in line with article 12 of the *CRC*, submissions on this topic to the original Steering Group set up to review the 2001 Act and the recommendation from the Law Reform Commission, children aged 16 and 17 years should be presumed to have capacity to consent to or refuse admission and treatment and that this needs to be expressly stated in any revised mental health legislation. For an admission of a child aged 16 or 17 to proceed on a voluntary basis the child therefore must also consent or at least must not object to his/her voluntary admission. In circumstances where a child neither consents nor objects to admission, voluntary admission may proceed with the consent of a parent or person as required acting in loco parentis. Where, however, the 16 or 17 year old objects, the case should then be referred to a child friendly District Family Law Court which can determine whether the child has the necessary maturity or capacity to make an informed decision. 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 Group considered the position of children under the age of 16 and acknowledges that there should be no automatic presumption of capacity for this category and that the decision to voluntarily admit such a child should remain with the parents or person as required acting in loco parentis. In line with Article 12 of the *CRC* however, the Group recommends that notwithstanding the fact that admission and treatment of such children on a voluntary basis must continue to require the consent of the parents or person as required acting in loco parentis, the views of the child should be heard by parents and service providers and given due weight in accordance with the child’s age, evolving capacity and maturity.

Section 25 of the 2001 Act, which is the only section that applies solely to a child, provides for the involuntary admission of children and adolescents. This section sets out certain procedural safeguards which are different to the system in place for the involuntary admission and treatment of adults.

The current Act provides that in order to have a child involuntarily admitted, the Health Service Executive (HSE) must apply to the District Court for an order authorising the detention in an approved centre. This is done where it is considered that the child is suffering from a mental disorder and the child requires treatment which he or she is unlikely to receive unless an order for involuntary admission is made. The initial admission order is for a period not exceeding 21 days while the first renewal order is for a period not exceeding three months

with the second and subsequent renewal orders allowing detention for a period not exceeding six months.

The Expert Group acknowledges that where the involuntary admission of a child is concerned it is and remains appropriate that such decisions be referred to a child friendly District Family Law Court for determination and confirmation that such detention is sought as a last resort. The Group did, however, give serious consideration to the support voiced for a more informal review mechanism as recommended by the Law Reform Commission (*Children and the Law: Medical Treatment*) specifically where decisions on renewal orders are concerned. The Group sees merit in having a more informal setting for children but ultimately decided that it remains in the best interests of the child that renewal orders also require the approval of the District Family Law Court which should seek to be as child friendly as possible. The Group is satisfied that the duration of initial admission orders should continue to be for a period not exceeding 21 days and renewal orders for periods of 3 and 6 months.

At present the Mental Health Commission's Code of Practice requires that information relating to admission and discharge of children is notified to the Commission. The Group believes that this should now be a specific requirement under the Act.

The Group notes that under section 19 of the Act adult patients have a right of appeal to the Circuit Court. The Group believes it is desirable that this right of appeal would also apply in respect of children and adolescents whose detention is subject to review. In addition, under the current Act adults who are detained as involuntary patients can choose to be admitted as a voluntary patient. There is no similar provision for children and the Group recommends that the option to change status should be available to them assuming they satisfy the relevant criteria.

It is recognised that children and adolescents detained under the Mental Health Act 2001 are in a particularly vulnerable situation and that it is appropriate that they be given every support. On that basis the Group recommends that children, their families and/or guardians should have advocacy services available to them.

The Garda Síochána have authority under section 12 of the 2001 Act to take a person believed to be suffering from a mental disorder into custody. While it is clear that this applies to adult patients, there has been uncertainty as to whether this section can also apply to children and adolescents. The Group therefore recommends that the matter should be clarified by giving the Gardaí the specific power to remove a child believed to be suffering from a mental disorder to a place where an age appropriate assessment can be performed. The revised legislation should include a reference to ensuring that this practice is used only where appropriate and there is no other alternative.

The role of the Gardaí under the Child Care Act 1991 refers to taking a child to a 'place of safety' for assessment, very often this is an emergency department. As none of the paediatric hospitals are approved centres, the Group also believes that ideally any places to which

children are taken for such assessments should fulfil certain specific criteria (e.g. availability of child and adolescent psychiatry) and that relevant stakeholders are available, involved and informed (Gardaí, parents, etc.). Also, certain locations may be inappropriate in this regard (e.g. a care home from which a child has absconded).

Recommendations:

- 111. Provisions relating to children should be included in a standalone Part of the Act and any provisions of the Child Care Act 1991 which apply should be expressly included rather than cross referenced.**
- 112. Child should be defined as a person under 18 and thus brought into line with the Children Act 2001.**
- 113. Dedicated children's Part of the Act should stipulate the following guiding principles:**
 - a. Every child should have access to health services that aim to deliver the highest attainable standard of child mental health.**
 - b. The autonomy and self-determination of the child should be respected insofar as practicable in conjunction with parents or persons as required acting in loco parentis.**
 - c. There must be consultation with the child at each and every stage of diagnosis and treatment with due weight given to his/her views consistent with his/her age, evolving capacity and maturity and with due regard to his/her will and preferences.**
 - d. Services should be provided in an age-appropriate environment wherever possible.**
 - e. Services should be provided in close proximity to family and/or carers wherever possible.**
 - f. The child must receive the least intrusive treatment possible in the least restrictive environment possible.**
 - g. Where there is an intervention on behalf of the child, his/her best interests must be taken into account, and 'best interests' 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 his/her age, evolving capacity and maturity and with due regard to his/her will and preferences.**
- 114. Children aged 16 or 17 should be presumed to have capacity to consent / refuse admission and treatment.**
- 115. For an admission of a 16 or 17 year old to proceed on a voluntary basis, the child therefore must also consent or at least must not object to his/her voluntary admission.**
- 116. Where a 16 or 17 year old objects, the case should then be referred to a child friendly District Family Law Court which can determine whether the child has the necessary maturity or capacity to make an informed decision. 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.

117. The Group acknowledges that there should be no automatic presumption of capacity for children under the age of 16.
118. In the case of a child under the age of 16, voluntary admission should only take place where the parents or person as required acting in loco parentis consents, however the views of the child must be heard by parents and service providers and given due weight in accordance with the child's evolving capacity and maturity.
119. Admission and renewal orders for the involuntary detention of a child (under 18) should continue to require a Court Order and require justification that it is used as a last resort.
120. The requirement to notify the Mental Health Commission of information relating to admission and discharge of children should be elevated to primary legislation.
121. Advocacy services to children and to the families of children in the mental health service should be available.
122. Gardaí (for clarity purposes) should be given the specific power to remove a child believed to be suffering from a mental illness satisfying the criteria for detention to a place where an age appropriate assessment can be performed and admissions should only be made to an age appropriate approved centre.
123. Places to which children are taken for such assessments should fulfil certain specific criteria (e.g. availability of child and adolescent psychiatry) and that relevant stakeholders are available, involved and informed (Gardaí, parents, etc.). Also, certain locations may be inappropriate in this regard (e.g. a care home from which a child has absconded).

2.24 Inspections of Approved Centres and Community Services

Inspectorates need to be flexible in order to deal well with the increasingly crosscutting nature of service provision. Internationally, for example, a proportionate approach to inspection is emerging as current best practice which leads to:

- offering less scrutiny for excellent performers in public services, providing greater flexibility and a reduced weight of inspection;
- inviting excellent public service performers to volunteer for themed and joint inspections, to incorporate good practice into the joint working agenda;
- concentrating on the priorities and on minimising the amount of inspection, for example by promoting joint and themed inspections and not doing this in addition to single service inspection; and

- considering using self-assessment and other approaches to review as a decision making tool for future activity and recognising the use of self-evaluating techniques within inspected bodies to help inspection focus on areas of identified weakness.

Inspections should target organisations where a range of data sources (such as previous inspection reports, data from other inspection bodies, data from the organisation's own clinical governance systems, routine activity data, etc.) suggest there may be problems. This would assist the Mental Health Commission in developing a risk based approach to inspection to ensure maximum effectiveness and efficiency in the use of scarce resources. The use of existing data in this way can also help to identify potential issues before they become problems. Overall, the Commission's review process should work on the principle of proportionality, investing review resources in proportion to the scale of the organisation or service being reviewed and the quality improvements that are likely to result from the review.

Over time, Inspectors should modify the extent of future inspection according to the quality of performance by the service provider. The principles of inspection should focus on:

- a) the purpose of improvement and specifically to generate data and intelligence that enable Inspectors more quickly to calibrate the progress of reform in their sectors and make appropriate adjustments,
- b) mental health outcomes,
- c) the service user perspective,
- d) evaluation of risk, based on impartial evidence, and
- e) dissemination of learning.

The Group, on that basis, was in broad agreement that inspections of approved centres should be proportionate, based on risk and should take place at least once every three years. This may require annual inspections if the risk profile merits such scrutiny. Community Services should be registered and inspected at reasonable intervals using a risk based system starting with all community mental health teams.

Under section 33(1) of the Mental Health Act 2001, the principal functions of the Mental Health Commission are to ‘*promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under this Act*’. The Group felt that in order to enhance the standard of care that is being provided in approved centres, the revised legislation should provide for the Mental Health Commission to make standards in respect of all mental health services and to inspect against those standards. The standards would be made by way of regulations and the regulations would be underpinned by way of primary legislation.

Recommendations:

- 124. The Group recommends the registration and inspection at regular intervals of the following mental health services:**

- **Phase 1: Continue to register approved centres and inspect at least once in every three years and more often according to targeted risk.**
- **Phase 2: Register all community mental health teams and inspect against an increasing proportion of the services provided in the community.**
- **Phase 3 Register all High, Medium and Low Support Hostels; Crisis/Respite Houses; any other Residential Services; Day Hospitals, Day Centres and other facilities in which mental health services are provided and introduce inspections on a phased basis.**

125. The new Act should give the Mental Health Commission specific powers to make standards in respect of all mental health services and to inspect against those standards. The Standards should be made by way of regulations and the regulations should be underpinned by way of primary legislation.

2.25 Advance Healthcare Directives

In line with the promotion of autonomy of the individual throughout this report, the Group discussed the important role advance healthcare directives can play in this regard. In the area of treatment for mental illness, advance healthcare directives are known to provide benefits both in terms of increasing patient empowerment and participation, in addition to improving the doctor-patient therapeutic relationship and potentially improving overall treatment outcomes.

Advance healthcare directives are defined as statements by competent adults setting out their wishes in relation to the type and extent of medical treatments they would or would not want to receive in anticipation of future incapacity to make decisions. Clearly, a prerequisite to making a valid advance healthcare directive is that the individual making one is an adult and that he or she has capacity.

While advance healthcare directives were originally developed to allow decisions regarding end-of-life care, the inclusion of such directives in mental health settings, which is a more recent development, allows persons with mental illness to participate in future treatment decisions over the course of their lives.

The Group recognises the importance of providing for advance healthcare directives in legislation and stresses that such legislation should apply to mental health on an equal basis with general health. While there is currently no specific legislation pertaining to advance healthcare directives in Ireland, proposals in this regard are being prepared by the Department of Health for inclusion in the Assisted Decision-Making (Capacity) Bill. The Group members received a presentation on the initial proposals for advance healthcare directives and made their views known to officials at a meeting of the Group.

The Group put forward the view that mental illnesses can be episodic in nature and advance healthcare directives can allow the individual to retain some control over their treatment

during any period of mental illness where the person loses capacity. Previous experience of specific treatments can ensure that individuals with capacity can focus their advance healthcare directives on maximising recovery on their terms by attempting to minimise unwanted interventions and treatments. It is on this basis that patient experience and insight can be harnessed to help improve the decision-making process within the mental healthcare setting.

However, while the Group recognises and supports the role of advance healthcare directives in promoting patient autonomy, it is also acknowledged that mental health legislation places restrictions on a person's autonomy. The Group also appreciates that the proposed Assisted Decision-Making (Capacity) Bill is before the Houses of the Oireachtas at present and further proposals relating to advance healthcare directives are due to be introduced to this Bill at committee stage. The necessary processes moving in tandem, along with the fact that revised mental health legislation is yet to be agreed following on from the completion of this report, make it challenging to chart a fully agreed approach to introducing law now regarding advance healthcare directives where mental health is concerned. It would be important, for example, that any such provisions introduced now would not bring about a dichotomy whereby a person with an advance healthcare directive would have greater rights than a person with capacity. In addition, with decisions on advance healthcare directives imminent and this report not yet finalised, it also has to be borne in mind that changing the law now where advance healthcare directives in the area of mental health are concerned, should not pre-empt the outcome of this report and decisions to be taken in due course on the future of mental health legislation.

Notwithstanding therefore that proposals on advance healthcare directives are to be introduced at committee stage of the Assisted Decision-Making (Capacity) Bill, the Group recommends that when revised mental health legislation is being framed, it either amends the Assisted Decision-Making (Capacity) Bill if necessary or introduces provisions in mental health law to deal in a more complete and comprehensive manner with the operation of advance healthcare directives in the area of mental health in the longer term.

For the moment, it is likely that legislation pertaining to advance healthcare directives will apply to mental health on an equal basis with general health. There will, however, be an important exception. A valid and applicable advance healthcare directive may be overridden if at the time when it is proposed to treat the person, he or she is suffering from a mental illness and his/her detention and treatment is regulated by Part 4 of the Mental Health Act 2001 and/or by the Criminal Law (Insanity) Act 2006. The authority to override such a treatment refusal will not apply where that refusal relates to the treatment of a physical illness.

The Group accepts that there will be disappointment expressed by many that the advance statements of those detained involuntarily may not necessarily be adhered to in full where treatment for a mental illness (in the context of detention under the 2001 Act) is concerned if current proposals are accepted in the context of the Assisted Decision-Making (Capacity) Bill

being considered by the Oireachtas. This is why the Group believes that this issue must be re-visited again when mental health legislation is being framed. The possibility of allowing advance healthcare directives to apply where a person's health rather than life is at risk is certainly an area that the Group would like to see further explored when the current proposals emerge and greater clarity is provided following the publication of this report.

Finally, the Group would also make it clear that advance healthcare directives should be drawn up when the person is well and should be completed, where possible, with the agreement of the treating teams as this would make them more effective in the longer term. An advance healthcare directive would also need to state in clear and unambiguous terms the specific treatments to which it relates and also the particular situations in which the treatment decisions are intended to apply. For example, the Code of Practice for the *Mental Capacity Act* (2005) (England and Wales) emphasises that such directives must state precisely what treatment is to be refused, whereas a general desire not to be treated expressed in a directive would not be sufficient.

Directives should also be recorded in the person's recovery plans and if, under law, an advance healthcare directive is overridden, the Inspector of Mental Health Services should be notified within 3 days and it must be included in the Inspector's report on the approved centre. Guidelines on advance healthcare directives should also be produced by the Health Information and Quality Authority (HIQA) and the Mental Health Commission with the involvement of the appropriate professional regulatory bodies.

Recommendations:

- 126. The introduction of legislation providing for advance healthcare directives which should apply to mental health on an equal basis with general health is recommended.**
- 127. Notwithstanding the introduction of legislation on advance healthcare directives as part of the Assisted Decision-Making (Capacity) Bill, the Group recommends that when revised mental health legislation is being framed, it either amends the Assisted Decision-Making (Capacity) Bill if necessary or introduces provisions in mental health law to deal in a more complete and comprehensive manner with the operation of advance healthcare directives in the area of mental health in the longer term.**
- 128. In particular, the authority to override a treatment refusal where a person's health as opposed to life is at risk, should be re-visited again when mental health legislation is being framed.**
- 129. An advance healthcare directive should state in clear and unambiguous terms the specific treatments to which it relates and also the particular situations in which the treatment decisions are intended to apply.**
- 130. Advance healthcare directives should be recorded in the person's recovery plan.**

- 131. If an advance healthcare directive is overridden, the Inspector of Mental Health Services should be notified within 3 days and it must be included in the Inspector's report on the approved centre.**
- 132. A valid and applicable advance healthcare directive may be overridden if at the time when it is proposed to treat the person, he or she is suffering from a mental illness and his/her detention and treatment is regulated by Part 4 of the Mental Health Act 2001 and/or by the Criminal Law (Insanity) Act 2006. (*This is merely noting the proposed provision to this effect in the Assisted Decision-Making (Capacity) Bill*)**
- 133. Guidelines on advance healthcare directives should also be produced by the Health Information and Quality (HIQA) and the Mental Health Commission with the involvement of the appropriate professional regulatory bodies.**

2.26 Contact with Families and Doctor/Patient Confidentiality

The Expert Group was specifically asked by Minister Lynch to consider whether 'mental health legislation should be amended to "*require health professionals to consult with the family of persons with mental health problems*".

A paper on the subject was presented to the members of the Expert Group and discussions over a number of meetings took place about the merits of amending mental health legislation as proposed.

While there was agreement among members of the Expert Group that this is an important issue that requires further examination, nonetheless there was a consensus that it would not be appropriate to amend primary legislation as requested.

It was pointed out that:

- some patients specifically request that contact not be made with families and if this confidence was breached in anything other than very extreme potentially life and death circumstances, it could damage the health professional/patient relationship,
- sharing information with families who have initiated the detention procedure can be complicated depending on the view of the patient,
- there are difficulties where family members wish to share information with the patient's doctor but explicitly ask that the Health Professional treat this information as confidential – Mental Health Professionals do not want to be put in the position of keeping information from the patient particularly when the patient has the right to see his/her file and can view any records of a Health Professional's exchange with family members for himself/herself,
- there is no similar requirement for other branches of medicine, and
- if autonomy is to feature as a prominent guiding principle in revised mental health legislation, a move to engage with families without the patient's consent, except in

extreme potentially life and death circumstances, would be a move in the wrong direction.

The members of the Group further noted that:

- the Medical Council's Ethical Guide already specifically allows a doctor to ethically breach confidentiality if, for example, he/she believes that the patient is at risk of harming himself/herself or others,
- the Mental Health Commission's Code of Practice currently draws particular attention to the need to encourage residents in approved centres to involve their family in their care, and
- research confirms that recovery is improved if families are involved.

The Expert Group further agreed the following exemplars:

- Patient presenting in primary care with mild to moderate depression or similar, there is no need to contact family or others in most cases.
- Patient attending primary or secondary care for services or presenting with enduring mental illness where family support may be helpful or necessary, the Healthcare Professional should encourage patients to involve family and /or give consent to healthcare professional consultation with them.
- Where there is a perceived risk of harm to the patient themselves or others, the Code of Ethics for all Mental Health Professionals providing treatment and care to mental health patients should specifically allow such professionals to consult family and/or others in the interests of the safety and health of the patient and/or others even where the patient does not give consent.

Taking the above into account, the Group acknowledges the importance of the specific additional points raised by the request in this case and agreed that where it is deemed appropriate, there should be proactive encouragement for the patient at all stages to involve his/her family/carer and/or chosen advocate in the admission process and in the development of the care and treatment plan with the patient's consent. In addition, the Group recommends that all relevant professional regulatory bodies involved in mental health care should write into their codes of practice guidelines for practitioners the need to involve families/carers in the development of care and treatment plans with the patient's consent especially in cases of serious and enduring mental health problems. The Mental Health Commission should also bring this matter before the Health, Social Care and Regulatory Forum (a network of agencies involved in health, social care and also regulators) to highlight the importance of the points made and to explore how best the relevant provisions could be expressed in codes of ethics/practice and guidance in this area by each of the professional regulatory bodies. The Mental Health Commission should develop also more detailed guidance in this area for application right across the mental health sector.

Recommendations:

- 134. Where it is deemed appropriate, there should be proactive encouragement for the patient at all stages to involve his/her family/carers and/or chosen advocate in the admission process and in the development of the care and treatment plan with the patient's consent.**
- 135. All relevant professional bodies involved in mental health care should write into their codes of practice guidelines for practitioners the need to involve families/carers in the development of care and treatment plans with the patient's consent especially in cases of serious and enduring mental health problems.**
- 136. The Mental Health Commission should bring this matter before the Health, Social Care and Regulatory Forum to highlight the importance of the points made and to explore how best the relevant provisions could be expressed in codes of ethics/practice and guidance in this area by each of the professional regulatory bodies.**
- 137. The Mental Health Commission should develop more detailed guidance in this area for application right across the mental health sector.**

2.27 Approved Clinician

Throughout the course of the review of the Mental Health Act 2001, the Expert Group has emphasised the importance of multi-disciplinary input in line with the recommendations of *A Vision for Change* and the increasing role such teams play in the delivery of mental health services. Accordingly, the Group has made a number of significant recommendations on the involvement of multi-disciplinary team professionals and the key roles they should play in revised mental health legislation in areas such as admission to approved centres, treatment of patients, administration of medicine, capacity and renewal orders.

During the deliberations on the involvement of multi-disciplinary professionals, the Group also discussed the possibility of moving away from the current situation where it is the responsibility of the Consultant Psychiatrist to determine issues such as capacity, admission and detention to a situation where a broader range of professionals can carry out these functions. In this regard, the Group looked at the provisions that operate in England where the Mental Health Act 2007 introduced an 'Approved Clinician' (AC) who for the most part supervises treatment given to a patient who either cannot or will not consent to it.

The range of professionals which can act as an Approved Clinician in England includes:

- Registered Medical Practitioners (doctors)
- Chartered psychologists
- First level nurses whose field of practice is mental health or learning disabilities
- Registered occupational therapists

- Registered social workers.

For comparison purposes, some of the functions of the Approved Clinician as set out in the English legislation include:

- Treatment without consent can only be given by or under the supervision of the AC in charge of the treatment
- An AC must be in charge of medication given to a detained patient who cannot or will not consent to it
- AC must be in charge of ECT given to a detained patient who cannot consent to it
- AC can only decide that treatment can be continued to avoid serious suffering to the patient
- Treatment can only be given to a patient who is unable to consent to treatment because of a lack of capacity or competence if there is an AC in charge of the treatment and it is given by or under the supervision of that AC.

While the Group was strongly supportive of the need for a more multi-disciplinary approach insofar as the admission and treatment of detained patients is concerned, it was pointed out that clinical responsibility for the care and treatment of patients is in the hands of the Consultant and is specifically stated in the Consultants contract and that such a fundamental change to our current system of clinical responsibility should not proceed solely in the area of mental health. Any such change would have to be considered in a broader healthcare context. The Group is satisfied that the recommendations made throughout the report to provide for a greater and more direct involvement of the multi-disciplinary team in the treatment of the person at the approved centre will be of benefit to the patient and will improve the delivery of care and treatment from a Mental Health Professional's point of view.

On this basis the introduction of Approved Clinicians is not recommended by the Group at this time. The Group believes that this should be considered again as part of future reviews of the legislation.

Recommendations:

138. The Group did not recommend the introduction of an 'Approved Clinician' at this stage.

139. The Group believes that the introduction of an 'Approved Clinician' should be considered again as part of future reviews of the legislation.

2.28 Miscellaneous

Following a meeting between the Mental Health Commission and the Chair of the Expert Group, a number of miscellaneous amendments to the Act were discussed and put forward to the Group for consideration. The following recommendations which relate broadly to the

Mental Health Commission, the role of the Office of the Inspector of Mental Health Services and membership of Mental Health Review Boards are therefore proposed by the Group:

- 140. When revised mental health legislation is being drawn up, membership of the Mental Health Commission should be reviewed in its totality as it is currently limited mostly to professional groups and is not in keeping with the current policy to appoint through the Public Appointments Service. Occupational Therapists are currently not represented on the existing Mental Health Commission. The criteria for membership should be based on the necessary skills and competencies required to govern. Ideally professional and service user insight should be achieved through membership of the Commission by persons who also have the necessary skills and competencies required to govern. However if that is not possible, the Group suggests that professional and service user views could either be received by way of provision of statutory advisory committees to the Board.**
- 141. Appointments to the Commission should be staggered so that no more than half the membership would be due to complete a term at any one time. This should allow for a greater degree of continuity at Commission level rather than the current practice of members all reaching the end of their term at the same time. Section 36 of the Act (*Terms of office of members of Commission*) will need to be amended.**
- 142. In addition, it should be clearly stated that no Commission member may serve more than two consecutive terms.**
- 143. Statutory responsibility for standards in mental health services (i.e. Mental Health Commission Quality Framework) should be explicitly referenced in a revised section 33 of the Act which specifies the functions of the Mental Health Commission.**
- 144. Section 55 of the Act allows the Inspector of Mental Health Services, or such other persons, if asked by the Commission, to inquire into certain matters as set out in this section. However, this section is silent in relation to the powers that the Inspector or other persons would have to assist them carry out the inquiry. The Inspector can rely on the explicit powers vested in him/her and assistant inspectors elsewhere in the Act, but the other ‘person’ currently has no powers. The section dealing with inquiries should specify the powers that the inquirer (Inspector or other persons) has for carrying out the inquiry. It is suggested that the powers of the Inspector outlined in Section 51(2) are explicitly included in a revised Section 55.**
- 145. Section 51(1)(iii) of the 2001 Act should be amended to ensure that there is compliance by approved centres with ‘all’ codes of practice prepared by the Commission including the standards in mental health services.**
- 146. The Group believes that it would be more appropriate to rename ‘approved centres’ as ‘registered inpatient facilities’.**

147. The Act should be amended so that the Inspector must visit a centre and provide a report to the Commission regarding the suitability for registration prior to it being entered in the register of approved centres.
148. There are a number of amendments required in relation to the registration of approved centres which would include the definitions of “approved centre”, “in-patient”, “resident” and “registered proprietor”. These details should be examined in more detail when revised legislation is being drawn up.
149. The Mental Health Commission should have the authority to establish that a registered proprietor, or intended registered proprietor, and each other person who will participate in the management of the approved centre is a fit person to be the registered proprietor of the approved centre and to participate in its management.
150. Section 64 should be amended to ensure that where a registered proprietor is not compliant with the Act or Mental Health Commission requirements under the Act in relation to one centre, any decision to de-list the registered proprietor may be deemed to apply only in respect of that one centre or should include other centres as specified by the Commission.
151. The procedure for removing a condition on the registration of an approved centre as detailed in section 64(11)(a) of the Act needs to be amended as it currently requires that if the Mental Health Commission wants to remove a condition attached to a registration, it must first issue a proposal to the applicant or the registered proprietor to do so and afford the registered proprietor 21 days to make representations before it makes its decision. The Commission then makes its decision and informs the registered proprietor that it has 21 days to appeal to the District Court. This procedure is appropriate where the Commission is attaching a condition but not where a condition is being removed.
152. The 2001 Act does not address the issue of the closure of approved centres and what follows if a closure takes place. The Group acknowledges that to some extent this has been dealt with in the Mental Health Act (Approved Centres) Regulations 2006 (S.I. 551 of 2006) which provide directions in relation to notice to the Commission of the intention to close an approved centre and the transfer of voluntary patients. It is recommended that section 64 of the Act (*Registration of approved centres*) should be amended to provide for this scenario.
153. The Mental Health Commission should be able to request a Statutory Regulation Report from an approved centre in a manner specified by the Commission before they attach a condition.
154. Provision for the charging of appropriate fees for registration and inspection of centres or services should be considered when revised mental health legislation is being drawn up.
155. Tribunal members are currently appointed for a three year period under section 48(6) of the Act and the Group believes that in future members of Mental Health Review Boards should be appointed for a five year term. In

addition, it should be clearly stated that no member may serve more than two consecutive terms.

156. Section 48(9) gives the Mental Health Commission the authority to remove a member from a Tribunal under certain conditions. While the Commission may form an opinion in this regard, there is no provision in existing legislation for the Commission to observe the workings of a Tribunal to assist them in their deliberations as to whether a member should or should not be removed. The Group recommends that such authority be provided to the Commission in revised mental health legislation. In addition, the 2001 Act should be amended to allow the Mental Health Commission develop a system of appraisal for Mental Health Review Boards. This amendment should include appropriate linkage with Section 48(9).
157. The purpose of Mental Health Review Board hearings for discharged patients where they take place pursuant to Section 28(5) of the Act should be clearly set out in any revised legislation to ensure that the admission process was followed correctly and that the order was made on a bona fides belief that the person was at that time suffering from a mental illness. Section 28 should also clearly outline that there is no appeal to the Circuit Court under this section.
158. Section 73 of the Act requires that an individual receive permission of the High Court before he or she can institute civil proceedings under the Act. Mindful of the fact that every person with a disability should have equal access to the law, the Group believes that this provision of the Act should now be repealed.
159. The Group recommends that for the purpose of clarity, the title ‘Clinical Director’ used in the Act should be renamed ‘Director of the Approved Centre (Registered Inpatient Facility)’ – however no change in the definition is required.
160. Mental Health Professional should be defined as a registered Health or Social Care Professional working in the mental health service.
161. The Mental Health Commission should develop a code of practice for the assisted admissions service. Mental health services should be required to monitor and report on these services in a manner and frequency requested by the Mental Health Commission.
162. Section 61 of the Act is entitled ‘Treatment of children in respect of whom an order under section 25 is in force’. The wording of this section when originally drafted was based on the wording used in section 60 (Administration of medicine). However, as the process for the detention of a child under section 25 is quite different to the involuntary admission of an adult, section 61 should be amended to take account of the detention process through the Courts for children.
163. In circumstances where a patient chooses to remain in an approved centre as a voluntary patient after they no longer meet the criteria for detention, the Mental Health Commission should be notified of the subsequent voluntary admission.

- 164. Section 21(2) details the circumstances where a Clinical Director of an approved centre is of the opinion that it would be for the benefit of a patient detained in that centre to transfer him or her to the Central Mental Hospital. The Group recommends that once a Mental Health Review Board authorises such a transfer, such authorisation shall remain in place for a maximum time period of 3 months and/or certification by a Registered Medical Practitioner that the appropriate treatment in the Central Mental Hospital is still required by the patient concerned.**
- 165. When revised mental health legislation is completed but before it is commenced, comprehensive and extensive training should be provided, with the support of service providers, the Mental Health Commission and professional bodies, for all Mental Health Professionals who may be involved in implementing the provisions of the revised Act.**

2.29 Conclusion

This report, as presented, reflects the majority views of the Expert Group members on each issue considered, and there is a consensus that the report's contents accurately reflect these majority views.

The members recognise that there are many important areas of mental health which key stakeholders would like to have seen addressed in a more complete manner in this review. This was not always possible as the Group's remit is explicitly related to a review of existing legislation. While the members acknowledge the importance of topics such as funding, posts and reorganisation of the services, ultimately these were not ones that the Group could explore in any detail.

In all, the members have made some 165 recommendations which they believe can, taken as a package of measures, significantly update and improve mental health legislation in this country. The Group recognises that a number of these recommendations will require further detailed examination at official and legal level before they can be translated into law. There are many features in the existing 2001 Act which are not specifically mentioned in this report. Broadly speaking and unless indicated to the contrary, members were satisfied with how these features have operated to date and would see such features retained in future mental health legislation.

The publication last year of the Assisted Decision-Making (Capacity) Bill which comes within the remit of the Department of Justice and Equality is a very necessary and long overdue piece of legislation. The Group would like to see capacity legislation in whatever will be its final agreed form enacted as soon as possible. A number of recommendations in this report, particularly those directly related to capacity, will need to be re-visited for confirmation or adjustment after the detailed legislative provisions relating to capacity, which is to include legislative provisions for advance healthcare directives, have been finalised in

the context of the Assisted Decision-Making (Capacity) Bill. It will be critically important that new mental health legislation should dovetail with the new laws relating to these two very important areas. It will be a benefit to drafters of revised mental health legislation in due course that the new capacity legislation should already be in place for a period of time. This should ensure that any potential gaps between the two pieces of legislation as well as any detailed mental health related capacity requirements can be dealt with in a timely and comprehensive manner.

The Group is not making any specific recommendation on whether the 2001 Act should be amended or replaced. That decision depends in the first instance on how many of the changes recommended in this report are accepted as being necessary and will be included in revised legislation. The Group accepts that when decisions are ultimately taken about the number and extent of the changes to be made, it will become clear as to whether an amended Act or a replacement Act is appropriate. In addition, the Group thinks it would be prudent to provide that any new mental health legislation when fully enacted should be subject to a further review in 5 to 10 years' time.

Members also wish to express their gratitude to Minister Kathleen Lynch for allowing the Group an extended period of time to fully examine the significant issues arising in a considered and constructive manner. The Group believes that the changes recommended are progressive and in line with both *A Vision for Change* and the Convention on the Rights of People with Disabilities.

Finally, the Group would like to see swift progress taken at Government and Department level to ensure that the recommendations contained in this report are acted upon without delay.

3 Complete List of Recommendations:

Guiding Principles

1. Insofar as practicable, a rights based approach should be adopted throughout any revised mental health legislation.
2. The following list of Guiding Principles of equal importance should be specified in the new law:
 - a. The enjoyment of the highest attainable standard of mental health, with the person's own understanding of his or her mental health being given due respect
 - b. Autonomy and self determination
 - c. Dignity (there should be a presumption that the patient is the person best placed to determine what promotes/compromises his or her own dignity)
 - d. Bodily integrity
 - e. Least restrictive care.

Mental Disorder /Mental Illness

3. Mental disorder should no longer be defined in mental health legislation but instead the revised Act should include a definition of mental illness.
4. The definition of mental illness should be separated from the criteria for detention (see section 2.4 of this report re criteria for detention).
5. The reference to 'significant intellectual disability' and 'severe dementia' in existing legislation should be removed.
6. The definition of mental illness should be: 'mental illness means a complex and changeable condition where the state of mind of a person affects the person's thinking, perceiving, emotion or judgment and seriously impairs the mental function of the person to the extent that he or she requires treatment.'

Definition of Treatment

7. Treatment should include ancillary tests required for the purposes of safeguarding life, ameliorating the condition, restoring health or relieving suffering.
8. The definition of treatment should be expanded to include treatment to all patients admitted to or detained in an approved centre.
9. Treatment should be clearly defined in revised mental health legislation and clinical guidelines should be further developed for the administration of various forms of treatment.
10. Traditionally the focus of treatment was on the administration of medication, the Group would like to make it clear that treatment includes a range of psychological and other remedies and where treatment is specifically mentioned in this report, it should be interpreted in its wider sense and not viewed simply as the administration of medication.
11. The provision of safety and/or a safe environment alone does not constitute treatment.

Criteria for Detention

12. Detention of a person with a mental illness cannot be permitted simply by virtue of the fact that the person may have such an illness or because his or her views or behaviour deviate from the norms of the prevailing society.
13. The recommended new criteria for detention are:
 - a. the individual is suffering from mental illness of a nature or degree of severity which makes it necessary for him or her to receive treatment in an approved centre which cannot be given in the community; and
 - b. it is 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 he or she should receive such treatment and it cannot be provided unless he or she is detained in an approved centre under the Act; and
 - c. the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit the condition of that person to a material extent.
14. Detention should only be for as long as absolutely necessary and the person continues to satisfy all the stated criteria.
15. Immediately a person no longer satisfies any one of these criteria, the admission or renewal order must be revoked. In those circumstances, the person may only remain in the approved centre on a voluntary basis or receive the required services which are provided in the community.

Exclusions

16. The involuntary admission of a person to an approved centre cannot be authorised by reason only of the fact that the person –
 - (a) is suffering from a personality disorder,
 - (b) is socially deviant,
 - (c) is addicted to drugs or intoxicants, or
 - (d) has an intellectual disability.

Capacity

17. If on admission of a patient, the admitting Mental Health Professional forms the view that the person may lack capacity to understand and give his/her informed consent to the proposed admission, they must refer the person for formal capacity assessment to be completed within 24 hours. The patient will be required to remain in the approved centre until such time as a capacity assessment is carried out.
18. The Mental Health Commission should develop and publish guidelines in relation to the assessment of capacity. Capacity assessment can be undertaken by Mental Health Professionals with the required competencies and such competencies should be accredited by the respective professional bodies who should provide support and training where required. The guidelines should also draw attention to the possibility that external factors such as ‘institutional

influence' can have a bearing on how people react to proposals or questions put to them.

19. Capacity should be monitored on an ongoing basis by the treating clinicians.
20. If following the capacity assessment, it is deemed that a person has capacity to admit themselves, a voluntary admission may proceed. If it is deemed that they need support to understand, to make, or to convey their decision, that support must be provided to assist in the voluntary admission process. If it is deemed that they do not have capacity in relation to this decision, and the person has a mental illness they may only be admitted on an involuntary basis provided they satisfy all the criteria for detention. A person who lacks capacity and has a mental illness but does not fulfil the criteria for detention, may in specified circumstances be admitted as an 'intermediate' patient.
21. Where relevant, information relating to how capacity is assessed and the right of appeal against a decision on their capacity to a Mental Health Review Board should be given to patients. In addition they, and their family or carers if appropriate, should also be given information relating to the supports that may be available to the individual under the proposed capacity legislation.

Voluntary Patient

22. A voluntary patient should be defined as a person who has the capacity (with support if required) to make a decision regarding admission to an approved centre and who, where the person retains capacity, formally gives his/her informed consent to such admission, and subsequent continuation of voluntary inpatient status and treatment on an ongoing basis as required. This provision should also apply equally to children and their parents or persons as required acting in loco parentis. *(See also section 2.23 Children)*
23. Lack of capacity on admission does not mean that further decisions relating to the patient's treatment should not be discussed with and put to the patient as and when each decision is required. It is important not to automatically presume that each person continues to lack capacity when decisions are required.
24. Where a person is deemed to lack capacity and therefore cannot give informed consent, then admission cannot take place on a voluntary basis even if a substitute decision maker (decision-making representative) has been appointed under the proposed Assisted Decision-Making (Capacity) Bill.
25. All voluntary patients on admission to an approved centre should be fully informed of their rights, including information relating to their proposed treatment as well as their rights regarding consent or refusal of treatment and their right to leave the approved centre at any time.

New Category of Patient

26. The Group recommends a new category of patient known as 'intermediate' who will not be detained but will have the review mechanisms and protections of a detained person. Such patients would not have the capacity to consent to admission and equally do not fulfil the criteria for involuntary detention.

27. The Mental Health Commission must be informed of the initial and ongoing admission of this category of patient.
28. The same timeframe recommended for Mental Health Review Boards for involuntary patients should also apply for intermediate patients.
29. The role of the Review Board for this cohort of patient must focus on the question of capacity as, by definition intermediate patients will not fulfil the criteria for detention.
30. A detailed set of guidelines should be produced for this category of patient and the Mental Health Commission and the Office of Public Guardian should have a role in this regard.
31. The Group recommends that it would be appropriate for a Consultant Psychiatrist to have the authority to override a refusal of treatment by a decision-making representative in emergency circumstances where treatment is deemed necessary and the person's actual behaviour is injurious to self or others and no other safe option is available.
32. A decision to override a refusal of treatment by a decision making representative should be subject to review by a Mental Health Review Board which would convene within 3 days to decide if the situation presenting to the Consultant Psychiatrist fulfils the criteria for emergency circumstances. If the Review Board agrees that the circumstances were of an emergency nature, then the treatment authorised by the Consultant Psychiatrist may continue for as long as the emergency circumstances prevail subject to other provisions relating to second opinions etc.
33. Advance healthcare directives should apply for this category of patient on the same basis as that proposed for voluntary patients.

Authorised Officers

34. The Group recommends that there should be a more expanded and active role for Authorised Officers where involuntary admissions to an approved centre are being considered. This new role can lead to more appropriate and least restrictive treatment for individuals in community or other mental health settings and bring a greater focus on involuntary admission being a treatment of last resort.
35. The Authorised Officer must, after consultation with family/carers where possible and appropriate, make the decision on whether or not an application for involuntary admission of the person should be made.
36. The Group recommends that an Authorised Officer should be the person to sign all applications for involuntary admission to an approved centre (this also includes change of patient status in an approved centre from voluntary to involuntary – see section 2.17 on Change of Status for details). This will have the effect of reducing the burden on families/carers in these difficult circumstances and reducing the involvement of Gardaí in the admission process.

37. An application by an Authorised Officer to involuntarily admit a person to an approved centre shall remain in force for 7 days from the time of the first application.
38. The Group considers that the sequencing of whether the Authorised Officer or the Registered Medical Practitioner sees the patient first is not relevant once they are undertaken independently. However, as regards completing and signing the appropriate documentation, the application for involuntary admission by the Authorised Officer must come first followed by the recommendation from the Registered Medical Practitioner.
39. 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. If some time has elapsed since an Authorised Officer previously assessed a particular individual for involuntary detention, the same Authorised Officer can be asked to look again at the case.
40. Where an Authorised Officer or family/carer seeks the opinion of a different Registered Medical Practitioner, they must disclose the facts relating to the previous application sought.
41. Where a person is taken into custody by the Gardaí under section 12 of the Act, the initial assessment, whether that is by the Authorised Officer or the Registered Medical Practitioner, should take place as soon as possible after the person is taken into custody. The maximum period which the person can be held prior to being assessed by the Authorised Officer or Registered Medical Practitioner should be 24 hours. A second 24 hour timeframe in which both the Authorised Officer and the Registered Medical Practitioner must carry out their assessments commences once the first such assessment is initiated.

Procedure for Involuntary Admission to an Approved Centre

42. The Registered Medical Practitioner must personally examine the person and in recommending detention must clearly certify how he/she came to the view that the person is suffering from a mental illness and also satisfies the criteria for detention. The Registered Medical Practitioner cannot play this role if he or she becomes the owner of an approved centre or an employee or agent of such centre, to which the person is to be admitted.
43. Admission must be certified by a Consultant Psychiatrist after examination of the patient and following consultation with at least one other Mental Health Professional of a different discipline that is and or will be involved in the treatment of the person in the approved centre. The opinion of that other Mental Health Professional should be officially recorded.

Patient Firstly Requiring Medical Treatment

44. Where either the Registered Medical Practitioner who recommended the involuntary admission of the person, a Clinical Director of the approved centre or a Consultant Psychiatrist on the staff of the approved centre, is of the view

that the patient first requires medical treatment for a physical condition, the patient may first be treated in an emergency department, hospital or clinic.

45. The stay at the emergency department, hospital or clinic should be for the shortest time possible and the Mental Health Commission should be notified.
46. The 24 hour timeframe for the admission process to the approved centre should commence on arrival at the emergency department, hospital or clinic as though it was the approved centre named in the application and the appropriate assessment and the making of an order should be done within that timeframe by the Clinical Director of the approved centre or by a Consultant Psychiatrist on the staff of the approved centre after consultation with a Mental Health Professional of another discipline.
47. Throughout this period when the patient is at the emergency department, hospital or clinic, responsibility for the mental health treatment of the person should remain with the Clinical Director of the approved centre to which the patient is being admitted.

Treatment prior to Detention

48. Treatment should not be provided to a patient without consent prior to an admission order being completed unless the Consultant Psychiatrist after consultation (to be officially recorded) with another Health Care Professional is of the opinion that it is necessary in emergency circumstances.
49. Emergency in this situation means that the treatment is deemed immediately necessary, that the person's actual behaviour is injurious to self or others and no other safe option is available.

Mental Health Tribunals

50. Mental Health Tribunals should in future be renamed 'Mental Health Review Boards'.
51. While decisions about the nature and content of treatment remain within the remit of the multi-disciplinary mental health team, Review Boards should have the authority to establish whether there is an individual care plan in place and if it is compliant with the law.
52. Review Boards should also establish that the views of the patient as well as those of the multi-disciplinary team were sought in the development of the care plan.
53. The patient's detention must be reviewed by a Review Board no later than 14 days after the making of the admission order or renewal order concerned.
54. There should be no change in the current make up of Review Boards at this stage. The question of having a one person Review Boards should be re-examined in any future review of the mental health legislation.
55. The Review Board members must continue to be clearly separate from the original decision-maker and those conducting the independent multi-disciplinary assessment for the Review Board.
56. The 'other person' appointed to the Review Board 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.

57. A patient should have a legal right to have a Review Board deferred for specified periods (2 periods of 14 days) if that is his/her wish. The deferral would have to be sought through the patient's legal representative.
58. The following individuals must attend a Review Board:
- Legal representative of the patient
 - Responsible treating clinician
59. The following individuals may attend a Review Board:
- Patient, who must always have a right to attend the Review Board
 - Advocate at the invitation of the patient exercising his/her right to such support
 - Independent Psychiatrist who undertook pre Review Board assessment if the Review Board so requests
 - 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 if the Review Board so requests.
60. It should be a matter for the Review Board to decide which additional persons should attend the Review Board hearing other than the absolute right of the patient to attend, their legal representative and their advocate if the patient so requests.
61. The patient'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.
62. The range of Mental Health Professionals that the independent Psychiatrist must consult with for a Section 17 assessment should be specified.
63. 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 that recommended for the independent Psychiatrist report. This report should concentrate on the non-medical aspects of the patient's circumstances.
64. 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.
65. This would include a mechanism to allow information in relation to decisions of Review Boards to be published in anonymised form which will ensure patient confidentiality. This will allow such decisions to be available for the Mental Health Commission and/or the public to view.

Renewal Orders

66. Renewal orders must be certified by a Consultant Psychiatrist after consultation (to be officially recorded) with at least one other Mental Health Professional of a different discipline involved in the treatment of the person at the approved centre.
67. Renewal orders at present can be for up to 3 months, 6 months or a year. The Group believes that the 3rd renewal order of up to 12 months is too long and should be reduced to a period not exceeding 6 months.

68. Section 15(2) should be amended by adding ‘and such renewal order shall only come into effect on the expiration of the time period provided for in the previous order be it an admission or renewal order’.
69. The Group agreed that there was no need for a ‘slip-rule’ procedure and it was best to leave section 18(1)(a)(ii) as it stands.

Absence With Leave

70. The provisions of Section 26 regarding permission to be absent from an approved centre for a specified period should be retained with greater clarification being provided in a Code of Practice (to be developed by the Mental Health Commission) which would outline the precise circumstances in which such provisions can be used. The time limit for such absences should be a maximum of 14 days and they should not be used as quasi-community treatment orders.

Grounds for Appeal

71. Grounds for appeal to the Circuit Court should be amended such that the onus of proof as to the existence or otherwise of a mental illness that meets all the criteria for detention falls on the approved centre rather than the patient as is currently the case.
72. S.I. 11/2007, Circuit Court Rules (Mental Health) should be amended to reflect the fact that the approved centre should be the respondent in cases brought before the Court and the Mental Health Commission’s potential involvement should be as a Notice Party.

Change of Status from Voluntary to Involuntary

73. The Group recommends that the existing powers of the Act to initially detain a voluntary patient and to allow for a change of status from voluntary to involuntary must remain. These powers insofar as possible, should only be used in very exceptional circumstances.
74. A Consultant Psychiatrist who has the clinical responsibility for the treatment of a patient, a Registered Medical Practitioner, Registered Psychiatric Nurse or a Mental Health Professional (registered with CORU in the case of the latter) who considers that a voluntary patient would satisfy the criteria for detention may detain such patient for a maximum period of 24 hours initially.
75. The Group recommends that during the initial detention period of 24 hours, an Authorised Officer should be called to attend the approved centre to consult with the patient and staff and make a determination as to whether or not to make an application for involuntary admission.
76. The Authorised Officer must consider the alternatives available, offer advice and mobilise support for the service user and the family where necessary.
77. Where the officer believes that the person satisfies all the criteria for detention and there is no alternative to detention, the officer should make an application for an involuntary admission in the normal way (this application must be made

within the initial 24 hours referred to above and then be subject to the time restrictions for completion of the process as though it was initiated in the community).

78. A Registered Medical Practitioner who is not the owner of an approved centre or an employee or agent of such centre, to which the person is to be admitted, should examine the patient within 24 hours of the application being made by the Authorised Officer and determine if there is a need to make a recommendation for admission.
79. The Group also agrees that it should no longer be a requirement that a patient must first indicate a wish to leave the approved centre before the involuntary admission process is initiated. The Act should also be amended to specifically allow that process to be initiated in such cases in the approved centre in line with the recent High Court ruling on this matter (*Judgement of KC v Clinical Director of St. Loman's Hospital*).
80. The Group recommends that every time section 23 is used to initially detain a patient (even if section 24 is not subsequently used to detain the person) the Mental Health Commission should be notified.
81. The Group also recommends that section 24 should be amended to state clearly that the involuntary admission procedure to be followed under this section is similar to the procedure set out in Sections 9, 10, 11 and 14, with any necessary modifications.

Consent to Treatment

82. The right of voluntary patients to refuse treatment should be explicitly stated.
83. All patients should be supported to make informed decisions regarding their treatment and 'consent' as defined in Section 56 relating to consent to treatment should include consent given by a patient with the support of a family member, friend or an appointed 'carer', 'advocate' or a support decision maker appointed under the proposed capacity legislation.
84. Section 57 should be amended so that the informed consent of a voluntary patient is required for all treatment.
85. Informed consent is also required from involuntary patients who are deemed capable of giving such consent.
86. A Consultant Psychiatrist, after consultation (to be officially recorded) with at least one other Mental Health Professional of a different discipline involved in the treatment of the patient, may administer treatment to a detained patient who lacks capacity where the patient does not have a DMR 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 he or she should receive such treatment and there is no safe and effective alternative available. Where a patient lacks capacity but has a DMR appointed under the capacity legislation, the DMR may accept or refuse treatment for the patient.

87. A Consultant Psychiatrist can override the decision of a DMR to refuse treatment on behalf of an involuntary patient in emergency circumstances where the treatment is deemed necessary, the patient is injurious to self or others and no other safe option is available. A Mental Health Review Board must meet within 3 days to determine that the treatment was given in the appropriate emergency circumstances. If the Review Board agrees that the circumstances were of an emergency nature, then the treatment authorised by the Consultant Psychiatrist may continue for as long as the emergency circumstances prevail subject to other provisions relating to second opinions etc.
88. The Group would emphasise the ongoing need for services to ensure that manual or other forms of seclusion and restraint are used only as a last resort, only where there is no other alternative and always in accordance with the rules drawn up by the Commission.
89. The Group believes it would be more appropriate for the section of the Act (69) dealing with seclusion and restraint to be included in Part 4 of the Act which deals with consent to treatment. The Group also recommends that the section should be broadened to include all forms of restraint including manual or other forms of seclusion or restraint, and appropriate guidelines should be produced by the Mental Health Commission. In addition, it should be made clear that this section applies to patients in the Central Mental Hospital.

Electro-Convulsive Therapy (ECT)

90. Section 59 should be amended to remove the authority to give ECT without consent in any circumstance where the patient is capable of giving consent but unwilling to do so. The Group recommended that the first possible opportunity should be taken to effect this change in the context of any future miscellaneous health bill. Where the patient is unable to give consent but a decision-making representative appointed legally under capacity legislation for the person gives that consent on the patient's behalf, then ECT may proceed.
91. Where a patient does not have capacity and a decision-making representative does not give consent to ECT, such treatment may only take place where it is required as a life-saving treatment, for a patient where there is a threat to the lives of others or where the condition is otherwise treatment resistant, and such ECT may then only be administered subject to approval by a Mental Health Review Board which must convene within 3 days of the decision being taken.

Administration of Medicine

92. The reference to 'unwilling' should be removed from Section 60, and where any patient who has the capacity to make a decision refuses to take medicine, this decision will be respected. The Group recommended that the first possible opportunity should be taken to effect this change in the context of any future miscellaneous Health Bill.
93. Section 60 should also be amended so that medicine may be administered to a detained patient without capacity for the purpose of ameliorating his or her

condition for a period not exceeding 21 days. The recommendation to continue the administration of medicine beyond 21 days must be made by the treating Consultant who must also consult with another Mental Health Professional of a different discipline involved in the treatment of the patient and this must be officially recorded. The recommendation to extend the administration of medicine beyond 21 days must also be authorised by a second Consultant Psychiatrist from outside the approved centre.

94. Section 60 should be amended to reflect the fact that the continued administration of the medicine concerned must be of therapeutic material benefit to the patient.
95. Further reviews of treatment should be undertaken every three months, and in the case of the first such review, a patient may request that this review take place at an earlier stage.
96. The recommendation to continue the administration of medicine every three months must be made by the treating Consultant who must also consult with another Mental Health Professional of a different discipline involved in the treatment of the patient 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.
97. Where psychotropic medication is proposed, the views of the patient should be recorded and, if appropriate, consultation held with the patient's family or advocate, also to be recorded. The functions of the Inspector of Mental Health Services could be extended in this area.

Provision of Information on Admission to Approved Centres and Complaints Mechanisms

98. On admission to an approved centre, every patient should have a right to information which would include their rights as a voluntary or involuntary patient, their rights regarding consent to or refusal of treatment, the range of services available in the centre, and any additional information as outlined in the Mental Health Commission Code of Practice.
99. There is also an obligation to ensure that the patient is made aware of the complaints mechanisms in place at the centre and any general complaints mechanisms that exist within the service generally.
100. The Group re-iterates that it is mandatory for the Inspector of Mental Health Services to meet a patient who has made a complaint when he/she is subsequently inspecting that approved centre and all patients must be informed of this right on admission to an approved centre and on the process for contacting the Mental Health Commission.
101. The Expert Group is not recommending a separate Mental Health Ombudsman at this juncture, however it should be re-examined as part of future reviews of any new Act.

Care Plans and Discharge Planning

- 102. Care planning function should be strengthened and extended to all persons in receipt of mental health services and provide a seamless recovery based approach towards discharge and support in the community.**
- 103. Recovery plans should be reviewed on a regular basis and the timing of the reviews should be decided based on the patient's individual needs.**
- 104. Patients must be offered the opportunity to sign off on their recovery plans and this must be recorded.**
- 105. Evaluation and feedback should form part of the review of a recovery plan and there should be a need to show evidence of the undertaking of a review.**
- 106. Wording of the legislation should be amended to ensure that it is the multi-disciplinary team that has responsibility for the clinical content of recovery plans rather than the proprietor.**
- 107. Care plans should be renamed as recovery plans and should refer to the person rather than the patient.**
- 108. Discharge plans must form part of a person's individual recovery plan.**
- 109. It is desirable that discharge planning meetings should take place with family members, carers or chosen advocate (with the consent of the patient) and there should be robust codes of practice produced on their implementation.**
- 110. Section 66 should be strengthened further to cover community based services.**

Children

- 111. Provisions relating to children should be included in a standalone Part of the Act and any provisions of the Child Care Act 1991 which apply should be expressly included rather than cross referenced.**
- 112. Child should be defined as a person under 18 and thus brought into line with the Children Act 2001.**
- 113. Dedicated Children's Part of the Act should stipulate the following guiding principles:**
 - a. Every child should have access to health services that aim to deliver the highest attainable standard of child mental health.**
 - b. The autonomy and self-determination of the child should be respected insofar as practicable in conjunction with parents or persons as required acting in loco parentis.**
 - c. There must be consultation with the child at each and every stage of diagnosis and treatment with due weight given to his/her views consistent with his/her age, evolving capacity and maturity and with due regard to his/her will and preferences.**
 - d. Services should be provided in an age-appropriate environment wherever possible.**
 - e. Services should be provided in close proximity to family and/or carers wherever possible.**
 - f. The child must receive the least intrusive treatment possible in the least restrictive environment possible.**

- g. Where there is an intervention on behalf of the child, his/her best interests must be taken into account, and ‘best interests’ 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 his/her age, evolving capacity and maturity and with due regard to his/her will and preferences.
114. Children aged 16 or 17 should be presumed to have capacity to consent / refuse admission and treatment.
115. For an admission of a 16 or 17 year old to proceed on a voluntary basis, the child therefore must also consent or at least must not object to his/her voluntary admission.
116. Where a 16 or 17 year old objects, the case should then be referred to a child friendly District Family Law Court which can determine whether the child has the necessary maturity or capacity to make an informed decision. 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.
117. The Group acknowledges that there should be no automatic presumption of capacity for children under the age of 16.
118. In the case of a child under the age of 16, voluntary admission should only take place where the parents or person as required acting in loco parentis consents, however the views of the child must be heard by parents and service providers and given due weight in accordance with the child’s evolving capacity and maturity.
119. Admission and renewal orders for the involuntary detention of a child (under 18) should continue to require a Court Order and require justification that it is used as a last resort.
120. The requirement to notify the Mental Health Commission of information relating to admission and discharge of children should be elevated to primary legislation.
121. Advocacy services to children and to the families of children in the mental health service should be available.
122. Gardaí (for clarity purposes) should be given the specific power to remove a child believed to be suffering from a mental illness satisfying the criteria for detention to a place where an age appropriate assessment can be performed and admissions should only be made to an age appropriate approved centre.
123. Places to which children are taken for such assessments should fulfil certain specific criteria (e.g. availability of child and adolescent psychiatry) and that relevant stakeholders are available, involved and informed (Gardaí, parents, etc.). Also, certain locations may be inappropriate in this regard (e.g. a care home from which a child has absconded).

Inspections of Approved Centres and Community Services

124. The Group recommends the registration and inspection at regular intervals of the following mental health services:
- Phase 1: Continue to register approved centres and inspect at least once in every three years and more often according to targeted risk.
 - Phase 2: Register all community mental health teams and inspect against an increasing proportion of the services provided in the community.
 - Phase 3: Register all High, Medium and Low Support Hostels; Crisis/Respite Houses; any other Residential Services; Day Hospitals, Day Centres and other facilities in which mental health services are provided and introduce inspections on a phased basis.
125. The new Act should give the Mental Health Commission specific powers to make standards in respect of all mental health services and to inspect against those standards. The Standards should be made by way of regulations and the regulations should be underpinned by way of primary legislation.

Advance Healthcare Directives

126. The introduction of legislation providing for advance healthcare directives which should apply to mental health on an equal basis with general health is recommended.
127. Notwithstanding the introduction of legislation on advance healthcare directives as part of the Assisted Decision-Making (Capacity) Bill, the Group recommends that when revised mental health legislation is being framed, it either amends the Assisted Decision-Making (Capacity) Bill if necessary or introduces provisions in mental health law to deal in a more complete and comprehensive manner with the operation of advance healthcare directives in the area of mental health in the longer term.
128. In particular, the authority to override a treatment refusal where a person's health as opposed to life is at risk, should be re-visited again when mental health legislation is being framed.
129. An advance healthcare directive should state in clear and unambiguous terms the specific treatments to which it relates and also the particular situations in which the treatment decisions are intended to apply.
130. Advance healthcare directives should be recorded in the person's recovery plan.
131. If an advance healthcare directive is overridden, the Inspector of Mental Health Services should be notified within 3 days and it must be included in the Inspector's report on the approved centre.
132. A valid and applicable advance healthcare directive may be overridden if at the time when it is proposed to treat the person, he or she is suffering from a mental illness and his/her detention and treatment is regulated by Part 4 of the Mental Health Act 2001 and/or by the Criminal Law (Insanity) Act 2006. (*This is merely noting the proposed provision to this effect in the Assisted Decision-Making (Capacity) Bill*).

133. Guidelines on advance healthcare directives should also be produced by the Health Information and Quality (HIQA) and the Mental Health Commission with the involvement of the appropriate professional regulatory bodies.

Contact with Families and Doctor Patient Confidentiality

134. Where it is deemed appropriate, there should be proactive encouragement for the patient at all stages to involve his/her family/carer and/or chosen advocate in the admission process and in the development of the care and treatment plan with the patient's consent.
135. All relevant professional bodies involved in mental health care should write into their codes of practice guidelines for practitioners the need to involve families/carers in the development of care and treatment plans with the patient's consent especially in cases of serious and enduring mental health problems.
136. The Mental Health Commission should bring this matter before their Health Social Care and Regulatory Forum to highlight the importance of the points made and to explore how best the relevant provisions could be expressed in codes of ethics/practice and guidance in this area by each of the professional regulatory bodies.
137. The Mental Health Commission should develop more detailed guidance in this area for application right across the mental health sector.

Approved Clinician

138. The Group did not recommend the introduction of an 'Approved Clinician' at this stage.
139. The Group believes that the introduction of an 'Approved Clinician' should be considered again as part of future reviews of the legislation.

Miscellaneous

140. When revised mental health legislation is being drawn up, membership of the Mental Health Commission should be reviewed in its totality as it is currently limited mostly to professional groups and is not in keeping with the current policy to appoint through the Public Appointments Service. Occupational Therapists are currently not represented on the existing Mental Health Commission. The criteria for membership should be based on the necessary skills and competencies required to govern. Ideally professional and service user insight should be achieved through membership of the Commission by persons who also have the necessary skills and competencies required to govern. However if that is not possible, the Group suggests that professional and service user views could either be received by way of provision of statutory advisory committees to the Board.
141. Appointments to the Commission should be staggered so that no more than half the membership would be due to complete a term at any one time. This should allow for a greater degree of continuity at Commission level rather than

the current practice of members all reaching the end of their term at the same time. Section 36 of the Act (*Terms of office of members of Commission*) will need to be amended.

142. In addition, it should be clearly stated that no Commission member may serve more than two consecutive terms.
143. Statutory responsibility for standards in mental health services (i.e. Mental Health Commission Quality Framework) should be explicitly referenced in a revised section 33 of the Act which specifies the functions of the Mental Health Commission.
144. Section 55 of the Act allows the Inspector of Mental Health Services, or such other persons, if asked by the Commission, to inquire into certain matters as set out in this section. However, this section is silent in relation to the powers that the Inspector or other persons would have to assist them carry out the inquiry. The Inspector can rely on the explicit powers vested in him/her and assistant inspectors elsewhere in the Act, but the other 'person' currently has no powers. The section dealing with inquiries should specify the powers that the inquirer (Inspector or other persons) has for carrying out the inquiry. It is suggested that the powers of the Inspector outlined in Section 51(2) are explicitly included in a revised Section 55.
145. Section 51(1)(iii) of the 2001 Act should be amended to ensure that there is compliance by approved centres with 'all' codes of practice prepared by the Commission including the standards in mental health services
146. The Group believes that it would be more appropriate to rename 'approved centres' as 'registered inpatient facilities'.
147. The Act should be amended so that the Inspector must visit a centre and provide a report to the Commission regarding the suitability for registration prior to it being entered in the register of approved centres.
148. There are a number of amendments required in relation to the registration of approved centres which would include the definitions of "approved centre", "in-patient", "resident" and "registered proprietor". These details should be examined in more detail when revised legislation is being drawn up.
149. The Mental Health Commission should have the authority to establish that a registered proprietor, or intended registered proprietor, and each other person who will participate in the management of the approved centre is a fit person to be the registered proprietor of the approved centre and to participate in its management.
150. Section 64 should be amended to ensure that where a registered proprietor is not compliant with the Act or Mental Health Commission requirements under the Act in relation to one centre, any decision to de-list the registered proprietor may be deemed to apply only in respect of that one centre or should include other centres as specified by the Commission.
151. The procedure for removing a condition on the registration of an approved centre as detailed in section 64(11)(a) of the Act needs to be amended as it currently requires that if the Mental Health Commission wants to remove a

condition attached to a registration, it must first issue a proposal to the applicant or the registered proprietor to do so and afford the registered proprietor 21 days to make representations before it makes its decision. The Commission then makes its decision and informs the registered proprietor that it has 21 days to appeal to the District Court. This procedure is appropriate where the Commission is attaching a condition but not where a condition is being removed.

152. The 2001 Act does not address the issue of the closure of approved centres and what follows if a closure takes place. The Group acknowledges that to some extent this has been dealt with in the Mental Health Act (Approved Centres) Regulations 2006 (S.I. 551 of 2006) which provide directions in relation to notice to the Commission of the intention to close an approved centre and the transfer of voluntary patients. It is recommended that section 64 of the Act (*Registration of approved centres*) should be amended to provide for this scenario.
153. The Mental Health Commission should be able to request a Statutory Regulation Report from an approved centre in a manner specified by the Commission before they attach a condition.
154. Provision for the charging of appropriate fees for registration and inspection of centres or services should be considered when revised mental health legislation is being drawn up.
155. Tribunal members are currently appointed for a three year period under section 48(6) of the Act and the Group believes that in future members of Mental Health Review Boards should be appointed for a five year term. In addition, it should be clearly stated that no member may serve more than two consecutive terms.
156. Section 48(9) gives the Mental Health Commission the authority to remove a member from a Tribunal under certain conditions. While the Commission may form an opinion in this regard, there is no provision in existing legislation for the Commission to observe the workings of a Tribunal to assist them in their deliberations as to whether a member should or should not be removed. The Group recommends that such authority be provided to the Commission in revised mental health legislation. In addition, the 2001 Act should be amended to allow the Mental Health Commission develop a system of appraisal for Mental Health Review Boards. This amendment should include appropriate linkage with Section 48(9).
157. The purpose of Mental Health Review Board hearings for discharged patients where they take place pursuant to Section 28(5) of the Act should be clearly set out in any revised legislation to ensure that the admission process was followed correctly and that the order was made on a bona fides belief that the person was at that time suffering from a mental illness. Section 28 should also clearly outline that there is no appeal to the Circuit Court under this section.
158. Section 73 of the Act requires that an individual receive permission of the High Court before he or she can institute civil proceedings under the Act. Mindful of

the fact that every person with a disability should have equal access to the law, the Group believes that this provision of the Act should now be repealed.

159. The Group recommends that for the purpose of clarity, the title ‘Clinical Director’ used in the Act should be renamed ‘Director of the Approved Centre (Registered Inpatient Facility)’ – however no change in the definition is required.
160. Mental Health Professional should be defined as a registered Health or Social Care Professional working in the mental health service.
161. The Mental Health Commission should develop a code of practice for the assisted admissions service. Mental health services should be required to monitor and report on these services in a manner and frequency requested by the Mental Health Commission.
162. Section 61 of the Act is entitled ‘Treatment of children in respect of whom an order under section 25 is in force’. The wording of this section when originally drafted was based on the wording used in section 60 (Administration of medicine). However, as the process for the detention of a child under section 25 is quite different to the involuntary admission of an adult, section 61 should be amended to take account of the detention process through the Courts for children.
163. In circumstances where a patient chooses to remain in an approved centre as a voluntary patient after they no longer meet the criteria for detention, the Mental Health Commission should be notified of the subsequent voluntary admission.
164. Section 21(2) details the circumstances where a Clinical Director of an approved centre is of the opinion that it would be for the benefit of a patient detained in that centre to transfer him or her to the Central Mental Hospital. The Group recommends that once a Mental Health Review Board authorises such a transfer, such authorisation shall remain in place for a maximum time period of 3 months and/or certification by a Registered Medical Practitioner that the appropriate treatment in the Central Mental Hospital is still required by the patient concerned.
165. When revised mental health legislation is completed but before it is commenced, comprehensive and extensive training should be provided, with the support of service providers, the Mental Health Commission and professional bodies, for all Mental Health Professionals who may be involved in implementing the provisions of the revised Act.

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