Mental Health Ireland

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[redacted],
Assistant Principal Officer, Mental Health Unit
Department of Health
50-58 Block 1
Miesian Plaza,
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April 8th 2021

RE: ***Mental Health Act 2001 Submission***

Dear James,

Mental Health Ireland would like to thank Minister Butler and the Department of Health for the opportunity to contribute to this Public Consultation exercise and welcomes the urgency that is now being applied to this process.

Mental Health Ireland is a national voluntary group founded in 1966 on the recommendation of the *Commission on Mental Illness*. Today, we are a leading provider of mental health promotion in the voluntary sector. Our aim is to promote positive mental health and wellbeing for all individuals and communities and to support people with lived experience of mental health challenges in their recovery, bringing practical expression to national policy objectives.

Mental Health Ireland has been an innovator in the promotion of positive mental health and wellbeing in Ireland for over half a century. We are now refocusing our mission and regenerating our activity to support our new vision; for an Ireland where mental health is valued as being an essential part of personal wellbeing and the health of the nation.

Mental Health Ireland is leading the way in informing Irish society's understanding of mental health and fostering a culture where people with mental health difficulties are respected and supported. Our network of Mental Health Associations promote positive mental health and support people with mental health difficulties within their own communities.

Mental Health Irelands Mission is to promotes positive mental health and wellbeing to all individuals and communities, and through our network of Mental Health Associations, we support people who experience mental health difficulties on their journey of recovery.

Our Vision is for an Ireland where mental health is valued as being an essential part of personal wellbeing and the health of the nation. Mental Health Ireland will lead the way in informing Irish society's understanding of mental health and fostering a culture where people with mental health difficulties are respected and supported.

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Reforming Ireland's Mental Health Legislation

In relation to the reforming our mental health legislation, Mental Health Ireland calls for a renewed commitment, over 6 years have been lost since the Expert Review Group's report was published in March 2015. Given the gravity of the recommendations and the unintended negative impacts of some of the features of the Mental Health Act 2001, there now must be a concerted effort to fundamentally revisit this important piece of legislation.

There can be a tendency to believe that this legislation impacts only on those 2,390 people actually Detained (*Mental Health Commission Annual report 2019*). This is not the case, this legislation impinges on the rights and freedoms of every citizen in the State and many families live out their lives orbiting around and within the shadow of this legislation. Notwithstanding its inherent complexity and interplay with neighbouring legislation, it must be immediately addressed with greater pace than seen to date.

When passed, the Mental Health Act 2001 represented a major leap forward from its predecessor, the Mental Treatment Act of 1945. So much had changed, advanced and progressed in the intervening 56 years in terms of our understanding of mental health, mental illness and the various treatment modalities that the premise on which the 1945 Act was founded was no longer relevant. Similarly, the current Mental Health Act while passed in July 2001, it was largely formulated during the 1990s, in a very different Ireland than the one we live in today.

Our social constructs, demographics, economic development, cultural diversity, lifestyles and technical capabilities have shifted greatly in the past 30 years. Equally, the Irish Public's knowledge, understanding and concern for mental health has also progressed and changed. This dynamism was anticipated in the 2001 Act when it incorporated a requirement for periodic review every 10 years. Now that the 20 years have elapsed since its passage through the Oireachtas, this revision of the Act is greatly welcomed by Mental Health Ireland.

The enormous social change that has occurred in Ireland over the past 2 decades, suggests that the next iteration of the legislation requires some fundamental changes well beyond tinkering or '*tweaking*'.

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Respecting Human Rights

Our mental health services have played various roles down through history, sometimes conflating the need for care, custody, treatment, social support, protection of people at a vulnerable time with some aspects coercive control. Today we celebrate and nurture human dignity, uniqueness, freedom, self-agency, personal responsibility and accountability and our Mental Health legislation must not stray from these fundamental tenets. Recovery is now an expectation and this ambition must be central to our new legislation.

Historic functions, structures, positions and infrastructures have exerted an undue influence and must be revisited if we are to have a truly person-centric approach to modern mental health care in Ireland. Even some of the titles used in the 2001 Act are no longer in vogue as the Health Service is continually reimagined. Our mental health service provision must be underpinned by legislation that values and respects the primacy of the individual using the service.

If we are to rebalance our services to a point where they can truly respond to the person, their family and community concerns we will need to recalibrate our approach to fully embrace the UN Convention on Human Rights, the UN Convention on the Rights of the Child, UN Convention on the Rights of People with a Disability, and the European Convention on Human Rights. These fundamental protections are universal and cannot be set aside. Even the 1945 Mental Treatment Act recognised significant mental illness as a dynamic and evolving process. It described three categories of Patient, as a Voluntary Patient, a Person of Unsound Mind and a was detained person was described as a Temporary Patient. This recognised that this was a transitory state, which would resolve in time and should be rescinded at the earliest opportunity.

Despite Ireland ratifying the *United Nations Convention on the Rights of Persons with Disabilities* in 2018, the current Mental Health Act is not fully in compliance with the United Nations Convention on the Rights of the Child (UNCRC) or the UNCRPD). A fundamental redrawing on this legislation is required to honour Ireland's international commitments and to safeguard the rights of its citizens.

As recommended by the Expert Group Review on the Mental Health Act in 2015, a rights-based approach should be adopted throughout any revised mental health legislation. This requires a substantial shift away from the often-paternalistic interpretation of mental health legislation by the Courts in order to comply with the European Convention on Human Rights (ECHR) and the Convention on the Rights of Persons with Disabilities (CRPD).

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Timely legislative Reform and Implementation

MHI supports the 165 recommendations of the Expert Review Group in that guiding principles should include definitions such as autonomy and self-determination, bodily integrity and least restrictive care. It is noted that to date, only two of the recommendations have progressed in the intervening 6 years. Mental Health Ireland encourages the renewed focus being applied to this reform and we ask that the implementation period for any new Mental Health Act would show equal haste and be explicitly proscribed in the legislation.

Part II of the Mental Health Act 2001 was not fully commenced until November 1st 2006. Mental Health Ireland appreciates the deep complexity of mental health legislation and its dynamic interplay with neighbouring acts (*e.g.* Assisted Decision Making (Mental Capacity) Act and the Criminal Law Insanity Act, the pace of legislative reform and its subsequent full implementation needs to quicken. If we are to repeat the timeline of the past we should expect to see the new Act implemented until 2027 at best. It simply cannot wait that long.

Scope and Reach of the Mental Health Legislation

As stated above, the reach of this legislation extends beyond the people who are Detained. Many individuals and families live in the shadow of this legislation. The daily presence of this Act has the potential to distort family relationships, to influence attitudes and shape decision making. It also informs how people who use and need mental health services interact with primary care and mental health professional. Many decline required services as they are not willing to risk readmission and its attendant lost of control.

There is some evidence that people who use services often minimise symptoms to avoid re-admission to hospital and some women are reticent to reach out for help for fear of losing custody of their children. These unintended consequences can delay effective treatment, hampering and delaying opportunities for recovery.

Progressing the Recommendations of the Mental Health Act Expert Review Group

Mental Health Ireland strongly endorses and supports the findings of the Expert Review Group on the Mental Health Act 2001. The need to revisit definitions included in the Act is clearly articulated as the needs of people with a Learning Disability or Dementia can be better accommodated within the Assisted Decision Making legislation. It would appear that these categories were included in the 2001 Act in order to retrospectively justify and regularise their continued detention under the Mental Health Act. This is no longer valid.

HiQA has repeatedly raised concerns about the *de facto* deprivation of liberty experienced by people with a disability living in congregated settings, who may have difficulty in communicating or vindicating their right to freedom which is enshrined in Article 40 of our Constitution. The Mental Health Act is not best suited to address these distinct needs.

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The fact that this legislation is addressed specifically to people with a disability (*mental illness*) places a tension between the Mental Health Act, Equal Status Acts and the UNCRPD, this must be successfully resolved in our new legislation.

Exclusions incorporated within the Act

The protective exclusions in Article 10 of the Mental Health Act can have the inadvertent effect of denying people with a Dual Diagnosis (*Mental illness and Drug or Alcohol Misuse)* access to timely inpatient mental health care. The artificial separation of these presentations relates more to system design and funding structures than the actual needs of real people who frequently self-medicate with alcohol or drugs to manage the immediate distress of mental illness. Our new legislation needs to find a more pragmatic and eloquent approach to better respond these frequently seen presentations.

An explicit emphasis on Community Based care options

It is recognised that 90% of mental health care is delivered via Primary Care with up to 35% of all GP consultations in Ireland relating to a mental health need. This accounts for some 6 million occasions of care each year in Ireland. Some 10% of these presentations are referred to community based secondary care. Many of these Community Mental Health Teams are now housed in co-located Primary Care settings, greatly facilitating continuity of care and what is sometimes referred to as a '*warm hand-over'* and continuing shared care.

This is where the majority of Irish people received their mental health care, with a minority receiving inpatient care. The majority of this activity is not well regulated and Mental Health Ireland would like to see the provision, constitution and practice of Community Mental Health Teams being formally approved and licensed. National mental health policies have repeatedly placed community based care at the heart of mental health service provision, but the current emphasis of the Act does not reflect this ambition.

Where one aspect of the spectrum of care is formally approved, licensed and regulated this then invites a disproportionate amount of clinical and managerial effort being invested in inpatient setting at the expense of community based care. It is not uncommon for community based staff to be retracted and redeployed to bolster inpatient staffing ratios. This is disruptive, undermining community based care paths and suggests that community services can be cannibalised to preserve capacity in the Approved Centre.

Mental Health Ireland would support quality standards with an legislative underpinning for Community Mental Health Teams for Children, Adults, Older Persons. We do not however support the concept of intrusive Community Orders seen in other jurisdictions. Practice shows that the sufficiency, adequacy and effectiveness of Community Mental Health Team provision is a significant factor in the reducing the rates of involuntary detention.

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Alternate Channels for people in distress

For many, a period of overwhelming stress can be safely and effectively managed through access to timely community based refuge, including services delivered by Peers in *Community Cafés*. Mental Health Ireland welcomes the recommendations in the new mental health policy '*Sharing the Vision*' (2020) on the development of *Community Café* type services.

Mental Health Ireland is currently collaborating with the HSE mental health services in CHO 2 in Galway in piloting such a model.

Mental Health Presentations in Irish Prisons

Each year, many individuals presented to the Irish Prison Service are known to community mental health services, however many have lost contact, have been insufficiently supported or decline such service options. Many people with pronounced mental health needs come to the attention of Gardaí for minor, but repeated public order issues. The provision of Court Diversion schemes can improve this situation for individuals, but a more systemic model is required to better understand the genesis of this problem. New legislation needs to codify this pragmatic and positive approach.

Where community provision is absent or inadequate and where the inpatient access is constrained, acutely distressed and mentally unwell people (*especially young men*) will be over represented in the criminal justice system. These presentations should also be considered to be involuntary admissions when gathering data on the true incidence of detention in Ireland.

Penrose's Law describes the close correlation between the reduction in the number of Psychiatric Beds and the growth in Prison Populations. In 1979, Ireland had 749 Prisoners and 15,000 mental health beds. The Irish Prison Service publishes the daily number of Prisoners in the State's 13 prisons and places of detention.

The data for Feb 2021 shows 3,729 Prisoners in Ireland. HSE data on number of public inpatient mental health beds amounts to 1,169 (*1,002 General Adult Beds, 72, CAMHS beds and 93 Forensic Inpatient beds)*. These acute inpatient units are supported by 68 High Support Community Residences and 142 Low Support community based facilities. The four 30 bed, Intensive Care Rehabilitation Units promised in '*A Vision for Change*' (2006) never materialised.

Mental Health Commission reports show 2,390 inpatients beds including private units.

In the absence of adequate community based provision and credible inpatient provision, many people with acute mental health presentations finds themselves inappropriately imprisoned. We can and must do better.

(Penrose Law from 1939 https://pubmed.ncbi.nlm.nih.gov/18985517/)

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Recasting Mental Health Service Capacity into Service Capability

Ireland's acute mental health inpatient bed to population ratio is now one of the lowest in the OECD, leading to bed pressures for acute inpatient care, premature discharge and acute presentations some of which are affected as involuntary under the Mental Health Act.

Mental Health Ireland has always supported the development of a dynamic and properly resourced range of accessible and acceptable community mental health services, as described in *A Vision for Change* (DoH 2006). We believe that Mental Health Service resources can be recast to deliver a more agile, dynamic and creative range of options for many individuals travelling through a personal crisis over overwhelming acute mental health needs.

Historically, Ireland was an outlier with very high inpatient bed to population ratios, with 425.29 Psychiatric Beds per 100,000 as recently as 1978. By 2013 this pendulum had swung to 49.9 mental health beds per 100,000 of our population. The mental health inpatient bed base has fallen by 88.3% over a 35 year period, without the commensurate development of community based services. No other aspect of Irish healthcare has seen such a dramatic shift.

Rapid population growth, redistribution and demographic shifts have overwhelmed many services in the Capital and other urban areas. Watching the decline in mental health service spending as a percentage of health spending in Ireland would suggest asset stripping. This loss of capacity and capability leads to late and dramatic interventions like involuntary admission, where earlier and more collaborative approaches would deliver better outcomes, sparing individuals and their families great distress.

Co-production and co-design with people who use services represents the most efficient way to recast such resources to best meet actual needs. Mental Health Ireland has partnered with the HSE National Office for Mental Health Engagement and Recovery to devise and develop a range of Peer led, Recovery Education and Recovery College programmes. Services developed in partnership with the pre-existing community infrastructure show better outcomes in terms of housing, education, employment and community integration.

It is important to restate that Mental Health Ireland is not in any way nostalgic for inpatient services, but timely access to inpatient care on a voluntary basis remains an important function in avoiding involuntary admission.

The average length of stay in an acute, Irish inpatient unit in 11.6 days, this can result as a hurried and incomplete intervention for many inpatients. Bed pressure is a common feature in urban mental health services and clinical prioritisation may lead to abrupt, unplanned and premature discharge.

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Properly resourced and agile community provision along with a sufficiency of inpatient capacity and the appropriate duration of care can help to avoid premature discharge and subsequent involuntary re-admission. A National *bed to population* ratio for inpatient service allocation would ensure more equitable access for all citizens.

The provision of well resourced, multidisciplinary, community based teams for Adults, Older Persons and Children can go a long way to reducing the incidence of dramatic and often traumatic involuntary admission and Detention. Regional disparities in the resourcing and the varied practice of community based teams illustrates this phenomena far too well.

Assumption of Capacity and Consent

Mental Health Ireland supports the Expert Review Group's recommendation that *'treatment'* be clearly defined in revised mental health legislation and clinical guidelines should be further developed for the administration of various forms of treatment.

The Expert Group also recommends that "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".

Access to and the role of a Peer Advocate needs to legally recognised in any new legislation.

The role of General Practitioner

Family members often experience delays and some reluctance on behalf of General Practitioners being available or becoming involved to conduct an assessment for involuntary admission. The new legislation will need to place an obligation on GPs to perform this difficult function. As *Out of Hours* and pooled Primary Care systems mature, it is often difficult to find a Doctor who is familiar, willing and able to examine the person in distress.

This introduces delay, uncertainty, distress and risk that is best avoided where possible. Training for GPs in fulfilling their duties under the Act must be in place and the *Irish College of General Practitioners* have an important role to play here if errors, incomplete forms and misunderstanding are to be avoided.

Role of Gardaí

Gardaí are often in the unenviable position of responding to a person or family in crisis and Section 12 provides for these occasions. However, it is not clear how often Gardaí use these powers and how many people are presented for assessement and do not meet the criteria for involuntary admission. Training and adequate data systems would help to size this problem and develop pragmatic solutions which can be reflected in the proposed new legislation.

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Section 13 Removal of a Person to an Approved Centre

Section 13 of the Act has given rise to the internationally unique '*Assisted Admission'* service in Ireland. This invaluable service delivers many insights and learning but as yet, it is not fully regulated. This important service needs to be monitored and regulated by the Mental Health Commission to protect and safeguard the interests of the Person, the Practitioner and the Provider of such services.

Subjective experience of Involuntary Admission

UK Research conducted by Priebe S, Amos T, Leese et Al in 2009 amongst Service Users one year after involuntary admission show that while some appreciated that involuntary admission was warranted and necessary, a majority found the experience to be traumatic and harmful. Like any clinical intervention, finding the balance of benefit over time can be difficult. Some Irish research on this experience would help guide legislators.

Rebalancing Power and Responsibility

The Mental Health Act 2001 places an enormous burden of responsibility upon the Consultant Psychiatrist who is represented at the Decision Making, provision of Second Opinion and in the Tribunal process. The development of multidisciplinary teams inspired by policy developments since Part II of the Act was commenced in November 2006 presents a new opportunity to rebalance this professional burden.

The increasing presence of Clinical Psychologists, Social Workers, Mental Health Nurses, Occupational Therapists, Speech and Language Therapists and Child Care Workers should allow for some greater task-sharing, responsibility and can facilitate a broader base for clinical decision making.

The fact that the Mental Health Act confers enormous powers of compellability on Consultant Psychiatrists, almost compels them to use these powers when addressing risk. It is noted that many of the issues presented to the mental health service are social in origin (*Housing, Employment, Poverty, Disadvantage, Discrimination)* and are not amenable to exclusively medical or psychiatric responses. When left with limited other options, mental health service are too often called upon to respond to these systemic and social failings.

These powers also have the potential to distort the vital therapeutic bond so essential to modern and effective mental health care. Where a power of veto is present, the risk is that any debate about concordance or compliance can be vetoed, short-circuited and can imply some degree of coercion. The threat of Detention is not subject to Tribunal review.

It is difficult to see how this phenomena can be completely mitigated, but there is a responsibility on legislators when granting such powers to recognise and appreciate this toxic side-effect when crafting new mental health legislation.

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Authorised Officers

The Authorised Officer role is key to improving how our mental health legislation happens in practice. Data from the Mental Health Commission shows that the majority of applicants for involuntary admission remains the Family Members or Gardaí. This no longer represents best practice. Where a family member is the applicant for an involuntary admission, the far reaching effect on relationships can be harmful, controlling and distorting.

A properly resourced and skilled Authorised Officer service must be available 24/7 and be in a position to resource credible alternate paths to respond to a person in need. Being in a position to fund or contribute to the cost of alternate accommodation may in some instances be sufficient to avert a crisis within a family context. Creative use of respite models, *community café* options and being familiar with the broad range of community based resources may obviate the need for involuntary hospitalisation.

There are now over 1,000 agencies active in mental health and suicide prevention in Ireland, some of whom may be in a position to offer tangible and timely responses to people in crisis. The Authorised Officer must be a budget holder and be in a position to commission alternate service options where these are appropriate.

The Act also needs to protect the Authorised Officer who in good faith, makes a decision not to make an application for involuntary admission, where this decision is followed by an adverse outcome. The ability to foresee the unforeseeable presents real challenges in this space. Positive risk taking must be a component if *automatic hospitalisation* is to averted.

Individual Care Planning

Involuntary admission has the potential to be degrading and this is compounded when the person is detained and not shown the courtesy of a Care Plan. If admission is necessary to effect care, than a Care Plan is a vital obligation and this needs to be enshrined in primary legislation. The current regulations are frequently ignored as seen far too often in reports of Care Planning breaches in the Inspector of Mental Health Service reports published by the Mental Health Commission.

Currently, there is no legal right to an individual care or recovery plan under the Act.

The Expert Review Group recommends that Individual Care Planning should be placed on a statutory footing and extended to all persons in receipt of mental health services. Specifically, it recommends that:

- 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

- Patients must be offered the opportunity to co-produce and sign off on their recovery plans and this must be recorded

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• 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

• 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

• Care plans should be renamed as recovery plans and should refer to the person rather than the patient

• Discharge plans must form part of a person's individual recovery plan.

In addition the Group recommended that each child should have an individual care plan and all necessary information relating to admission, detention and treatment should be provided as appropriate. Mental Health Ireland supports these important measures being placed on a statutory footing.

Recognising the role of family members

'You don't have to have a mental illness, to suffer from mental illness'

Most families make extraordinary efforts to support loved ones with a mental illness and this can place an intolerable strain on many families. Mental Health Ireland recognises that Clinicians primary responsibility is to the person using the service and that their wishes must be paramount and their consent to information sharing is key.

Many families experience what they describe as the '*Cloak of Confidentiality'* and feel actively excluded from care planning decisions, while being expected to be an active co-therapist in providing care and support. This is most acutely left by families as a young person transitions from CAMHS to Adult Mental Health Services at the age of 18.

Families provide context, support and can play an important role in recovery, but this must be balanced against the need for confidentiality and privacy. An explicit understanding of Tarasoff Rules (*where confidentiality can be breeched when there is a known risk or threat to an identifiable individual*) is vital to safe and inclusive practice.

The rights of a family member to deposit information with the Clinical Team is tempered with the right of the person using the service to know who has provided such information. These can be difficult features of modern mental health care where Home Based treatment is the preferred option. Where possible a tripartite, '*Trialogic'* approach (*actively including the Service User, invited Family Member and the Mental Health professional*) in a dialogue works best, where this is possible.

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Many Family members have described their need to disengage from an adult who will not actively include them in their care and treatment plans, resulting in great personal distress and homelessness. Where this can be avoided, it should be. Mental illness has a way of finding and exacerbating pre-existing family fault lines and this presents real challenges.

As per the recommendation of Mental Health Reform, Mental Health Ireland believes that the revised legislation should place a duty on the health service to provide information of a general nature on mental health to the family members of a person with a mental health condition upon request and with the permission of the service user.

Furthermore, the legislation should place a duty on the health service to assess the support needs of family members of a person receiving treatment for a mental health condition upon request of the family member and with the permission of the service user. Provision of generalised information and education can be delivered through the network of Recovery Colleges or through other accredited national NGOs. The Act should be amended to place a duty on the clinical director to involve the family in discharge planning where the individual concerned is being discharged to the family's home and the individual has given their permission.

Mental Health Ireland believes it is vitally important that where the family members include children or adolescents under the age of 18, there should be a duty on the health service to assess the needs of the children and provide appropriate supports. Growing up with a parent who has a mental health problem is an adverse childhood experience that can have consequences for the child into adulthood if it is not recognised and addressed.

Voluntary patients

Under the current Act, voluntary patients do not have basic rights to information and advocacy enshrined in the legislation, this needs to be addressed. In line with the Expert Review Group, Mental Health Ireland recommends that all voluntary patients on admission to an approved center 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 center at any time.

The principle of co-production, proactive engagement and inclusion must be cited as a fundamental tenet of quality mental health care and this approach should be enshrined in the new legislation.

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 center 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.

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Change of Legal Status for Voluntary to Involuntary

Sections 23 and 24 of the Mental Health Act, create a mechanism to change the legal status of a Voluntary Patient to Involuntary. Mental Health Ireland believe that this facility should be removed as it changes the fundamental rights of a Voluntary Patients.

Few individuals appreciate that they are surrendering some of their fundamental freedoms by accepting inpatient care on a voluntary basis. While the intention of this provision is understood, it is not respectful of the person's will and preference. Should involuntary admission be considered necessary, the formal process and path to detention should be the same as for any other adult.

Section 25 and the needs of Children

Mental Health Ireland endorses the recommendations of the Expert Review Group in the needs of children with a mental health need. We also note that the Mental Health Commission permits Children can be admitted to an Adult Unit in '*Exceptional Circumstances'* the *Committee on the Prevention of Torture, Degrading and Inhuman Treatment* has described the treatment of children in an adult mental health setting as inappropriate and this practice should be discontinued.

Of course when a child is presented in immediate need of inpatient mental health care an urgent place of safety must be created with additional safeguards in place to protect the child. In practice this is often to provide single room accommodation and '*special'* one to one Nursing care until transfer to an age appropriate setting can be arranged. The geographical considerations of having only four age-appropriate CAMHs public units means that children may first be presented to one of the 35 Approved Centres.

New mental health legislation needs to proscribe how these arrangements are put in place, the maximum duration and what criteria must be applied and where extended care in an adult unit is permitted. Some older adolescents may present a risk to younger children within a CAMHS unit. If care is to be tailored and person centric, then exceptions within known parameters must be a feature of the new legislation.

With the development of new CAMHs 10-bed capacity at the new National Forensic Hospital in Portrane and the upcoming 30-bed inpatient unit at the New Children's Hospital on the St James' campus, the occasion for such exceptions will be very limited.

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Restraint

Physical Restraint is a degrading and risky intervention for all concerned. The risk to Service Users are obvious with soft tissue injuries, fractures, exhaustion, respiratory distress and cardiac arrest being real possibilities. Some 80% of injuries to mental health professionals occur during such interventions and these are best avoided where possible.

Mental Health Ireland believes that the definition of restraint in the Act should be extended to include chemical restraint. The use of chemical restraint should be governed by clear rules and subjected to the same oversight as other means of restraint. The Inspector of Mental Health Services has raised concerns about the cumulative use of polypharmacy and the Act requires periodic medication reviews. This protection needs to be extended to all inpatients.

Recognising increasing Diversity and Demographic changes

Ireland's population has witnessed and benefitted from a period of enormous change over the past two decades. We have welcomed people from all over the World, bringing new skills, beliefs and viewpoints. We must actively accommodate diversity, cultural and linguist competence, respecting the wider range of values and beliefs within our mental health legislative framework.

Access to competent translation services should be guaranteed in law so that a person can be fully advised and informed in their own language. This expectation should also be afforded to Irish speakers, Members of the Deaf Community as well as Service Users who cannot converse or do not have a full command of the English language. Our legislation should make it clear that informed consent requires that such services are proactively provided for.

As well as translation services, Information notices, Guides, Care Planning and Discharge Planning materials should be available in the most frequently seen language formats.

Legislating for Transnational Mental Health Care

Ireland is at the forefront of globalisation and aspires to provide World class mental health care. We must insure that our legislation acts to give impetus to continuously improving mental health service quality for our citizens at home and abroad. Measures facilitating repatriation of Irish citizens who become unwell overseas needs to be reflected in the new legislation.

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Mental Health Act and provision for all Island Service Models

Access to specialist Forensic Mental Health Care for people in Northern Ireland who identify as Irish Citizens should be considered and facilitated in the renewed legislation.

Residents of Northern Ireland who cannot be adequately cared for in the Shannon (*Medium Secure)* Unit at Knockbracken, Belfast are currently transported across jurisdictions and across legislative frameworks for specialist Forensic inpatient care in *The State Hospital* in Carstairs, Scotland. With the opening of the new National Forensic Mental Health Facility at Portrane, Dublin in 2021 there is potential to see how such a service can be provided in the Republic of Ireland and our new legislation should not preclude this eventuality.

Each year, many Irish Adults and Children are referred to overseas for specialist inpatient services. Since January 2021, post-Brexit, many of whom are now cared for outside of the EU in the UK, beyond the protection and reach to the European Court of Human Rights. On the provision of the overseas mental health care and treatment the current Act is silent.

The Mental Health Commission needs to have a role in monitoring, regulating and sanctioning such treatment-abroad options, to ensure equivalence of standards with additional safeguards in place to safeguard, protect and preserve family contact and integrity.

Public Expectation and Mandate

Mental Health services cannot operate in a vacuum and must reflect the evolving societal values and expectations. Our Mental Health laws must be understood, have the support of and be considered legitimate of the wider community. Dated, pejorative and stigmatising beliefs prevail and need to be addressed if our mental health legislation is to reflect community values. Efforts should be made to assess the current public mandate for such legislation and to proactively communicate the role, function and necessity for comprehensive mental health legislation. A community engagement, information and education campaign should be considered. As before, the new legislation should include a periodic review.

The need to provide public education programmes for people using mental health services and the families more directly impacted should also be included in the revised legislation. A number of Recovery Colleges supported by Mental Health Ireland and the HSE already include courses on Mental Health Legislation on their syllabi, many of which are now available online. The Mental Health Commission could directly provide such programmes or collaborate with NGO partners, Recovery Educators and Service User representatives to make these programmes more widely available.

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Lay Person perspective on Tribunal

The current Mental Health Act recognises the importance of the public perspective in the construct of Mental Health Tribunals by including a Lay person.

Section 28 c) of the Act specifically debars Registered Medical Practitioners or Registered Nurses from fulfilling the role of a Lay Person on a Mental Health Tribunal. This limit should be extended to other professions now represented on Community Mental Health Teams – such as Clinical Psychologists, Mental Health Social Workers, Occupational Therapists, Speech and Language Therapists and Child Care Workers. To allow these professions to participate as '*Lay Person'* members of a Mental Health Tribunal is to undermine their professional standing within the Act.

Involuntary Detention, impact on Family Members and Family Dynamics

At Mental Health Ireland, all of our work is developed in co-production with people who use mental health services, family members and mental health professionals. It is only by integrating these three perspectives that lasting and sustainable outcomes can be achieved, which can mobilise the essential contribution of each party. While it may not always be possible to include family members, a supportive friend should be included where the index service user permits.

Many people who have been detained describe how they felt infantilised, that as responsibility had been removed from them, they no longer felt responsible, lose their sense of self agency and control. Once removed, this can be difficult to restore in a meaningful way. Others describe living '*under probation'* and how they had to censor their language, avoid family disagreements for fear of being hospitalised against their will.

Rebuilding Professional Relationships post involuntary Admission

Once the trust that forms the basis of progressive mental health care has been breached, it can be very difficult to fully re-established. Experienced Mental Health Care Professionals understand this dynamic and try to avoid involuntary admission where this can be safely achieved.

Given the extraordinary powers that this legislation confers upon in one profession, Consultant Psychiatrists, the need to dissipate this authority and responsibility amongst a wider professional base must be considered. The Consultant Psychiatrist is the decision maker, the provider of a Second Opinion (*under Section 17 1 (c)*) and as an influential Tribunal member. This concentration of power and authority within any singular profession invites risk and places an unfair burden on the individual practitioner.

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Recovery is the shared objective and many people who have recovered from significant mental health concerns will cite the moment that they felt responsible for their own decisions, actions and behaviour is the moment that their recovery began. Involuntary admission risks stalling that epiphany and can delay or indeed snuff-out that impetus. Taking back control, personal decision making and embracing adult responsibilities are at the heart of the recovery process. This does not happen abruptly on discharge from hospital. The new Act needs to protect the often fragile path to recovery while including progressive steps to restoring self-agency, decision making and personal autonomy.

Advanced Directives and the Mental Health Act

Currently, *Advanced Directives* can be set aside when a person is Detained under the Mental Health Act. This is not in keeping with the person's will and preference stated while stable and well, and should be re-considered. The new and revised mental health legislation will need to co-exist and dovetail with the Assisted Decision Making provisions so that the person's clearly articulated wishes can be respected.

Legislative Changes relating to the Covid-19 Pandemic

Mental Health Ireland would ask that the emergency and exceptional powers necessary to address the Covid-19 pandemic be rescinded once it is safe to do so. Changes to the physical presence of Tribunal Members, the need for a Second Opinion being independent of the treating Approved Centre and access to Home Leave should be restored at the earliest opportunity.

The impact of restricted visiting measures, while recognised as being absolutely necessary and protective, during the pandemic have been particularly difficult for Young People in the acute CAMHS inpatient settings.

At Mental Health Ireland all of our work is developed through a process of co-production which actively includes the view of People with lived experience of mental illness, family members and mental health professionals. We would recommend that the Department of Health utilise the many new platforms and fora available to engage actively with this community when developing the new Act. Mental Health Ireland other NGO partners would be very happy to facilitate any such initiatives.

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Mental Health Ireland would like to acknowledge the contribution of our Board Member, Dr Pat Bracken, and Recovery Co-ordinator Margaret Sweeney, our partners at Mental Health Reform and Alcohol Action Ireland in compiling this submission. If we can in any way contribute to the work of the Department in developing the new legislation we would be happy to do so.

We greatly appreciate the opportunity to contribute to this consultation process and we look forward to working with Minister Butler, Officials from the Department of Health and other Public Representatives as the new legislation is formed and framed over the coming months.

Martin Rogan
Chief Executive Officer

April 2021.