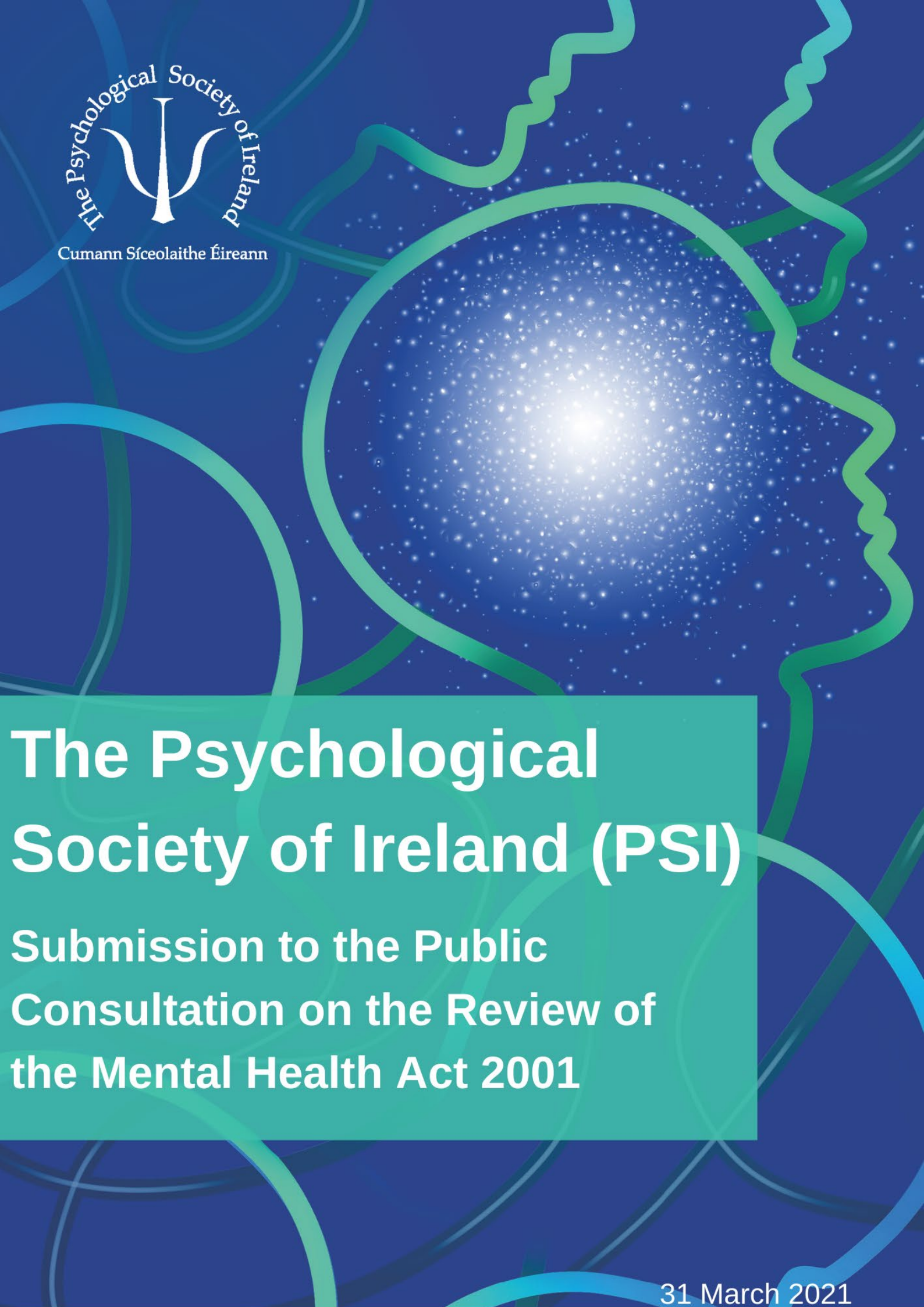

The Psychological Society of Ireland (PSI)

Submission to the Public Consultation on the Review of the Mental Health Act 2001

31 March 2021

The Psychological Society of Ireland (PSI) is the learned professional body for psychology in the Republic of Ireland. The Society is committed to maintaining high standards of practice in psychology and to exploring new and innovative ways of furthering psychology as an applied science.

The PSI welcomes the opportunity to contribute to the public consultation on the review of the Mental Health Act.

The primary focus of this submission is in relation to The Mental Health Act 2001, which sets out the care and treatment of people who need inpatient mental health care.

The recommendations in this submission are also made in the context of other relevant legislation such as:

- Assisted Decision Making (Capacity) Act 2015;
- Mental Health (Amendment) Act 2018;
- Criminal Law (Insanity) Act 2006;
- Mental Health Parity Act 2017 – James Brown Bill (lapsed due to dissolution of Dáil).

The PSI is also guided by the Report of the Expert Group on the Review of the Mental Health Act 2012 – 2015, and the 165 recommendations of the report.

Since the enactment of the Act there have been significant changes to mental health policy and direction in Ireland starting with 'A Vision for Change' (2006) and, most recently, 'Sharing the Vision - A Mental Health Policy for Everyone' (2020).

Core values are central to 'Sharing the Vision', underpinning its service philosophy, and these include:

- Respect;
- Compassion;
- Equity Hope.

The Service Delivery Principles promoted within the policy focus on important areas such as:

- Recovery;
- Trauma Informed;
- Human Rights;
- Valuing & Learning.

There should be a symbiosis between mental health policy and legislation ensuring that the core values and service delivery principles in the overarching mental health policy is reflected in primary legislation.

In making this submission, the PSI has considered each part of the Mental Health Act 2001 as laid out below.

Part 1: Preliminary and General (1-7)
Part 2: Involuntary Admission (8-30)
Part 3: Independent Review of Detention (31-55)
Part 4: Consent to Treatment (56-61)
Part 5: Approved Centres (62-68)
Part 6: Miscellaneous (69-75)

In amending the 2001 Act, the Department of Health (DoH) must accept the fundamental requirement of parity between mental health and general health and the natural consequences that flow from an acceptance of that principle.

The PSI recommends that the following guiding principles be incorporated in to the amended 2001 Act:

- Parity between mental health and general health is a fundamental requirement and must be reflected in the amended 2001 Act and the 2015 Assisted Decision Making (Capacity) Act;
- There must be alignment between the 2001 Act and the 2015 Act;
- A rights-based approach must underpin the 2001 Act.

The PSI submission is detailed, under the below headings/themes, over the following pages.

- **Capacity and Advance Healthcare Directives**
- **Definitions**
- **Involuntary Admission**
- **Independent Review of Detention (Sections 31-55)**
- **Requirement for Consent to Treatment (Sections 56-61)**
- **Psycho-surgery Section 58(1)**
- **Electro-convulsive Therapy (ECT) Section 59**
- **Approved Centres (Sections 62 – 68)**
- **Miscellaneous (Sections 69 – 75)**
- **Governance**
- **Provision Related to Children**

Capacity and Advance Healthcare Directives

- There must be a presumption of capacity in the amended 2001 Act and the 2015 Act.

- Presumed that every person has capacity to make decisions affecting himself or herself unless the contrary is shown in accordance with the provision of the 2015 Act.

- Capacity should not form part of the criteria for involuntary admission to an inpatient facility and a capacity assessment should not take place prior to the making of an admission order (Part 4 of the 2001 Act - 'Consent to Treatment').

- Determination of capacity must be issue specific; while a person may have capacity in one area, the person may not have capacity in another.

- If a person who is detained under the 2001 Act is considered to lack capacity, the person's capacity must be assessed in the same manner as persons who are not detained under the 2001 Act. The provisions in the 2015 Act for the assessment of capacity, namely an application to court with the provision of supports, should apply to all persons, including those detained under the 2001 Act.

- In relation to capacity, it is suggested that the DoH structure this section of the Act as follows:
    1. Those that have capacity and consent;
    2. Those that have capacity and do not consent;
    3. Those that do not have capacity but have provisions in place in order that decisions may be made with and/or for them;
    4. Those that do not have capacity and have no provisions in place for decisions to be made with and/or for them.

- Advanced Healthcare Directives (AHDs), as referenced in the 2015 Act, must be applicable in the same way to patients receiving treatment for physical and mental health conditions and the 2015 Act should be amended to ensure that AHDs be extended to include persons detained under the Mental Health Act 2001.

- The fundamental criteria for detention of a person under the 2001 Act should be treatment, not risk; the likelihood of a person causing harm to himself or another should not be part of the criteria for involuntary admission. Treatment should be the only purpose of all involuntary detentions.

- In relation to life-saving treatment – treat on parity, in so far as that is possible, with general health.

- A fundamental change of focus for the delivery of mental health service is required. What is needed is a seven-day service in the community with admission to an approved inpatient facility, preferably on a voluntary basis, where treatment cannot be given in the community. Involuntary admission to an approved inpatient facility should be seen as the last resort.

Definitions

The PSI is supportive of the Expert Report Group (ERG) recommendations 1 and 2 (a, b, c, d and e) regarding changes to definitions within the Act.

- All defined terms (*Interpretation 2(1)*) relating to the entire Mental Health Act should be inserted in Part 1, Section 2.

- It is recommended that the term "*person*" be used instead of patient, or resident or service user be they voluntary or involuntary in an approved inpatient facility, community residence or community mental health service.

- **Clinical Director** – means a person appointed under Section 71 (*Part 6: Miscellaneous*) – the PSI recommends that this is changed to include other appropriately qualified mental health professionals or nursing (*as well as a Consultant Psychiatrist*) and all would be considered for the role of Clinical Director (*the rationale for same is covered later in this submission under the heading of Governance*).

- **Examination** – all types of examination covered, and in person and or via telehealth where appropriate.

- **Treatment** – all form of treatment. Remove reference to "*medical"* and amended to "*clinical*" which encompasses care other than that provided by a registered medical practitioner (*as per ERG recommendations 7 – 11*).

- **Adult** – person over 18 years of age.

- **Child** – person under 18 years of age (*with separate definition for children aged 16 and 17 years in relation to consent – see page 13 of this submission and the provision of the 2001 Act as it relates to children*).

- **Mental illness** rather than mental disorder (*2001 Act 3(1)*) as per ERG recommendations 3 – 6.

- **Approved Centre** – the PSI recommends that this is changed to "*approved inpatient facility"* and provide clear definitions as to this.

- **Criteria for Detention/Involuntary Admission** – the PSI is not supportive of the ERG recommendation 13(b) in relation to the criteria for detention related to risk. The fundamental criteria for detention of a person under the 2001 Act should be treatment, not risk; the likelihood of a person causing harm to himself or another should not be part of the criteria for involuntary admission. Treatment should be the only purpose of all involuntary detentions.

- **Best Interest** - This reference in the 2001 Act should be changed and the term "*guiding principles*" used instead.

- **Mental Healthcare Professional** - means registered healthcare professional who is part of a person's multidisciplinary team (in an approved inpatient facility or approved community residence or approved mental health service) and has the required training as prescribed by way of regulation (General Register of Medical Practitioners, Specialist Register for Psychiatry, An Board Altranais, CORU, the Psychological Society of Ireland).

- **Registered Medical Practitioner** - means a person whose name is entered in the General Register of Medical Practitioners.

- **Consultant Psychiatrist** – should be employed by the Health Service Executive (HSE)/governing body of an approved inpatient facility and on the specialist register to ensure the highest possible standards are maintained.

- **Registered Nurse** – means a person whose name is entered in the register of nurses maintained by An Board Altranais under section 27 of Nurses Act, 1985.

- **Registered Health and Social Care Professional** – means a person whose name is entered in the register of Health and Social Care Professions (HSCP) by CORU and the Psychological Society of Ireland.

- **Voluntary person** – as per 2001 Act

- **Involuntary person** – a person who meets the criteria for involuntary detention in Section 8 and has capacity. See the following regarding 'Involuntary Admission'.

- **Capacity** – 2015 Act should apply.

Ensure that a person with an intellectual disability has access to and receive mental health supports and services where required.

Not supportive of the ERG (recommendation 102 – 110) proposed amendment of the term "*recovery plan*" – suggest that the term *"individual care plan (ICP)"* is wider than recovery plan and includes a recovery plan. An ICP should be on a statutory basis and extended to all individuals in receipt of mental health service. Discharge planning should form part of an ICP.

Legal right to information for both voluntary and involuntary persons, and individuals be fully informed of their rights, their care and treatment, rights regarding consent or refusal of treatment and rights to leave the approved centre at any time (if voluntary detained) (ERG recommendations 98-101).

Involuntary Admission

- The PSI recommends a revision of the ERG recommendation 13 and remove 13(b) "*risk*" as grounds for detention.

- The PSI is supportive of the ERG recommendations 12, 14, 15 and 16.

- The PSI recommends the below criteria for involuntary admission to an approved inpatient facility (8(1)):
    - (a) *the person is suffering from a mental illness of a nature or degree of severity which makes it necessary for him or her to be involuntarily detained in an approved inpatient facility to receive treatment which cannot be given in the community*; and,
    - (b) *the detention and treatment of the person concerned in an approved inpatient facility would be likely to ameliorate the condition of the person to a material extent with a view to contributing to the person's discharge*.

- The ERG recommended an expanded role for Authorised Officers (AO) (recommendations 34 – 41). The PSI welcomes this proposed amendment but for this to be enacted it will require:
    - Funding from the HSE to ensure the service is:
        a) available throughout the country; and,
        b) available for all approved inpatient facilities both public and private.

- The professional requirements to be defined for someone to be appointed as an AO and the relevant health care professional and assessment tool/criteria to be applied in deciding to make an application etc.;
- That the person with mental illness is protected in relation to confidentiality and data protection.

The PSI is of the view that there is no reason why an AO should be required to contact the Gardai directly at application stage of the process and believe that this is contrary to human rights of the person with mental illness.

- The ERG recommended (41) that, in cases where a person is taken into Garda custody under section 12 of the 2001 Act, an initial assessment by an AO should take place as soon as possible. The PSI recommends that "*as soon as possible*" is not adequate and that the person should be detained for the shortest period of time.

- The PSI recommends that this would be for a maximum period of six hours (not 24 hours) (ERG recommendations 74, 75, 77,78).

- The AO should be available 24/7, 365 days per year (*of note, in comparison, if a person under suspicion of being under the influence of an intoxicant while in charge of a motor vehicle is taken into custody a GP must attend within three hours*).

- The PSI endorses the ERG recommendations (61 - 63) for a more interdisciplinary approach be taken to the care and treatment of persons under the 2001 Act.

- The PSI is supportive of the recommendation that a Consultant Psychiatrist would consult with a mental health professional from a different discipline *(and for the mental health professional to complete an assessment*) prior to the making of an admission order and at the point of a renewal order (*ERG recommendation 63*). A psychosocial report should be carried out by a member of the multidisciplinary care team and provided to the tribunal.

- The PSI is in agreement with the ERG recommendation 53, to shorten tribunal heading from 21 days to 14 days.

- Consultant Psychiatrist responsible for the care and treatment of an involuntary detained individual should be required to attend the tribunal (ERG recommendation 63).

- Limit leave to 14 days (*ERG recommendation 70*) – leave means that the Consultant Psychiatrist responsible for the care and treatment of an involuntary detained individual can grant permission to the individual to be absent from the approved centre for a specified period of time.

- Shorten administration of medication to person involuntary detained (Section 60) from three months to 21 days to protect the rights of individuals (Mental Health (Renewal Orders) Act 2018) (*ERG recommendation 92-97*).

- Change of status from "*voluntary*" to "*involuntary*" (*ERG recommendation 73-81*).

Independent Review of Detention (Sections 31-55)

The PSI recommends changing the title of Part 3 to "*Commission*" as they are the responsible body for conducting independent review.

Requirement for Consent to Treatment (Sections 56-61)

In relation to consent, it has been suggested that this be divided in five parts and the PSI would be supportive of this suggestion as follows:

1. Those that have capacity and consent;
2. Those that have capacity and do not consent;
3. Those that do not have capacity but have provisions in place in order that decisions may be made with and/or for them;
4. Those that do not have capacity and have no provisions in place for decisions to be made with and/or for them;
5. Life-saving treatment – treat on parity, in so far as that is possible, with general health. A new section is required to be inserted to address life-saving treatment, which would align with what occurs in general medical hospitals and other such facilities where life-saving treatment is required but consent cannot be obtained. While there is no express legislative provision dealing with what happens in general hospitals it is our understanding that the common law is applied and the same should apply in mental health.

Psycho-surgery Section 58(1)

- This provision has never been used and, therefore, the PSI would query whether it should be retained in the Act. There is no expertise in Ireland to carry out such procedure and where psycho-surgery is performed it is not done within a mental health setting but in a neurosurgical environment.

- If retained, an appropriate definition of the term psycho-surgery would be required and if performed it should require the consent of the Court (Circuit Court or High Court).

Electro-convulsive therapy (ECT) Section 59

The PSI recommends that ECT is not administered to a person unless they give their consent in writing. In addition, the PSI would recommend that the Mental Health Commission (MHC) provides rules and guidance in relation to the use of ECT, and that ECT would only be administered in accordance with the MHC rules.

Approved Centres (Sections 62 – 68)

- A provision should be inserted into the revised legislation to allow for all mental health services to be subject to regulation.

- Propose three categories of mental health services to be regulated by the MHC and change the name of Part 5 from "*Approved Centres*" to "*Regulation of Mental Health Services*".
- Inspection cycles are follows:
    - Approved Centres: three-year inspection cycle;
    - 24-hour mental health community residences: five-year inspection cycle;
    - Community mental health service: five-year inspection cycle.

- The MHC be granted power to request a "statutory regulation report" from an approved inpatient facility prior to attaching a condition to registration.

- Include all aspects of regulatory functions in Part 5.

Miscellaneous (Sections 69 – 75)

Bodily restraint and seclusion Section 69(1)

- The PSI recommends that bodily restraint and seclusion be revised and that a new Part be inserted in the Act to deal with all restrictive practices as follows:
    1. Seclusion – currently section 69 – this should be dealt with separately to mechanical restraint;
    2. Suggestion to change of the term "*seclusion*" to *a "sanctuary, a safe space or a quiet room"*. Consideration of underlying isolation and punishment aspect of

seclusion to be considered, and choice of a calming, respectful, quiet room to be available on request and/or for use as a '*seclusion*'. Access to optional calming/grounding/soothing/distraction strategies should be considered. Purpose-built single rooms with en-suite with reduced risk could serve this function as well. This would align with trauma-informed aspect of service delivery principles;

3. Physical restraint – not addressed in the 2001 Act;
4. Mechanical restraint – currently section 69 but, as per 'seclusion', this should be dealt with separately;
5. Chemical restraint – this is not addressed in the 2001 Act.

- The PSI recommends that the MHC develops regulations, codes or rules relating to each restrictive practice and that any breach of these would be an offence subject to a fine or a conviction.

Governance

Clinical Director (section 71(1))

- The PSI recommends that "*The governing body of each approved centre shall appoint in writing a Consultant Psychiatrist to be clinical director of the centre*." be expanded to include other appropriately qualified mental health professionals or nursing (as well as Consultant Psychiatrists).

- The 'Vision for Change' policy document (2006) recommends a '*shared governance model*':

    - *RECOMMENDATION 9.2: The cornerstone of mental health service delivery should be an enhanced multidisciplinary Community Mental Health Team (CMHT), which incorporates a shared governance model, and delivers best-practice community-based care to serve the needs of children, adults and older people (p80).*

- 'Sharing the Vision' (2020) recommends a review of existing Clinical Leadership models of governance:

    - *The engagement for this policy indicates that models of leadership for the CMHTs should be reviewed in line with international practice. Clinical leadership, as described in AVFC 2006–16, was vested in the consultant psychiatrist role, in*

keeping with the requirements of legislation. Consideration should be given to amending legislation to facilitate the delivery of a shared governance model.

- Such a 'shared governance' and 'distributed responsibility' model of Mental Health Service will lead to a more effective and accessible service for families that are more consistent with client centred, recovery-oriented models of practice with people using mental health services.

- A centralised model of clinical responsibility ('*ultimate clinical responsibility of the Consultant Psychiatrist*') is not in keeping with current models of practice (MHC, 2010, p.20).

- The appointment of a Clinical Director should not be based on privilege of profession without due regard for competencies required.

- A more appropriate model, and reflective of how negligence cases are settled (e.g., with our State Claims Agency), is one of distributed clinical responsibility whereby responsibility is distributed among the involved team members according to their role and contribution.

- In Mental Health Services there needs to be parity of esteem among colleagues in multidisciplinary teams. A well governed service is clear about what it does, how it does it, and is accountable to its stakeholders.

- Also, it is unambiguous about who has overall executive accountability for the quality and safety of the services delivered. Formalised governance arrangements ensure that there are clear lines of accountability at individual, team, and service levels so that healthcare professionals, managerial staff and everyone working in the service are aware of their responsibilities and accountability. The PSI believes that the appropriate clinical governance structure is a 'distributed' model of responsibility, where responsibility is distributed among the involved team members according to their role and contribution. This model emphasises mutual accountability and the notion of 'being in the boat together' with regard to achieving team goals.

- Good clinical governance allows for a model of clinical responsibility that recognises that each individual clinician carries clinical autonomy (and responsibility) with regard to their own specific treatment/intervention. The MHC document 'Teamwork within Mental Health Services in Ireland' (2010) articulates this well and the principles should be incorporated into the revised 2001 Act. The MHC teamwork document (p20) proposes a 'distributed model of responsibility' whereby clinical responsibility 'is distributed among the involved team members according to their role and contribution'.

- The Mental Health Commission (2006a) discussion paper received a significant number of respondents indicated that this role should not be based on privilege of profession without due regard to the competencies required.

- The PSI recommends that the 2001 Act define the professional requirements for someone to be appointed as Clinical Director and the relevant mental health care professionals eligible to apply and the assessment tool/criteria/competencies to be applied in deciding to make an application and subsequent appointment.

- The PSI believes that the post should be discipline non-specific, the post holder must be an experienced mental health professional, with the necessary clinical skills and possesses the requisite organisational and interpersonal skills for the role.

- The recently published 'Mental Health Services for Adults with Intellectual Disabilities: National Model of Service' (HSE, 2021) has a chapter on governance for Mental Health Intellectual Disability (MHID) teams that is supportive of the above. Section 7 of the model of service outlines all the different areas of governance for MHID teams, covering accountability, communication, and monitoring.

    - Each head of discipline (for example, area director of nursing, principal psychologist) holds responsibility for ensuring that each team member operates to the highest clinical standard (7.1 Team governance).

    - In keeping with 'A Vision for Change', each member of the MHID team takes responsibility for the delivery of care in a collaborative and respectful manner, always adhering to a sense of parity of esteem. Clinical governance will be seen as a multidisciplinary activity requiring collaboration across disciplines, supported by the local professional management structures. In addition, all members of the team must adhere to their individual professional code of ethics, and the level of individual clinical responsibility associated with their job description, and their scope of practice. (7.2 Clinical responsibility)

- The PSI recommends that this new approach to Clinical Governance, as outlined above, is reflected within the Mental Health Act.

Provision Related to Children

- The section relating to children in the Mental Health Act 2001 has been the subject of significant criticism over many years and the revised Act needs to ensure that the rights of children are enhanced in the area of mental health.

- There is a need for the DoH to draft primary legislation in relation to children and it would be important that due consideration is given to this and dedicated expertise in child mental health be involved in drafting the Heads of Bill in relation to this section of the Act given that this expertise was not on the ERG that reviewed the 2001 Act in 2012- 2015.

- Not with-standing the above, the PSI would support the following:

    - Provision related to children should be included in a standalone Part of the Act (*ERG recommendation 111*). The section of the Mental Health Act, that relates to children needs to be a separate standalone section, and the Child Care Acts are not appropriate in relation to applications for the involuntary detention of children and reference to them in the 2001 Act should be removed;

    - "*Child"* should be defined as a person under 18 years of age (*ERG recommendation 112*);

    - There should be a set of guiding principles to apply to children under the 2001 Act that reflects the Mental Health (Amendment) Act 2018 and Recommendation 113 of the ERG;

    - Children aged 16 and 17 years should be presumed to have capacity to consent to or refuse admission and treatment (*ERG recommendation 114*);

    - In relation to children under 16 years of age, a parent (*or an appropriately designated person acting in loco parentis*) must consent to voluntary admission of said child, but the views of the child should be taken into account by parents and service providers and given due weight having regard to the age and maturity of the child;

    - The PSI recommends that the same provisions, in as far as possible, apply to children as to adults in relation to mental health;

- The ERG recommended revised criteria for involuntary detention in an approved inpatient facility (*recommendation 13*) and these new criteria should be adapted and added to the new child specific part of the Act;

- The ERG recommended that adult admissions order be for 14 days and the same time period should be applied to children;

- The ERG recommended that that another mental health care professional (*other than a Consultant Psychiatrist*) be required to provide a report when an order of detention is extended for adults and this should also apply to children;

- As a general principle, a child should be given the same safeguards as the adults under the Act and the PSI recommends that each child should be appointed a legal representative in relation to involuntary detention from the start of the process and for the duration of the involuntary detention and legal representation should be provided via the legal aid scheme. This would ensure that the rights of the child are protected, and the Act is fit for purpose now and for the next 10 to 20 years;

- While a child may have a Guardian Ad Litem (GAL) under the Child Care Act the PSI would consider that a related but separate matter. Furthermore, if a GAL is appointed, they should not be appointed a solicitor. Only the child should be appointed a solicitor, as it is the child's interests that are at issue, not the GAL. The appointment of legal representative for a child should be a statutory requirement under the 2001 Act;

- The PSI would support the MHC involvement in all applications made to involuntarily detain a child and for the MHC to review the approved inpatient facility where the child is due to be detained to ensure it is appropriate;

- It is essential that issues relating to children under 16, and children aged 16 and 17 years, are dealt with separately. However, the position of parents in relation to children aged 16 years and older would need to be considered and how best they can continue to be involved in decisions of consent or refusal to treatment of their child;

- The PSI would also recommend that the child is provided with the opportunity to be involved in all proceedings relating to them. There may be situations where the child is not well enough and, therefore, it may not be possible for the child to attend in certain circumstances; however, there should be clearly documented clinical reasons for this;

- Of note, during the current COVID-19 health crisis the courts have started to allow parties to participate in cases via video link. The provision of video links from approved inpatient facilities would allow a child to participate in proceedings while not having to attend court (which can be intimidating for a child) and this would ensure the child is informed and their voice is heard;

- In relation to the administration of medicine for children, this should be in line with recommendation 93 of the ERG in relation to adults in that the period should be reduced from three months to a period not exceeding 21 days;

- It would be important that clear information is provided to children and their parents in relation to the Mental Health Act in a language that is easily understood by all;

- Managing transitions from child and adolescent to adult services is not resolved. Primary health services have a lifespan approach in some cases to overcome discontinuation. However, mental health outpatient services remain disjointed;

- The PSI recommends that consideration should be given to including provision that prior to a handover to adult services on their 18th birthday it be reviewed in conjunction with the young person whether a move to adult services is in the young person's best interests at that time. This is also consistent with 'Sharing the Vision':

    - *The Youth Mental Health Task Force Report recommends that the age range for eligibility for CAMHS be increased to 25 in order to improve continuity of care and lead to better outcomes for service users, as the transition from CAMHS to adult services is complex. At present, young people make the transition to adult services at the age of 18. This can be an age in life when change, uncertainty and vulnerabilities prevail. Failure to secure a safe transition can lead to disengagement and ultimately to poorer health outcomes;*

    - *In the interim, an immediate priority is to ensure that short-term additional supports are available for individuals who are making the transition from CAMHS to General Adult Mental Health Service (GAMHS) at age 18, given the issues and vulnerabilities that can prevail.*

- Inpatient and 24/7 residential treatment facilities are currently separated into child/adolescent and adult and there may need to be additional considerations of young persons moving to adult services.