National Disability Authority’s Submission to the Review of Mental Health Act 2001

# Introduction

The National Disability Authority is the lead state agency on disability issues, providing independent expert advice to the Minister on policy and practice and promoting Universal Design in Ireland. Within this remit the National Disability Authority welcomes the opportunity to make a submission to the Department of Health on the review of the operation of the Mental Health Act 2001. Over the last few weeks the National Disability Authority engaged with a number of stakeholders who are involved in the area of Mental Health, including service users, providers, advocates and organisations. The National Disability Authority wishes to acknowledge their contribution which helped inform this submission.

The National Disability Authority acknowledges that the current Mental Health Act 2001 is a significant advancement on the provisions of the Mental Treatment Act which had governed practice and service provision in the field of mental health since 1945.

The National Disability Authority particularly welcomed the establishment of the Mental Health Commission and the unique contribution it has made to the field and to the practice of mental health service provision. The Mental Health Commission discharges a crucial role in promoting and maintaining quality standards of care in services and has made efforts, since its establishment, to work in partnership to foster high standards in the delivery of mental health services. In addition, the National Disability Authority also notes the significant work of the Mental Health Tribunals and of the Inspector of Mental Health Services which has been systematic and thorough. While important work remains to be done the National Disability Authority acknowledges the achievements to date.

# Context for comments

The Mental Health Act 2001 provides a framework within which people who have a mental disorder and require treatment or protection can be cared for and treated. It puts in place mechanisms by which the standards, care and treatment in mental health services can be monitored, inspected and regulated. The Act provided for the establishment of the Mental Health Commission as an independent statutory body to promote, encourage and foster the establishment and maintenance of high standards and good practice in the delivery of mental health services and to protect the interests of people detained under the 2001 Act. It also provided for the establishment of the Office of the Inspector of Mental Health Services. The Act has been fully implemented since 2006.

Since the commencement of this Act there have been changes in mental health policy (**Vision for Change**) and in international human rights law (**UN Convention on the Rights of Persons with Disabilities**). In addition, cases that have been taken through the European Court of Human Rights (regarding procedures for detention) and in the Irish courts (for example, EH v St. Vincent’s Hospital and Others, Supreme Court 2009, regarding the status of a voluntary patient) have raised issues relevant to the adequacy of the Act relating to capacity and consent.

New legislation is pending, for example, the Mental Capacity Bill and the Mental Health (Involuntary Procedures) Bill, and these will impact on the Mental Health Act.

The Act needs to be updated to reflect this changed environment.

# Concerns regarding people outside the scope of the current Act

## The Act and wards of court

The National Disability Authority is concerned at the exclusion of wards of court from the scope of the Act. The National Disability Authority believes that there are between 60-70 long term residents in mental health facilities who are currently wards of court. Wards of court are at significant disadvantages because of their exclusion from the Act. Those who have mental illnesses, and those who do not have mental illness but are improperly placed in approved centres, are deprived of the procedures under the Act. There is a need for a mechanism where wards of court with mental health problems can be afforded the safeguards of the Act.

## The Act and service users with a dual diagnosis

The National Disability Authority is concerned at the position of persons with a dual diagnosis of mental illness and intellectual disability, or behavioural or conduct disorders, and the difficulties experienced by these groups in accessing services.

The Inspector of Mental Health Services in her 2005 report noted the impact of de-designation of wards on some vulnerable groups. In relation to persons with an intellectual disability she wrote “…it is accepted internationally that persons with an intellectual disability have a higher than average risk of having a co-existing mental illness or severe behavioural disturbance. In the absence of special mental health services for….those with an intellectual disability, de-designation [of wards] left many vulnerable people without easy access to the mental health care they needed.” (page 58)

The Act should be amended if necessary to make explicit reference to the inclusion of persons with conduct / behavioural disorders (as part of a dual diagnosis with an existing mental illness) within the scope of the legislation.

The National Disability Authority’s 2003 report **‘Review of Access to Mental Health Services for People with Intellectual Disabilities’** in 2003 has information on the type and quantum of services available for persons with intellectual disabilities and psychiatric illness and/or challenging behaviour in Ireland. The report found that between 900 and 2,400 of those with intellectual disabilities will exhibit challenging behaviours and that up to two thirds of this group will have a psychiatric condition. The report contains valuable information about persons with a dual diagnosis and their experiences in accessing mental health services.

A **Vision for Change** set out proposals in its Chapter 14 on mental health services for people with an intellectual disability. As noted in the reports of the Independent Monitoring Group, there has been little progress achieved in this area to date. There is a need for appropriate supports for those with acute needs and for appropriate community-based services

The National Disability Authority recommends that the Department of Health’s review of the operation of the Mental Health Act should be informed by these two reports.

## Detention of persons with disabilities who do not have a mental disorder

The National Disability Authority is concerned that individuals who are detained who do not have a mental disorder are afforded protections under the Act. The following case highlights this:

On the 3rd of March 2011, Mr Justice Bermingham delivered a judgement in the High Court that a man aged 26 years who was found not to be of unsound mind, not suffering from a mental disorder and not having a mental illness could be detained in the Central Mental Hospital as requested by the HSE, and with which his Guardian Ad Litem agreed. The man, since childhood had a personality disorder and some Asperger Syndrome traits. He manifested extreme aggression, first displayed on his expulsion from nursery school aged four years. He was eventually placed and detained in England and the HSE wished to repatriate him to Ireland. The only suitable placement was in the Central Mental Hospital, Dundrum. Exercising his power in terms of the inherent jurisdiction of the Court, Mr Justice Bermingham agreed that he could be so detained. The Hospital agreed to receive him. He will be detained indefinitely. As the case is outside the Mental Health Act, 2001, there will be no review under that act of his detention. His detention will be reviewed by Order of the Courts. (See: In the matter of J.O’B and in the matter of the inherent jurisdiction of the High Court, Between the HSE (Plaintiff) and J.O’B represented by his Guardian ad Litem, (H.O’B) Citation 2011 IEHC 1973*).*

This is a case which falls outside the Mental Health Act but which has significant implications for people with communication difficulties or other conditions, for detention of persons not with a mental disorder and for civil liberties.

# The review process

The National Disability Authority welcomes the Government’s commitment to “review the Mental Health Act 2001 in consultation with service users, carers and other stakeholders, informed by human rights standards.” While acknowledging the call for public submissions by a certain date, the National Disability Authority suggests that further consideration be given as to how service user stakeholders could be further engaged in this review, and in particular, how the views of children and young people with mental health difficulties could be heard.

The National Disability Authority also suggests engagement with the relevant court services to address the rights of wards of court and others with disabilities who are detained in mental health facilities outside the parameters of the Act.

The National Disability Authority would also suggest that the Department’s review should analyse the reasons for the low numbers of Circuit Court appeals, the high numbers of appeals withdrawn and the fact that very few Circuit Court Appeals are successful.

In addition, the Department’s review should look at the number of complaints made through current procedures and the manner and nature of their resolution. This should be done in consultation with service users regarding their experience of complaints procedures.

# Why the Act needs to be amended

The Act as a whole needs to be audited and updated to render it compliant with international human rights law in particular the **UN Convention on the Rights of Persons with Disabilities 2006** which espouses the social as opposed to the medical model of disability found in the Act. Ireland has signed and intends ratifying the Convention once mental capacity legislation has been introduced. It is important in this regard to ensure that:

* **People with mental health difficulties have equal recognition before the law**. Any mental health legislation must recognise the right of the person with mental health difficulties to make decisions with support where he or she does not have the capacity to make decisions independently (See Article 12 of the Convention)
* People with mental health difficulties should be facilitated by legislation to **make advance health care directives** providing for what is to happen in future situations where they lack capacity to make decisions relating to their health care. In this way their will and preferences and right to autonomy, expressed when they retained capacity, may be respected at a stage when they lack capacity and are found to require treatment

The **UN Convention on the Rights of Persons with Disabilities 2006** raises aquestion as to whether the existence of a separate Mental Health Act providing for the detention and treatment of people with mental health difficulties is, in fact, a discriminatory measure within the context of Article 14 the **UN Convention on the Rights of People with Disabilitie**s and whether within the context of Articles 2, 5 and 12 of the Convention the treatment of objectives of the current Act might not be better met by a system of supportive decision making for all people with disabilities in relation to health care and all the other aspects of their lives where that support is required. (See Michael Bach and Lana Kerzner “A New Paradigm for Protecting Autonomy and the Right to Legal Capacity.” Prepared for the Law Reform Commission of Ontario. October 2010).

Until the Committee of UN Convention on the Rights of People with Disabilities sets out its views on these matters, it is important that interim amendments are made to the Act in order to ensure compliance with human rights standards in international human rights law.

The Act needs to be updated to render it consistent with the continued evolution of the jurisprudence of the European Court of Human Rights in the field of mental health. For example, the Act should be amended to reverse the burden of proof for Circuit Court appeals to ensure compliance with Article 5(4) of the European Convention on Human Rights.

The Act also needs to be reviewed in the light of the policy framework for mental health of the population of Ireland – **A Vision for Change.** The National Disability Authority recommends that there should be a legal underpinning for a **Vision for Change** in the following areas:

* **Designate a senior position as Director of Mental Health Services**, with similar status to the position of Director, HSE National Cancer Control Programme, and as the budget holder for the mental health services. Consider if an amendment to the Health Act would be important to underscore the authority of such a position
* **License all mental health services**. The National Disability Authority recommends that all mental health services should be licensed and be placed under the remit of the Mental Health Commission. The scope of Part 5 of the Act which deals with the registration and approval of mental health services could be extended to apply to community based services. In addition Section 51 of the Act which outlines the duty of the Inspector of Mental Health Services to inspect approved centres and report on inspections should be extended to apply to inspection of community based mental health services. HIQA’s power to withdraw licences from public or private facilities, such as nursing homes, has proved to be a powerful instrument for enforcing standards. The National Disability Authority would recommend that similar powers be exercised by the Mental Health Inspector
* **Formalise links between Mental Health Inspectorate and HIQA**

The National Disability Authority recommends that there should be formal links between the Mental Health Services Inspectorate and HIQA’s Social Services Inspectorate with a view to ensuring alignment, insofar as possible, between standards against which mental health services and other disability services are addressed. This would support the development of a comprehensive overall inspection regime of services for people with mental health problems irrespective of the setting

* **Provide a care plan**. The Act should require that every patient whether voluntary or involuntary be given a care plan which should be created and revised in consultation with the patient and his/her multi-disciplinary care team and should incorporate a discharge plan that is consistent with the recovery ethos in **A Vision for Change**

## Render the Mental Health Act 2001 consistent with the Mental Capacity Bill

The Act needs to be reviewed so as to render it consistent with the terms of the proposed Mental Capacity Bill.

## Consider in light of court cases

The Act should be reviewed in the light of cases taken in the Irish courts which highlight deficiencies in the legislation.

## Other areas for review

The Review of the Act should consider carefully the reforms proposed in relation to:

* the definition of “voluntary patient” (Section 2) by the Irish Human Rights Commission in February 2010
* children made by the Law Reform Commission’s **Consultation Paper in relation to Children and the Law: Medical Treatment** published in December 2006.

# Specific issues pertaining to the current Act

## Terms and Definitions

The National Disability Authority is of the view that the following terms and definitions in this Act that should be improved upon:

* **“Best interests”** in section 4 of the Act should be defined in a way that is consistent with the terms of the **UN Convention on the Rights of Persons with Disabilities** and the terms of the forthcoming Mental Capacity Bill
* The Mental Health Act 2001 should contain a set of **guiding principles** to govern the interpretation of the Act, consistent with the proposed Mental Capacity Bill. These should include:
* respect for dignity
* autonomy
* privacy
* bodily integrity
* the right to equality and non-discrimination
* the right to treatment in the least restrictive environment possible
* the right to information
* The use of the term **“patient”.** A number of service users have indicated a preference for the use of the term “person with mental health difficulties”
* The definition of a **“voluntary patient”** in section 2 of the Act should be amended to mean people with mental health difficulties who have capacity to make a decision in relation to admission and treatment in an approved centre and who have freely consented to admission to an approved centre and continue to do so as long as they are in the centre
* “**Actual behaviour” should be defined to mean “relevant and recent behaviour”.** Consideration should be given to the amendment of section 3(1) (a) of the Act so that it requires that there be “immediate and objective reasons based on the actual behaviour” of a person as opposed to “a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons” to justify the detention of a person on the “risk of harm” ground

The National Disability Authority is of the view that the following terms and definitions in this Act that should be removed:

* “**Intellectual disability”** should be removed from the definition of “mental disorder”. Intellectual disability is not in itself a mental illness and is not responsive to psychiatric treatment. However, people with intellectual disability who also have a “mental illness” would still fall within the Act
* The reference to “**impaired judgment”** in section 3(1) (b) should be deleted and a person should only be involuntarily admitted to an approved centre if she or he lacks capacity to consent to admission and the other criteria in the subsection are met

## Detention

The National Disability Authority suggests that the following should be addressed within the legislation and amendments made:

* **Section 12 should be amended so that the Garda should be obliged to bring the person to an approved centre for assessment**. Where the Garda 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 the Garda should be obliged to bring the person to an approved centre for assessment and only where that is not possible should the person be kept in Garda custody and then only for the minimum time it would take for an assessment by a medical practitioner to take place
* The Act should provide for **training of all Gardaí** before they are permitted to become involved in an admissions process
* **Legal representation and Code of Practice.** The Act should include a provision entitling a person to request a change of legal representativeto another representative on the panel established by the Mental Health Commission or to a privately instructed solicitor where objectively appropriate. In addition, the person should have a right to have a legal representative appointed to him/her within 24 hours of his/her detention to ensure prompt and adequate consultation. The Act should entitle the legal representative to access to the patient’s medical records in advance of the hearing provided the patient consents. If the patient lacks capacity, no consent will be required. A Code of Practice should provide that the legal representative should act in accordance with their client’s legal interests and in accordance with their instructions. The Code of Practice should also set out what a client’s legal interest entails where the patient lacks capacity. As far as possible this should reflect the patient’s previously expressed wishes and preferences
* **The grounds for appeal to the Circuit Court should be expanded** to include non-compliance with the procedural requirements of the Mental Health Act. In addition, where an appeal against the decision of the Tribunal takes place, the Act, at section 19(4), places the burden of proof on the person with the mental disorder to disprove the diagnosis rather that on the authority/hospital to prove it. This puts the service user at a disadvantage as against the hospital. This should be addressed to achieve greater parity between the two parties
* **Capacity assessments should be carried out by a person who is independent of the treating medical practitioner** but allowing consultation between the treating medical practitioner and the assessor. Capacity assessments should, as far as possible be multi-disciplinary and not solely medical in nature and involve input from psychologists, social workers and members of the person’s support network

## Deprivation of liberty and compliant incapacitated voluntary admission

Formal detention results in loss of liberty under the Act and where this occurs, such patients have certain safeguards available. There is another form of detention under the Act that applies to people who are compliant in being admitted as voluntary patients, but are unable to assert their rights to refuse treatment or leave hospital. There are no safeguards applying in the Act to this latter group of patients. The current review provides an opportunity to provide safeguards for these patients.

The factors required to establish a deprivation of liberty necessitating safeguards for the compliant but incapacitated “voluntary” patient were outlined in two decisions of the European Court of Human Rights in *HL v. United Kingdom* (2004) 40 EHRR 32and **Storck v. Germany** Application no.61603/00 16th June 2005 dealing with both public and private admissions and these rulings have application to Ireland.

The European Court of Human Rights in *HL* referred to the “striking” contrast between the lack of any fixed procedural rules by which the admission and de facto detention of compliant incapacitated persons is conducted, compared to the extensive network of safeguards applicable to psychiatric committals covered by the legislation. (The relevant legislation in that case was the English Mental Health Act 1983). In addition, there were no formalised admission procedures which indicated who could propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions. The European Court of Human Rights referred to the absence in *HL* of a requirement to fix the exact purpose of admission, assessment or treatment and, consistently, no limits in terms of time, treatment, or care, attached to the admission or of continuing clinical assessment.

As a result of the lack of procedural regulation and limits, the European Court of Human Rights observed that the hospital's health care professionals assumed full control of the liberty and treatment. The very purpose of procedural safeguards is to protect individuals against any “misjudgements and professional lapses.” The European Court of Human Rights held that the further element of lawfulness under Article 5(1), the aim of avoiding arbitrary deprivations of liberty on grounds of necessity, had not been satisfied. Any procedure depriving a person of his liberty should issue from, and be executed by, an appropriate authority and should not be arbitrary. This authority does not have to be a court and can be the hospital manager or the head of the psychiatric service and may vary from jurisdiction to jurisdiction.

In **Storck v. Germany***,* similar principles were applied to private institutions, “in particular those where persons are held without a court order, need not only a licence, but also competent supervision on a regular basis of whether the confinement and medical treatment is justified.” These factors need to be taken into account in the current review and appropriate provisions put in place. The tribunal system is one element of the oversight process. The inspection processes also have an important and distinct contribution to ensuring that services are appropriate and of an acceptable standard.

The National Disability Authority recommends that:

* The numbers of compliant incapacitated patients in approved centres must be ascertained by the Mental Health Commission, and a separate category of **“informal patients”** who are entitled to the same statutory safeguards as involuntary patients should be established in the Act
* Voluntary patients should be **entitled to information** about their rights including their rights to:
* be discharged from the approved centre
* consent
* refuse treatment
* access a complaints procedure
* put in place advance directives and enduring powers of attorney
* **Equal treatment of all people.** The provisions of Part 4 of the Act should apply equally to voluntary and involuntary patients
* A **Code of Practice** should indicate that where a voluntary patient is subjected to seclusion or restraint the question of whether the patient is truly voluntary arises and consideration needs to be given as to whether the patient’s status should be changed from voluntary to involuntary
* Section 57 of the Act (Treatment Not Requiring Consent) should be amended. A requirement should be introduced such that the **free and informed consent of a patient shall be required in all cases** unless in cases of emergency (defined according to the doctrine of necessity) where the person

1. lacks capacity to make a decision with or without support and
2. is reasonably believed to lack capacity with or without support and compliance with section 60 would cause such delay as to lead to harm to the person

* Such emergency treatment should be administered for no longer than 72 hours (time recommended by the World Health Organisation)
* **The Mental Health Commission should** **review** the reasons for the high number of **revocations of involuntary admission and detention orders** which occur before tribunal hearings take place. In addition, in every case where a patient’s status is changed from involuntary to voluntary, a tribunal hearing should be held to review whether the patient has capacity and in fact has given free and informed consent to remaining in the approved centre. This should be the case unless the patient waives the right to a hearing in writing

## Safeguards for the administration of electroconvulsive therapy and the administration of medication

Under the Act, detained patients can be given medicine forcibly for a three-month period before the second opinion safeguard applies (section 60) despite statements in section 57 appearing to grant autonomy to patients with capacity. The autonomy is limited by section 60 where the competent and refusing adult can be forcibly treated on the basis of the treating psychiatrist’s opinion and a second opinion. This safeguard follows the three-month period, and in reality the majority of patients will be discharged before such provision applies.

There is an inconsistency between this section 57 and section 60 in that section 57 provides for consent unless the patient is in one of the named situations – e.g. life-threatening – **and** is also incapable. Section 60 provides for overriding the unwilling but presumably capable patient as well as the patient without capacity when it comes to consent to medicine, even where the patient was not resisting during the first three months.

The National Disability Authority recommends that:

* The provisions in **section 57(2)** need to be **more clearly stated**
* **Mental Health Tribunals should be enabled to review at regular intervals the long-term administration of medication**. These reviews would cover

1. the functional capacity of the patient to consent to or refuse treatment and whether the patient has given free informed consent and
2. the necessity and appropriateness of the treatment

* **A person with a mental health difficulty should have the right to apply to Tribunal regarding administration of medication.** Where a proposal to administer medication is concerned a person with a mental health difficulty who objects to the administration of medication should have a right to apply to the Tribunal for a review of the decision to administer the medication and the Tribunal should be empowered to review the person’s functional capacity to consent to the medication and to review the necessity for the treatment
* There should be a right of appeal to the Circuit Court, by the person with a mental health difficulty, a representative or next of kin against a decision of the Tribunal to allow the continued administration of medication to a person who lacks capacity
* The Act should specifically provide that if a person regains capacity the programme of medication should be discontinued unless the person gives his/her free and informed consent

The second-opinion safeguard, where the patient refuses electroconvulsive therapy treatment or medicine (after the 3 months), is not required to be independent of the service and can be requested by the patient’s psychiatrist.

These omissions are significant in relation to the imposition of treatment on a mentally competent refusing adult or child. It was originally thought that these second opinions in treatment would come from outside the actual service but the Act does not require any level of independence. The European Committee for the Prevention of Torture has recommended that Section 59 and 60 of the Mental Health Act be amended to provide that the second consultant is independent (CPT, Report on Ireland, p.65).

The National Disability Authority recommends that:

* The **Mental Health Tribunal should be empowered to review** whether a person with a mental health difficulty
* has the capacity to consent to such treatment
* has given free and informed consent to such treatment
* that such treatment is the least intrusive and is necessary as a last resort for the persons health needs
* Where a person with a mental health difficulty lacks capacity, treatment should only be administered if the treating consultant psychiatrist and a second independent consultant psychiatrist has certified that the person lacks capacity, **and** that the treatment is necessary as a last resort, **and** is the least intrusive treatment or therapy appropriate to the person’s health needs
* Electroconvulsive treatment should not be administered if this would conflict with a valid advance directive of the person in relation to electroconvulsive treatment or a refusal by a substitute decision maker (e.g. personal guardian or done of an enduring power of attorney) appointed by the person
* A decision by a Tribunal to authorise electroconvulsive therapy treatment should be open to appeal to the Circuit Court

## Bodily restraint and seclusion

The practice of seclusion and restraint is not subject to any formal safeguards or access to review of the practice in the Act. Section 69 has no requirement of consent or a second opinion, regardless of whether the patient has capacity. This lack of formal safeguards, or independent monitoring and review of seclusion, or an independent second opinion before it commences, is also a cause of concern. The Mental Health Commission *Code of Practice regarding Physical Restraint* (COP-S33(3)/02/2006) provides for some safeguards but these do not include second opinions or independent monitoring of any kind.

## Mechanical bodily restraint

Section 69 of the Mental Health Act 2001 provides for the use of seclusion and mechanical means of bodilyrestraint. The provision applies to all adult patients both detained and voluntary as well as to detained children. Mechanical bodily restraint is defined as “the use of devices or bodily garments for the purpose of preventing or limiting the free movement of a patient’s body”.[[1]](#footnote-1) The National Disability Authority considers that bodily restraint should be considered only after every other approach has been exhausted.

The National Disability Authority recommends that

* The remit of the Mental Health Act should also be broadened to regulate the use of chemical and physical restraint in accordance with **international best practice**
* **Mental Health Tribunals should be given a role in reviewing treatment** decisions and proposals to administer medication where a patient objects to such treatment
* The Act should provide that **restraint** for the administration of treatment should only be used **in exceptional circumstances** in cases of necessity and as a last resort and in accordance with the principle of the least restrictive treatment available
* **Specific criminal offences for the ill treatment**, neglect, exploitation or abuse of mental health users should be included in the Act
* The Act should provide for an **independent mental health services** **complaints mechanism** and in which the Mental Health Commission or the Inspector of Mental Health Services is given a role.

# Provisions relating to children

## Involuntary admission and children

The 2001 Act makes provision for adults who are detained to choose to be voluntary patients, but does not have a similar facility for children.

The rights applying to adults with regard to information do not apply to children, even taking account of age and understanding. Guidance on how to address this issue could be found in the approach taken in relation to the provision of information for children in the context of the Freedom of Information legislation. See http://www.foi.gov.ie for details.

Parents also have rights in the context of an involuntary admission of a child and should be given the opportunity to be involved in the decision-making process. Where court orders are sought and granted copies should be given to the parents and to the child as appropriate.

The place in which children are admitted and treated is significant. The National Disability Authority is concerned at continuing reports by the Inspector of Mental Health Services of inappropriate placements in adult facilities.

The child has no express rights in terms of leaving hospital or refusing treatment and is effectively under the control of the hospital staff and is similar to adults who are de facto detained. Effective supervision and review of the experiences of children in these situations is essential to safeguard their rights and to take their views into consideration.

The National Disability Authority recommends that:

* Provisions in relation to children and young people should be contained in a **separate, self-contained part of the Act**
* The provisions of the Act in relation to children and young people should be subject to a number of overriding **guiding principles** which apply to children which reflect the international human rights of children. These include:
* respect for dignity
* autonomy
* privacy
* bodily integrity
* the right to equality and non-discrimination
* the right to treatment in the least restrictive environment possible
* the right to information about admission, treatment and their effects
* the right to be heard in accordance with the principle of respect for their evolving capacities
* that their “best interests” be informed by their views which are to be given due weight in accordance with their age and maturity
* consultation with children in a unit in the course of inspections of individual units
* An **advocacy service** should be established for children who have been admitted for mental health treatment. It should assist them, amongst other things, to make complaints where they wish to do so

## Children and consent

The principles in section 4 apply also to decisions concerning children (i.e. a person less than 18 years) and consent and the Mental Health Commission *Reference Guide for Children* refers to consideration of the child’s view having regard to age and maturity. However, Section 56 (consent) does not apply to children, and statutory clarification is needed on the refusal of a 16 to 18 year old who is a competent patient. Situations of conflict may arise in relation to the older voluntary child where parents’ opinion conflicts with that of the child.

In relation to medicine for mental disorder, a detained child can have treatment imposed in the same way as an adult for three months. The treatment can be continued with the detained child for further periods of three months on a similar basis with no requirement of consent by the child who may be 17 years of age and no issue as to the capable child. There is no requirement to have an independent second opinion or the opinion of a Child Psychiatrist, and in view of the current numbers of young people under 18 in adult psychiatric care, this is a significant deficit. Article 12 of the **Convention on the Rights of the Child** refers to participation of the child, and should be reflected in the Act.

The court must approve psychosurgery and electroconvulsive treatment for children, but there is no detail on what reports are required by the court, in an area where independent opinions and representation are essential.

The Act fails to consider the capacity of a 16-year old, yet common law decisions and statute permit consent at this age. Most 16 to18 year olds are competent to consent.Human rights standards provide that the opinion of the minor should be taken into consideration as an increasingly determining factor, in proportion to his or her age and degree of maturity (**Convention on Human Rights and Biomedicine**, Article 6(2)). Current Irish provisions are out of step with this.

Geoffrey Shannon, the Special Rapporteur on Child protection in his Fourth Report to the Oireachtas (December 2010,p7) stated

“The issue of consent to mental health treatment is one of considerable importance as it categorises the legal status of a patient undergoing such treatment ( i.e. voluntary or involuntary).The assignment of a patient to either category has significant legal consequences, so the consent stage of the legal process is of the highest importance.

Not only is there a need to have due regard for the categorisation of a child prior to undergoing mental health treatment, but it is imperative that proper review mechanisms be put in place throughout the period of treatment. Children are not afforded the same opportunities as adults to advocate their views throughout treatment. Those institutions that provide mental health treatment must be regularly inspected and their procedures reviewed so as to ensure that the rights of children are upheld”.

The National Disability Authority, in the light of the protections for human rights set out in the UN Convention of the Rights of Persons with Disabilities, asks that careful consideration be given to the following changes:

* Amending the Act should to provide for young persons aged **16 and 17** **years** shall be presumed to have capacity to make decisions regarding admission and treatment unless proved otherwise. That they **would have the same rights as adults**
* **Enabling the Mental Health Tribunals** rather than the District Court **to review** **detention orders for children and young people**. The proceedings of such tribunals should be appropriate for children and young people and be consistent with the provisions of the Convention on the Rights of the Child
* Amending Section 25 so that it expressly **prohibits psycho-surgery** on children and young persons. This is consistent with current practice in Ireland. It should also prohibit the administration of electroconvulsive therapy treatment to children and young persons as recommended by the WHO
* Reviewing the Act’s provisions on **seclusion and restraint** and amending as required to ensure that they contain provisions appropriate to children
* Making provision in the Act that **no child or young person be admitted to an adult inpatient unit** whether voluntarily or involuntarily save in exceptional circumstances where it is in his/her best interests to do so. If admitted the Act should provide that the child be accommodated in an area separate from adults in an age appropriate environment, with appropriate education, recreation and other age-appropriate facilities
* Providing in the Act should for a fourth (the third being compliant incapacitated person with mental health difficulty) **category of informal persons** with mental health difficulties, who are children or young people admitted with parental consent. They should not be classified as “informal patients” simply because parents have given consent. The Act should require that their admission be reviewed in the same manner as involuntary patients
* Ensuring in the Act that the treating consultant psychiatrist and any independent psychiatrist asked to give an **independent opinion** on the child’s admission or treatment have specialist training in child and adolescent psychiatry
* Making provision in the Act for the child or young person who is subject to a detention order (or a person acting on their behalf) has the **right to apply to a Tribunal for a review or his/her detention** on the grounds that he/she no longer fulfils the grounds for detention under the Act
* Making provision in the Act for the same **safeguards and procedures** **in** relation to the administration of **medication to children** as apply in relation to adults

# Other issues highlighted by stakeholders

The National Disability Authority wishes to highlight a number of other issues raised by external stakeholders whom it consulted with regarding this submission. These could be addressed either by changes in practice or procedures, or, if necessary, in the legislation. These include:

* **The transfer of a patient from home/street involuntarily to hospital** has very frequently involved the Gardaí who are the only professionals available on the streets or in rural areas on a 24 hour basis. Despite protocols and appeals to the HSE to nominate designated persons for these transfers, it had not happened up to the end of 2010. Gardaí who accompany patients to facilities and sit with them often for many hours prior to their admission are in a legal limbo because they cannot detain that person – who has committed no offence – and since they have not yet, been admitted they are not in State custody. This is unacceptable for both patients and Gardaí
* **Patient not present at a Tribunal**. Where the directors of a mental health facility refuse to present a willing patient to a properly convened Tribunal, the Mental Health Commission should be notified by the Tribunal Chair so that legal clarification takes place on the same day as to location of the patient and rationale for non-presentation. In the absence of this, the patient has in effect ‘disappeared’ in law. This is contrary to the UN Convention on Human Rights and the Irish Constitution that citizens shall not be detained except in accordance with the law
* **Verification that a patient is in the facility.** Where an involuntary patient declines to attend a Tribunal or through incapacity is unable to comprehend the invitation to attend, the Chairman of the Tribunal should briefly visit the ward or room where the patient is located and note that the patient is where she/he is indicated to be
* **Restrictions on lawyers’ right to defend patients.** Lawyers assigned to a patient must be empowered to address breaches of the patient’s rights apart from involuntary detention. At present, they may not pursue public or publicly-funded bodies whose decisions may have resulted in the individual becoming homeless, nor pursue them in relation to the patient’s social welfare situation or other basic rights. They may only deal with the Tribunal issues of detention.
* **People outside of the jurisdiction.** The Act does not provide specific provisions for overseas/non resident persons. Non-national mentally ill persons may drift into Ireland and end up being involuntarily detained – often associated with long periods of ill health in other jurisdictions. An involuntary detention of a non-national should immediately trigger a notification to the relevant Embassy or consul
* **Patients in detention for prolonged periods**. Some patients have been detained in mental health facilities for several or more years. In the Central Hospital some patients are there for 10 + years. Their Reviews take place only once a year. This infrequent review breaches the right of such patients to an independent review of their detention in a reasonable duration of time. Such patients should have a Review every six months. The Annual Report of the Mental Health Commission should document the numbers of people detained for prolonged periods and the nature of such detention (voluntary or involuntary)
* **Patients’ right to dignity.** The Mental Health Commission should inform all Designated Centres that unless force majeure, all patients attending Tribunals must be allowed to wear day clothes and should not be constrained to appear in pyjamas and dressing gowns
* **Deaf people with mental health difficulties**. There is a need to address this in an appropriate and adequate way given that Deaf people are dependent on Irish Sign Language. A number of vulnerable Deaf people have never been offered a satisfactory opportunity to live and learn with other people the needs of people who are Deaf. They can therefore feel further isolated in treatment environments that are primarily geared around the needs of people who are not Deaf and who have mental health difficulties

# Concluding comment

The mental health of persons is an important matter of significant concern to the National Disability Authority. The National Disability Authority strongly recommends that a review provision be contained within the revised legislation on Mental Health. This is an important mechanism to ensure that the legislation is in conformance with best international practice in the area of Mental Health and in line with international legislation and conventions. The National Disability Authority would be pleased to discuss any point raised in this submission with relevant officials.

1. Mental Health Commission *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint*, R-69(2)/02/2006 [↑](#footnote-ref-1)