Submission to the Department of Health

Public consultation on draft legislation to update the Mental Health Act 2001

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1. Background to this Submission | The UN Convention on the Rights of Persons with Disabilities

The Mental Health Act 2001 is at odds with Ireland's obligations under the UN Convention on the Rights of Persons with Disabilities. Since the Expert Group's Report was published in 2015 Ireland ratified the CRPD and the UN Committee on the Rights of Persons with Disabilities have clarified its implications for domestic mental health legislation. It is important to note that State Parties obligations under Article 14 (the right to liberty and security of the person) of the CRPD have been the subject of much debate over the past number of years and have been informing and shaping mental health law reform. The text of Article 14 reiterates the general right to liberty, stating that it cannot be removed unlawfully or arbitrarily. Article 14 specifically provides that "disability shall in no case justify a deprivation of liberty". It was initially thought that Article 14 added little to international human rights law, as disability is not a sole justification for loss of liberty. Rather, the combination of disability with a perception of danger to oneself or to others historically justified deprivation of liberty (subject to legal safeguards). Therefore, it was thought that Article 14 merely required a narrowing of the criteria for loss of liberty. Article 14(2) of the CRPD provides that if persons with disabilities are deprived of their liberty through any process, they are entitled to all the due process guarantees available to others under international human rights law and shall be treated in conformity with the objectives and principles of the CRPD. However, it has emerged that the implications of Article 14 are much more significant than the tightening of the criteria upon which loss of liberty can occur. This understanding of the CRPD was not reflected in the Report of the Expert Group.

The UN Committee on the Rights of Persons with Disabilities has interpreted Article 14 of the CRPD as a key non-discrimination provision that is particularly relevant for persons with intellectual disabilities and mental health issues, who are at increased risk of deprivation of liberty.[1] The Committee, in its guidelines on Article 14, emphatically state that involuntary detention on healthcare grounds violates the absolute ban on deprivation of liberty and the principle of free and informed consent of the person to healthcare under Article 25 of the CRPD. The Committee has consistently stated that States Parties to the CRPD need to repeal provisions that permit the involuntary detention of "persons with disabilities in mental health institutions based on actual or perceived impairments".[2] The Committee has noted that involuntary detention in mental health services results in the denial of legal capacity to make a range of decisions about healthcare, treatment, and admission to a hospital, and as such violates Article 12 (legal capacity / equal recognition before the law) in conjunction with Article 14.[3]

It is important that a greater emphasis is given to the CRPD and its implications are reflected in the reform of the Mental Health Act 2001. The framework provided by the CRPD provides a pathway to moving away from practices, policies and processes that have

[1] See Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities (Geneva: Committee on the Rights of Persons with Disabilities, adopted during the Committee's 14th session, held in September 2015).
[2] Ibid, at para.10.
[3] Ibid.

violated the human rights of persons who come into contact with mental health services and a shameful history of institutionalisation in this jurisdiction. It is essential that the reform of the Mental Health Act 2001 reflects the paradigm shift required by Ireland's ratification of the CRPD and provides an opportunity to leave "behind the legacy of human rights violations in mental health services". [4] The right to the highest attainable standard of health needs to be understood as requiring the cultural shift from paternalism and coercion.

A cultural shift is needed to affect the change in practice required under the CRPD, the Assisted Decision-Making (Capacity) Act 2015, and the Mental Health Amendment Act 2018. This will require training and education and the appointment of supported decision-making champions in all parts of the mental health services. Monitoring and implementation of supported decision-making should be put in place to achieve these goals. The Mental Health Act should seek to implement a coordinated approach with the 2015 Act to ensure a comprehensive system of supports and alternatives to coercion for persons admitted under the Mental Health Act and otherwise to ensure they are able to exercise their legal capacity and are free from coercion and non-consensual treatment on an equal basis with others.

The language in the current Mental Health Act is based on the medical model of disability and needs to be replaced with more inclusive language reflective of the CRPD, the 2015 Act and the social model of disability to reduce stigma. The word 'patient (s)' should be replaced throughout the current Mental Health Act with 'person (s)' in line with the CRPD and the 2015 Act. The terms 'mental disorder' or 'mental illness' should be excluded from the Mental Health Act, and the Act should instead refer to persons admitted for mental health treatment/care or 'persons with psychosocial disabilities' in line with the UN CRPD.

We acknowledge that it is unlikely that revisions to the Mental Health Act 2001 will prohibit involuntary detention and coercion in the shorter term. Therefore, in this submission we make a number of recommendations, which we believe will better protect the human rights of persons who are going to be subject to the provisions of the revised legislation. However, the reform to the legislation needs to lay a solid foundation for the end of coercion in Irish mental health services. A concrete step in ensuring that mental health services would be to allow persons who are admitted to approved centres to be permitted to stay for a period of time if they wish to do so, even if they do not wish to receive the treatment proposed.

A key priority in the revised legislation is to focus on children in the revised Act to avoid the continuation of the after-thought approach, which has been prevalent under the 2001 Act. This would result in a more successful system for continuity of appropriate support children as they become adults.

The Expert Group acknowledged that the 2001 Act does not reflect the need to move away from the "often paternalistic interpretation" of the Act by the courts which is at odds with

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

requirements of the ECHR and the CRPD as well as current policy. In addition the report refers to,

> the significant changes in thinking about the delivery of mental health service such as the shift to community-based services, adoption of a recovery approach in every aspect of service delivery and the involvement of service users as partners in their own care empowering and recovery-oriented approach to mental health service and in the development of the service

We would respectfully urge the Department of Health to consider Dr Lucy Series research on the English Mental Capacity Act and its interaction with the Mental Health Act in response to proposed reforms in England. This research has highlighted the unintended consequences of the more recent reforms of the DOLS system in the newly proposed Liberty Protection Safeguards (LPS) due to come into operation in 2022.[5]

It would be useful for Irish law reformers and policy makers to be able to rule out such risks in the face of the unprecedented legislative changes contained in: the full introduction of the 2015 Act, including the DOLS and the Advance Healthcare Directives, the revised Mental Health Act 2001 and the "Sharing the Vision policy" as well as general healthcare policy. The potential for excellent co-ordination is a real possibility. However, there is a real risk of a fragmented approach.

2. Changes to definitions in the Act

The importance of the Expert Group's recommendations on the definitions in the Act are not so much the removal of various categories, which come within the definition of mental disorder. Rather the importance is the proposed separation of the term 'mental illness' from the criteria for detention. This appears to be a major development and would seek to put an end to the notion that having a mental illness *per se* may be grounds for detention. However, it is not clear if this is what was recommended by the expert group. The report recommends the removal of significant intellectual disability and severe dementia as part of the criteria. The removal of these categories of persons who are subject to the legislation is to be welcomed. However, the retention of a category of persons defined as having "mental illness" is problematical. The Expert Group in their Report recommend that the term "mental illness" should replace the term "mental disorder", regarded by the Expert Group as reflecting a strongly medical model approach. However, it is not clear how mental illness is any less reflective of a medical model approach, which has been dominant heretofore. A definition that singles out persons with disabilities as being subject to involuntary detention and treatment fails to comply with the UN Convention on the Rights of Persons with Disabilities.

[5] Lucy Series article https://thesmallplaces.wordpress.com/2021/03/18/unintended-consequences-of-taking-people-with-learning-disabilities-and-or-autism-out-of-scope-of-the-mental-health-act-1983/

3. Inclusion of guiding principles

The Expert Group believed from the outset that a "substantial shift away from the paternalistic interpretation of mental health legislation by the Courts is required" in order to comply with the ECHR and the CRPD, the "best interests" paradigm must be replaced by the "will and preferences" paradigm.

The guiding principles set out in s. 3 of the Mental Health Amendment Act 2018 (10) have not yet commenced. These guiding principles were deemed necessary, "for the purpose of strengthening the protection of the rights of individuals, both adults and children, who receive inpatient mental health treatment and bringing certain sections of the 2001 Act into line with the Assisted Decision-Making (Capacity) Act 2015." (Dáil Debates 2 May 2017(Second Stage). This legislation will progress Ireland's compliance under international human rights law. One of the most important elements of the guiding principles is their empowering ethos that is embedded, their usefulness in guiding the courts and others who may be involved in making or assisting with difficult decisions. They act as benchmarks against which decision making can be tested. They are also integral to the definition of capacity referenced in s.4(13) of the 2018 (10) Act.

Importantly they mirror those in the 2015 Act including the presumption of capacity for all adults. Included is an innovative principle embracing two themes, one referring to access to health services which aims to deliver the highest attainable standard of mental health and, the second having due regard to the person's right to his/her own understanding of his or her mental health. Section 4(13) cross references s.3 of the ADM Act 2015 stating that capacity has the same meaning in both Acts. Synergy is important for what will be two closely operated laws making them easier to understand and avoiding many of the difficulties that have occurred in the fragmented English system.

3.1 Children

A number of the guiding principles for children in 2018 (10) are similar to those for adults. While the best interests' principle is important for those under 18, due weight must be given to a number of factors, e.g. to the child's views and his or her will or preferences. Linking the similarities of both sets of principles should lead to a more person centred ethos in interpreting the legislation and importantly avoid the current harsh divisions on the age margins of the child into adult services.

The guiding principles reinforce the importance of care in an appropriate environment and the consideration of the proximity to the child's family, the subject of many reports. However, the guiding principles for older children in 2018 (10) do not specify, as recommended, that 16 and 17 years old should have the presumption of capacity and must consent or at least not object to voluntary admission. During the Dáil Debates on 2018 (10) some unconvincing effort was made to explain these omissions from the Expert Group recommendations for the 16/ 17 year olds despite years of campaigning for change. (Seanad Debates 16 May 2018 (Report and Final Stage). This is a lost opportunity to clarify

their rights so that admission and treatment for this group will remain uncertain, difficult and confusing.

4. Changes to the criteria for detention

Despite statements to the contrary the Report of the Expert Group states that mental illness will be a necessary element for the criteria for detention where it is of such a degree or severity. Detention must be "immediately necessary for protection of life", from a serious and imminent threat to health of person or for the protection of others with no alternative for treatment. The current benefit requirement is retained but drops the more easily satisfied "alleviate the condition" aspect. When any of the criteria are not met the order is revoked and the person may only remain as a voluntary patient or receive community services.

The recommendations of the Expert Group did not sufficiently consider the implications of Ireland's obligations under the CRPD. The Expert Group recommended that the criteria for detention would include where it was immediately necessary for the protection of life of the person, for protection from a serious and imminent threat to the health of the person, or for the protection of other persons that he or she should receive such treatment and it cannot be provided unless they are detained in an approved centre under the Act. The UN Special Rapporteur on Health has noted that the notion of "dangerousness" is often grounded on "inappropriate prejudice, rather than evidence".[6] The UN Special Rapporteur also identified that the "proliferation of paternalistic mental health legislation" and the corresponding lack of alternatives has resulted in widespread medical coercion.[7] The justification for the use of coercion is often predicated on both "medical necessity" and/or "dangerousness".[8] These principles are subjective and the UN Special Rapporteur notes that they are not supported by research and their application is open to broad interpretation and raise questions as to their arbitrariness.[9]

While the reference to community mental health services is welcome in the Report of the Expert Group, it is clear that there is inadequate provision of community mental health services. The UN Special Rapporteur notes that the right to health is a powerful guide for States in implementing the "paradigm shift that is recovery and community-based, promotes social inclusion and offers a range of rights- based treatments and psychosocial support at primary and specialized care levels".[10] A right to community mental health services should be provided for in the revised Mental Health Act 2001. This will ensure that alternatives to inpatient services are available and will support the State in meetings in obligations to eliminate coercion in mental health services.

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[6] Dainius Pūras "Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Human Rights Council, June 2017) at page 14.
[7] Ibid.
[8] Ibid.
[9] Ibid.
[10] Ibid, at page 17.

5. Enhanced role for Authorised Officers

Should involuntary detention be retained in the Mental Health Act 2001, the role of the authorised officer (AO) needs to be addressed. The role of the AO has been continuously raised in the Mental Health Commission's Annual Reports, highlighting the failure to meet the potential of the role as an alternative to the family having to make the application for admission, despite various efforts. The number of AOs has remained low and inconsistent throughout the country, despite commitments to train and involve greater numbers. In 2018 there were 1,825 involuntary admissions from the community, 14% were applications for admission by AOs compared with 5% in 2009, a miniscule increase.[11]

The Expert Group recommended a broader role for the AO as a "dedicated and informed mental health specialist."[12] The AO could provide immediate information to a family in a crisis and ultimately, where other more appropriate service are not available, would make the decision to progress an involuntary admission. The intention is that it could lead to a more appropriate and a less coercive approach, more focus on the community alternatives and ensure that involuntary admission was truly a last resort (unlike present day where it's the only resort in many instances). The AO should be the person to sign all applications for involuntary admission to an approved centre with the intention of reducing the burden on the family and reducing the involvement of the Gardai. A more robust approach by the HSE was called for on many occasions to ensure a full distribution of AOs throughout the country. The question of involving peer advocates to carry out some aspects of this role has not been properly addressed and could be a lost opportunity if not.

This is one of the recommendations that stands to make a significant difference to the sensitive areas of potential involuntary admission and is fully supported by the authors of this submission.

6. Interdisciplinary approach to care and treatment

The current approach to mental health care and treatment in Ireland is heavily weighted towards the medical model. An interdisciplinary approach to care and treatment is needed to reflect the social model of disability under the CRPD. Under the social model of disability, a range of interdisciplinary supports are put in place to enable a person to participate in decisions on an equal basis with others. This approach should include mental health professionals from a range of backgrounds including social and psycho-social professions, and the provision of independent trained advocates at all levels of treatment and care. The independent opinion process regarding the making of admission orders, renewal orders; decisions relating to the person's ongoing capacity to consent to admission and treatment/care; including evidence and reports to Mental Health Tribunals should also include individuals from a range of interdisciplinary backgrounds. For example, the responsible consultant psychiatrist should consult with a mental health professional from a different discipline prior to the making of an admission order, and renewal order or in

[11] Mental Health Commission Annual Report 2018
[12] Department of Health, Expert Group Review p34

decisions on the person's capacity to consent to treatment. Ideally, independent second opinions on admission and renewal orders should come from outside the approved centre in which the person is detained. The interdisciplinary approach to care and treatment should also include independent trained advocates (peer or other), who may provide input on the person's will and preference regarding their ongoing treatment and care, or a trusted people close to the person. A person who is subject to an admission or renewal order should have a right to access an independent advocate (outside of legal representation) under the Mental Health Act. Independent advocacy should also be provided to people who are admitted voluntarily to the approved centre.

7. Changes to time limits

We support the revision of timeframes where this enhances the safeguards for the person. This group particularly supports the focus on persons who require support to exercise their decision making capacity and the reduction in the time for the administration of medicine. Treatment should not be given upon admission to an approved centre until all supports have been given to enable the person to consent to or refuse the treatment proposed. Currently, a person can be given treatment without consent if they are deemed unable to consent under the Mental Health Act, and 21 days elapse before the person has a Tribunal to determine whether the involuntary admission meets the criteria for detention and treatment under the Act, during which time they may be treated without their consent if deemed to lack capacity. Treatment should not be given without consent outside of very narrow emergency circumstances where there is an imminent threat to life, and even in these situations consent should be sought with appropriate supports if needed.

8. Enhancing safeguards for individuals (including seclusion and restraint)

The use of seclusion and restraint in mental health services raises serious human rights issues. The UN Committee on the Rights of Persons with Disabilities has called on States Parties to the CRPD to protect the security and personal integrity of persons with disabilities who are deprived of their liberty, including by eliminating the use of seclusion and various methods of restraint in medical facilities, including physical, chemical and mechanic restrains.[13] The Committee has found that these practices are not consistent with the prohibition of torture and other cruel, inhumane or degrading treatment or punishment against persons with disabilities pursuant to article 15 of the CRPD. As such the Mental Health Act 2001 should be amended to prohibit the use of seclusion and restraint for both voluntary and involuntary patients and this should include a prohibition on other forms of restraint such as chemical restraint.

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

9. Mental health tribunals

We note the recommendations of the Expert Group relating to title and power, timing, composition, attendance, role of the independent psychiatrist and oversight. However, the recommended reforms do not go far enough in supporting and safeguarding the rights of persons subject to the mental health legislation. These recommendations are insufficient to make the current tribunals effective in vindicating the rights of persons subject to the Mental Health Act 2001.

The current Mental Health Tribunal process does not adequately protect the human rights of persons admitted under the Mental Health Act. Less than 12 per cent of admission orders are revoked at hearing.[14] Tribunal composition is heavily weighted towards the medical model and professional opinion with little or no multi-disciplinary or advocacy input. The Tribunal decision is highly deferent to the evidence of the responsible consultant psychiatrist, the report of the independent consultant psychiatrist and the opinion of the tribunal consultant psychiatrist. In reality, the opinion of the independent consultant psychiatrist or tribunal consultant psychiatrist rarely deviates from that of the treating responsible consultant psychiatrist and does not provide any real independent input. The "will and preferences" of the person have little bearing on Tribunal members decision in affirming or revoking the admission or renewal order, and presumptions of incapacity are common. The remit of the Tribunal is limited to considering whether the person meets the definition for mental disorder as set out in s.3 of the Mental Health Act. The Tribunal remit needs to be expanded to consider issues such as the 'will and preferences' of the person in relation to their admission, detention, care and treatment in line with the 2015 Act and the 2018 (Amend) Act. If a person wishes to be treated on a voluntary basis without coercion, this wish should be respected, and a system of supports should be put in place to enable a person to be treated in a less restrictive manner regardless of capacity or insight. In Scotland, the tribunal has to consider the content of the person's AHD when making decisions. The person should have access to the support of an independent advocate (outside of legal representation) or other trusted support person at Tribunal hearings. The composition of the Tribunals should be reviewed to include more multidisciplinary, and advocacy input and to place the "will and preferences" of the person rather than medical evidence at the centre of the process. All tribunal members should receive training and education on human rights under the UN CRPD in line with WHO guidance to provide a greater understanding of the impact of coercion, and the need to move towards an alternative system of supports, which places the "will and preferences" of the person at the centre of all Tribunal decisions.

The Act does not provide a right to advocacy services for either voluntary or involuntary "patients". The qualitative research exploring service user's experiences of mental health tribunals indicates the need for greater support.[15] Service users have described their experiences as follows:

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

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

> "a deficit in emotional support at perceived critical time points, including their initial transfer to hospital and before, during, and after their tribunal. In particular, participants who were physically restrained … during their transfer to the hospital recalled that the absence of a familiar person was extremely disconcerting and frightening at this time... A small number of participants … also described feeling scared and anxious about their upcoming mental health tribunal and its potential outcome and described feeling like they had no one to talk to or support them at this time... Whilst this was not the experience of all participants, these participants spoke of the need to have someone to explain the process, help them feel part of the process and someone to talk to about the tribunal process".[16]

It is disappointing that the Expert Group did not make a recommendation in respect of providing advocacy services for adults. The right to advocacy for both voluntary and involuntary persons should be put on a statutory basis.

10. Change of status from voluntary to involuntary

The UN Committee Against Torture referred to the lack of clarity on the regrading of voluntary to involuntary status under the Act as it does not comply with international human rights standards.[17] People who use mental health services perceive the powers in ss 23 and 24 as coercive, used to "persuade" them to remain as voluntary patients and take treatment.

The Court of Appeal in *PL v St Patricks Hospital* stated that any restriction on liberty would be unlawful under Article 40.4.1 of the Constitution unless there was a legal basis for it.[18] The court affirmed the holding power in s.23 requires that the staff must have the opinion that the person has a "mental disorder". The Court held that voluntary patients cannot be prevented from leaving an approved centre except pursuant to the provisions of s.23.

The Expert Group recommended that all voluntary patients being admitted to an approved centre must be fully informed of their rights. This includes their right to leave the approved centre, and this should be the norm. Despite this view the Report has recommended the retention of ss.23 and 24 but without the need to express a wish to leave, but that this power should only be used in exceptional cases.[19] Exceptions inevitably become the norm over time. In effect, ss.23 and 24 mean that any person admitted to an approved centre is never truly voluntary as they can be detained if they express a wish to leave or in view of the expert group recommendations do not express a wish to leave. This widens the net of coercion even further. These holding powers should be replaced with an alternative system of supports for the person and should not be used outside of very narrow defined emergency circumstances where there is an imminent threat to life. The new Vision for Change policy

[16] Ibid.
[17] UN Committee Against Torture 2011 Report to the Irish government
[18] *PL v St Patricks Hospital* [2012] IEHC 15, [2014] 4 IR 385
[19] Department of Health, Expert Review Report 2015 , p55 Rec 73

states that involuntary detention should not be used outside of emergency circumstances, but emergencies need to be defined to prevent widening of the criteria.

A new process is proposed where the AO should consider alternatives and mobilise support for the person and the family where necessary. If the AO believes the person satisfies the criteria for detention and there is no alternative, then they should make an application for a recommendation using the normal procedures as in admission from the community. Since one third of all detentions (600+) arise from the s.24 procedure it is important that appropriate safeguards are in place and the full procedure is used. The Expert Group recommends this approach following the decision in KC.[20] It also recommended that each time s.23 is used even if s.24 is not the Commission should be notified.

The 2018 (10) Act, when commenced, will redefine a voluntary patient as someone who is truly voluntary. Based on the Expert Report a new patient category, the 'intermediate" patient, will be introduced to ensure that people who are not truly voluntary, but do not meet the involuntary admission criteria, can be admitted for care and treatment and have appropriate safeguards for their human rights.[21] It is essential that a right to decision-making support in provided for in the Mental Health Act 2001 to ensure that persons who need support are provided with it.

11. Capacity and advance healthcare directives

11.1 Capacity

The presumption of capacity to make decisions regarding treatment and care is a guiding principle of the Assisted Decision-Making (Capacity) Act 2015. The 2018 (Amend) Act seeks to bring the Mental Health Act 2001 in line with the 2015 Act and strengthen the rights of people who are admitted to approved centres. The principles include a presumption of capacity to make treatment/care decisions and the provision of appropriate supports to make such decisions. The 2018 (Amend) Act replaces the "best interests" with the guiding principles of the 2015 Act which includes respecting the "will and preferences" of the person in all decisions in relation to care and treatment.

The presumption of capacity to make treatment/care decisions needs to be strengthened throughout the Mental Health Act for all persons admitted to mental health services on a voluntary or involuntary basis. This presumption should not be displaced unless all practicable steps have been taken to support the person to make the treatment/care decision in line with the 2015 Act, and the 2018 (Amend) Act. In addition, a person should not be considered unable to make a treatment/care decision by reason of making, having made, or being likely to make an unwise decision in line with the guiding principles. The perceived rationality of a decision along with 'lack of insight' are commonly used to deprive

[20] *KC v St Loman's Hospital* [2013] IEHC 310.
[21] Department of Health, Expert Review Report 2015 -cross ref to s2 and to s29.

people of their liberty and capacity to make treatment decisions in the mental health context even though the research suggests that the vast majority of mental health inpatients have the capacity to make these decisions. A recent Irish study suggested 98 per cent of mental health inpatients had either full capacity (47.4%) or partial capacity (50.7%) to make treatment decisions, compared to 73 per cent of medical inpatients.[22] Where the presumption of capacity is displaced, clear evidence should be provided by a minimum of two treating professionals (one of which should be from a multidisciplinary background) and only after all possible steps have been taken without success to support the person to make the treatment/care decision. In circumstances where it is not possible to determine the person's current wishes regarding treatment/care, the person's past "will and preferences" should be used to inform the treatment/care decision either through an advance healthcare directive, or through an appointed supported decision-maker or designated healthcare representative.

The focus should be on the supports the person needs to make treatment/care decisions rather than deficits in capacity. Capacity determinations are subjective and fraught with complexities. Persons with mental health issues are particularly vulnerable to findings of incapacity even though the research does not support this finding. Where an assessment of supports/capacity is needed to enable a person to make decisions in relation to treatment/care, independent multidisciplinary input should be provided. The person should have the right to appeal any determination on capacity or supports needed to the Mental Health Tribunal. The onus should be on the approved centre to provide the supports necessary to enable a person to consent to admission or treatment/care in accordance with his/her will and preferences and without coercion under the least restrictive care principle set out in the 2018 (Amend) Act. A system of informal and formal supports to enable a person to exercise capacity in relation to treatment/care decisions should be provided for in the Mental Health Act in line with the 2015 Act. Any support provided should be tailored to the needs of the individual. Supports may include providing information in a format the person understands, giving the person time to consider the information, providing access to an independent advocate, the support of a trusted person close to them, or through an advance healthcare directive (AHD). For example-a person may need the support of a decision-making assistant to make decisions in relation to their treatment and care when they are unwell. This does not mean that the person lacks capacity to make treatment or care decisions, but that s/he may need support to make treatment decisions during periods of mental distress. All persons in receipt of mental health services should be supported to develop an advance healthcare directive as part of the discharge/recovery process for any future treatment/care where they may need support to make decisions. The advance healthcare directive should be reviewed on a regular basis particularly after each mental health admission. Under the 2018 (Amend) Act, the person has the right to the least restrictive care. This should include a legal right to be treated as a voluntary patient if the person so wishes to be treated.

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

11.2 Advance Healthcare Directives

Advance healthcare directives (AHDs) are provided for in the 2015 Act for decisions regarding future healthcare treatment in the event the person is unable to communicate or make such decisions. This includes decisions regarding future mental health treatment. AHDs are considered a critical support to enable people to exercise their capacity in treatment/care decisions and avoid the need for coercion and non-consensual treatment under the UN CRPD. The research suggests the process of developing an AHD confers recovery and capacity building benefits for the person.[23] An international systematic review showed AHDs reduced involuntary admissions by 23 per cent.[24] AHDs are also associated with a reduced need for readmission into hospital,[25] and enhanced recovery.[26] This is particularly relevant in the Irish mental health system where 65 per cent of admissions are readmissions.[27]

While AHDs can be made for mental health treatment/care decisions, under Part 8 of the 2015 Act, they are not legally enforceable for persons involuntarily detained under the Mental Health Act. An AHD can be taken into consideration, but it is not legally enforceable in these circumstances. The exclusion of persons detained under the Mental Health Act violates the CRPD as it discriminates on the grounds of disability. Similar legislative provisions were litigated as discriminatory under the American with Disabilities Act in the US in 2003.[28] The Assisted Decision-Making (Capacity) Amend Bill 2019 proposed to remove this exclusion from the 2015 Act. The Bill reached Seanad stage but lapsed with the dissolution of the Dáil in March 2020. This discriminatory exclusion urgently needs to be removed from the 2015 Act. Equal access to AHDS should be provided for in both the 2015 Act and the Mental Health Act. AHDs are a critical support measure which should be made equally available to everyone, particularly those who are involuntarily detained under mental health legislation. The research exploring this area in Ireland suggests that the group who need AHDs the most to increase trust and respect are excluded from the legislation.[29] AHDs should be provided for all persons on an equal basis with others in both the Mental Health Act and the 2015 Act.

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

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

[25] Claire Henderson and others, 'Effect of Joint Crises Plans on Use of Compulsory Treatment in Psychiatry: Single Blind Randomised Controlled Trial' (2004) 329 British Medical Journal 136; Chris Flood and others, 'Joint Crisis Plans for People with Psychosis: Economic Evaluation of a Randomised Controlled Trial' (2006) 333 British Medical Journal 729.

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

[27] There were 17,000 admissions to the Irish psychiatric hospitals in 2018. Antoinette Daly and Sarah Craig, 'Activities of Irish Psychiatric Units and Hospitals 2018', (Health Research Board, 2019).

[28] *Hargrave v State of Vermont*, No.2: 99-CV 128 (2001); Hargrave v State of Vermont, 340 F 3d 27 (2nd Cir 2003).

[29] Fiona Morrissey, 'The Introduction of a Legal Framework for Advance Directives in the UN CRPD Era: The Views of Irish Service Users and Consultant Psychiatrists' (2015) (1) Ethics, Medicine and Public Health 325.

12. Consent to treatment

We note that the recommendations of the Expert group have been partially implemented by way of the Mental Health (Amendment) Act 2015, which is to be welcomed. However, significant additional changes are needed to the Mental Health Act 2001 to bring it into compliance with international human rights law. The right to consent and refuse treatment needs to be strengthened for persons admitted on a voluntary and involuntary basis under the Mental Health Act and linked to the presumption of capacity to make admission/treatment/care decisions with support of needed. The 2018 (Amend) Act affirms that persons admitted on a voluntary basis cannot be given treatment without consent and that persons admitted on an involuntary basis cannot be given treatment without consent except in circumstances where they are deemed to lack capacity to treatment/care decisions. Currently, it is not clear that persons admitted under the Mental Health Act and otherwise have a right to consent to and refuse treatment if they are found 'unable' to consent to such treatment. As mentioned above the research suggests that the majority of mental health inpatients in Ireland have either full capacity (47.4%) or partial capacity (50.7%) to make treatment decisions.[30] Though the term 'unwilling' to consent to the administration of ECT was deleted from the Mental Health Act, 2001 (s. 59 (1) (b)), the reality is that persons can still be administered ECT and other treatments without their consent once their treating psychiatrist and another psychiatrist deem that they are 'unable' to consent. This provides little safeguard for the person or independent input. This, in effect, means that any person who is 'unwilling' to consent can still be given ECT or other treatments, if s/he is found "unable" to consent, even if that person clearly states in advance s/he does not want to have the treatment and/or the family disagrees with it. The assessment of capacity can be subjective, and people are often found to lack capacity to consent when disagreeing with the treatment proposed. Any advance healthcare directive that the person makes in relation to mental health treatment can be taken into consideration but is not legally enforceable if the person is detained under the Mental Health Act, negating this protection. This exclusion affects all persons admitted for mental health treatment due to regrading powers under ss 23 & 24 of Mental Health Act. Even if a person is admitted on a voluntary basis, their status can be changed to involuntary if they express a wish to leave under current legislation, and their treatment wishes set in the advance healthcare directive no longer have to be respected.[31]

The Committee on the Rights of Persons with Disabilities have stressed that States Parties should ensure that the provision of health services, including mental health services are based on free and informed consent.[32] In its General Comment No. 1 on Article 12 the Committee also stressed that States parties have an obligation to require all medical

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

[31] 575 people were regraded from voluntary to involuntary in 2019. https://www.mhcirl.ie/what-we-do/mental-health-tribunals/mental-health-tribunal-statistics/mental-health-tribunal

[32] See Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities (Geneva: Committee on the Rights of Persons with Disabilities, adopted during the Committee's 14th session, held in September 2015) at para 11.

professionals to obtain the free and informed consent of persons with disabilities prior to any medical treatment.[33] The Committee has been unequivocal in stating:

> "in conjunction with the right to legal capacity on an equal basis with others, States parties have an obligation not to permit substitute decision-makers to provide consent on behalf of persons with disabilities. All health and medical personnel should ensure appropriate consultation that directly engages the person with disabilities. They should also ensure, to the best of their ability, that assistants or support persons do not substitute or have undue influence over the decisions of persons with disabilities."[34]

The continued mandate for coercion under the Mental Health Act 2001 through involuntary detention and treatment is hugely problematical. The UN Special Rapporteur on the Right to Health has noted that decisions "to use coercion are exclusive to psychiatrists, who work in systems that lack the clinical tools to try non-coercive options. The reality in many countries is that alternatives do not exist and reliance on the use of coercion is the result of a systemic failure to protect the rights of individuals".[35] Given that the right to health is now understood within the framework of the CRPD immediate action is required to "radically reduce medical coercion and facilitate the move towards an end to all forced psychiatric treatment and confinement".[36]

The recommendations as currently framed in the Expert Group report are insufficient to address the move away from coercion. The Special Rapporteur's recommendations below need to be resourced in parallel to the reform of the 2001 Act in order to deliver deliberate, targeted, and concrete action in safeguarding the right to consent or refuse mental health treatment. The recommendations are as follows:[37]

1. Mainstream alternatives to coercion in policy with a view to legal reform
2. Develop a well-stocked basket of non-coercive alternatives in practice
3. Develop a road map to radically reduce coercive medical practices, with a view to their elimination, with the participation of diverse stakeholders, including rights holders
4. (Establish an exchange of good practices between and within countries
5. Scale up research investment and quantitative and qualitative data collection to monitor progress towards these goals

There should be a statutory provision in the legislation requiring the Mental Health Commission to set targets for implementing alternatives to coercion with the goal of phased elimination over a 5 year period and provisions for monitoring and implementation.

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[33] General Comment No. 1: Equal Recognition Before the Law (article 12) (Geneva: UN Committee on the Rights of Persons with Disabilities, 11 April 2014).
[34] Ibid at para 41
[35] Dainius Pūras "Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Human Rights Council, June 2017) at page 15.
[36] Ibid.
[37] Ibid.

13. Information and individual care/recovery planning

Individual care plans are a key mechanism by which the person's 'will and preferences' regarding their care and treatment are documented and developed. The Mental Health Commission emphasises the importance of individual care planning asserting that the essential dignity, autonomy and right to self-fulfilment of the individual is enshrined most strongly in this area. The 2001 Act regulations require an individual care plan for each resident. Ireland's in-patient mental health units have been consistently non-compliant with regulatory requirements relating to individual care planning suggesting a need to make it a legal requirement. The Expert Group has recommended that individual care/recovery plans be placed on a statutory basis. The Mental Health Commission Inspectorate is particularly concerned with non-compliance due to lack of resident involvement in the planning process. A 2018 inspectorate report found that more than 40 per cent of approved centres were non-complaint with Regulation 15: Individual Care Plans.[38]

The ongoing challenges in providing individual care plans, which are fully participative, person-centred and recovery focused needs to be addressed. Individual care planning is particularly important in light of the 2018 (Amend) Act, which replaces "best interests" in the Mental Health Act with the guiding principles of the 2015 Act, which includes respecting the 'will and preferences' of the person in all decisions including treatment and care. According to the principles, the person in respect of whom the decision is being made shall be permitted, encouraged and facilitated, in so far as practicable, to participate, or to improve his/her ability to participate as fully as possible, in the decision. There needs to be greater understanding of the need to develop individual care plans with the full participation of the person and the provision of appropriate supports to do this. Mental health professionals from a range of multidisciplinary backgrounds and trained advocates should be involved in facilitating care planning with the person. Training should be provided on the importance of meaningful participation in the care planning process to achieve a cultural shift in practice in the area. All persons in receipt of mental health services should have legal right to an individual care plan, which involves their full and active participation including the provision of appropriate support if needed. Support may include providing information in a format the person understands, giving them time to make the decision, providing access to an independent advocate, or talking to a trusted person who can support them to participate in the planning/decision-making process. The individual care plan should also form the basis for the development of an advance healthcare directive. Each person in receipt of mental health services should also be provided with the opportunity to develop an advance healthcare directive with support if needed as part of the recovery/discharge process.

[38] Mental Health Commission, 'Annual Report 2018 Including Report of Inspector of Mental Health Services' (Mental Health Commission, 2018).

13.1 Information

All persons in receipt of inpatient mental health services (on a voluntary or involuntary basis) should have a legal right to information in a format that they can understand. This should include providing information in an accessible easy to read, verbal or visual format. Each person should have a right to support to help them understand information regarding their rights. This support should include providing access to an independent advocate or other trained person who can help the person understand the information. Each person should be fully informed of their rights regarding their admission, care and treatment including the right to consent to and refuse treatment, and the right to the least restrictive form of care. Individuals being treated on an involuntary basis should be informed both verbally and in writing that they may be treated as a voluntary patient if they so wish to be treated as per the Patient Notification Form. The right to be treated as voluntary patient if the person so wishes to be treated should be statutory right under the Mental Health Act in view of the right to the least restrictive form of care principle in the 2018 (Amend) Act.

14. Inspection, regulation and registration of mental health services

It is essential that the registration and inspection of all community mental health services is provided for in the revised mental health legislation. The proposals around a reduction in some inspections in particular contexts, using a risk-based approach seems to be based on best international practice in order to maximise resources and effectiveness. The power to request a "statutory regulation report" prior to attaching conditions to registration is also positive. The recommendation that the Inspector should visit a centre in advance prior to an applicant approved centre being added to the register of approved centres makes sense.[39]. Clearly resources and reframing will be an issue for these recommendations to be fulfilled. There should be a provision inserted into the Mental Health Act that requires the standards developed by the Inspector to embed human rights obligations and ensure that the guiding principles are realised within mental health services.

15. Provisions related to the Mental Health Commission

15.1 Composition

The composition of the Commission should reflect the core area of its work-the reason it exists and have a more inclusive range of people in the 13 members. Best practice indicates that there needs to be more than just two people with experience of mental health services and also family members all of whose experience would be very useful to an otherwise professional loaded body. The Expert Group discussed and made recommendations on the requirements in these circumstances.

[39] Department of Health, Expert Review Report 2015 p103 Rec 147

15.2 Standards

The evidence, if needed, for underpinning standards for community services is no longer avoidable.[40] Continuing reports from the Inspector to the Commission highlight this issue from an enforcement perspective.[41] The evidence of the inadequacy of the system from a human rights perspective has been particularly stark since the Expert Review Report in 2015.

The Rehabilitation and Recovery Report 2018/9 provides examples, where 30 nursing staff are recommended and 3 staff are available and there is little training.[42] The report highlights the key issues-encapsulated in recent quote from the Inspector,

> The majority of people with severe and enduring mental illness are unemployed, have poor education levels, impaired social skills and limited contacts. Many people with serious mental illness also experience poor physical health. The high and continuing levels of burden associated with serious mental illness have prompted mental health professionals, service users and carers to call for widespread systemic change to the way mental health services are delivered, promoting an increased emphasis on shared decision-making, financial, residential and personal independence, and social connectedness…Early access to rehabilitation interventions has been associated with better functional outcomes. [43]

The Inspector's Report on the Physical Health of People with Severe Mental Illness 2019 exposes the stark fact that people in this situation "will typically die between 15 and 20 year earlier than someone without, and that mentally ill people continue to suffer unnecessarily with undiagnosed or poorly managed conditions."[44] Similarly the 2018 Inspections of 24-hour Supervised Residences report and the previous ones continue to highlight the difficulties. [45]

The recommendation on underpinning the standards is fundamental, essential to appropriate services, should be resourced and services legally obliged to meet appropriate standards. Section 51(1)(iii) should be amended to ensure that there is compliance with "all" codes of practice prepared by the Commission.[46]

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[40] Mental Health Commission, Inspector of Mental Health Services reports

[41] Mental Health Commission, Dr Susan Finnerty, Inspector of Mental Health Services, *2018 Inspections of 24-hour Supervised Residences* 2019 available at, https://www.mhcirl.ie/publications/2018-inspections-24-hour-supervised-residences.

[42] Ibid on CHO West.

[43] Mental health Commission, 2019 *Rehabilitation and Recovery mental health services in Ireland*, Dr. Susan Finnerty, Inspector of Mental Health Services, available at, mhcirl.ie/publications/rehabilitation-and-recovery-mental-health-services-ireland-2018/2019…

[44] IMHC, Inspector of Mental Health services Dr Susan Finnerty, *Report on the Physical Health of People with Severe Mental Illness 2019 available at https://www.mhcirl.ie/publications/physical-health-people-severe-mental-illness*

[45] Mental Health Commission, Dr Susan Finnerty, Inspector of Mental Health Services, *2018 Inspections of 24-hour Supervised Residences* 2019 available at, https://www.mhcirl.ie/publications/2018-inspections-24-hour-supervised-residences

[46] Department of Health, Expert Review Report 2015 p83 Rec 145.