Mental Health Commission
Submission
on the
Review of the Mental Health Act 2001

December 2011

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Introduction

The Mental Health Commission welcomes the review of the Mental Health Act 2001 ("the 2001 Act") by the Department of Health and the opportunity to prepare a submission to inform the review. This submission has been informed by our experience of operating the 2001 Act for the past five years. It is largely thematically structured and commences with recommendations relating to government mental health policy *A Vision for Change* and an acknowledgement of cost implications associated with some of the recommendations.

The Commission highlights the position of Wards of Court in mental health services. All Wards of Court should be afforded the protections of an amended 2001 Act and the proposed new capacity legislation.

A Vision for Change

The Commission supports the full implementation of A Vision for Change. We believe that consideration needs to be given to underpinning this policy in legislation. The regulation of mental health services in accordance with Part 5 of the 2001Act focuses on inpatient settings, and the care and treatment provided in such settings.

The Commission would favour the expansion of regulation of mental health services beyond approved centres in keeping with the model of service provision outlined in A Vision for Change. We believe that consideration should be given to expanding the roles of the Mental Health Commission and the Inspector of Mental Health Services in relation to licensing, standard setting and inspection of community mental health services. The approved centres regulations (S.I. No. 551 of 2006), for example, provide minimum standards for inpatient mental health services in accordance with Section 66 of the 2001 Act, however, the Act does not provide a legislative basis for the registration / licensing of community-based mental health services.

We also believe that there is a need to consider broadening the roles of other multi-disciplinary health professionals in the legislation in line with this national policy.

The Quality Framework for Mental Health Services was published by the Commission in March 2007 following a period of extensive consultation. This framework comprises 8 themes and 23 standards for all mental health services in Ireland including community services. The framework however does not have a statutory basis like rules, regulations and codes of practice and is not required to be inspected under Section 52(d).

The Commission carried out a comparative analysis of the Quality Framework for Mental Health Services (MHC, 2007) and A Vision for Change in 2007, and noted significant overlap between

the recommendations enunciated in the national policy and the themes and standards contained in the framework. Therefore, it is suggested that consideration should be given to providing a statutory basis for the standards in the framework in order to deliver on the majority of the recommendations in a Vision for Change.

The MHC recommends the following:

The Commission highlights the position of Wards of Court in mental health services. All Wards of Court should be afforded the protections of an amended 2001 Act and the proposed new capacity legislation.

The regulation of mental health services should be extended beyond approved centres in line with the model of service provision outlined in A Vision for Change.

The Department should consider expanding the registration of mental health services under the Act beyond inpatient services.

Consideration should be given to broadening the role and requirement of the Inspector to inspect community mental health services.

There is also a need to explore broadening the role of other multi-disciplinary health professionals in an amended Mental Health Act.

The possibility of underpinning the Quality Framework with statutory provisions should be explored.

Cost Implications

This submission contains the Commission's views and associated recommendations regarding the 2001 Act. While it must be acknowledged that some recommendations carry cost implications, notably the revision and expansion of the role of authorised officer, mental health tribunals and recommendations in relation to children, the Commission strongly believes that such changes are required in order to provide mental health services which are in keeping with international human rights principles and appropriately safeguard the welfare and interests of those using mental health services in Ireland.

The Mental Health Commission

The Mental Health Commission is an independent statutory body established in 2002 under Part 3 of the Mental Health Act 2001. The Mental Health Commission consists of members as follows:

Members of the Mental Health Commission

Section 35 of the 2001 Act provides that the Commission shall consist of 13 members who shall be appointed by the Minister. The term of office for a member of the Commission is five years and members are eligible for re-appointment (Section 36). The current term of office expires on the 4th April 2012.

Members are appointed by the Minister following nomination to carry out the role of a member of the Mental Health Commission and exercise governance over the executive of the Commission. It is therefore important that the independence of representation of members is upheld. It is suggested that membership of the Commission should reflect the full spectrum of multi-disciplinary mental health professionals including occupational therapists. Persons with financial expertise and representation of youth mental health should also be considered for membership of the Commission.

Consideration of a 'phased standing down' of members of the Commission would further enhance governance of the Commission. For example, a fifty per cent rotation of members every two and a half years.

The MHC recommends consideration of the following:

The composition of the Mental Health Commission should be reviewed in line with the future development of mental health services.

The composition of the Commission should ensure the independence of representation is upheld.

Membership of the Commission should be limited to two terms and there should be a mechanism for staggering '*standing down*' of members so that 50% of members change every 2.5 years.

Functions of the Commission- Section 33(1)

The principal functions of the Commission as specified in Section 33(1) are "*to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of those detained in approved centres under this Act."* The Commission has the power to regulate both statutory and independent sector providers.

Under Section 33(3) (e), the Commission shall prepare codes of practice "*for the guidance of persons working in the mental health services*". The Commission is aware that this provision limits the ability of the Commission to provide guidance to other groups who play a role in the delivery of mental health services but who are not working in the mental health services.

The MHC recommends consideration of the following:

The functions of the Commission should be extended to protect the interests of all those using mental health services.

Consideration should be given to extending Section 33(3) (e) to include persons carrying out functions under the 2001Act.

Title of Act

The Act's long title primarily refers to its purpose as providing for the involuntary detention of people with mental disorders and the establishment of the Mental Health Commission and the Office of the Inspector of Mental Health Services. The Commission believes that this title should be expanded to reflect changes recommended to the legislation.

The MHC recommends the following title:

This is an Act that provides for the best possible care and treatment for persons with mental illness in line with the guiding principles of a modern mental health service as outlined below. Everything in this Act should respect and safeguard the human rights of all persons in receipt of a mental health service.

Key Terms and Guiding Principles

Interpretation – Section 2

Section 2 of the Act defines a number of key terms that are central to an understanding of the Act. Other definitions are however also included in later sections of the Act.

The MHC recommends consideration of the following:

It is the Commission's view that all definitions should be set out at the start of the Act for ease of reference and understanding. New definitions and legislation that amended the 2001 Act should be included in any revision to the 2001 Act.

Authorised Person

Sections 13 and 26 of the 2001 Act have been amended by the Health (Miscellaneous Provisions Act) 2009 by providing for an authorised person. The terms 'authorised officer' (Section 9) and 'authorised person' (Section 13) are referred to in the 2001 Act and may cause confusion. It is suggested that consideration is given to changing the term 'authorised person'.

The MHC recommends consideration of the following:

The definition of authorised person which was introduced to the 2001 Act by amendments made in the Health (Miscellaneous Provisions Act) 2009 needs to be incorporated directly into an amended Mental Health Act.

Changing the term 'authorised person' to avoid confusion with 'authorised officer'.

Civil Partner

Section 98 of the Civil Partnership and Certain Rights and Obligations of Cohabitants Act (2010) has since amended a number of sections of the 2001 Act e.g. Section 2(1), 9(1)(a), 9(2)(b), 9(2)(f), 9(8), 10(3)(c), 14(3)(a), 24(1).

The MHC recommends consideration of the following:

The amendments to the Mental Health Act 2001 as outlined in Section 98 of the *Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010* need to be incorporated directly into an amended Mental Health Act.

Consultant Psychiatrist
Section 2 of the Act defines the term consultant psychiatrist.

The MHC recommends consideration of the following:

Any amendment to the term consultant psychiatrist should take cognisance of the provisions of Medical Practitioners Act 2007.

Examination
The definition of examination is currently limited in scope in that it only relates to a recommendation, an admission order or a renewal order.

The MHC recommends consideration of the following:

The definition of examination is currently limited in scope and consideration should be given to redefining it to also include therapeutic benefit to the patient.

Mental Health Service
Section 2 of the 2001 Act defines mental health services as *"services which provide care and treatment to persons suffering from a mental illness or a mental disorder under the clinical direction of a consultant psychiatrist".*

The MHC recommends the following:

Consideration should be given to providing a definition for '*clinical direction'*.

Patient

The legal definition of patient in the 2001 Act differs from the common use of the word patient which refers to a person who is receiving health care and treatment. An involuntary patient would more accurately reflect the specific meaning given to the term at present.

Furthermore, the meaning of the term patient is modified in a number of sections in the Act, e.g. Section 26, 27 and 69. This may cause confusion for service users receiving care and treatment and those carrying out functions under the 2001 Act.

The MHC recommends the following:

Consideration should be given to amending the 2001 Act to identify "*a person to whom an admission order or renewal order relates*" as an involuntary patient.

Voluntary Patients

The current definition of voluntary patient does not reflect the everyday usage of the term voluntary as someone who freely consents to their own admission. It also does not distinguish between patients who have the capacity to consent and a category of residents in approved centres who are "*incapacitated compliant patients".*

Both the High Court and Supreme Court have considered the definition of a voluntary patient. In **EH -v- St Vincent's Hospital and MHT [2009] 3 IR 774 (SC), [2009] 2 ILRM 149 (HC).**

The issue of "*incapacitated compliant patients*" was addressed in the Bournewood case i**.e. HL v United Kingdom (2004)** which was heard at the *European Court of Human Rights*.
It is suggested that a category of 'informal admission' to reflect this status is considered.

The MHC recommends consideration of the following:

The definition of voluntary patient should be reviewed and revised to reflect those who have capacity to consent and freely do so. This is in line with the Human Rights Commission's (2011) recommendations.

The 2001 Act or capacity legislation should be amended to provide appropriate safeguards for the incapacitated compliant patient. There is a need for synergy between both mental health legislation and capacity legislation.

Treatment

Section 2 of the Act defines treatment in relation to patients only. No provision regarding treatment for other categories of persons is included in the legislation.

Case Law

The High Court has recently considered if the law provides "*for a broad reading of treatment when those treating a patient conclude she cannot consent*" i.e. **HSE -v- X (APUM) [2011] IEHC 326.**

The MHC recommends consideration of the following:

The definition of treatment may need to be revisited following consultation in light of the judgment in HSE -v- X (APUM), (2011).

The definition should be expanded so that it is made clear that treatment applies to all categories of persons receiving care and treatment i.e. not only those with a mental disorder.

Clinical Director

The 2001 Act allocates a number of key roles to the clinical director of the approved centre. In certain sections of the Act such as Section 13 (2), the possibility of the Clinical Director being unavailable is acknowledged by also including a reference to "*a consultant psychiatrist acting on his/her behalf*". However, the 2001 Act did not include this provision in all sections of the Act that makes reference to a clinical director. It is suggested that consideration be given to amending the following sections of the 2001 Act accordingly: Section 10 (4), Section 14, Section 20(1) & (2), Section 21 (1) & (2) & (3), Section 22 (1) and Section 72 (5).

The MHC recommends consideration of the following:

Section 10 (4) of the 2001 Act and relevant other sections should be amended such that whenever there is a reference to the Clinical Director that it also states "or consultant psychiatrist acting on his/her behalf".

Mental Disorder – Section 3

The standard of proof required to conclude that a person is suffering from a 'mental disorder' was considered in **M.R. –v- Cathy Byrne and MHT [2007] 3 IR 211.** In this case the Court following the decision in **Goodren and St. Otteran's Hospital [2005]3IR** adopted a purposive approach to the construction of the 2001 Act. The Court stated that the 2001 Act may be regarded as *"…. As of a paternal character, clearly intended for a care and custody of persons suffering from mental disorder."*

The definition of mental disorder within Section 3(1) was commented on in particular in relation to the (a) and (b) components. The Court stated;

> *" I am quite satisfied that these two bases are not alternative to each other and indeed it would be probable in my view that in a great many cases of severe mental illness there would be a substantial overlap between the two. Thus it would be very likely in my opinion that in a great many cases in which a person could be considered to fall within the categorization in Section 3 (1) (a) that they would also be likely to fall within Section 3(1) (b)."*

The Court examined the various elements of the component parts of what constituted 'mental disorder' and the relevant extracts from the judgment are replicated below.

Firstly in relation to the standard of '*serious likelihood*' in Section3 (1) (a) the Court held that:

> *"Insofar as Section 3(1)(a) is concerned the threshold for detention in an approved centre by way of either an Admission Order or as in this case a Renewal Order is set high. There must be a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons.*
>
> *In the course of argument in this case it became common case that the standard of "serious likelihood" was said to be higher than the ordinary standard of proof in civil actions namely balance of probability but somewhat short of certainty.*
>
> *In my view what the Act envisages here is a standard of proof of a high level of probability. This is beyond the normal standard of proof in civil actions of "more likely to be true", but it falls short of the standard of proof that is required in a criminal prosecution namely beyond a reasonable doubt and what is required is proof to a standard of a high level of likelihood as distinct from simply being more likely to be true."*

The Court then considered what is meant by the word '*immediate*', as follows:

> *"The harm apprehended must in the first instance be "immediate". This presents obvious difficulties of construction, in the context of mental illness, because of the unpredictability of when the person concerned may cause harm either to themselves or others.*
>
> *In my view the critical factor which must be given dominant weight in this regard is the propensity or tendency of the person concerned to do harm to themselves or others. If the clinicians dealing with a person concerned are satisfied to the standard of proof set out above that that propensity or tendency is there then in my view, having regard to the unpredictability of when the harm would be likely to occur, the likelihood of the harm occurring would have to be regarded as "immediate.""*

The Court then considered what constitutes "*serious*" and '*harm*' and held as follows:

> *'The word "harm" is a very general expression and clearly its use is intended to encompass the broadest range of injury. Thus physical and mental injury are included.*
>
> *The term "serious" is somewhat more difficult to fully comprehend. In this regard it may very well be that a somewhat different standard would apply depending upon whether the harm was inflicted on the person themselves or on others. Clearly the infliction of any physical injury on another could only be regarded as "serious" harm, whereas the infliction of a minor physical injury on the person themselves could be regarded as not "serious".*
>
> *Thus assaults directed at others, which had the potential to inflict physical injury, could be considered to fall within the ambit of the term "serious". Behaviours on the part of a person suffering from mental illness, dementia or disability, where there was a serious likelihood of these behaviours resulting in serious actual physical injury to the person concerned, should rightly be regarded as "serious" harm. Where the likely end result of these behaviours was merely trivial injury, it would not or should not, normally be regarded as constituting "serious" harm for the purposes of Section 3(l) (a.).'*

The Court examined the requirements of Section3 (1) (b):

> *'This brings me to Section 3(1) (b*). *In my view it is appropriate to take the two parts of this subsection together namely (b) (i) and (ii). Between them they establish three essential elements which must be present before "mental disorder" under this provision is established. These are as follows:*
>
> *(1) the severity of the illness mental, disability or dementia must result in the judgment of the person concerned being impaired to the extent that failure to admit the person to an approved centre is likely to*

(2) lead to a serious deterioration in his or her condition or prevent the administration of appropriate treatment that can be given only on such admission and

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

These elements in Section 3(1) (b) (i) and (ii) are in my view clear and self explanatory. It is perhaps worth drawing attention to the fact that in 3(l) (b) (i) there are alternative provisions, namely that or the failure to admit to an approved centre be likely to lead to a serious deterioration in the condition of the person or that the failure to admit into an approved centre would prevent the administration of appropriate treatment that could be given only by such admission."

The Commission supports an amendment to the Act to reflect this Court decision. The Commission suggests that consideration be given to amending Section 3(1) (a) such that the terms "*serious likelihood*" and "*immediate and serious harm*" are defined. The Mental Health Commission has revised the relevant specified forms accordingly.

The Commission is of the view that significant intellectual disability should not remain as one of the criteria for mental disorder. This does not preclude the involuntary admission of persons with intellectual disabilities to approved centres where they meet the criteria for mental disorder because of co-morbid mental illness or severe dementia. Data returned to the Commission show that between November 2006 and the end of 2010, only 0.5% of orders revoked by responsible consultant psychiatrists (where a discharge diagnosis was returned to the Commission) were of persons with intellectual disability.

The MHC recommends the following:

Consideration should be given to an amendment of Section 3(1) of the Act to reflect the judgment in MR -v- Cathy Byrne and MHT [2007] 3 IR 211 (2007) such that 3(1)(a) and 3(1)(b) are not alternative to each other.

Consideration should be given to defining the terms "serious likelihood" and "immediate and serious harm".

Consideration should be given to amending Section 3(1) to exclude significant intellectual disability from the definition of mental disorder.

Best Interests – Section 4

Section 4 of the 2001 Act outlines the best interests' principle and other guiding principles to be considered when making a decision under the Act concerning the care or treatment of a person. *"Best interests"* is identified as the "*principal consideration*", which causes difficulty in determining what is the nature of the "*due regard*" that should be given to the other principles identified in Sections 4(2) and 4(3). It is suggested that consideration be given to re-naming this section *Guiding Principles* to highlight that there are a range of principles in addition to best interests that apply to decisions taken under the Act.

It is suggested that consideration be given to moving the additional principles specified in section 4(3) to section 4(1) so that they are given greater priority., The Commission supports the inclusion of ten additional principles in this section of the Act which mirror those set out in the *Mental Health (Care and Treatment) (Scotland) Act 2003*. These ten principles are as follows:

- Non-discrimination
- Equality
- Respect for diversity
- Reciprocity
- Informal care
- Participation
- Respect for carers
- Least restrictive alternative
- Benefit
- Child welfare**.**

The Commission believes that it is essential that the revised legislation includes a definition of "*best interests*". Advanced Directives should form part of the definition. The best interests principle has been interpreted in a number of court cases, including **MR -v- Cathy Byrne and MHT [2007] 3 IR 211**, and **T.O'D -v- Kennedy, Central Mental Hospital, HSE and MHC [2007] 3 IR 689.**

Interpretation of the 2001 Act has been perceived as paternalistic and is at odds with the person-centred ethos of current mental health policy as reflected in *A Vision for Change* (Department of Health and Children, 2006).When defining best interests, consideration should be given to:

- The recommendations of the UK Richardson Committee Report (UK 1999), which favoured a definition of best interests which "*gives priority to the assumed wishes of the patient as far as they are ascertainable*".

The MHC recommends the following:

Consideration should be given to re-naming Section 4 of the Act "*Guiding Principles*" to clarify that there are additional important principles other than best interests which must be considered by those taking decisions under the Act.

The additional principles which are identified in Section 4(3), including autonomy, should be given greater priority than they are at present. This could be achieved by moving them from the last subsection to a more prominent place in Section 4.

Ten new principles should be considered for inclusion in the Act. They are the principles of non-discrimination, equality, respect for diversity, **reciprocity**, **informal care**, **participation, respect for carers**, **least restrictive alternative**, **benefit and child welfare**.

"*Best interests*" should be defined within Section 4. Advanced Directives should form part of the definition.. The definition should be consistent with the principles of *A Vision for Change* and the rights based approach to people with disabilities expressed in the UN Convention on the Rights of Persons with Disabilities.

There needs to be a compatible approach between capacity legislation and a revised Mental Health Act in relation to best interests.

Involuntary Admission of Persons (Adults) to Approved Centres

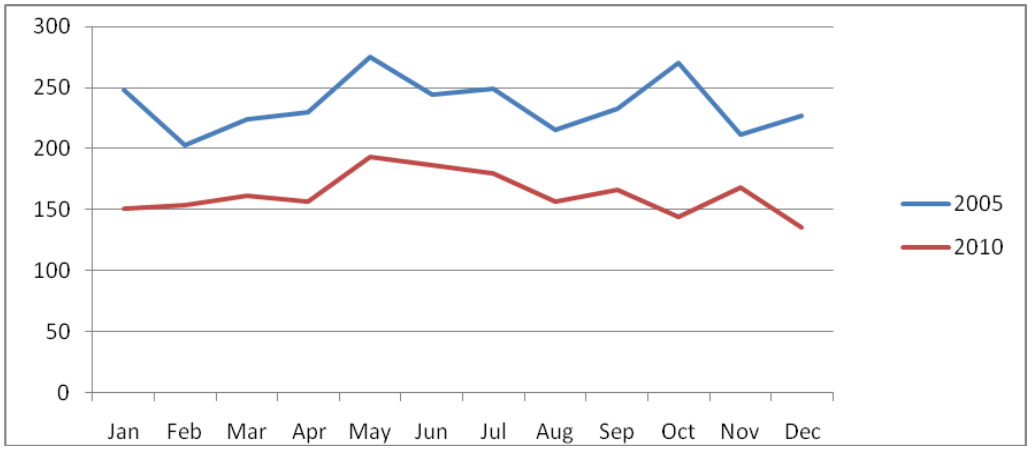
Background

Part 2 of the Mental Health Act 2001 was commenced on the 1 November 2006, following close cooperation and liaison between the Department of Health and Children, the Health Service Executive and the Mental Health Commission. This Part provide for the involuntary admission of persons to approved centres and an independent review of detention. An overview of involuntary admission activity from 2005, just prior to the full commencement of the 2001 Act, until 2010 is provided followed by recommended amendments to those sections within Part 2 of the Act.

Overview of Involuntary Admission Activity

A comparison of involuntary admission activity under the 2001 Act with activity under the *Mental Treatment Act 1945* highlights that there has been an overall decrease of 31% in involuntary admission activity between 2005 and 2010. There were 2,830 involuntary admissions in 2005, compared to 1,952 in 2010. This is based on a comparison of monthly involuntary admission orders made in 2005 under the *Mental Treatment Act 1945* with monthly involuntary admission orders (Form 6 and Form 13) made in 2010 under the 2001 Act. This analysis is shown in Figure 1 below. This suggests that the changes introduced to involuntary admission procedures through the 2001 Act have played a role in reducing the number of involuntary admissions in Ireland.

FIGURE 1: COMPARISON OF TOTAL INVOLUNTARY ADMISSION ORDERS 2005 AND 2010



There has also been a slight decline in involuntary admission activity under the 2001 Act between 2007 and 2010 as can be seen in Table 1 below. There were 1,406 involuntary

admission orders (Form 6) in 2010 compared to 1,503 orders in 2007. There were also 623 detentions (regrading) of voluntary patients in 2007 compared to 546 such detentions in 2010. Similarly, the number of renewal orders has fallen from 1,296 in 2007 to 1,102 in 2010.

Table 1: INVOLUNTARY ADMISSION (ADULTS) 2006 TO 2010

	NOV/DEC 2006	**2007**	**2008**	**2009**	**2010**
Form 6, *Involuntary Admission Order*	207	1,503	1,420	1,434	1,406
Form 13, *Certificate & Admission Order to detain a Voluntary Patient (Adult)*	105	623	584	590	546
Form 7 Renewals Orders	115	1,296	1,324	1,163	1,102
Form 11 Proposal to Transfer to CMH	1	21	10	7	2
Form 14 Revoke before hearing by RCP	249	1,444	1,290	1,376	1,347

Pre-Admission Process

Applications, Role of Authorised Officers and Role of Gardai – Sections 9 & 12

Section 9 outlines the different categories of persons who are permitted to make applications to have a person involuntarily admitted to an approved centre and has since been amended by the *Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010* (See Interpretation – Section 2).

The 2001 Act provide for applications to be made by specific employees of the HSE known as '*authorised officers'*. Research on applicants by the Commission and the Health Research Board on the pathways into involuntary admissions (MHC/ HRB 2004) in 2002 i.e. under the *Mental Treatment Act 1945* showed that 76% of applications were carried out by a relative, 7% by a health board official, 9% by members of the Gardai, and 5% by others.

The Commission has analysed data relating to the categories of persons who have applied for a person to be involuntarily admitted under section 9 of the 2001 Act. These data cover the four year period from 2007 to 2010 and are shown in Table 2.

TABLE 2: ANALYSIS OF APPLICANT: INVOLUNTARY ADMISSIONS 2007 -2010 (ADULTS)

		2007	2008	2009	2010
Form Number	**Type**	**Number (%)**	**Number (%)**	**Number (%)**	**Number (%)**
1	Spouse/Relative	1,034 (69%)	908 (64%)	886 (62%)	852 (61%)
2	Authorised Officer	102 (7%)	65 (5%)	84 (6%)	97 (7%)
3	Garda Síochána	235 (15%)	324 (23%)	324 (23%)	324 (23%)
4	Any other Person	132 (9%)	123 (9%)	140 (10%)	133 (9%)
	TOTAL	**1,503 (100%)**	**1,420 (100%)**	**1,434 (100%)**	**1,406 (100%)**

The table shows that the majority of applications are still undertaken by family members (i.e. a spouse or relative) although there has been a fall in the proportion of applications undertaken by family members compared to the MHC/HRB 2002 research (61% in 2010 versus 76% in 2002). Furthermore, the proportion of applications carried out by a spouse or relative has fallen each year since the full commencement of the Act from 69% of applications in 2007 to 61% of applications in 2010. While we might expect that the rate of applications by authorised officers might therefore have increased, it has been disappointingly low in all years and has never been more than 7% of the total.

The proportion of applications carried out by Gardai has been 23% in each of the years from 2008 – 2010 and is an increase from the 9% of applications carried out by Gardai in 2002. The "*any other person*" category highlighted in Table 2 above has typically included health or care staff, friends, partners, prison staff, business professionals and relatives.

The Commission is of the view that consideration should be given to prioritising applications made by authorised officers and that applications by any other category of person, i.e. spouse/relative, or "any other person" should be considered if an authorised officer is not available. As a member of An Garda Siochana may make an application pursuant to section 12 it is suggested that consideration be given to removing a garda as an applicant pursuant toSection 9 of the 2001 Act.

The Commission supports an expanded role for authorised officers within any proposed amendments to the legislation. Consideration should be given to specifying a requirement that Authorised Officers must be qualified mental health professionals. The definition of Authorised Officer Section 9(8) may need to be reviewed to make provision for appointment of authorised officers by mental health service providers other than the Health Service Executive.

The Commission recommends that consideration be given to a role for an authorised officer in relation to Section 12. Section 12(2) provides that where a member of an Garda Siochana takes a person into custody under subsection (1) he/she or another member of the force ***shall make an application forthwith***. It is suggested that consideration be given to specifying an outer time limit within which the application must be made. Where an application is not made within such a time period, the person should be released from custody.

The MHC recommends the following:

Consideration should be given to:
Amending Section 9 such that a hierarchy of person who can make applications is established with an authorised officer the first-mentioned applicant.

Removing reference to a member of the Garda as an applicant from Section 9 of the Act.

Defining the role of an Authorised Officer.

Making provision for mental health professionals as authorised officers within the Act and Regulations made thereunder (S.I. No. 550 of 2006).
Extending the appointment of Authorised Officers outside of the HSE.

Prescribing an outer time limit within which an application must be made under Section 12.

Removal of Persons to Approved Centres

Section 13(1) currently provides for the applicant to arrange for the removal of the person to an approved centre once a recommendation has been made in respect of that person. Section 13 (2) refers to where an applicant is unable to arrange for the removal of the person concerned the Clinical Director or consultant psychiatrist acting on his or her behalf, shall at the request of the registered medical practitioner who made the recommendation arrange for the removal of the person to the approved centre by members of the staff of the approved centre or by authorised persons.. It is suggested that consideration be given to amending this section to permit an authorised officer to arrange for the removal of the person to the approved centre without recourse to the clinical director.

The Commission recommends that within Section 13 explicit reference be made to a requirement for persons responsible for the removal of the person to an approved centre to respect the human rights and dignity of the person and adhere to the guiding principles underpinning an amended 2001 Act.

Section 13 of the 2001 Act was amended by the Health (Miscellaneous Provisions Act) 2009 to provide for the removal of persons to approved centres by persons other than staff of the approved centre i.e. "*authorised persons*". It is suggested that this amendment should be incorporated directly into an amended Mental Health Act. The terms "*authorised persons*" and "*authorised officer*" are similar and it suggested that consideration be given to changing one of the terms to avoid any possible confusion. (See definitions section).

The MHC recommends the following:

The Commission suggests consideration of an amendment to Section 13(2) to permit an Authorised Officer to arrange for the removal of the person concerned to the approved centre without recourse to the clinical director.

It is suggested that explicit reference be made within Section 13 for 'removal of persons' to be effected in a manner that respects the human rights and dignity of the person and be guided by the proposed revised guiding principles.

Consideration should be given to using a term other than "authorised person" to describe those who can arrange for the removal of persons to approved centres in order to minimise any potential confusion between the terms "authorised officer and "authorised person".

Provision of Information

Section 16 sets out certain written information that must be provided to the patient by the consultant psychiatrist who made the admission or renewal order not later than 24 hours after the making of the order. The importance of the current statutory requirement to provide information to the patient was stressed in **the Supreme Court in MD -v- St Brendan's Hospital, MHC and MHT [2007] IESC 37.**

The Commission is of the view that patients have the right to be provided with information much earlier in the admission process than is required at present. Ideally, this should occur once an application has been made to have a person involuntarily detained. Furthermore, information should be revisited thereafter during the involuntary admission to ensure understanding. The need to provide information to voluntary patients is addressed in a later section.

The requirement to provide information exists in order to ensure that persons understand what is happening to them and what their rights are. Providing written information will not always ensure that these goals are achieved as this format will not be accessible to all service users. The provision of information in different formats is therefore recommended.

The MHC recommends the following:

Consideration should be given to amending the 2001 Act such that there is a requirement to provide information to persons once an application has been made to have them involuntarily admitted to an approved centre unless it is prejudicial to the persons mental health, well-being or emotional condition. There should also be a requirement to provide information to involuntary patients thereafter and to revisit and discuss these rights with him/her during his/her stay to ensure understanding.

It is suggested that the 2001 Act should be amended to require that information must be available and provided in different formats i.e. "orally" as well as in written format to ensure understanding.

Renewal Orders – Section 15

Under the 2001 Act the detention period for an admission order lasts for 21 days, then may be extended for periods no longer than up to three months, up to six months and thereafter periods of up to 12 months, referred to as renewal orders in section 15. In 2010, there were 841 renewal orders in the up to three month category, 135 in the up to six month category and 126 in the up to twelve month category. The up to 12 month period is a particularly long period during which patients only have one tribunal hearing to review their detention. The Commission supports limiting the maximum time period for which renewal orders can be made to 6 months.

It is suggested that Section 15(2) is amended to clarify that a renewal order only becomes effective after the expiry of the previous admission order or renewal order. This issue has been addressed in two cases which have come before the courts i.e. **MD -v- St Brendan's Hospital, MHC and MHT [2007] IESC 37,** and **AMC -v- St Luke's Hospital Clonmel [2007] 2 IR 814**,..

In order to ensure that an adequate period of time elapses between the review of a patient's detention made using an admission order and the review of the same patient's extended detention made using a renewal order, Section 18(2) would also need to be amended. It needs to provide that a mental health tribunal hearing to review the renewal order only takes place within 21 days of the effective date of the renewal order as provided for in Section 15(2).

The MHC recommends consideration of the following:

Amendment of the 2001 Act to delete renewal orders of up to 12 months.

Amendment of Section 15 (2) to clarify that a Renewal Order only becomes effective after the expiry of the Admission Order or the previous Renewal Order with the use of the following words: "***and such renewal order shall only come into effect on the expiration of the time period provided for in the previous order be it an admission or renewal order".***

Amendment of Section 18 (2) to read as follows: "A decision under subsection (1) shall be made as soon as may be but no later than 21 days after the making of the Admission Order concerned or*, *21 days from the effective date of the Renewal Order as provided for in Section 15 (2)".*

Review by a Mental Health Tribunal- Sections 17-19 and 48-49

Within 21 days of the making of an admission (or renewal) order, a three person mental health tribunal consisting of a barrister or a solicitor as chair, a consultant psychiatrist and a person other than the aforementioned persons or a registered medical practitioner or a registered nurse, shall review the admission (or renewal) order. Over 8,100 mental health tribunal hearings took place between November 2006 and December 2010.

One of the Commission's key roles in relation to involuntary detentions is to refer the matter to a mental health tribunal to undertake such reviews. However, the wording of Section 17(1) at present states that upon receipt of an admission order or renewal order, the Commission shall "*refer the matter to a tribunal*". The Commission supports an amendment to Section 17 (1) which clarifies that its role is to "*appoint a tribunal*". This amendment should also clarify that the purpose of appointing a tribunal, assigning a legal representative to represent the patient concerned and arranging for an independent report to be carried out by an independent consultant psychiatrist, is to ensure that the review by a tribunal is completed within the required time period.

Currently, the report prepared by the independent consultant psychiatrist based on the requirements of Section 17(1) which is provided to the tribunal and the patient's legal representative is not based on any input from other members of the patient's multidisciplinary team apart from the responsible consultant psychiatrist (RCP). The Commission suggests consideration of an amendment to Section 17(1) (c) to require the independent consultant psychiatrist to consult with at least one other member of the multidisciplinary team in addition to the RCP when preparing his or her report. This input would support the integrated multidisciplinary approach to care and treatment which is one of the central principles underlying *A Vision for Change*.

During the earlier years of the operation of the tribunal system, some legal representatives reported difficulty in accessing the assigned patient's medical records in the absence of the patient's consent. This was addressed in **EJW v. Watters [2008] IEHC 462.** The Commission supports an amendment to the Act to reflect the decision in this case. Such an amendment must ensure the legal representative's right of access to the medical records of assigned patients lacking capacity to consent.

While patients are represented by a legal representative at a mental health tribunal hearing, they do not have the right enshrined in the 2001 Act to have a family member, carer, advocate or friend accompany them to the tribunal. Service user representative groups have reported that this would be a very welcome development for patients who can find the tribunal experience to be a daunting one. The Commission supports such an amendment which should be accompanied by

an appropriate clause to require people nominated in such a way to uphold the confidentiality of matters discussed at the tribunal hearing.

The Commission does not have the power to adequately appraise the quality of mental health tribunal reviews by appointing appropriately qualified appraisers who would compile anonymised reports on selected mental health tribunals. The Commission supports an amendment to this effect which is consistent with its statutory duty to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission also supports an amendment such that there is a requirement to specifically restate the proposed newly defined guiding principles within both Sections 17 and 18.

"A tribunal shall hold sittings for the purpose of a review by it under the 2001 Act and at the sittings may receive submissions and such evidence as it thinks fit" (Section 49(1)). The Commission is of the view that this clause should be enhanced by the addition of "*in line with fair procedures*".

The MHC recommends consideration of the following:

Section 17(1) be amended as follows: "*Following the receipt by the Commission of a copy of an admission order or a renewal order, the Commission shall, arrange for the following to be done to ensure that the review by a tribunal is completed within the required time period – "appoint a Tribunal ….."*

Section 17 be amended to clarify that the patient's legal representative should have the right to review the medical records of a patient who lacks capacity to consent to such provision at the approved centre to reflect the judgement in the EJW v. Watters [2008] case.

Consideration should be given to requiring an amendment to Section 17(1) (c) such that the independent consultant psychiatrist must consult with at least one other member of the patient's multidisciplinary team in addition to the RCP when preparing his or her report.

Amendment of Sections 18 and 49 of the Act should be considered to clarify that a patient for whom a tribunal hearing is scheduled should have a right to nominate one person to accompany him or her to the tribunal. This amendment should be accompanied by an appropriate confidentiality clause.

Amendment of the 2001 Act to allow the Commission to appoint appropriately qualified

appraisers who would compile anonymised reports on selected mental health tribunals as part of a system of appraisal. This amendment should include appropriate linkage with Section 48 (9) which provides for the removal of persons from membership of the tribunal.

The proposed newly defined guiding principles should be restated within Sections 17 & 18 of the Act.

Section 49 (1) be amended such that the provisions is enhanced by the addition of "in line with fair procedures".

Appeal to Circuit Court - Section 19

The Oireachtas recognised the importance of offering patients whose detentions were upheld by mental health tribunals an appropriate appeals mechanism. Section 19 makes provision for an appeal to be made to the Circuit Court. 201 appeals were filed in the Circuit Court between November 2006 and the end of 2010 and no decision of any mental health tribunal has been overturned. This may be linked to the very limited grounds for appeal which are currently specified in the Act. Section 19 should be reviewed to ensure patients have access to a robust appeals mechanism.

The MHC recommends the following:

Consideration should be given to reviewing Section 19 of the Act in order to ensure that it offers patients a robust appeals mechanism.

Transfer to Central Mental Hospital - Section 21

In the period 2007 to 2010, the Commission received 40 proposals to transfer a patient to the Central Mental Hospital. However, data collected by the Commission (see Table 1 – page 16) show that there have been fewer proposals to transfer in more recent years. There were 21 proposals in 2007, and only 2 such proposals to transfer patients to the Central Mental Hospital were considered by mental health tribunals in 2010.

When a patient's detention in the Central Mental Hospital under the Criminal Law Insanity Act (2006) comes to an end, a complex procedure of admission to another approved centre and the instigation of the procedures for a proposal to transfer from the Central Mental Hospital have to occur. The lack of interaction between the 2001 Act and the Criminal Law Insanity Act (2006) may lead to risks that the delivery of the appropriate care to patients could be disrupted. Avoiding such disruption to patient care should be a key focus of an amended 2001 Act which must interact appropriately with the Criminal Law Insanity Act (2006).

The MHC recommends consideration of the following:

The 2001 Act be amended to provide greater interaction with the Criminal Law Insanity Act (2006) such that the delivery of appropriate care to patients is not disrupted.

Absence with Leave - Section 26

The 2001 Act provides for a patient's responsible consultant psychiatrist to grant him or her permission to be absent with leave. The Inspector of Mental Health Services has reported that this provision of the legislation is being used to make committal orders relating to individuals residing in the community i.e. de facto community detention. (Report of the Inspector of Mental Health Services, 2009) The Commission considers that the granting of leave to patients is appropriate in certain circumstances. However, such leave should be subject to certain specified time periods set out in a revised Act. In particular, it should not be longer than one month subject to the existing provision that it cannot be granted for a period of time longer than the remaining duration of the admission or renewal order. The Act should also expressly prohibit the making of a renewal order for a patient who is absent with leave subject to Section 26.

The Commission also supports an amendment to require a multidisciplinary review of all patients absent with leave on a weekly basis.

The MHC recommends the following:

Consideration should be given to amending Section 26 to prohibit the granting of absence with leave to a patient for longer than one month subject to the existing provision that it cannot be granted for a period of time longer than the remaining duration of an admission or renewal order.

Consideration should be given to expressly prohibiting the making of a renewal order for a patient absent with leave from the above centre subject to Section 26.

All patients absent with leave should be reviewed on a weekly basis by members of the multidisciplinary team.

Discharge of a Patient- Section 28

Section 28 requires the consultant psychiatrist responsible for the care and treatment of the patient to revoke an order where he/she is becomes of opinion that the patient is no longer suffering from a mental disorder as defined in the Act and discharge the patient. The person may opt to stay to receive treatment on a voluntary basis.

The 2001 Act and Articles 3 and 15 of the *Mental Health Act 2001 (Approved Centres) Regulations 2006* do not make reference to discharge planning. Discharge planning should commence as soon as possible after admission as recommended in the Commission's *Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre*. The Commission supports an amendment to the Approved Centre Regulations such that the definition of an individual care and treatment plan includes reference to a discharge plan.

Section 28 of the 2001 Act provides that where a patient is discharged and a review by a mental health tribunal under section 18 has not yet occurred, the review shall not be held unless the patient indicates by notice in writing addressed to the Commission within 14 days of his or her discharge that he or she wishes such a review to be held. There have been 78 requests for such reviews in the period 2007 to 2010. The 78 tribunals held between 2007 and 2010 represent only 1.4% of all orders that were revoked before a hearing took place during these years.

The current system requiring patients to inform the Commission in writing that they wish to have their detention reviewed after an order has been revoked may be unsatisfactory and a review of Section 28 is suggested.

The MHC recommends the following:

It is recommended that Articles 3 and 15 of Statutory Instrument No. 551 of 2006 - the Mental Health Act 2001 (Approved Centres) Regulations 2006 - be amended such that the definition of an individual care plan includes reference to a discharge plan.

A review of Section 28 is recommended.

Voluntary Patients – Sections 2, 23, 24 & 29

Voluntary admissions make up the vast majority of admissions to approved centres in Ireland. In 2010, they accounted for 91.8% (1,602/19,619) of all admissions (HRB, 2011). However, the Act is largely silent in relation to voluntary patients and the provisions that specifically mention voluntary patients focus on the circumstances in which they can be detained.

Recommendations in relation to the definition of voluntary patients are included earlier in the submission. In relation to incapacitated compliant patients, the Commission supports an amendment to the Act such that there are appropriate safeguards and review of these persons who are resident in approved centres in line with H.L. v United Kingdom (2004).

The right to be provided with appropriate information currently restricted to involuntary patients in Section 16 should be extended to voluntary patients and include information on their rights. The Act should include a specific provision that requires information to be provided to persons prior to a voluntary admission outlining the fact that in exceptional circumstances they may be detained.

Sections 23 & 24 of the Mental Health Act 2001 outline the procedures relating to a decision to re-grade a voluntary patient to involuntary status. A voluntary patient can only be detained if he or she "indicates at any time that he or she wishes to leave the approved centre". The admission order is made by the RCP on a statutory form, *Form 13 Certificate & Admission Order to Detain a Voluntary Patient (Adult),* following completion of a certificate by another consultant psychiatrist who is satisfied that the person concerned is suffering from a mental disorder.

In its report on its 2010 visit to Ireland, the CPT noted that the "status of voluntary patient cannot easily be changed to involuntary" (CPT, 2011). Section 23 requires a detailed review as it may be posing difficulties from an operational perspective. The Commission's support for greater involvement of the authorised officer in the operation of the Act also extends to the provisions of this section. An amendment should be considered such that an authorised officer or advocate as appropriate, be made available to voluntary patients who are prevented from leaving an approved centre under Section 23 of the 2001 Act.

The Commission also suggests amending Section 24 such that the involuntary admission procedure to be followed under this section is similar to the procedure set out in Sections 9, 10, 11 and 14, including the proposed amendments

The MHC recommends consideration of the following:

The Commission suggests an amendment to the Act such that there are appropriate safeguards and periodic review of incapacitated compliant patients who are resident in approved centres in line with H.L. v United Kingdom (2004).

Voluntary patients must be provided with information prior to and during their admission. This must include information on their rights. There should also be a specific requirement in the 2001 Act to inform voluntary patients prior to their admission that they could be involuntarily detained in exceptional circumstances.

It is suggested that a detailed review of Section 23 is undertaken.

The 2001 Act be amended such that an authorised officer/advocate is made available to voluntary patients who are subject to the provisions of Section 23.

It is suggested that the involuntary admission process under Section 24 of the Act be amended to follow the procedures outlined Sections 9, 10, 11 & 14 with any necessary modifications.

Children and the Act- Sections 25, 61

Section 25 of the 2001 Act is the only section that applies solely to a child. It sets out procedural safeguards for the involuntary admission of a child to an approved centre. It is suggested that the 2001 Act be revised to provide for a comprehensive and separate Part relating to children which should be positive in tone and highlight the visibility of the young person in the Act.

This new Part should include the proposed guiding principles of the Act as well as child appropriate principles. In particular the newly defined "*best interests*" principle should be refocused to be child-centred and emphasise the participation of the child in all decisions affecting him or her as a fundamental requirement.

The provisions in the Child Care Act 1991 relating to the child and his/her family should also be explicitly incorporated into an amended 2001 Act. The interface of these two Acts needs to be addressed.

Definition of a Child, Consent and Capacity

The definition of child is one of the first considerations in an amended 2001 Act. Serious consideration needs to be given to the area of capacity and the age of consent of a child. In particular, questions have been raised in relation to 16 and 17 year olds where their opinion may differ to that of their parents for example. Based on the proposed guiding principles and the Law Reform Commission's (2011) proposals in its report '*Children and the Law: Medical Treatment'*, it is the Mental Health Commission's view that 16 and 17 year olds should be presumed to have capacity to consent to and refuse treatment. The Commission in its '*Code of Practice on the Admission of Children under the Mental Health Act 2001*' highlighted the lack of clarity between the interface of provisions of the 2001 Act and Section 23 of the Non-Fatal Offences against the Person Act 1997. It is important that this is clarified in order to provide practitioners with clearer guidance as to their powers and functions under the 2001 Act.

The MHC recommends the following:

It is suggested that a Part of the Act should be dedicated to children. This would provide greater clarity on the rights and protections of children. This Part should clarify all definitions as they relate to children.

The Part of the Act addressing child provisions should restate that all proposed guiding principles of the Act (Section 4) apply to children. 'Best interests' should be refocused to be child-centred.

The interface between the Mental Health Act 2001 and sections of the Child Care Act 1991 should be specifically stated in the primary legislation.

The definition of a child should be re-considered in line with the recommendations of the Law Reform Commission (2011).

The provisions of the 2001 Act and those of the Non-Fatal Offences against the Person Act 1997 should be clarified in order to provide practitioners with clearer guidance as to their powers and functions.

Involuntary Admission of Children – Section 25

Section 25 of the Act provides for the involuntary admission of a child. This process occurs through an application to the District Court.

Table 3 shows involuntary child admissions by year and unit type in the period from 2007 to 2010. It shows that there were 14 involuntary admissions[1] of children to approved centres in 2010, which is a slight increase on 2009 figures. In contrast to previous years the majority of involuntary admissions were to child units in 2010.

Table 3: Involuntary Admissions by Unit Type 2007 – 2010 (MHC, 2010)

Year	No. of admissions to Adult Units	No. of admissions to Child Units	Total No. Admissions
2007	3	-	**3**
2008	6	2	**8**
2009	7[a]	3	**10**
2010	3[b]	11	**14**
Total	**19**	**16**	**35**

[a] *includes one admission under S18 (1) of the Child Care Act 1991*

[b] *includes one admission under S15 (2) of the Criminal Law Insanity Act 2006*

It would appear that the involuntary admission process for adults may afford greater protections under the Act than for children. In particular, unlike the process for adults:

- Children are not afforded the right to have their detention reviewed by a Mental Health Tribunal.
- The consultant psychiatrist's report submitted to the district court under Section 25 does not have to be completed by an independent psychiatrist or by a child psychiatrist.
- The child does not have an automatic right to legal representation.
- There are no statutory requirements to notify the Commission of involuntary admissions of children.

It is recommended that Section 25 be redrafted to provide clearer guidance to those operating the legislation. Legislative clarity is also needed on the position of children in HSE care being transferred to HSE mental health inpatient care in order to ensure that the interests and welfare of the child are adequately protected through independent oversight.

The Mental Health Commission supports the proposal of the Law Reform Commission that the formal admission or detention of children under 16 years old by the courts should continue but

[1] If a child was transferred from one approved centre to another approved centre under a single Section 25 Order this was only reported as one involuntary admission. There were three such instances in 2010.

with follow up by a mental health tribunal. Where a person over 16 has capacity and consents to his/her admission, whether in state care or not, that child should not need to have an order from the court. However, there should be a provision which provides for their admission to mental health care to be subject to independent oversight.

Renewal of Orders of Child's Detention under Section 25

Section 25 provides that where a court is satisfied that a child is suffering from a mental disorder, the court shall make an order that the child be admitted and detained for treatment in a specified approved centre for a period not exceeding 21 days. From 1st November 2006 until 14th October 2011, the Commission was notified of 47 orders. Of these orders, 43 were for 21 days; two were for 20 days and two were for 19 days.

Thirty one children remained in the same approved centre until discharge, two were transferred to another approved centre and four had their orders extended. Data are not available for ten admissions as they were not returned to the Commission. There is no statutory requirement on services to provide such information to the Commission. Of the 31 children who remained in the approved centre to which they were first admitted, 17 were voluntary on discharge, while 14 remained involuntary.

Of the 14 involuntary patients, the shortest admission was for 5 days and the longest was for 71 days. The average length of stay was 17.8 days.

Four children out of the 47 had their orders extended. These extension orders varied as follows: one was for 22 days (not exceeding 6 months); one was for 6 weeks, and two were for a period not exceeding 3 months. This data suggests that the second and third review periods set out in the Act may be long compared to the typical lengths of stay of a child.

Table 4: Notification of Section 25 Orders (1st November 2006- 14th October 2011

		Legal Status on Discharge		
	Total	**Voluntary**	**Involuntary**	**Unknown/ No Information**
Number of Section 25 Orders	47	17	14	10
Mean Duration of Admission (days)	-	23.6	17.8 (13.7 if exclude admission that lasted 71 days)	-
Median Duration of Admission (days)	-	19	18.5	-
Number of Transfers	2	1	1	-
Section 25 Orders extended	4	2	1	1

Treatment of a Child Detained

Section 61 provides for the continued administration of medication beyond three months to a child detained under Section 25 for the purposes of ameliorating his or her mental disorder. The current Section 61 needs to be revised. The Commission is of the view that greater protection should be afforded to such children. This may include input or reports from other members of the child's multi-disciplinary team. It might also include reference to a tribunal particularly in light of the low number of children who would be in an approved centre for this period of time.

There needs to be a principled approach to capacity to consent, even where the child is detained on a court order.

The MHC recommends consideration of the following:

Provision of a separate Part of an amended 2001 Act to address all matters relating to children including a reiteration of child centric principles.

Provision be made in the legislation for age-specific mental health tribunals.

The legislation needs to clarify the position of children in HSE care being transferred to a HSE approved centre in order to ensure appropriate independent oversight.

The consultant psychiatrist's report submitted to the district court under Section 25 be

completed by an independent consultant child psychiatrist.

In Section 25(6): the reference to subsection (1) should be amended to refer to subsection (2).

A legal representative and/or advocate should be made available on a mandatory basis to children detained under the Act (MHC, 2008)

It is recommended that a review of the timeframes for detention of children is undertaken. Consideration should be given to reducing the length of an admission order. The current provision enables the court to make an order for detention and treatment for up to 21 days and the majority of orders to date have been made for 21 days. It is suggested that the longest period of detention should be revisited and in any case be less than 3 months.

A requirement to notify the Commission of the involuntary admission and discharge of children using specified forms should be provided for in the Act.

In section 61 the "either" in line 5 should be deleted and "*the consent, or as the case may be*" should also be deleted.

Greater protection should be afforded to children who are given medication beyond 3 months to include relevant multidisciplinary participation.

All references to the Child Care Act 1991 that apply to children detained under the 2001 Act should be explicitly stated within an amended Act.

Children Admitted on a Voluntary Basis

The majority of admissions of children to approved centres take place on a voluntary basis.

Table 5: All Child & Adolescent Admissions by Unit Type 2007 - 2010

Year	No. admissions to Adult Units	No. of Admissions to Child Units	Total Number of Admissions
2007	217	135	**352**
2008	247	145	**392**
2009	205	166	**371**
2010	155	274	**429**

In 2010, 415 out of 429 child admissions were made on a voluntary basis. The 2001 Act has presented challenges when it comes to the voluntary admission of children.

Significantly, a child admitted as a '*voluntary patient'* has his or her status determined by his or her parents i.e. it is parental consent that renders a child's admission as voluntary, irrespective of the child's views and so, the term '*voluntary*' has a different meaning to that of an adult *'voluntary patient'* under the Act.

The Law Reform Commission discusses children and consent to mental health treatment in greater detail in their 2011 report entitled *Children and the Law: Medical Treatment* and the Mental Health Commission supports the recommendations contained therein. A third category should be provided for, where a child under 16 is admitted by parents/loco parentis, and this should be called *'an informal'* admission. Despite parental/*loco parentis* involvement, the child should be consulted on all matters affecting him or her. The role of the mature minor should also be considered where they may have capacity to make decisions. Article 12 of the UN Convention on the Rights of the Child states that:

"*State Parties shall assure that to the child who is capable of forming his or her views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child".*

Information and Advocacy

The 2001 Act does not expressly provide for the views of a person under 18 years to be heard or information on their rights to be provided to them. In the absence of age appropriate advocacy services the Commission developed a self advocacy and rights-based toolkit entitled the '*Headspace Toolkit'* in 2010. Section 16 of the Act provides for certain information, for example, to be given to adults who are admitted involuntarily but there is no statutory requirement to provide children with information on their rights on admission.

The Commission in its *Code of Practice on the Admission of Children under the Mental Health Act 2001* has called for independent advocacy services to be made available to children as a matter of priority. This is particularly the case for children admitted involuntarily who currently may be appointed a guardian ad litem by the Courts. The MHC has been informed by clinicians that this happens only if requested by the treating Consultant Psychiatrist. This view has been similarly expressed by the Law Reform Commission (2009) and the Special Rapporteur on Child Protection (Shannon, 2010).

Treatment Issues and Children

The Act does not explicitly prohibit the administration of ECT to children; it can be given to a detained child with the approval of the court. The Section 59 Rules provide procedural safeguards for the administration of ECT to adults detained in approved centres but do not include children.

The MHC recommends consideration of the following:

The Law Reform Commission's (2011) recommendations on children and consent to mental health treatment should be incorporated into amended legislation. This includes provisions being made for a third category of child admission called 'an informal admission'.

The legislation should ensure that children are active participants in their care and treatment and that the views of every child are given due weight in accordance with the age and maturity of the child. The views of the family should also be taken into account.

Children must be given information in accessible formats and made aware of their rights on admission.

Independent advocacy services should be made available to children on a statutory basis.

Additional procedural safeguards should be put in place where it is proposed to give ECT to children.

Inspector of Mental Health Services - Sections 50 – 54

Inspections have been carried out by the Office of the Inspector of Mental Health Services since 2004. Under Sections 51 and 52, the Inspector furnishes a report in writing annually to the Commission. Seven annual reports detailing the inspections carried out by the Inspectorate have been submitted to the Commission since 2004 and have been included in the Commission's Annual Reports as per Section 42(2) of the 2001 Act as the Report of the Inspector of Mental Health Services (MHC, *Annual Reports* 2004-2010).

Sections 51, 52 & 54 set out the functions and duties of the Inspector of Mental Health Services and Assistant Inspectors of Mental Health Services. It is suggested that Section 54 of the 2001 Act (Assistant Inspectors) be moved to follow on from Section 50 (Inspector of Mental Health Services).

The Commission is of the view that the Office of the Inspector of Mental Health Services must continue to be independent and be seen to be independent in the carrying out of its functions. Governance arrangements in relation to the Office of the Inspector of Mental Health Services and the Mental Health Commission require clarification within an amended Act.

The functions of the Inspector as outlined in Section 51 do not cross reference the provision in Section 16 (2)(d) whereby a patient who is detained must be given a notice in writing which states *inter alia* that he or she is entitled to communicate with the Inspector. It would therefore be helpful if an amendment was made to Section 51 such that the Inspector must follow up with any communication from a patient as appropriate. One of the duties of the Inspector as set out in Section 52 (b) is to "*see every patient the propriety of whose detention he or she has reason to doubt*". The Act is silent on what course of action is available to the Inspector in such situations. The Commission suggests that the Inspector has recourse to referral to a mental health tribunal should he/she deem it to be appropriate. An amendment to Section 52 (b) to provide such a power to the Inspector should therefore be considered.

Since 2007, all approved centre inspections have included an assessment of compliance with the Codes of Practice issued by the Commission, the *Mental Health Act 2001 (Approved Centres) Regulations 2006* and the Rules as per Sections 51(1) (b) (iii) and 52(b). These provisions require the Inspector to report on the degree of compliance with "*<u>any</u> code of practice prepared by the Commission under Section 33(3) (e)*" and to "*ascertain whether <u>any</u> regulations made under section 66*" and "*<u>any</u> rules made under sections 59 and 69*" are being complied with. The Commission suggests an amendment to Section 51(1) (b) (iii) to remove the word "*any*" before "*code of practice"* and change "*code*" to "*codes*". Similarly, it also recommends deleting the word "any" from before regulations and before rules in Section 52 (d).

The MHC recommends consideration of the following:

The Commission is of the view that the Office of the Inspector of Mental Health Services must continue to be independent and be seen to be independent in the carrying out of its functions. Governance arrangements in relation to the Office of the Inspector of Mental Health Services and the Mental Health Commission require clarification within an amended Act.

The Commission suggests that Section 54 is reordered to follow Section 50.

If a patient contacts the Inspector following notification under Section 16, there should be a requirement under Section 51 that the Inspector follows up on such communications as appropriate.

In view of the establishment of mental health tribunals, Section 52(b) of the Act may be enhanced by conferring the power on the Inspector to refer such patients to a review by a tribunal if he/she has cause for concern.

Amendments be made to Section 51 (1)(b)(iii) so that the word "any" is deleted from before "code of practice" and the word "code" is amended to "codes".

Amendments be made to Section 52(d) so that the word "any" is deleted from before "regulations" and from before "rules".

Inquiries - Section 55

Section 55 provides that the Commission may and shall if so requested by the Minister, cause the Inspector or such other person as may be specified by the Commission to enquire into a number of specified matters. There have been two inquiries since commencement date.

The Commission's suggests that Section 55(1) be amended to include: *"the Inspector and/or such other person"* as may be specified by the Commission.

In both inquiries carried out to date, external persons were included on the inquiry team which also included assistant inspectors. Section 55 is silent in relation to any powers that the '*person*' may have to enable them to carry out their Inquiry. To enable these '*persons'* to carry out the inquiry, the Commission appointed them as assistant inspectors so that the powers of assistant inspectors as specified in section 51, 53 and 54 would apply.

The MHC recommends consideration of the following:

The Commission recommends that Section 55(1) be amended to include: *"the Inspector <u>and/or</u> such other persons"* as may be specified by the Commission.

Section 55 should be broadened to provide specific powers to facilitate the carrying out of an Inquiry pursuant to Section 55 in situations where the inquiry is being undertaken by an 'other person'.

Consent to Treatment - Sections 56, 57, 58, 59 and 60

The Act deals with treatment and consent as it applies to involuntary patients. As previously stated, there is a lack of a legal framework generally for the provision of treatment to voluntary patients under the 2001 Act. The Commission supports the introduction of Advance Directives as a useful method of enhancing the right of autonomy and care planning.

Consent

Part 4 relates to consent to treatment. Section 56 deals with the definition of consent as it applies to a patient as defined in section 2 of the 2001 Act. Provisions need to be put in place for where a patient may require treatment but lacks capacity to consent.

Furthermore, consent implies that it should always be '*informed'*, that is where the person is deemed to have capacity, where appropriate information is provided and where consent is voluntary.

The MHC recommends consideration of the following:

All sections that refer to consent should be reviewed in line with capacity legislation and the UN Convention on the Rights of Persons with Disabilities.

Consent should always be informed and amendments should be clear when it is appropriate to limit consent.

Psychosurgery - Section 58

It is important that if a proposal for psychosurgery is referred to a tribunal, that such tribunal members have access to appropriate expertise to review the proposal and make a decision.

The MHC recommends consideration of the following:

Tribunal members should have access to appropriate expertise in the area of psychosurgery.

Electro-convulsive therapy – Section 59

Electro–convulsive therapy (ECT) is the specific focus of Section 59 of the Act. It provides for the Mental Health Commission to make rules governing the use of ECT and states that ECT must not be administered to a patient unless it is in accordance with these Rules. In contrast to a provision enacted in respect of Mental Health Commission Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint in Section 69(3), it is not stated that a person who contravenes Section 59(2) Mental Health Commission Rules Governing the Use of ECT shall be guilty of an offence. The Commission considers the 2001 Act to be inconsistent in this regard and recommends that an appropriate amendment be made.

As the ECT Rules apply only to '*patients'*, the Commission published a *Code of Practice Governing the Use of Electro-Convulsive Therapy for Voluntary Patients* in approved centres in 2008 in order to provide guidance to those administering ECT to voluntary patients. A small number of service users also receive ECT as day patients. They typically attend day hospitals and day centres and receive maintenance ECT in approved centres. The Commission considers it prudent that any service user who receives ECT in an approved centre is entitled to the same protections which are offered by the *Rules Governing the Use of Electro-Convulsive Therapy*. An amendment should therefore be considered in relation to Section 59 to extend the scope of the *Rules Governing the Use of Electro-Convulsive Therapy* to all those who are administered ECT in approved centres with appropriate distinctions made in relation to the different consent provisions that apply to involuntary patients.

In order to ensure respect for the rights of patients who have capacity to consent to medical treatment, the Commission supports a significant amendment to Section 59(1)(b). At present, ECT may still be administered to patients who refuse to give consent in certain circumstances and the Commission supports an amendment to the Act which would prohibit this. The words "*or unwilling*" should therefore be deleted from Section 59(1)(b). A more appropriate reference to those who lack the capacity to consent to ECT would be achieved by replacing the words "*is unable"* with "*lacks the mental capacity*".

The 2001 Act also provides that where the patient is unable or unwilling to give consent, ECT must be approved by the consultant psychiatrist responsible for the care and treatment of the patient and another consultant psychiatrist following referral of the matter to him/her by the first-mentioned consultant. There is no requirement, however, that the second consultant psychiatrist is independent of the patient and or the approved centre in which the patient is currently receiving care and treatment. The independence of consultant psychiatrists who prepare reports for mental health tribunals is facilitated by the Commission's operation of a panel of consultant psychiatrists to carry out independent medical examinations for this purpose. The Commission proposes that this panel's purpose is extended such that its members are also available to carry out examinations of a patient who lacks the capacity to consent to ECT. Section 59 should also be amended to require a consultant psychiatrist who proposes administering ECT to a patient who lacks the capacity to consent to refer the matter to the Commission. The Commission should then appoint a consultant psychiatrist from this panel to examine the patient for the purposes of deciding if the administration of ECT should proceed.

The MHC recommends consideration of the following:

It is suggested that Section 59 should include a subsection which states that it is an offence not to comply with the Rules on ECT similar to the provisions in Section 69(3).

The Rules on ECT should apply to all persons receiving ECT in an approved centre.

Section 59(1)(b) be amended by replacing the words "*is unable*" to with "*lacks the mental capacity*" and that the words "*or unwilling*" be deleted.

The second opinion consultant psychiatrist currently specified in Section 59(1)(b) be independent of the patient and /or the approved centre in which the patient is currently receiving care and treatment.

Administration of Medicine - Section 60

The capable and willing patient can consent for up to three months in full support of their right to autonomy. After three months however that same capable person can lose their right to refuse 'that medicine' based on a second opinion. It is important therefore that continued administration of 'that medicine' should have a requirement that the medication concerned is of a material therapeutic benefit to the patient. This section should also provide further clarification on the definition of 'that medicine' to which it is referring. It is important that as a minimum the second consultant is required to examine the patient in advance of making a decision of whether or not to authorize the continued use of 'that medicine'.

It is suggested that this section is also considered in light of the recent case of the **HSE -v- X (APUM) [2011] IEHC 326**.

The MHC recommends consideration of the following:

The continued administration of 'that medicine' should have a requirement that the medication concerned is of a therapeutic material benefit to the patient.

The second opinion consultant psychiatrist should be required to examine the patient prior to making a decision of whether to authorize continued administration of 'that medicine'.

The Act needs to be amended to clarify what components of the patient's medication are dealt with under Section 60 beyond the term '*that medicine*'.

The review of this section should consider the case of the HSE -v- X (APUM) [2011] IEHC 326.

Miscellaneous

Bodily Restraint and Seclusion – Section 69

The Commission currently places a key role in the regulation of seclusion and restraint through the *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint*. These have been prepared by the Commission in accordance with Section 69(2) of the 2001 Act and apply to persons subject to seclusion and mechanical restraint in approved centres. The 2001 Act specifies two situations in which these two interventions may be used i.e. for the purposes of treatment or to prevent the patient from injuring himself or herself or others. The Commission is of the view that such interventions are not treatment options. They are both restrictive interventions which should only be used in rare and exceptional circumstances and only in the best interests of the patient when he or she poses an immediate threat of serious harm to self or others. It is suggested that Section 69 should be amended such that no provision is made for the use of seclusion or restraint for the purposes of treatment.

At present, seclusion and mechanical restraint may also be used on voluntary patients and children detained in accordance with Section 25. Such a deprivation of liberty should only be used in exceptional circumstances for voluntary patients as outlined above. The Commission is of the view that the use of seclusion and mechanical means of bodily restraint on a voluntary patient must involve a consideration of whether involuntary admission of the patient on the grounds of mental disorder is warranted so that appropriate safeguards are activated. However, the 2001 Act only permits a voluntary patient's status to be changed to involuntary where he or she indicates a wish to leave the approved centre. This poses challenges for staff caring for a voluntary patient where such a patient begins to exhibit challenging behaviour such that they are posing an immediate risk of harm to self or others. This difficulty should be considered during the review of Sections 23 and 24 that relate to the detention of voluntary patients.

If the Commission proceeds with a prosecution of an approved centre or person for a breach of the Rules, the Commission is of the view that such a prosecution would be facilitated by an expressed provision which would place the burden of proof on approved centres to show that they have complied with the Rules. This would be similar to a provision outlined in Section 81 of the *Safety, Health and Welfare at Work Act 2005*.

The 2001 Act does not make reference to the use of physical restraint in Section 69. However, the Commission considered it appropriate to issue a code of practice in relation to its use as a means of providing best practice guidance in relation to the use of a restrictive intervention which is also frequently used within approved centres across the country. There were a total of 2,855 episodes of physical restraint reported in 47 approved centres in 2009. Physical restraint is therefore used more often and in more approved centres than the other restrictive interventions that are regulated by the Commission i.e. seclusion (2,517 episodes in 29 approved centres in

2009) and mechanical restraint (15 episodes in 6 approved centres in 2009). However, residents of approved centres who are physically restrained are not afforded the same protections as residents who are secluded or mechanically restrained as a Code of Practice cannot offer the same legal protections as Rules made under the provision of primary legislation. The Commission therefore supports an amendment to Section 69 such that the scope of the Rules is extended to cover physical restraint.

The MHC recommends consideration of the following:

The Act should be amended such that the use of seclusion or mechanical means of bodily restraint is not permitted for the purposes of treatment and can only be used to prevent a patient from injuring himself or herself or others.

Consideration should be given to amending the applicability of Section 69(2) Rules to voluntary patients. Any review should consider the review of Sections 23 and 24 that relates to the detention of voluntary patients.

Section 69 should be amended to encompass physical restraint so that the Commission would issue Rules providing for the use of physical restraint. Section 69(1) should therefore be amended to state that: "A person shall not place a patient in seclusion or apply <u>physical and/or</u> mechanical means of bodily restraint to the patient……"

It is suggested that the Act should be amended such that the burden of proof is placed on approved centres to show that they have complied with the Rules in a case where the Commission may be required to prosecute an approved centre for a breach of the Rules.

Adverse Event / Incident Reporting and Death Notifications

The Commission issued a code of practice on the area of death notifications and incident reporting in 2009. The code requests services to furnish the Commission with 6 monthly summary incident reports, which are made available to the Inspectorate to inform inspection of services. In the absence of a national incident reporting taxonomy (categorisation) and given the wide variation in incident reporting systems used by mental health services, it was not possible to report on these data at a national level. The Commission welcomed the Joint Adverse Event Reporting Group established by the DOHC in 2009/2010 following publication of *Building a Culture of Patient Safety*: Report of the Commission on Patient Safety and Quality Assurance. (Department of Health and Children, 2008). Streamlining the process nationally will provide a safer service for all.

Approved Centres are required to notify the Commission of the death of any resident of an approved centre in accordance with Article 14(4) of the Mental Health Act 2001 (Approved Centres) Regulations 2006 and Section 2.2 of the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. In 2010, 42 approved centres notified the Commission of 162 deaths. Based on the information reported to us, 14% of notifications (n=22) related to sudden unexplained deaths.

The MHC recommends consideration the following:

A national mandatory Adverse Events Reporting System based on the WHO taxonomy (categorisation) should provide for the MHC to set standards and receive notifications of incidents/adverse events in line with the rest of the health system. It is suggested that an amended Mental Health Act should have synergy with the proposed Health Information Bill in this regard.

Admission, Transfer and Discharge to and from an Approved Centre

The Commission issued a *Code of Practice on Admission, Transfer and Discharge* in 2010. This code was intended to improve the continuity of care provided to service users, ensure their involvement in decisions regarding their care and treatment and facilitate transition back into the community following discharge in line with Standard 1.2 of the Quality Framework for Mental Health Services (MHC, 2007). The code is applicable to all service users regardless of their legal status, and was issued particularly in light of the lack of a statutory framework for the admission, transfer and discharge of voluntary patients. The code places a heavy emphasis on the rights of all service users, particularly as it relates to the provision of information. Individual care planning involving the patient's multi-disciplinary team and discharge planning are also given prominence in this code. Discharge planning is considered particularly important in ensuring continuity of care post discharge and avoiding re-admission to approved centres.

The MHC recommends consideration of the following:

Greater application of the Act to voluntary patients should be considered in line with the provisions in this code of practice.

Registration/Licensing of Approved Centres – Sections 62, 63, 64, 65, 67, 68

One of the Commission's key functions is to establish and maintain the *Register of Approved Centres* under Section 64 of the Mental Health Act 2001. Section 62 of the 2001 Act defines a centre as "*a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder".* The Mental Health Commission established and has maintained a register of approved centres in accordance with Part 5 of the Mental Health Act 2001 since 1st November 2006.

There are currently 64 approved centres on the register (as at 1st December 2011) and 9 centres currently have 16 conditions attached. Under Section 63 of the 2001 Act, a centre must not operate unless registered with the Mental Health Commission.

Definitions

The 2001 Act defines ‘’*Centre”* as “*a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder”* (Section 62). The definition of ‘*approved centre’* must be construed in accordance with Section 63 as it is a centre that is registered.

The term ‘*in-patient’* is not defined within the 2001 Act. The 2001 Act does not differentiate between approved centres designated for adults, children, forensic or other specialist services. Within Part 5 of the 2001 Act there is generally a lack of specification as to what constitutes an approved centre, and the criteria for registration.

The *‘registered proprietor’* (RP) is defined as the ‘*person’* carrying on the centre. Person is interpreted in accordance with the Interpretation Act 2005 which enables it to be a corporate body. The ‘HSE’ is currently the registered proprietor for all HSE approved centres. There are currently only five named persons (registered proprietors) responsible for nine approved centres out of the 64 approved centres on the register. The registered proprietors for the remaining 55 approved centres are corporate bodies. It is suggested that consideration be given to amending the 2001 Act to make provision for a ‘*registered proprietor’* as an owner and also provide for a *‘responsible person’* who is a named individual who has responsibility for the approved centre.

Where a number of approved centres have the same registered proprietor difficulties may arise if the registered proprietor concerned contravenes a condition of registration in relation to one of the centres, as he/she shall be guilty of an offence. This would prohibit that registered proprietor from being the registered proprietor of the other approved centres concerned.

Another issue arises in relation to Section 64(10) where the registered proprietor retires for example, as it requires the centre to re-apply for registration. The Commission considers it appropriate that there is a legal requirement placed on centres to inform the Commission of a change in registered proprietor/fit person under 64(10)(ii) and that the Commission then determines if such a person can be regarded as a ‘fit person’.

The term *‘resident’* is only used in Part 5 of the Act, it is not used elsewhere. The Commission suggests that the use of the term Resident in this Part of the 2001 Act should be reviewed to ensure consistency in an amended Act.

Other Sub-Sections

Under Section 64(3), the duration of the period of registration is 3 years. The Commission suggests that consideration be given to enable the Commission to register a centre for a shorter period of time, for example, when a centre moves location temporarily while it is being renovated.

It is suggested that Section 64(5) be reviewed to word it in the positive i.e. '*The Commission shall remove or refuse to register……'.*

Case law to date (JH v Clinical Director, Cavan General Hospital, 6th February 2006) reflects the inextricable link between detention, registration (licensing) and the quality of mental health service provision which must be overseen by the Mental Health Commission. This approach is consistent with case law from the European Court that detention justified under Article 5(1) (e) of the European Convention on Human Rights must be in an appropriate clinical setting, a standard which will not be met if the conditions are not fit for purpose. It is noted therefore, that the licensing of in-patient facilities is tightly interwoven with the involuntary admission process, and appropriate care provision and clinical setting.

Section 64(12) refers to '*the board'*. This term is not used elsewhere within the 2001 Act

Offences are dealt with under various sub-sections. It is suggested that all offences are dealt with in the same section e.g. 63(2), 64(8), 64(13). It is suggested that there should also be a reverse onus provision in respect of offences in line with Section 81 of the Safety, Health and Welfare at Work Act 2005.

There is no requirement under the legislation to have a service inspected before it becomes registered for the first time. There is currently only a legislative requirement to inspect existing approved centres.

The MHC recommends consideration of the following:

Greater clarity is needed in the definition of a '*centre*'.

The Act should make provision for a registered proprietor i.e. an owner and a 'responsible person' i.e. a named individual who has responsibility for each approved centre.

The Act should specify the requirements/appropriate competencies of the responsible person.

It would be preferable if a legal requirement was placed on centres to inform the Commission of a change in registered proprietor under 64(10) (ii) rather than necessitating the new registered proprietor to re-apply for registration.

The term '*resident'* is used solely in Part 5 of the 2001 Act. There is a need for consistency in terminology across the 2001 Act.

The Commission recommends that the timeframe for registration of approved centres be revisited. The Act should, at a minimum, allow the Commission to prescribe a shorter time period for registration where appropriate.

It is proposed that there should be additional regulations regarding criteria that a service must meet in order to be registered. It is imperative that care and treatment is provided to mental health service users in appropriate clinical settings and in buildings fit for purpose.

The term '*the board'* should be deleted from Section 64(12) of the Act.

All offences should be dealt with under the one section and all penalties reviewed.

There should be a legal requirement to have a service inspected before it is registered for the first time.

Participation in Clinical Trials - Section 70

MHC Recommends consideration of the following:-

Patients should be able to participate in Clinical Trials once informed consent has been obtained.

Leave of High Court for certain Proceedings- Section 73

This may require an amendment in light of case law such as the Supreme Court Judgment on the 1945 Act (LB 2008), which found it to be unconstitutional. The following cases are relevant to this section:

BL -v- The Minister for Health & Children, Ireland and the Attorney General [2009] 1 IR 275 (SC), [2004] 3 IR 610 (HC).

MP -v- Health Service Executive and ors. [2010] IEHC 161,

AL -v- Clinical Director of St. Patrick's Hospital [2010] IEHC 62,

The MHC recommends consideration of the following:

Section 73 needs to be reviewed in light of concerns that it may be unconstitutional and discriminatory.

Review of the Act- Section 75

The Mental Health Act 2001 currently provides a mechanism for review. We believe any future legislation should similarly have a review mechanism built in line with good practice.

The MHC recommends consideration of the following:

There should be a similar provision in any amended legislation for an automatic review period to be built in.