College of Psychiatrists of Ireland

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Commentary on Report of Expert Group Review of the Mental Health Act 2001

Law Committee

EAP/LC September 2016

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Version 1 August **2016**

Introduction

The Law Committee welcomes the report of the Expert Group on the review of the Mental Health Act 2001.

The Law Committee has had reservations about the composition of the Expert Group and has previously expressed these reservations. In particular we note that there has been no representation from Child and Adolescent Psychiatry and General Practice. We consider that the lack of representation of medical professionals working in the areas of Child and Adolescent Mental Health significantly detracts from the credibility of any of the recommendations made in this area by the Expert Group.

The Law Committee notes the sterling work done on behalf of the College by Professor Brendan Kelly.

The Committee notes that it is in agreement with a fit for purpose Mental Health Act that operates within the Civil Law and is compatible with the European Convention on Human Rights.

We note the discussion around the concept of best interests and the recommendation to remove "best interests" as guiding principle in the operation of the Mental Health Act. The Law Committee collectively recommends that our College maintain its disagreement with this recommendation. We recommend instead a reformulation of the principle of best interests as recently articulated by Professor Kelly.

We note that the Irish Medical Council is explicit in its view that doctors should always act in the best interests of their patients.

We note and comment below on the recommendations re section 51 concerning the Inspector and add the following:

1. The reporting relationship of the Inspector of Mental Health Services to the CEO of the MHC questions the independence of the Inspector.
2. There is no definition of Consultant Psychiatrist vis a vis who can be appointed as the Inspector. E.g. 'should be on the specialist register for the division of psychiatry and have been in a post of consultant psychiatrist for X period of time.'

Format of this Response

We have discussed each of the recommendations in the Law Committee and formulated a response in terms of agreement or disagreement with the particular recommendation.

Where we have disagreed we have included a brief explanation of our reasoning for so doing. The exception to this format is the recommendations in respect of Children and Adolescents.

Our Child and Adolescent Psychiatry colleagues have forcefully argued that a response to each recommendation on a recommendation by recommendation basis is unhelpful and that they should be rejected in their entirety by the College. The submission by the College Faculty of Child and Adolescent Psychiatry to the Law Committee can be read in appendix 4.

There exists broad agreement in the other College Faculties that the issue of children's and adolescents' ability to consent to medical treatment, including psychiatric treatment, needs to be regularised and that as a medical subspecialty psychiatric treatment should automatically come under the ambit of medical treatment and be subject to the provisions of the Non-Fatal Offences against the Person Act 1997.

Responses received from College Faculties are included in the appendix.

Recommendations of the Expert Group and coinciding Response of the College Law Committee

Expert Group	Response of the Law Committee
Guiding Principles	
1. Insofar as is practicable, a rights based approach should be adopted throughout any revised mental health legislation.	**1 & 2 Agreed Broadly** The Law committee broadly agrees with recommendation 1 and 2.
2. The following list of Guiding Principles of equal importance should the specified in the new law: **a) The enjoyment of the highest attainable standard of mental health, with the person's own understanding of his or her mental health being given due respect** **b) Autonomy and self determination.** **c) Dignity (there should be a presumption that the patient is the person best placed to determine what promotes/compromises his or her own dignity).** **d) Bodily integrity.** **e) Least restrictive care.**	We hold the view that the "best interests" concept should not be discarded and should be re formulated along the lines recommended by recent review of the Northern Ireland Mental Health Act. An extended defence of the concept of best interests, as updated, is provided by the submission of the Forensic Faculty, included in the appendix.

Mental Disorder/Mental Illness	
3. Mental disorder should no longer be defined in mental health legislation but instead the revised Act should include a definition of mental illness.	**3 Agreed**
4. The definition of mental illness should be separated from the criteria for detention (see section 2.4 of this report re criteria for detention).	**4 Agreed**
5. The reference to "significant intellectual disability" and "severe dementia" in existing legislation should be removed.	**5 Agreed**
6. The definition of mental illness should be: "mental illness means a complex and changeable condition where the state of mind of a person affects the person's thinking, perceiving, emotion or judgement and seriously impairs the mental function of the person to the extent that he or she requires treatment"	**6** We would note in passing the definition makes no reference to the fact that mental disorders are part of a constellation of disorders of the brain that manifest in neurological, mental health and substance use disorders.

Definition of Treatment	
7. Treatment should include ancillary tests required for the purpose of safeguarding life, ameliorating the condition, restoring health or relieving suffering.	**7 Agreed** The Law Committee is in agreement with recommendations 7-11 respectively.
8. The definition of treatment should be expanded to include treatment to all patients admitted to or detained in an approved centre.	**8 Agreed**
9. Treatment should be clearly defined in revised mental health legislation and clinical guidelines should be further developed for the administration of various forms of treatment.	**9 Agreed**
10. Traditionally the focus of treatment was on the administration of medication, the Group would like to make it clear that treatment includes a range of psychological and other remedies and where treatment is specifically mentioned in this report, it should be interpreted in its wider sense and not viewed simply as the administration of medication.	**10 Agreed** We consider treatment to involve a range of interventions that are rooted in professional and mutually respectful therapeutic relationships and involving behavioural, psychological and medication interventions.
11. The provision of safety and/or a safe environment alone does not constitute treatment.	**11 Agreed**

Criteria for Detention	
12. Detention of a person with a mental illness cannot be permitted simply by virtue of the fact that the person may have such an illness or because his or her views or behaviour deviate from the norm of the prevailing society.	The Law Committee is of the view that the criteria for detention set out in the previous Act are sufficient. We do not regard them as in need of revision at this time and consider that they balance the rights of the patient not to have treatment on an involuntary basis with their rights to treatment of their medical condition, in this instance mental disorder.
13. The recommended new criteria for detention are:	**13 Agreed & Not Agreed**
a) The individual is suffering from mental illness of a nature or degree of severity which makes it necessary for him or her to receive treatment in an approved centre which cannot be given in the community; and	**13a Agreed** Specifically on these criteria the law committee is in agreement with criterion 13 a
b) It is immediately necessary for the protection of life of the person, for protection from a serious and imminent threat to the health of the person, or for the protection of other persons that he or she should receive such treatment and it cannot be provided unless he or she is detained in an approved centre under the Act; and	**13b Not Agreed** We have very significant concerns in respect of the wording of criterion 13 b as the effect of the addition of the adjectives “immediately” and” imminent” will serve to alter the threshold for treatment under the Act and will deprive patients of effective treatment. We are not in agreement with criterion 13 b and in particular with the adjective “immediately” and” imminent”.
c) The reception, detention and treatment of the person concerned in an approved centre would be likely to benefit the condition of that person to a material extent.	**13c Agreed**

14. Detention should only be for as long as absolutely necessary and the person continues to satisfy all the stated criteria.	
15. Immediately a person no longer satisfies any one of these criteria, the admission or renewal order must be revoked. In those circumstances, the person may only remain in the approved centre on a voluntary basis or receive the required services which are provided in the community.	

Exclusions	
16).The involuntary admission of a person to an approved centre cannot be authorised by reason only of the fact that the person – **a) Is suffering from a personality disorder,** **b) Is socially deviant,** **c) Is addicted to drugs or intoxicants, or** **d) Has an intellectual disability**	There has been an extended discussion on recommendation 16 and in particular criterion D; "cannot be authorised by reason only of the fact of an Intellectual Disability". Forensic colleagues have reserved their position on this wording. **The Faculty of Learning Disability Psychiatry is broadly in agreement on this wording**

Capacity	
17. If on admission of a patient, the admitted Mental Health Professional forms the view that the person may lack capacity to understand and give his/her informed consent to the proposed admission, they must refer the person for formal capacity assessment to be completed within 24 hours. The patient will be required to remain in the approved centre until such time as a capacity assessment is carried out.	**17 – 21** The discussion of capacity in these recommendations is very limited. It is clear that any revised Mental Health Act will have to be compatible with the Assisted Decision Making (Capacity) Act 2015. The Law Committee remains of the view that there should be a presumption of capacity on the part of the patient unless incapacity can be demonstrated in respect of a particular decision. All medical staff is trained in the assessment of capacity of individual patients to make decisions in respect of their healthcare and do so on a daily basis. The Irish Medical Council has consistently advised medical practitioners in respect of the need for accurate and informed consent to healthcare interventions.

18. The Mental Health Commission should develop and publish guidelines in relation to the assessment of capacity. Capacity assessment can be undertaken by Mental Health Professionals with the required competencies and such competencies should be accredited by the respective professional bodies who should provide support and training where required. The guidelines should also draw attention to the possibility that external factors such as "institutional influence" can have a bearing on how people react to proposals or questions put to them.	The recommendation in the text and specifically on point 17 that is a formal and external capacity assessment should be completed within 24 hours is incompatible with the current level of resource provision; if this is to be carried out by an external medically trained professional. The committee makes the point that decisions on mental capacity of patients in respect of decisions affecting their healthcare needs are routinely carried out by medical professionals across a range of medical disciplines. **Notwithstanding these reservations in broad terms the committee does not have any fundamental disagreement with recommendations 17-21**.
19. Capacity should be monitored on an ongoing basis by the treating clinicians.	**19 Agreed**
20. If following the capacity assessment, it is deemed that a person has capacity to admit themselves, a voluntary admission may proceed. If it is deemed that they need support to understand, to make, or to convey their decision, that support must be provided to assist in the voluntary admission process. If it is deemed that they do not have capacity in relation to this decision, and the person has a mental illness they may only be admitted on an involuntary basis provided they satisfy all the criteria for detention. A person who lacks capacity and has a mental illness but does not fulfil the criteria for detention, may in specified circumstances be admitted as an "intermediate" patient.	**20 Agreed**
21. Where relevant, information relating to how capacity is assessed and the right of appeal against a decision on their capacity to a Mental Health Review Board should be given to patients. In addition they, and their family or carers if appropriate, should also be given information relating to the supports that may be available to the individual under the proposed capacity legislation.	**21 Agreed**

Voluntary Patient	
22. A voluntary patient should be defined as a person who has the capacity (with support if required) to make a decision regarding admission to an approved centre and who, where the person retains capacity, formally gives his/her informed consent to such admission, and subsequent continuation of voluntary inpatient status and treatment on an ongoing basis as required. This provision should also apply equally to children and their parents or person as required acting in loco parentis. (see also section 2.23 Children)	**22-25 No specific disagreement** We note that capacity is functional and may vary in relation to particular decision making.
23. Lack of capacity on admission does not mean that further decisions relating to the patients treatment should not be discussed with and put to the patient as and when each decision is required. It is important not	

to automatically presume that each person continues to lack capacity when decisions are required.	
24. Where a person is deemed to lack capacity and therefore cannot given informed consent, then admission cannot take place on a voluntary basis even if a substitute decision maker (decision-making representative) has been appointed under the proposed Assisted Decision-Making (Capacity) Bill.	
25. All voluntary patients on admission to an approved centre should be fully informed of their rights, including information relating to their proposed treatment as well as their rights regarding consent or refusal of treatment and their right to leave the approved centre at any time.	

New Category of Patient	
26. The Group recommends a new category of patient known as "intermediate" who will not be detained but will have the review mechanisms and protections of a detained person. Such patients would not have the capacity to consent to admission and equally do not fulfil the criteria for involuntary detention.	**26 Agreed**
27. The Mental Health Commission must be informed of the initial and ongoing admission of this category of patient.	**27 Agreed**
28. The same timeframe recommended for Mental Health Review Boards for involuntary patients should also apply for intermediate patients.	**28 Agreed**
29. The role of the Review Board for this cohort of patients must focus on the question of capacity as, by definition, intermediate patient will not fulfil the criteria for detention.	**29 Agreed**
30. A detailed set of guidelines should be produced for this category of patient and the Mental Health Commission and the Officer of Public Guardian should have a role in this regard.	**30 Agreed**
31. The Group recommends that it would be appropriate for a Consultant Psychiatrist to have the authority to override a refusal of treatment by a decision-making representative in emergency circumstances where treatment is deemed necessary and the person's actual behaviour is injurious to self or others and no other safe option is available.	**31 Agreed**
32. A decision to override a refusal of treatment by a decision making representative should be subject to review by a Mental Health Review Board which would convene with 3 days to decide if the situation presenting to the Consultant Psychiatrist fulfils the criteria for emergency circumstances. If the Review Board agrees that the circumstances were of an emergency nature, then the treatment authorised by the Consultant Psychiatrist may continue for as long as	**32 Agreed** We note that we consider that a decision to overrule a refusal of treatment by a decision making representative should be adjudicated/decided on in advance of a proposed intervention rather than after it by a Mental Health Review Board.

the emergency circumstances prevail subject to other provisions relating to second opinions etc.	
33 Advance healthcare directives should apply for this category of patient on the same basis as that proposed for voluntary patients.	**33 Agreed**

Authorised Officer	
34 The Group recommends that there should be a more expanded and active role for Authorised Officers where involuntary admissions to an approved centre are being considered. This new role can lead to more appropriate and least restrictive treatment for individuals in community or other mental health settings and bring a greater focus on involuntary admission being a treatment of last resort.	**34-41 Broadly in agreement** Multidisciplinary working is usual in healthcare and is usual in patient mental health care. Multidisciplinary working does not abnegate individual and in particular senior clinical responsibility and we note that a decision for detention on grounds of mental disorder is and remains a medical responsibility. It is very clear in the Irish Medical Council's ethic guide that each patient has a nominated consultant who is responsible for their care. The standard HSE 2008 Consultant Contract is also very clear on this point. This responsibility for patient care rests with the Consultant Psychiatrist
35 The Authorised Officer must, after consultation with family/carers where possible and appropriate, make the decision on whether or not an application for involuntary admission of the person should be made.	
36 The group recommends that an Authorised Officer should be the person to sign all applications for involuntary admission to an approved centre (this also includes change of patient status in an approved centre from voluntary to involuntary - see section 2.17 on Change of Status for details). This will have the effect of reducing the burden on families/carers in these difficult circumstances and reducing the involvement of Gardai in the admission process.	
37 An application by an Authorised Officer to involuntary admit a person to an approved centre shall remain in force for 7 days from the time of the first application.	
38 The Group considers that the sequencing of whether the Authorised Officer or the Registered Medical Practitioner sees the patient first is not relevant once they are undertaken independently. However, as regards completing and signing the appropriate documentation, the application for involuntary admission by the Authorised Officer must come first followed by the recommendation from the Registered Medical Practitioner.	
39 Family/carers can request a second Authorised Officer to look at their case if they are not happy with the recommendations of the first Authorised Officer. If some time has elapsed since an Authorised Officer previously assessed a particular individual for involuntary detention, the same Authorised Officer can	

be asked to look again at the case.	
40 Where an Authorised Officer or family/carer seeks the opinion of a different Registered Medical Practitioner, they must disclose the facts relating to the previous application sought.	
41 Where a person is taken into custody by the Gardai under section 12 of the Act, the initial assessment, whether that is by the Authorised Officer or the Registered Medical Practitioner, should take place as soon as possible after the person is taken into custody. The maximum period which the person can be held prior to being assessed by the Authorised Officer or Registered Medical Practitioner should be 24 hours. As second 24 hour timeframe in which both the Authorised Officer and the Registered Medical Practitioner must carry out their assessments commences once the first such assessment is initiated.	

Procedure for an Involuntary admission to an approved centre	
42 The Registered Medical Practitioner must personally examine the person and in recommending detention must clearly clarify how he/she came to the view that the person is suffering from a mental illness and also satisfies the criteria for detention. The Registered Medical Practitioner cannot plan this role if he or she becomes the owner of an approved centre or an employee or agent of such centre, to which the person is to be admitted.	**42 Agreed**
43 Admission must be certified by a Consultant Psychiatrist after examination of the patient and following consultation with at least one other Mental Health Professional of a different discipline that is and or will be involved in the treatment of the person in the approved centre. The opinion of that other Mental Health Professional should be officially recorded.	**43 Agreed**

Patient Firstly Requiring Medical Treatment	
44 Where either the Registered Medical Practitioner who recommended the involuntary admission of the person, a Clinical Director of the approved centre or a Consultant Psychiatrist on the staff of the approved centre, is of the view that the patient first requires medical treatment for physical condition, the patient may first be treated in an emergency department, hospital or clinic.	**We note that recommendations 44-47 received significant comment on feedback from the College membership** **44 Agreed.**
45 The stay at the emergency department, hospital or clinic should be for the shortest time possible and the Mental Health Commission should be notified.	**46 Broadly Agreed** We note if a patient requires treatment for a general medical condition on an emergency basis then that treatment is required and whatever the associated duration of that treatment is the necessary duration.

	This should not be subject to any arbitrary limits simply because the patient is subject to the Mental Health Act.
47 The 24 hour timeframe for the admission process to the approved centre should commence on arrival at the emergency department, hospital or clinic as though it was the approved centre named in the application and the appropriate assessment and the making of an order should be done within that timeframe by the Clinical Director of the approved centre or by a Consultant Psychiatrist on the staff of the approved centre after consultation with a Mental Health Professional of another discipline.	**46 Not agreed** This recommendation takes no account of the actual existing medical circumstances; it may be possible or not possible to progress with the assessment for involuntary treatment and it makes no clinical sense to mandate the time frame in the manner.
48 Throughout this person when the patient is at the emergency department, hospital or clinic, responsibility for the mental health treatment of the person should remain with the Clinical Director of the approved centre to which the patient is being admitted.	**47 Not agreed** This is entirely impracticable in practice; the responsibility of acute medical care rests with the responsible Consultant Physician in the acute hospital setting and transfers to the Consultant Psychiatrist once the patient is medically fit for discharge from the acute hospital setting.

Treatment Prior to Detention	
48. Treatment should not be provided to a patient without consent prior to an admission order being completed unless the Consultant Psychiatrist after consultation (to be officially recorded) with another Health Care Professional is of the opinion that it is necessary in emergency circumstances.	**48 and 49 Broadly agreed** **We note:** Emergency medical situations are governed by common law. Responsibility again rests with the senior medical professional, in this case the Consultant Psychiatrist. Senior medical professionals routinely converse with other members of the multidisciplinary team and the text "after consultation to be officially recorded with another healthcare professional" is not logical and not required
49. Emergency in this situation means that the treatment is deemed immediately necessary, that the person's actual behaviour is injurious to self or others and no other safe option is available.	

Mental Halth Tribunals	
50. Mental Health Tribunals should in future be renamed "Mental Health Review Boards".	**50 Agreed**
51. While decisions about the nature and content of treatment remain within the remit of the multidisciplinary mental health team, Review Boards would have the authority to establish whether there is an individual care plan in place and if it is compliant with the law.	**51 Not agreed** The Law Committee was of the view that Mental Health Review Tribunals do not have the competence to review treatment plans/multidisciplinary care plans
52. Review Boards should also establish that the views of the patient as well as those of the multidisciplinary team were sought in the development of the care plan.	**52 Agreed**

53. The patient's detention must be reviewed by a Review Board no later than 14 days after the making of the admission order or renewal order concerned.	**53 Agreed** We think 14 days is sensible
54. There should be no change in the current make up of Review Boards at this stage. The question of having a one person Review Boards should be re-examined in any future review of the mental health legislation.	**54 Agreed** The Law Committee was in agreement that the current make up of the Review Boards remain. The committee does not agree that the option of one person Review Board should be re-examined
55. The Review Board members must continue to be clearly separate from the original decision-maker and those conducting the independent multidisciplinary assessment for the Review Board.	**55 Agreed**
56. The "other person" appointed to the Review Board should be known as the "community member" and the person appointed to this role should not be or never have been a Medical Practitioner, Nurse or Mental Health Professional, Barrister or Solicitor in the State or in another jurisdiction.	**56 Agreed**
57. A patient should have a legal right to have a Review Board deferred for specified periods (2 periods of 14 days) if that is his/her wish. The deferral would have to be sought through the patient's legal representative.	**57 Agreed**
58. The following individuals must attend a Review Board: **- Legal representative of the patient** **- Responsible treating clinician**	In respect of recommendation 58 it should be the responsible treating clinician or his/her nominated deputy, that is to say a doctor working on the multidisciplinary mental health team.

59. The following individuals may attend a Review Board:	**59 Agreed**
- Patient, who must always have a right to attend the Review Board	
- Advocate at the invitation of the patient exercising his/her right to such support	
- Independent Psychiatrist who undertook pre Review Board assessment if the Review Board so requests	
- The author of the psychosocial report or if they are unable to attend, another member of the multidisciplinary team may attend on behalf of the Review Board so requests.	
60. It should be a matter for the Review Board to decide which additional persons should attend the Review Board hearing other than the absolute right of the patient to attend, their legal representative and their advocate if the patient so requests.	
61. The patient's detention must be subject to an assessment report by an independent Psychiatrist with input (to be officially recorded) from another Mental Health Professional of a different discipline to be carried out within 5-7 days of the Review Board hearing.	**61 Agreed**

62. The range of Mental Health Professionals that the independent Psychiatrist must consult with for Section 17 assessment should be specified.	**62 Agreed**
63. A psychosocial report should also be carried out by a member of the multidisciplinary tram from the approved centre who is registered with the appropriate professional regulatory body (i.e. CORU, Nursing and Midwifery Board or Medical Council) in the same timeframe as that recommended for the independent Psychiatrist report. This report should concentrate on the non-medical aspects of the patient's circumstances.	**63 Agreed**
64. The revised legislation should provide for the oversight of the integrity of the process of Review Boards by the Mental Health Commission in line with best practice.	**64 Agreed**
65. This would include a mechanism to allow information in relation to decisions of Review Boards to be published in anonymised form which will ensure patient confidentiality. This will allow such decisions to be available for the Mental Health Commission and/or the public to view.	**65 Agreed**

Renewal Orders	
66. Renewal orders must be certified by a Consultant Psychiatrist after consultation (to be officially recorded) with at least one other Mental Health Professional of a different discipline involved in the treatment of the person at the approved centre.	**66 Agreed**
67. Renewal orders at present can be for up to 3 months, 6 months or a year. The Group believes that the 3rd renewal order of up to 12 months is too long and should be reduced to a period not exceeding 6 months.	**67 Agreed**
68. Section 15(2) should be amended by adding "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 o renewal order".	**68 Agreed**
69. The Group agreed that there was no need for a "slip-rule" procedure and it was best to leave section 18(1)(a)(ii) as it stands.	**69 Agreed**

Absence with Leave	
70. The provisions of Section 26 regarding permission to be absent from an approved centre for a specified period should be retained with greater clarification being provided in a Code of Practice (to be developed by the Mental Health Commission) which would outline the precise circumstances in which such provisions can be used. The time limit for	**70 Agreed**

such absences should be a maximum of 14 days and they should not be used as quasi-community treatment orders.	

Grounds for Appeal	
71. Grounds for appeal to the Circuit Court should be amended such that the onus of proof as to the existence or otherwise of a mental illness that meets all the criteria for detention falls on the approved centre rather than the patient as is currently the case	**71 Agreed**
72. S.I. 11/2007, Circuit Court Rules (Mental Health) should be amended to reflect the fact that the approved centre should be the respondent in cases brought before the Court and the Mental Health Commission's potential involvement should be as a Notice Party.	**72 Agreed** But further discussion required.

Change of Status from Voluntary to Involuntary	
73. The Group recommends that the existing powers of the Act to initially detain a voluntary patient and to allow for a change of status from voluntary to involuntary must remain. These powers, insofar as possible, should only be used in very exceptional circumstances.	**73 Agreed**
74. A Consultant Psychiatrist who has the clinical responsibility for the treatment of a patient, a Registered Medical Practitioner, Registered Psychiatric Nurse or a Mental Health Professional (registered with CORU in the case of the latter) who considers that a voluntary patient would satisfy the criteria for detention may detain such patient for maximum period of 24 hours initially.	**74 Agreed**
75. The Group recommends that during the initial detention period of 24 hours, an Authorised Officer should be called to attend the approved centre to consult with the patient and staff and make a determination as to whether or not to make an application for involuntary admission.	**75 Agreed**
76. The Authorised Officer must consider the alternatives available, offer advice and mobilise support for the service user and the family where necessary.	**76 Agreed**
77. Where the officer believes that the person satisfies all criteria for detention and there is no alternative to detention, the officer should make an application for an involuntary admission in the normal way (this application must be made within the initial 24 hours referred to above and then be subject to the time restrictions for completion of the process as though it was initiated in the community).	**77 Agreed**
78. A Registered Medical Practitioner who is not the owner of an approved centre or an employee or agent	**78 Agreed**

of such centre, to which the person is to be admitted, should examine the patient within 24 hours of the application being made by the Authorised Officer and determine if there is a need to make a recommendation for admission.	
79. The Group also agrees that it should no longer be a requirement that a patient must first indicate a wish to leave the approved centre before the involuntary admission process is initiated. The Act should also be amended to specifically allow that process to be initiated in such cases in the approved centre in line with the recent High Court ruling on this matter (Judgement of KC v Clinical Director of St. Loman's Hospital).	**79** Agreed
80. The Group recommends that every time section 23 is used to initially detain a patient (even if section 24 is not subsequently used to detain the person) the Mental Health Commission should be notified	**80 Agreed**
81. The Group also recommends that section 24 should be amended to state clearly that the involuntary admission procedure to be followed under the section is similar to the procedure set out in Sections 9, 10, 11 and 14, with any necessary modifications.	**81 Agreed**

Consent to Treatment	
82. The right of voluntary patients to refuse treatment should be explicitly stated.	**82 Agreed**
83. All patients should be supported to make informed decisions regarding their treatment and "consent" as defined in Section 56 relating to consent to treatment should include consent given by a patient with the support of a family member, friend or an appointed "carer", "advocate" or a support decision maker appointed under the proposed capacity legislation.	**83 Agreed**
84. Section 57 should be amended so that the informed consent of a voluntary patient is required for all treatment.	**84 Agreed -** this is the existing standard in medicine.
85. Informed consent is also required from involuntary patients who are deemed capable of giving such consent	**85 Agreed**
86. A Consultant Psychiatrist, after consultation (to be officially recorded) with at least one other Mental Health Professional of a different discipline involved in the treatment of the patient, may administer treatment to a detained patient who lacks capacity where the patient does not have a DMR and the Consultant Psychiatrist considers it immediately necessary for the protection of life of the person, for protection from a serious and imminent threat to the	**86 Agreed**

health of the person, or for the protection of other persons that he or she should receive such treatment and there is no safe and effective alternative available. Where a patient lack capacity but has a DMR appointed under the capacity legislation, the DMR may accept or refuse treatment for the patient.	
87. A Consultant Psychiatrist can override the decision of a DMR to refuse treatment on behalf of an involuntary patient in emergency circumstances where the treatment is deemed necessary, the patient is injurious to self or others and no other safe option is available. A Mental Health Review Board must meet within 3 days to determine that the treatment was given in the appropriate circumstances. If the Review Board agreed that the circumstances were of an emergency nature, then the treatment authorised by the Consultant Psychiatrist may continue for as long as the emergency circumstances prevail subject to other provisions relating to second opinions etc.	**87 Agreed**

88. The Group would emphasize the ongoing need for services to ensure that manual or other forms of seclusion and restraint are used only as a last resort, only where there is no other alternative and always in accordance with the rules drawn up by the Commission.	**88 Agreed**
89. The Group believes it would be more appropriate for the section of the Act (69) dealing with seclusion and restraint to be included in Part 4 of the Act which deals with consent to treatment. The Group also recommends that the section should be broadened to include all forms of restraint including manual or other forms of seclusion or restraint, and appropriate guidelines should be produced by the Mental Health Commission. In addition, it should be made clear that this section applied to patients in the Central Mental Hospital.	**89 Agreed**

Electro-convulsive therapy	
90. Section 59 should be amended to remove the authority to give ECT without consent in any circumstance where the patient is capable of giving consent but unwilling to do so. The Group recommended that the first possible opportunity should be taken to effect this change in the context of any future miscellaneous health bill. Where the patient is unable to give consent but a decision-making representative appointed legally under capacity legislation for the person gives that consent on the patient's behalf, then ECT may proceed.	**90 Agreed**
91. Where a patient does not have capacity and a decision-making representative does not give consent to ECT, such treatment may only take place where it is required as a life-saving treatment, for a patient where	**91 Agreed** Agreed with the modification that the Mental Health Review Board should review and agree the proposed ECT in advance of its application.

there is a threat to the lives of others or where the condition is otherwise treatment resistant, and such ECT may then only be administered subject to approval by a Mental Health Review Board which must convene within 3 days of the decision being taken.	

Administration of Medicine	
92. The reference to "unwilling should be removed from Section 60, and where any patient who has the capacity to make a decision refuses to take medicine, this decision will be respected. The Group recommended that the first possible opportunity should be taken to effect this change in the context of any future miscellaneous Health Bill.	**92 Agreed**
93. Section 60 should also be amended so that medicine may be administered to a detained patient without capacity for the purpose of ameliorating his or her condition for a period not exceeding 21 days. The recommendation to continue the administration of medicine beyond 21 days must be made by the treating Consultant who must also consult with another Mental Health Professional of a different discipline involved in the treatment of the patient and this must be officially recorded. The recommendation to extend the administration of medicine beyond 21 days must also be authorised by a second Consultant Psychiatrist from outside the approved centre.	**93 Not agreed** **We fundamentally disagree with recommendation 93 as it stands**. It is good practice to consult with a consultant colleague before insisting on medication of a detained patient who does not consent to the administration of same. The Law Committee noted there were multiple submissions noting the non-logical nature of the particular requirement to consult with another Mental Health Professional without specifying the discipline of that professional. The Law Committee is definitely of the view, as are members of the College who commented on this recommendation, that the appropriate consultation is with another Consultant Psychiatric colleague or another colleague with an expertise in therapeutics and psychopharmacology. In the usual run of matters this would be with another Consultant Psychiatrist or a Mental Health Pharmacist. No other colleagues on the team have the requisite training or experience in psychopharmacology and therapeutics.
94. Section 60 should be amended to reflect the fact that the continued administration of the medicine concerned must be of therapeutic material benefit to the patient.	**94 Agreed**
95. Further reviews of treatment should be undertaken every three months, and in the case of the first such review, a patient may request that this review take place at an earlier stage.	**95 Agreed**
96. The recommendation to continue the administration of medicine every three months must be made by the treating Consultant who must also consult with another Mental Health Professional of a different	**96 Not agreed** Again the only Mental Health Professional with any confidence to advise on the psychopharmacological treatment of a patient detained or otherwise is another

discipline involved in the treatment of the patient and this must be officially recorded. The recommendation to extend the administration of medicine every three months must also be authorised by a second Consultant Psychiatrist from outside the centre.	Consultant Psychiatrist, or a Pharmacist with a particular training and experience in Mental Health. No other discipline within the multidisciplinary mental health team has any training or expertise in therapeutics or psychopharmacology. There is no disagreement with seeking the agreement of an independent Consultant Psychiatrist from outside the approved centre.
97. Where psychotropic medication is proposed, the views of the patient should be recorded and, if appropriate, consultation held with the patient's family or advocate, also to be recorded. The functions of the Inspector of Mental Health Services could be extended in this area.	**97 Not Agreed.** We are entirely unclear as to what is meant or suggested by this recommendation, particularly in reference to the Inspector, and therefore do not agree with recommendation 97.

Provision of Information on Admission to Approved Centres and Complaints Mechanism	
98. On admission to an approved centre, every patient should have a right to information which would include their rights as a voluntary or involuntary patient, their rights regarding consent to or refusal of treatment, the range of services available in the centre, and any additional information as outlined in the Mental Health Commission Code of Practice.	**98 Agreed**
99. There is also an obligation to ensure that the patient is made aware of the complaints mechanisms in place at the centre and any general complaints mechanism that exists within the service generally.	**99 Broadly Agreed** In broad terms we are agreeable but stress however there are times when patients may not be capable of being made aware owing to their mental state and therefore the rider "where possible" should be added to recommendation 99.
100. The Group re-iterates that it is mandatory for the Inspector of Mental Health Services to meet a patient who had made a complaint when he/she is subsequently inspecting that approved centre and all patients must be informed of this right on admission to an approved centre and on the process for contacting the Mental Health Commission.	This section relates to the function of the Inspector and it is unclear whether this group has the requisite authority to recommend a change in these functions.

101. The Expert Group is not recommending a separate Mental Health Ombudsman at this juncture, however it should be re-examined as part of future reviews of any new Act.	In general terms all Mental Health revision should either come under the ambit of the Mental Health Commission or ideally under the ambit of an overarching Health Information and Quality Authority that would licence and accredit all centres

Care Plans and Discharge Planning	

102. Care planning function should be strengthened and extended to all persons in receipt of mental health services and provide a seamless recovery based approach towards discharge and support in the community.	This seems a reasonable aspiration and we have no disagreement with it as an aspiration. We would note that there exists a significant additional resource requirement to make this recommendation a reality.
103. Recovery plans should be reviewed on a regular basis and the timing of the reviews should be decided based on the patient's individual needs.	**103 Agreed**
104. Patients must be offered the opportunity to sign off on recovery plans and this must be recorded.	It is unclear what is being suggested but on the basis that there exists a written care plan, a formal sign off on same between patient and team would seem reasonable
105. Evaluation and feedback should form part of the review of a recovery plan and there should be a need to show evidence of the undertaking of a review.	**105 Not Agreed** It is unclear what exactly is being recommended in operational terms, and as we are unclear we are **not in a position to agree 105.**
106. Wording of the legislation should be amended to ensure that it is the multidisciplinary team that has responsibility for the clinical content of recovery plans rather than the proprietor	**106 Agreed**
107. Care plans should be renamed as recovery plans and should refer to the person rather than the patient.	**107 Not Agreed** Care plans should remain and as a person is in receipt of behavioural, psychological and medical treatments the person should be continued to be referred to as the patient, as that is the nature of the relationship between the patient and the medical professionals involved in his/her care.
108. Discharge plan must not form part of a person's individual recovery plan.	**108 Not Agreed**
109. It is desirable that discharge planning meetings should take place with family members, carers or chosen advocate (with the consent of the patient) and there should be robust codes of practice produced on their implementation.	**109 Not Agreed** **Not agreed as wording is unclear** Agree with the concept, communication with family and relevant others with patient consent but it is unclear what is meant by robust code in this context.

110. Section 66 should be strengthened further to cover community based services	**110 Not agreed** It is unclear what is being suggested by recommendation 110.

Children and Adolescents	
Recommendations 111-123	**111-123 Not Agreed** As noted earlier in the text CAP Faculty have noted their disagreement with the process that led to these recommendations and the inadequate nature of these recommendations. CAP has recommended rejection of these recommendations and this position is endorsed by the Law Committee at this time

124. The Group recommends the registration and inspection at regular intervals of the following mental health services: **- Phase 1: Continue to register approved centres and inspect at least once in every three years and more often according to targeted risk.** **- Phase 2: Register all community mental health teams and inspect against an increasing proportion of the services provided in the community.** **- Phase 3: Register all High, Medium and Low Support Hostel; Crisis/Respite Houses; any other Residential Services; Day Hospitals, Day Centres and other facilities in which mental health services are provided and introduce inspections on a phased basis.**	**Phase 1 Not Agreed** We do not agree that yearly inspections should be discontinued and move to 3 yearly. **Phase 2 and phase 3 Agreed** That is to say the committee recommend ongoing yearly inspections of approved centres.

125. The new Act should give the Mental Health Commission specific powers to make standards in respect of all mental health services and to inspect against those standards. The Standards should be made by way of regulations and the regulations should be underpinned by way of primary legislation.	**125 Agreed** There is a broader issue as to whether mental health services and in particular community and approved centres should come under the agesis of an overarching health accreditation authority. We are not in any specific disagreement with 125 as it currently stands

Advanced Healthcare Directives	
126. The introduction of legislation providing for advance healthcare directives which should apply to mental health on an equal basis with general health is recommended.	**126 Agreed**
127. Notwithstanding the introduction of legislation on advance healthcare directives as part of the Assisted Decision-Making (Capacity) Bill, the Group recommends that when revised mental health legislation is being framed, it either amends the Assisted Decision-Making (Capacity) Bill if necessary or introduces provisions in mental health law to deal in a more complete and comprehensive manner with the operation of advance healthcare directives in the area of mental health in the longer term.	**127 Agreed**
128. In particular, the authority to override a treatment refusal where a person's health as opposed to life is at risk should be re-visited again when mental health legislation is being framed.	**128 Agreed**
129. An advance healthcare directive should state in clear and unambiguous terms the specific treatments to which it relates and also the particular situations in which the treatment decisions are intended to apply.	**129 Agreed**
130. Advance healthcare directives should be recorded in the person's recovery plan.	**130 Agreed** We believe that advanced healthcare directives should be recorded in the patient's care plan.

131. If an advance healthcare directive is overridden, the Inspector of Mental Health Services should be notified within 3 days and it must be included in the Inspectors report on the approved centre.	**131 Not Agreed** We do not agree that an Advanced Healthcare Directive (AHD) made by a competent adult person should be overridden by a team involved in their care, without legal authorisation of same. Sanction to override such a directive should be sought from the High Court in the same manner as sanction to override an AHD in the treatment of other somatic conditions. There should be a legal process that would authorise, or not authorise as determined, non adherence on the part of the treating team with a patient's advanced healthcare directive
132. A valid and applicable advance healthcare directive may be overridden if at the time when it is proposed to treat the person, he or she is suffering from a mental illness and his/her detention and treatment is regulated by Part 4 of the Mental Health Act 2001 and/or by the Criminal Law (Insanity) Act 2006. (This is merely nothing the proposed provision to this effect in the Assisted Decision-Making (Capacity) Bill).	**132 Not Agreed** A valid and applicable advanced healthcare directive may be overridden even if at that time when it is proposed to treat a person he/she is suffering from a mental illness and his/her detention and treatment is regulated by part 4 of the Mental Health Act 2001 and/or by the Criminal Law Insanity Act 2006 (this is merely noting the proposed provision to this effect in the assisted decision making capacity bill). We have noted in our response of the Assisted Decision Making Capacity Bill 2013 that advanced healthcare directives should apply equally in the area of physical and mental health. An Advanced Healthcare Directive should not be subject to being set aside simply by reason of the fact that the patient at the time has his treatment regulated by part 4 of the Mental Health Act 2001 or by the Criminal Law Insanity Act 2006.
133. Guidelines on advance healthcare directives should also be produced by the Health Information and Quality (HIQA) and the Mental Health Commission with the involvement of the appropriate professional regulatory bodies.	The enactment of the Assisted Decision Making Capacity Act 2015 would address these concerns.

Contact with Families and Doctor Patient Confidentiality	
134. Where it is deemed appropriate, there should be proactive encouragement for the patient at all stages to involve his/her family/carer and/or chosen advocate in the admission process and in the development of the care and treatment plan with the patients consent.	**134 Agreed**
135. All relevant professional bodies involved in mental health care should write into their codes of practice	**135 Not Agreed** We note it is for the Medical Council as the regulatory

guidelines for practitioners the need to involve families/carers in the development of care and treatment plans with the patients consent especially in cases of serious and enduring mental health problems.	organisation for all medical professionals including Consultant Psychiatrist to make a decision on their Ethical Guidelines. This body has no competence in this regard. We also note that contact with any other individuals/bodies in respect of treatment of physical or mental illness can only be with the consent of the patient unless otherwise directed by law. There exists no need to involve any other persons routinely save with the consent of the patient.

Mental Health Commission	
136. The Mental Health Commission should bring their matter before their Health Social Care and Regulatory Forum to highlight the importance of the points made and to explore how best the relevant provisions could be expressed in codes of ethics/practice and guidance in this area by each of the professional regulatory bodies.	**136 Not Agreed** The Health Social Care and Regulatory Forum or the Mental Health Commission does not have any competence or authority in the framing of codes of ethics for medical professionals.
137. The Mental Health Commission should develop more detailed guidance in this area for application right across the mental health sector.	**137 Not Agreed** Further discussion of this complex area could be facilitated by the Mental Health Commission. We do not agree that it develop guidance as this is provided by varying professional regulatory organisations.

Approved Clinician	
138. The Group did not recommend the introduction of an "Approved Clinician" at this stage.	**138 Agreed** Law Committee is not in agreement with the introduction of an approved clinician status ie a non medically trained professional who would have authority under the Mental Health Act to detain or discharge patients on grounds of their medical diagnoses
139. The Group believes that the introduction of an "Approved Clinician" should be considered again as part of future reviews of the legislation	**139 Not Agreed** The Law Committee and many colleagues are very clear that we are not in agreement with recommendation 139. Detention on grounds of mental disorder requires certification of the presence of mental disorder and the appropriate clinicians with the requisite competence and experience are medically trained doctors. Reference Winterwerp v the Netherlands the European Court ruling – see appendix 1 page 27/28

Miscellaneous	
140. When revised mental health legislation is being drawn up, membership of the Mental Health Commission should be reviewed in its totality as it is currently limited mostly to professional groups and is	**140 Not Agreed** **This is a truly awful paragraph.** The Law Committee does not have any objection in

not in keeping with the current policy to appoint through the Public Appointments Service. Occupational Therapists are currently not represented on the existing Mental Health Commission. The criteria for membership should be based on the necessary skills and competencies required to govern. Ideally professional and service user insight should be achieved through membership of the Commission by persons who also have the necessary skills and competencies required to govern. However if that is not possible, the Group suggests that professional and service user views could either be received by way of provision of statutory advisory committees to the Board.	principle to appointments to the Mental Health Commission being made from service users, carers and across the broad range of professions involved in multidisciplinary Mental Health Care. **We recommend this paragraph be recomposed to reflect this aspiration.**
141. Appointments to the Commission should be staggered so that no more than half the membership would be due to complete a term at any one time. This should allow for a greater degree of continuity at Commission level rather than the current practice of members all reaching the end of their term at the same time. Section 36 of the Act (Terms of office of members of Commission) will need to be amended.	**141 Agreed**
142. In addition, it should be clearly stated that no Commission member may service more than two consecutive terms.	**142 Agreed**
143. Statuatory responsibility for standards in mental health services (i.e. Mental Health Commission Quality Framework) should be explicitly referred in a revised section 33 of the Act which specified the function of the Mental Health Commission.	**143 Agreed**
144. Section 55 of the Act allows the Inspector of Mental Health Services, or such other persons, if asked by the Commission, to inquire into certain matters as set out in this section. However, this section is silent in relation to the powers that the Inspector or other persons would have to assist them carry out the inquiry. The Inspector can rely on the explicit powers vested in him/her and assistant inspectors elsewhere in the Act, but the other "person" currently has no powers. The section dealing with inquiries should specify the powers that the inquirer (Inspector or other persons) has for carrying out the inquiry. It is suggested that the powers of the Inspector outlines in Section 51(2) are explicitly included in a revised Section 55.	**144 Agreed**
145. Section 51 (1)(iii) of the 2001 Act should be amended to ensure that there is compliance by approved centres with "all" codes of practice prepared by the Commission including the standards in mental health services.	**145 Not Agreed** This recommendation needs to be re-worded before endorsement.
146. The Group believes that it would be more appropriate to rename "approved centres" as	**146 Agreed**

"registered inpatient facilities".	
147. The Act should be amended so that the Inspector must visit a centre and provide a report to the Commission regarding the suitability for registration prior to it being entered in the register of approved centres.	**147 Not Agreed** This appears a particularly onerous recommendation and would impact significantly on time available to the Inspector to fulfil their other duties under the Act.
148. There are a number of amendments required in relation to the registration of approved centres which would include the definitions of "approved centre", "in-patient", "resident" and "registered proprietor". These details should be examined in more detail when revised legislation is being drawn up.	**148 Not Agreed**
149. The Mental Health Commission should have the authority to establish that a registered proprietor, or intended registered proprietor, and each other person who will participate in the management of the approved centre is a fit person to be the registered proprietor of the approved centre and to participate in its management.	**149 Not Agreed** **Disagreed as Unclear.** It is unclear what is actually being suggested and how this is to be achieved. On that basis we cannot at this time support recommendation 149 in its current wording.
150. Section 64 should be amended to ensure that where a registered proprietor is complaint with the Act of Mental Health Commission requirements under the Act in relation to one centre, any decision to de-list the registered proprietor may be deemed to apply only in respect of that one centre or should include other centres as specified by the Commission.	**150 Not Agreed** **Disagreed as Unclear.** Again this is unclear; check on majority view in relation to endorsement or non endorsement.
151. The procedure for removing a condition on the registration of an approved centre as detailed in section 64 (11) (a) of the Act needs to be amended as it currently requires that if the Mental Health Commission wants to remove a condition attached to a registration, it must first issue a proposal to the applicant or the registered proprietor to do so and afford the registered proprietor 21 days to make representations before it makes its decision. The Commission then makes its decision and informs the registered proprietor that it has 21 days to appeal to the District Court. This procedure is appropriate where the Commission is attaching a condition but not where a condition is being removed.	**151 Agreed**
152. The 2001 Act does not address the issue of closure of approved centres and what followed if a closure takes place. The Group acknowledges that to some extent this has been dealt with in the Mental Health Act (Approved Centres) Regulations 2006 (S.I. 551 of 2006) which provide directions in relation to notice to the Commission of the intention to close an approved centre and the transfer of voluntary patients. It is recommended that section 64 of the Act (Registration	**152 Agreed**

of approved centres) should be amended to provide for this scenario.	
153. The Mental Health Commission should be able to request a Statutory Regulation Report from an approved centre in a manner specified by the Commission before they attach a condition.	**153 Not Agreed** **Disagree Unclear** It is unclear what is intended by this recommendation. The formulation is unclear and cannot be endorsed.
154. Provision for the charging of appropriate fees for registration and inspection of centres or services should be considered when revised mental health legislation is being drawn up.	**154 Agreed**
155. Tribunal members are currently appointment for a three year period under section 48(6) of the Act and the Group believes that in future members of Mental Health Review Boards should be appointed for a five year term. In addition, it should be clearly stated that no member may severe more than two consecutive terms.	**155 Agreed**

Appendices

Appendix 1:

Faculty of Forensic Psychiatry

Response to the Expert Group's Review of the Mental Health Act 2001

The faculty of Forensic Psychiatry welcomes the publication of the Expert Group's review of the Mental Health Act 2001. As part of its terms of reference, the Expert Group adopts a rights-based approach to the review with the aim of making recommendations that bring Irish mental health legislation in line with the European Convention on Human Rights (ECHR), the UN Convention on the Rights of Persons with Disability (CRPD) and government mental health policy (*A Vision for Change*). Whilst the report provides some useful discussion, we have identified a number of serious limitations with the review process, the scope of the review and the reports' recommendations that will very likely compromise the stated goal of ensuring "that the rights of a vulnerable section of our population are protected" (p6).

Our main concerns are as follows:

Group composition

There was no representative general practitioner (or primary care representative) on the expert group for the majority of its tenure. No reasons are given as to why a replacement was not found in July 2013 when the incumbent GP stepped down. This was a serious omission. Primary health care is pivotal in the provision of mental health services. GPs are at the coal-face of treatment and management of mental health problems in the community. As registered medical practitioners, GPs are central to the process of administrating the Mental Health Act 2001 in cases where applications for involuntary admissions are made. Similarly, there was no representative from Child and Adolescent Mental Health Services. This was also a serious omission.

Removing "best Interests" as a guiding principle

A revised list of guiding principles of equal importance is proposed (Recommendation 2). Placed alongside a right to enjoy the highest attainable standard of mental health are the rights to autonomy and self-determination, dignity, bodily integrity and least restrictive care. The Group recommends the elimination of "best interests" as a guiding principle taking the view that "best interests as it has been interpreted and applied, is at the opposite end of the scale from autonomy" (p.12).

Throughout the report "best interests" is portrayed as an outmoded approach to mental health care which should be superseded by the "free will and preferences" of the individual and that somehow "best interests" and "recovery" are conflicting principles. In pursuing a rights-based approach to the review the Expert Group's guiding philosophy is a Libertarian and Legalistic one. In this vein the report presents a narrow interpretation of human rights legislation and misrepresents the recovery principles as set out in *A Vision for Change*.

We believe that there are more balanced ways to follow a rights-based approach which would better safeguard patient rights. Our view is that removal of the "best interests" principle would take away an important safeguard which protects and upholds the human rights of our patients.

Best Interests and the Doctor-Patient Relationship

The principle of "best interests" is an integral part of the doctor-patient relationship and the medical-decision-making process. As medical practitioners we are bound by the four pillars of ethical medical practice: autonomy, beneficence, non-maleficence and justice. Thus medical ethics dictates that doctors must respect the will and preferences of their patients giving due regard for dignity, bodily integrity, privacy and autonomy. "Best interests" arises from the principle of beneficence and is an essential component of the doctor-patient relationship. The imperative to consider a patient's "best interests" is highlighted in the Irish Medical Council guide for registered medical practitioners which requires that "doctors must always be guided by their primary responsibility to act in the best interests of their patients, without being influenced by any personal consideration". It is therefore incumbent upon all medical practitioners to act in their patient's best interests whilst respecting their will and preferences. It is a fundamental precept of medical decision-making that it is informed by an understanding of what is in a patient's "best interests". This applies as much to agreeing treatment and care plans in community settings as it does to making decisions to detain involuntarily in an approved centre.

In the latter scenario, where medical expertise is a legal requirement (see below), the doctor-patient relationship becomes a vital conduit for recovery. In this context the concept of recovery best describes a therapeutic journey from a position of vulnerability and impaired capacity towards increasing autonomy and personal responsibility. Where mental disorder has intervened to impair a patient's decision-making capacity, it is part of the medical duty of care to assist in the restoration of decision-making capacity as far as is practicable or medically possible.

In the specific circumstance of involuntary admission, not being explicit about "best interests" has the potential to cause conflict between patients, their treating psychiatrist and their multidisciplinary teams. In itself involuntary detention is highly sensitive and carries the risk of rupturing the therapeutic relationship. An honest and accurate representation from the outset of the rights and responsibilities germane to an involuntary admission is essential in mitigating this risk and for its future reparation of the doctor-patient relationship where necessary. There is no place for any sense of falsehood or deception in these circumstances. Assisting patients to make autonomous, informed choices about care and treatment to the fullest extent possible requires consideration of patients' best interests. Retaining "best interests" as a guiding principle can therefore be seen as supporting the doctor-patient relationship and conversely its removal as unsupportive to patients' recovery. There is existing legal precedent requiring consideration of "best interests". Medical expertise, and therefore consideration of "best interests", is a legal requirement for detention under mental health legislation in order to uphold an individual's right to liberty under **Article 5 of the ECHR**. **In the case of Winterwerp v the Netherlands** the European Court ruled on the

deprivation of liberty of those with a mental disorder, stipulating that in order for the detention of "person of unsound mind" to be lawful (under article 5(1)e of the ECHR), the following minimum criteria must be satisfied:

Except in emergency cases, no one can be deprived of liberty unless he or she can be

- Reliably shown to be of unsound mind on the basis of objective medical expertise.
- The mental disorder must be of a kind or degree warranting compulsory confinement.
- The validity of continued confinement depends on the persistence of the disorder.
- The court also held that the detention must be effected in accordance with a procedure prescribed by law.

The Winterwerp ruling is explicit in the requirement for medical expertise in making a decision to detain an individual with a mental disorder. While this requirement exists, "best interests" should always be a guiding principle in making decisions for involuntary admissions under mental health legislation.

Recommendation regarding "best interests" - In the interest of protecting patients' rights and promoting recovery it would be far more helpful to retain the term "best interests" and define how it should be interpreted with respect to the other guiding principles.

We therefore strongly recommend the retention of "best interests" as one of the guiding principles in the Act with rules to protect against an overly paternalistic interpretation. For example, the **Northern Irish Mental Capacity Bill 2014** proposes the consideration of the individual's "past and present wishes and feelings", "beliefs and values", and "other factors that [the person] would be likely to consider if able to do so" with a requirement to "consult the relevant people about what would be in [the person's] best interests" and "take into account the views of those people (if practicable)". We believe that this approach would best serve, in the fullest manner possible, to protect an individual's rights and to preserve the therapeutic relationship with treating team and doctor and thereby uphold the principles of recovery.

Raising the threshold for involuntary admission

The Group asserts "that in order for the definition (of mental disorder) to be compliant with the ECHR and CRPD, it needed to be more focused" (p 16) and thereby recommends that the definition of mental disorder be revised to "raise the standard of proof" in order to "limit the number of involuntary admissions to the greatest extent possible" (p 16). To this end the proposal for a revised definition removes "significant intellectual disability" and "severe dementia" as criteria for mental disorder. Furthermore it is recommended that the term "mental illness" should be adopted in preference to "mental disorder" which, according to the group "reflects a strongly medical model approach to mental illness" (p 16). Contrary to the groups assertion we believe there is nothing within the EHCR or the CRPD that advocates that State Parties should narrow the definition of mental disorder in mental health legislation. The groups stated goal of limiting involuntary admissions to the greatest possible extent is arbitrary. There is no discussion as to how this recommendation would protect an individual's human rights. Removal of the terms dementia and intellectual disability from the definition is arbitrary. There is no consideration of the likely consequences of such measures. In our view the approach recommended by the Expert Group will in fact infringe the rights of individuals with mental disabilities as set out in the CRPD. The report

advocates to be taken as if it is self-evident that it will protect an individual's rights. We believe that this recommendation again reflects a narrow interpretation of a rights-based approach to the review. No consideration is given to the consequences of such an approach. No consideration is given to evidence to support this approach. We believe it is likely to have negative consequences for the rights it purports to uphold. CRPD Article 25 Health Article 25: "States parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability." The Group does not provide any substantive reason for the recommendation to remove "significant intellectual disability" and "severe dementia" from the definition of mental disorder. The report, in addition to spuriously invoking the EHCR and CRPD as requiring a focused definition of mental disorder also cites criticism from the Committee for Prevention of Torture (CPT) for admitting intellectually disabled individuals to psychiatric units. However, while acute psychiatric units may not be appropriate therapeutic settings for settings for people with dementia or intellectual disabilities the CPT's criticism is more an argument for assessing the needs and developing appropriate therapeutic inpatient facilities for treating such individuals involuntarily where the need arises. There is compelling evidence that chronic cognitive impairment is a core feature of serious mental illness. Thus serious mental illness has much in common with other disorders of cognition like dementia, intellectual disability and acquired brain injury with may impair decision making capacity. The decision to remove dementia and intellectual disability is arbitrary and discriminatory. In addition to a lack of appropriate facilities the absence of any statutory protection under the Mental Health Act will guarantee that individuals with chronic cognitive impairments will be denied access to appropriate treatment in an appropriate environment in a timely fashion. The current wardship legislation and future capacity act will do nothing to help their plight.

CRPD Article 3 General Principles

Article 3(c): "Full and effective participation and inclusion in society" Raising the threshold for admission will result in increasing numbers of mentally disordered individuals entering the criminal justice system. The Groups' response to the latter concern is perplexing. Referring to the potential "unintended consequence of certain people ending up in the criminal justice system rather than seeking or accepting treatment" the report outlines the Group's belief "that if it is deemed that an individual needs treatment for mental illness members of the multidisciplinary team should clearly explain the need to the individual and outline the options for treatment available to the individual". The report avers to the right of an individual to make bad decisions where they have decision making capacity.

This blinkered view of the rights of the individual is naïve to the clinical realities. The patients in question have serious mental disorders, impaired insight into their mental disorder and lack decision making capacity. They are frequently socially disadvantaged and disenfranchised, homeless and substance abusing. While the aspiration is always towards treating individuals in the least restrictive fashion, community mental health services are simply ill equipped and inappropriate to manage the complex treatment needs of these difficult to engage individuals who

not infrequently require hospital admission. More barriers to admission will further alienate this group of patients and do nothing to promote their participation and inclusion in society.

Article 2 ECHR (Right to Life)

It is our view that arbitrarily raising the threshold for admission will deny timely access to treatment for those most in need of it and this will in turn increase the likelihood of serious adverse outcomes. This should be considered in the context of an individual's rights under Article 2 (Right to Life) of the ECHR and the responsibilities of the state in this regard.

In **Osman vs UK** the positive obligation on a state to protect life owed under Article 2 of the ECHR was established. This obligation can be shown to be violated if: (i) the authorities knew or ought to have known of the existence of a real and immediate risk to life, and; (ii) that they failed to take adequate measures to avoid that risk. In the **UK the Supreme Court (Rabone & Anor v Penine NHS Care Trust)** has ruled that this operational duty has been extended to include a duty upon the state to protect specific individuals from threats to their life from suicide.

Reducing involuntary admissions to the greatest possible extent by increasing the threshold for admission will in our opinion increase the risk of breaches of the positive obligation under Article 2. It is noteworthy that an independent review is underway in the UK looking at the provision of adult inpatient facilities. This was instigated following an analysis of coroners' reports linking seven suicides and one homicide to not being able to access inpatient care. Recommendation regarding increasing the threshold for involuntary detention the term "mental disorder" should remain and the definition should include "severe dementia", "significant intellectual disability" or equivalents.

We suggest consideration of other legislative measures to protect the rights of vulnerable individuals with serious mental illness who require involuntary admission. In the UK Section 117 of the mental health act places a statutory obligation on health authorities and local social services in conjunction with voluntary agencies to provide after-care for certain categories of detained patients. Similar amendments to the Mental Health Act 2001 could enable the executive to be called to account for any shortfalls in the provision of mental health services and thereby protects patients' rights.

We propose a need for further consideration of the rationale for and consequences of raising the threshold for admission through legislation as recommended by the Expert Group and as part of current mental health policy aimed at reducing acute admission bed capacity. At some point increasing legal thresholds for involuntary admission and reducing in bed capacity will necessarily compromise access to inpatient care for the sickest and most vulnerable patients. To anticipate when this tipping point may be reached, if not already, a comprehensive evidence-based needs assessment is required in order to determine the balance of mental health service

provision between community and hospital including the type (secure vs non secure) and number of inpatient mental health beds required. We must avoid service provision and planning based on narrow interpretations of human rights legislation and learn from the international experiences of deinstitutionalisation in order to protect the rights of our patients.

Yours sincerely

MCRN 22584 Dr Stephen Monks
Chair of the Faculty of Forensic Psychiatry

MCRN 147095 Dr Ronan Mullaney
Vice Chair

Appendix 2

Faculty of Old Age Psychiatry

The Faculty welcomes the review and congratulates the expert group on a thorough and thought provoking report. While involuntary patients need to be protected by legislation this should not impact detrimentally on voluntary patients. A concern is that the resources required to meet all provisions of the Mental Health Act will not also be provided to voluntary patients, at least not without a massive increase in resource to the mental health services overall.

2.1 Guiding Principles – the group has been clear in the reasoning to move from 'best interests' to will and preferences and to add dignity as a guiding principle. However the lack of clarity regarding 'dignity' may leave clinical staff working in a grey area dealing with the most ill patients.

Other jurisdictions use 'reciprocity' to balance some of the restrictions resulting from use of the Mental Health Act to detain patients. This puts the onus on health services to provide the resources needed to improve the individual's mental health. Was this considered in the review?

2.2 Mental disorder/Mental illness – from an old age psychiatry viewpoint dementia care is a significant part of the workload. However the lines between moderate / severe dementia are unclear and raise difficulties if an individual needs to be detained. Currently a patient can be detained if they have severe dementia, not if they have a moderate dementia, unless there is another mental disorder that meets the terms of the Act. Removing this category simplifies the issue to whether a person requires treatment for a mental health issue regardless of the severity of their underlying dementia. This is positive.

2.3 Treatment – many older patients have a mental disorder complicated by physical ill health, so including ancillary tests under treatment makes absolute sense. The addition of recommendation 11 is important to prevent patients being detained purely to keep them safe when alternative options are available (albeit often slower) and more appropriate to people with dementia.

2.6 Capacity – clear guidelines need to be developed in line with the changes to the Mental Health Act so the clinical staff are not left in limbo managing recommendation 17. Clarity needs to be given to who can complete these assessments - is it the treating consultant, another member of the MDT or an independent clinician? The awaited incapacity legislation is hugely important in managing this group of people who currently are managed in a variety of ways. The 'intermediate' patient is potentially helpful; however some patients with dementia may remain actively psychiatrically unwell for months or longer with a requirement to be managed in an approved centre. As an Old Age sychiatrist may have a significant number of these patients at any one time the review mechanisms will have a considerable resource implication for the individual psychiatrist and their team. How will

this be balanced? Patients with responsive behaviour secondary to dementia tend to settle over weeks if not months, so the timetable of review is too quick to see significant change between tribunals.

Recommendation 29 states the focus of the Board will be on the question of capacity. While it is accepted that patients can regain capacity if they have a functional illness whatever age they are this is unlikely for patients with moderate to severe dementia which makes this recommendation unhelpful. Surely the focus should be on how best to improve the patients' current behaviour/situation with a view to ensuring the best possible outcomes.

Recommendation 33 – there needs to be greater encouragement for patients to consider AHDs.

2.9 Authorised Officers – we welcome the increased use of authorised officers to take pressure of families and prevent damaging conflicts.

2.10 not allowing the consultant psychiatrist to recommend detention creates difficulties particularly in small communities where GPs may find it difficult to detain a patient who they may know well. Surely if a known patient is clearly becoming unwell it may be reasonable for the responsible consultant to be involved in the detention. Most of us (all of us?) do not tend to go looking for people to detain but may have situations where a patient clearly needs to be treated in hospital but the GP is reluctant to be involved.

Recommendation 59 – for training purposes - may trainee psychiatrists or other trainee mental health professionals be allowed to observe tribunals - vary in whether or not they agree to this.

Recommendation 63 – will there be guidance issued as to what the psychosocial report entails and who may be allowed to do it?

Recommendation 72- given it is the tribunal service that affirms the detention it is unclear why it is the approved centre that should be the respondent.

Recommendations 79 and 90 – excellent.

Recommendation 136 – agree all clinical staff need to be clear and confident about information sharing, and confidentiality and we would welcome clarity from professional bodies regarding this complex but crucial issue

Recommendation 138 – given the current legal and professional case law in this county for Consultants an approved clinician cannot be considered at this time.

With regard to patients with dementia we have concerns that the act might be used as a way of accessing medical treatment for patients with dementia who do not require inpatient psychiatric treatment. Because of the recommendation that the definition of severe dementia (which includes currently a requirement for severe psychiatric or behavioural symptoms) will not be included anymore, and because of the possibility that patients can be transported to ED before going to the psychiatric unit, it is likely that the Mental Health Act would be considered as a way of accessing medical treatment for patients with dementia. Many of us have experience of this happening already (i.e. GPs using the assisted admission team to bring acutely ill elderly patients who are refusing medical treatment to hospital).

We would recommend that when considering changes to the Mental Health Act efforts are made to safeguard against this possibility. One suggestion is that recommendation 16 would include dementia. i.e. involuntary admission cannot be authorised by reason only of the fact that the person has dementia.

Appendix 3.

Faculty of Liaison Psychiatry

Following on from the Faculty of Liaison Psychiatry meeting yesterday, and further discussion with Prof Brendan Kelly, we wish to note that we greatly appreciate all the work that members of the College, in particular Prof Brendan Kelly, have put into this review process.

We agree with the Expert Group recommendations, and particularly emphasise the importance of an integrated progress with Capacity Legislation in a timely manner. We welcome the clarity the Expert Group has brought to the application of the Mental Health Act for patients who require general medical inpatient care.

Finally, we remain concerned about the ongoing inequity regarding the age of consent for patients who require medical or surgical treatments (over 16 years) vs psychiatric treatments (over 18 years).

Appendix 4.

Faculty of Child and Adolescent Psychiatry

The Faculty of Child and Adolescent Psychiatry has reviewed the Expert Group Report on the Mental Health Act 2001, with particular interest regarding the section relating to children.

It is unfortunate that the membership of the Expert Group did not include expert representation from Child and Adolescent Psychiatry. This prevented information on the practical operation and experiences for children following the implementation of the Mental Health Act 2001. It prevented necessary expertise regarding presentation, assessment, diagnosis, and treatment of mental health disorders, and discussion of issues that arise for children, either within CAMHS or during admission to approved mental health centres.

We wish to express our disappointment and concerns that the recommendations from the Expert Group did not address the key practical issues which have arisen from the operation of the Mental Health Act 2001 (the Act). This includes the following examples:

- The lack of a specific section dealing with aspects of admission and treatment of young people under the Act.
- The process and procedures required to enable admission of children in the care of the state to an approved centre.
- A lack of clarification regarding the provisions for treatment for children following admission under the Mental Health Act 2001.
- A lack of clarity regarding the provision of medical assessment and treatment, in particular during the treatment of young people with eating disorders.
- Challenges regarding the process of involuntary admission of children and young people.

The Expert Group makes recommendations regarding the assessment of capacity and consent of 16 and 17 year olds, with separate comments for those younger than 16 years. These recommendations proposed are confusing, convoluted, and lack clarity regarding the process of assessment and determination of capacity by the courts, and the interaction with parental rights to provide consent. It does not consider how a mental health disorder may interact with presumed capacity, and how the judiciary is expected to make the determination. These factors present serious practical obstacles to implement the process.

There are inaccuracies in the report, as for example on page 69, it states “the 2001 Act has also incorporated various aspects of the Children Act 2001, whilst these are referred to specifically in section 25(14) the detailed provisions are not quoted”. The Mental Health Act does not incorporate the Children Act but does incorporate aspects of the Child Care Act 1991, some of which are referred to in Section 25 (14).

The current Section 25 arrangements are a potential human rights violation and unsafe. The Act does not support an adequate independent review of children receiving enforced treatment or detention. An application can lead to the denial of civil liberty without mechanism for the child to appeal and without mechanism to make representation in court. The Act provides no right of audience to court for the individual denied liberty under Section 25 of the MHA. We recommend that all provisions for the admission and treatment of young people to approved centres under the Act are provided within a separate section of the Act. We recommend that the Expert group reconvene a working group with recognised experience, as recognised in law, to participate effectively in developing recommendations. This working group must include experienced practitioners within the field of Child and Adolescent Psychiatry. The Faculty of Child and Adolescent Psychiatry will always remain available to support the deliberations to promote safe and knowledge based developments in the interests of children and adolescents.

Yours sincerely

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Chair
Faculty of Child and Adolescent Psychiatry

Dr Lisa Kelly
Vice Chair