Centre for Disability Law & Policy
NUI Galway

Submission to the Department of Health on its Review of the *Mental Health Act 2001*

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The Centre welcomes the opportunity to make this submission on the review of the *Mental Health Act 2001*. The Centre for Disability Law and Policy (CDLP) at the National University of Ireland Galway was formally established in 2008. The Centre's work is dedicated to producing research that informs national and international disability law reform. Since its establishment, the CDLP has organised a number of key events to provide a space to discuss disability reform, such events include: an International PhD Colloquium (2010), an international conference on national disability strategies (2010) and a Summer School in conjunction with the Harvard Project on Disability (2011). The Centre regularly runs seminars and public lectures and produces policy briefings. The CDLP runs a Ph.D programme and a Masters (LL.M) in International and Comparative Disability Law and Policy.

Table of Contents

Executive Summary

The Centre for Disability Law and Policy welcomes the opportunity to make this submission on the 5-year review of the Mental Health Act 2001. This review is particularly timely given the entry into force of the United Nations Convention on the Rights of Persons with Disabilities (CRPD), the adoption of *A Vision for Change*, and the changing economic climate within which resources are dedicated to mental health services in Ireland. The United Nations Convention on the Rights of Persons with Disabilities requires State Parties to dramatically rethink its mental health laws. This involves ending coercion and dismantling laws that provide for involuntary detention on the basis of having a mental disorder and supporting every citizen in exercising their legal capacity. This submission will examine the Mental Health Act using a rights-based approach to determine its impact on the fundamental rights of people with mental health problems in Ireland. In acknowledgement that it is unlikely that this 5-review of Irish Mental Health Act will result in the repeal of involuntary detention and treatment – a number of reforms to the Mental Health Act are suggested as a step towards realising Ireland's obligations under international human rights law.

Section 1 of the submission relates to the general operation of the Act, and takes a principled approach. It focuses on the guiding principles of autonomy, dignity, privacy and bodily integrity, as set out in section 4(3) of the 2001 Act, in order to shift the focus away from 'best interests', which can lead to an overly paternalistic approach to mental health treatment. In light of the forthcoming Mental Capacity Bill, the submission highlights the importance of self-determination, and an assumption of legal capacity, which have knock-on impacts for the system of voluntary admission, requiring patients to be truly 'voluntary' and for voluntariness to be respected regarding admission, treatment (including issues of consent, seclusion and restraint), and any decision to leave an approved centre. Specific recommendations regarding children in mental health services are also made, including the introduction of a new part of the Act on children, which would take a positive, rights-based approach, and recognise the visibility of children in mental health services. Finally, with respect to access to justice, this section reaffirms the need to repeal the provision on application for leave to the High Court for certain proceedings.

Section 2 addresses the implications of Ireland's position as a signatory to the UN Convention, and steps, which need to be taken in light of Ireland's forthcoming ratification of the Convention. These recommendations reaffirm and strengthen the points made in section 1, including moving from an overly medical approach of 'best interests' towards an empowering and supportive approach to mental health treatment. The key recommendations in this section focus on Article 12 of the Convention on equal recognition before the law and support required to exercise one's legal capacity, Article 13 on access to justice, Article 14 on liberty and security of the person and Article 19 on independent living and inclusion in the community. This submission advocates a move towards dismantling

involuntary admission as currently conceived under the 2001 Act, and replacing this with a system which truly respects the voluntary nature of the decision to undergo treatment, and provides effective safeguards for this process. However, this section recognises that prior to dismantling involuntary admission it is vital to put in place an effective alternative through the provision of crisis and ongoing mental health supports in the community.

Section 3 of the submission highlights the extent to which the 2001 Act can be amended to provide a legal underpinning for A Vision for Change. Recommendations made focus on embedding the recovery model of mental health service in the Act, and moving towards a system of mental health care in the community. These are issues, which could be addressed, in the long title of the legislation, as well as in the substantive provisions. Other issues raised in this section include the need to include a legislative provision to establish a National Mental Health Services Directorate with budgetary power, recognition of the role of the peer advocate in supporting individuals through mental health treatment and the introduction of an individual care plan for all which sets out the steps towards recovery and integration in the community.

Finally, Section 4 of the submission examines the impact of the current economic climate on persons with mental health problems in light of the 2001 Act. It demonstrates that although there is an increasing prevalence of mental health issues due to the economic downturn, positive initiatives exist in many communities, which support people through crisis situations. Ireland has long been rich in social capital and it is important to draw on the existing resources in our communities to ensure that the recovery approach to mental health services can be realised. However, the submission also acknowledges that an injection of capital is needed in order to achieve the structural change required in the delivery of mental health services. In addition, the submission highlights the human cost to neglecting mental health services and failing to implement a recovery-based approach to mental health treatment. It is also noted that the progressive realisation of socio-economic rights as a defence for failure to provide appropriate community based supports for persons with mental health problems is vulnerable to challenge given the resultant restriction on civil and political rights.

In conclusion, the recommendations made in each of the 4 sections on general operation, the UN Convention, A Vision for Change and the economic climate all reinforce and strengthen each other in calling for a new empowering and recovery-oriented approach to mental health service delivery which should be recognised in the 2001 Act. Concrete recommendations are outlined throughout the submission and also captured in a separate section towards the end of the document for ease of reference. It is hoped that the proposals for reform set out in this submission can lead us to implement the vision of an Ireland where people with mental health problems are supported within their communities to achieve full, inclusive and effective citizenship.

Section 1: General Operation since commencement of the Act

Guiding Principles: Section 4

The principles section is fundamental in setting the tone for the operation of the Act and in the interpretation of the Act. The current best interests principle needs to be defined, the interpretation by the courts has been overly paternalistic and the extent to which the best interests principle applies throughout the Act is unclear. Consideration should be given to adopting a person centred principle in accordance with the CRPD.

Section 4(2) was intended to support consultation and the participation of the person in decisions concerning admission care and treatment. It does not appear to have been taken seriously. Consideration should be given to see how this can link with the revised principles, and enhance autonomy.
In Section 4(3) the words "due regard" are not very meaningful; they need to be strengthened. The provisions in this section are core human rights principles; the whole principles section should start with these. Vision for Change principles (e.g.) Recovery ethos, can be supported and underpinned in this section. (See Section 2)

The fact that the "best interests" of the person is the "principal consideration" in the Section 4(1) principles creates a difficulty when attempting to have "due regard" to respect the right of the person to autonomy etc in Section 4(3). (See Best interests in Section 2)

The 2008 MHC *Report on the Review of the Operation of Part 2 of the Mental Health Act 2001* (2008) recommended that "best interests" would be defined as it was leading to uncertain outcomes. The External Commentary in the Review report states "the failure to define best interests is unfortunate, because the lack of guidance from the legislature, which has the necessary democratic legitimacy to determine this, means the matter falls to the courts." The best interests standard can be used to justify a wide range of actions and interferences when it is not defined in the Act. "Section 4 of the Mental Health Act, 2001 infuses the entire of the legislation with an interpretative purpose … "[1]

As a result, various approaches to interpretation can be taken depending on whether the guiding principle is autonomy where people are enabled to make their own choices or paternalism where someone else decides. The Act was intended to reflect a new era based on human rights standards and the expectation was that key elements such as the "best interests" principle would reflect this change to a more patient centred focus.

[1] *TOD v CMH* 2007.

Instead, a good deal of uncertainty remains with the varied results from the courts-mainly towards a very paternalistic approach. Assistance to make decisions is crucial for personal empowerment. The inclusion of advance directives indicating the will and preferences of persons is a key element of a move away from paternalism and needs to be considered in the revised Act. (See Advance Directives)

Decisions of the courts in interpreting the Act have differed with some holding that the old paternalism reflected in case law prior to the Act prevails, (*JD v CMH* (2007) incl. reference to *Gooden* 2005 and *Clarke* 1950) with fewer decisions holding that the principle of "best interests" would strengthen the rights under the Act. Some acknowledged the patient centred focus in the Act while referring to the Act as paternalistic. (*JH v Lawlor* (2007)

Although the best interests principle specifically applies to care, treatment and admission orders, the Act does not specify its application to the work of the Tribunals and other areas.

Recommendations:

The autonomy principle, as well as the other principles, in section 4(3) should be set out at the start of the Guiding Principles section. Consideration should be given to including principles from the Report of the Expert Group on Mental Health Policy, *A Vision for Change*, 2006 (VFC) particularly the principle of Recovery which "should inform every level of the service provision..." (VFC 2006, p5).

The presumption of capacity, as a logical adjunct to the above principles, should be included in order to have the highest level of compatibility with proposed mental capacity law.

The current best interests principle needs to be defined, and consideration should be given to adopting a principle in accordance with the CRPD.

The principle, in section 4(2), of consultation and active participation of the person in decisions should be strengthened as a key underpinning principle of VFC. Consideration should be given to see how this can link with the revised principles and can enhance autonomy along with the inclusion of support in situations where capacity issues arise.

The principle of supported decision making to enable people to make their own decisions is a key element in advancing all other principles.

Criteria for detention: Sections 3, 8

The absence of any reference to involuntary admission as an approach of 'last resort' in the 2001 Act in incompatible with government policy in the area of mental health. VFC recommends that Community Mental Health Teams should offer multidisciplinary home-based and assertive outreach care, and a comprehensive range of medical, psychological and social therapies relevant to the needs of services users and their families.

The definition of mental disorder is overly broad and results in an unacceptable level of uncertainty as to who falls within its scope. In particular, the inclusion of 'significant intellectual disability' in the definition of mental disorder and the consequent potential for persons with such a disability to be subject to involuntary admission is inappropriate and contrary to understood best practice regarding the treatment of persons with intellectual disabilities. More generally, the term 'mental disorder' reflects a strongly medical model approach to mental illness and is potentially stigmatising for persons subject to the provisions of the Act. A more neutral term such as 'patient' or 'person with a mental health condition' should replace it. (See Section 2)

Recommendations:

The Act should be amended so as to expressly require involuntary admission to be a practice of last resort and only where voluntary admission or support in the community is no longer possible.

The definition of persons who are capable of being admitted involuntarily should be more precisely defined and the term 'mental disorder' replaced with less stigmatising label.

In line with international best practice, persons with intellectual disabilities should be excluded from the provisions of the Act.

Voluntary admission: Sections 29 and 23

The Section 2 definition refers to a voluntary patient as someone receiving care and treatment who is not the subject of an admission/renewal order. The word "voluntary" implies an ability to consent to admission and treatment. Many compliant persons may not have the appropriate support to enable them to assert their legal rights and are therefore not truly voluntary. (See Section 2)

The definition supports a broad interpretation to include compliant incapacitated persons and it has resulted in a paternalistic approach that does not address the need for safeguards for this group. The Irish courts

have interpreted "voluntary" to include those who are not truly voluntary. (*EH v St Vincent's Hospital*) There is no requirement in the Act to assess if a person is truly voluntary and is able to give informed consent to either admission or treatment. The person's autonomy may be compromised by reduced mental capacity and assistance with decision making may be required. No safeguards apply in the current law regarding persons in this situation.

The presumption of capacity should apply to all voluntary admissions and this needs to be stated in the Act. Their capacity needs to be assessed with regard to choice about admission or treatment. The role of supported decision-making must be acknowledged. (See Section 2) Safeguards for people whose decision-making capacity is found to be reduced may be provided under the proposed mental capacity law. (*HL v. UK* 2005, *Bournewood 1999*). This section will need to be amended to accommodate the interface with the proposed mental capacity law to reflect this reality.

Primarily, the Act needs to reflect and promote confidence in people who are or could be willing to be admitted voluntarily based the principle of the least restrictive alternative and therefore should include a strong enabling provision around voluntary admission. This should be reflected also in the proposed revised principles. The "shadow of compulsion" (Fennell 2011) hangs over voluntary patients so that many may conform rather than risk formal detention. Some may be subject to restrictive regimes which render the admission not truly voluntary.(*JH v Russell* 2007))

There is no requirement in the Act to inform a voluntary patient of the range of common law rights associated with that status such as, the right to leave the approved centre and the right to give or withhold informed consent to treatment. There is no requirement in the Act to inform a person that where they indicate a wish to leave they must be allowed to do so unless they have a mental disorder and that they may be held for 24 hours for such a decision. They should be told before admission that restriction on leaving is exceptional as an aspect of enhancing the voluntary status.

The regrading of the person to voluntary status discharges the person from detention (section 28) but not necessarily from the centre and the person may remain as a voluntary patient. The Act does not specify if the person must remain voluntarily or as a voluntary patient. This seems to indicate that this is an informal status. (*EH v St Vincent's Hospital* 2009) & (*McN v HSE* 2009) If the person has reduced capacity and needs support to decide to remain this is important in the activation of safeguards. These safeguards apply to the person subject to compulsion but not when the person is remaining in the centre as a voluntary patient. Where this person is "deprived of liberty" in terms of the level of control over him or her there must be safeguards to comply with the ECtHR decision in *HL v UK* 2005.

Recommendations:

The Act needs to include the principle of the least restrictive alternative and therefore should include a strong enabling provision around voluntary admission.

The presumption of capacity must apply to all voluntary admissions and this needs to be stated in the Act.

The role of supported decision-making and safeguards for people whose decision-making capacity may be reduced should be recognised to ensure compatibility with proposed mental capacity law.

Voluntary patients should be informed of the range of common law rights associated with that status including informed consent to treatment.

Prevention of voluntary person from leaving: Section 23

The Act needs to have positive statements supporting voluntary admission and deter efforts to undermine any consensual admission. (See Section 2)

Unless a voluntary patient "indicates" a wish to leave the approved centre that person cannot be detained under the provisions of section 24. The 2008 MHC *Report on the Review of the Operation of Part 2 of the Mental Health Act 2001* (18 month review) referred to comments by the Department of Health where the Minister recommended that the status of patients should not be lightly changed from voluntary to involuntary. This report referred to difficulties with the "practical application of section 23 and 24 where a voluntary patient has a mental disorder, is not indicating a wish to leave and is refusing to consent to treatment." The report recommended that the legal scope for using the normal involuntary admission procedures under sections 9 & 10 be explored by the Department of Health "to provide clearer guidance to staff in approved centres."

The principles underpinning the Act are very important here in addressing the disempowering impact of the Act. Research indicates about 50% of patients feel coerced even where they are not formally detained. The requirement that all voluntary patients in some services give 24 hour notice of intention to leave is disproportionate, leads to fear of being detained and persons feeling coerced into remaining. Although the Act requires an indication of a wish to leave, many people do not feel they can do so due to fear of compulsory powers, or loss of future service and the general power imbalance inherent in the system. The MHC is not required to be informed of the holding power and this should be addressed in the

review in order to track the number of times and circumstances in which it is used.

Recommendation:

The Act needs to have positive statements supporting voluntary admission and deter efforts to undermine any voluntary admission.

Part 4 Consent to treatment: Section 56

The principles in section 4 already apply to Part 4 on consent to treatment but the sections ensure that the autonomy principle weighs at a lower level and the best interests principle, as currently interpreted, has a broader reach. Revised principles, including those in VFC, the Recovery ethos, would serve to strengthen the patient-centred approach.

Collaboration should be the goal of all interventions. The importance of informed consent and patient participation as elements of autonomy and treatment decision-making should be recognised in the revised Act. (Council of Europe, Report of CPT, 2011) Supported decision making would enable the people to participate as far as possible in their own treatment plan. This is in keeping with the principles and supported by research as advancing a therapeutic approach. (See Section 2)

The definition in the Act is at odds with the capacity test proposed in the Scheme of the Capacity Bill 2008 and in relation to general medical treatment. It places a higher burden on people who are detained.

The capacity of the person to consent is likely to fluctuate so that frequent review of their capacity is required. An independent assessment of capacity should be required and should incorporate a multi-disciplinary element. The rationale for treating a person without consent must be narrowly drawn for the shortest period and be subject to independent second opinion.

Recommendations:

The importance of informed consent and patient participation, as elements of autonomy and treatment decision-making should be recognised in the revised Act

Regular review of capacity is required and should include an independent assessment that would include a multi-disciplinary element.

Treatment not requiring consent: Section 57

People should retain their legal rights even where the law permits uninvited intrusions. The issue of capacity is highly significant in this section. The exceptions to requiring consent are broad ranging and arguably over inclusive leaving little room for choice in decision making where a mental disorder is regarded as impacting on capacity.

The individual care plan provided for in Section 66(g) and in the Approved Centre Regulations (S.I. 551, 2006) needs to be strengthened and linked with the consent provisions. It should be a key point for identification of personal wishes and maintaining decision making skills as well as providing a seamless plan towards return to life in the community. This is key element in advancing the person's will and preferences. (See Section 2)

The individual care plan is the core of the person's reason for receiving treatment and needs to be strengthened in the statute. The participatory, collaborative, multidisciplinary and social element should be subject to review on a regular basis. Its focus should be on recovery ethos, linked with a discharge plan and support to return to the community. The revised legislation should underpin this in the most enabling and extensive way possible. This will also assist towards underpinning VFC. (See Section 2 and Article 19)

The individual care plan provided for in Section 66 and in the Approved Centre Regulations needs to be strengthened and linked with the consent provisions.

Recommendation:

Consideration should be given to support to enable people to choose their treatment and to narrow the broad range of exceptions.

Centralise the individual care plan, which should be holistic and collaborative.

ECT treatment: Section 59

A certain level of agreement appeared to have been reached on the removal of the word "unwilling" in a proposed amendment in 2010 and proposals have been made for safeguarding persons regarded as "incapable". Informed consent is crucial regardless of the status of the person and any departure from this principle must be subject to rigorous oversight. (Council of Europe, CPT 8th Report 1998)

There should be a requirement that ECT would not be given until the Tribunal hearing and any advance directive refusing treatment with ECT should be taken into account. Where a person whose capacity is in question and whose wishes are not well known and has an enduring power of attorney or advance directive, that must be considered in any decision about this treatment. (**See Section 2**)

The Mental Health Commission should appoint the independent psychiatrist required for the continued administration of ECT treatment.

Recommendation:

Informed consent is essential for this treatment and any departure should be subject to oversight and include independent opinion and multidisciplinary team.

Administration of medicine: Section 60

Difficulties arise with the capable unwilling person and how this is reconciled with autonomy rights and the Recovery ethos. Informed consent must be given to the treatment. (see Section 2)

The capable and willing patient can consent for up to 3 months in full support of their autonomy rights. That same capable person can loose their right to refuse treatment based on a second opinion after 3 months. This means that capable adults are permitted to consent but not refuse treatment. This is in need of clarification.

Where the person is regarded as incapable of consenting the treatment should only be given on the basis of the "convincing necessity" standard and as the least restrictive alternative. The treatment programme must be linked with the individual care plan and subject to regular review in collaboration with the person and with the multi disciplinary team.

The Mental Health Commission should appoint the independent psychiatrist required for the continued administration of treatment. Issues about capacity should be assessed by a multidisciplinary team and supported decision-making included.

The concern of the overuse of medication is constantly repeated in reports and feedback from people who use services. A greater level of oversight is required. The sustainable approach would be to collaborate with service users and support them in their decision-making. The element of participation is critical in this area.

Recommendations:

Informed consent and collaboration in the treatment plan.

Departure from this principle should be subject to independent opinion and multidisciplinary team.

Advance Directives

The UN CRPD provides a right to legal capacity in all areas of life including decisions relating to medical treatment. The right of individuals to make decisions about their own treatment and care should be placed at the centre of legislative reform. Decisions in relation to mental health treatment should be made either by individuals themselves independently, or with support.[2] Article 12 of the UN CRPD implies that a range of support measures are needed to assist in the exercise of legal capacity. Supported decision-making measures such as advance directives should be included in the revised Act to address deficits in capacity. An advance directive sets out the way a person wishes to be treated, or not treated, in the event of becoming mentally unwell and being unable to make decisions in relation to mental health treatment. The explicit wishes of the individual are therefore addressed when the person cannot give informed consent. Advance directives are proposed as an innovative and effective way to reduce the need for coercive treatment and strengthen autonomy in the mental health context. High readmission rates warrant the consideration of such measures which have the potential to reduce the need for hospitalisation and involuntary treatment.[3] The Act does not currently allow a person to set out how they wish to be treated during periods of impaired capacity.

The medical model is predominant in the Act and provisions for consent to treatment are generally weak.[4] The decision as to whether a person is capable of consenting to treatment is made by the responsible consultant psychiatrist and lacks an independent review mechanism. Currently, the Act reflects a substitute decision-making model by conferring decision-making powers on the consultant psychiatrist where the patient lacks capacity. This conflicts with the approach to legal capacity under Article 12 of the UN CRPD. The provisions are over-reliant on medical opinion and the opinion of persons from a variety of multidisciplinary backgrounds would be more fitting with the social model of disability. The Act needs to

[3] Health Research Board, *National Psychiatric In-patient Reporting System (NPIRS) - National Bulletin Ireland 2009* (Dublin: Health Research Board, December 2010), available at http://www.hrb.ie/publications/mental-health/ [Accessed October 25th 2011].

[4] Mental Health Act, 2001, s.s. 56-57

move away from medical decision-making and loss of capacity in mental health settings. Presumptions of incapacity permeate mental health so assumptions of capacity need to be reinforced in the Act.

Advance directives can enhance patient autonomy and avoid the need for substitute decision-making. Decision-making capacity is pivotal for executing, invoking and revoking an advance directive. A list of persons from a range of multidisciplinary backgrounds should be named in the revised Act to identify any decision-making barriers in this regard. The revised Act should also ensure individuals are supported to make an advance directive particularly where deficits in capacity may exist. Advance directives represent the least restrictive alternative and encourage patient participation in decisions about treatment and care. A Vision for Change also explicitly supports the use of advance directives, which can be put into effect at times when the user may not be well enough to make informed decisions.[5] The revised Act should place an obligation on treatment providers to take account of the past and present wishes and feelings of the person expressed in an advance directive. The Mental Health Tribunal in reaching a decision could also defer to an advance directive. At present, the Mental Health Tribunals have no power to review treatment decisions. Any treatment overriding a valid advance directive should be reported to the Mental Health Commission setting out the reasons in writing. This provides a system of accountability. A similar requirement is provided for advance statements under the Mental Health (Care and Treatment) (Scotland) Act (2003). While some parties advocate providing for advance directives in general legislation, this fails to address some of the issues, which can arise while separate mental health legislation still exists. A specific provision for advance directives in the revised Act will address issues, which arise in relation to detention and advance consent to and refusal of mental health treatment. A separate provision will also encourage participation in mental health treatment decisions.

Recommendations:

The revised Act should introduce advance directives to:

Reinforce the supported decision making model and the assumption of capacity.

Assist in the implementation of the person's wishes and preferences
Preserve decision-making autonomy during periods when deficits in capacity may occur.

[5] Department of Health and Children, *A Vision for Change: Report of the Expert Group on Mental Health Policy* (Dublin: Stationary Office, 2006), 30.

Reduce the need for involuntary treatment by involving individuals in decisions about their mental health treatment and recovery.

Encourage patient participation in decisions about future mental health treatment.

Seclusion and Restraint: Section 69

The fact that a person may be subject to seclusion and restraint does not mean that their rights to privacy and autonomy have been lost-they continue to hold these rights whether deemed capable or not. The use of advance directives in relation to seclusion and restraint should be explored.

Section 69 is extremely limited in guidance permitting a wide discretion in effect as it applies also to voluntary patients and children subject to detention although the MHC has published very specific Rules on Seclusion and Restraint.(2006) The principle of the least restrictive alternative must be applied.

The inclusion of voluntary patients in the definition of patient in section 69 (4)(a) & (b) raises the question as to why someone who needs to be secluded or restrained should not be admitted formally and have the safeguards associated with the restrictions in the removal of liberty. The use of restraint against voluntary patients can be carried out under the common law but the scope is not clear even allowing for the medical necessity test.

Section 69(2) provides for use of seclusion and restraint as a form of treatment. This does not accord with best practice that it is never used as a form or treatment. It is normally used to prevent injury.

Recommendations:

The scope of the provision is too wide as it applies to voluntary patients and to children.

The principle of the least restrictive alternative should be applied and the person's own views should be ascertained.

Absence on Leave: Section 26

This provision should be closely linked with the individual care plan. The Inspector has expressed concern that this provision is being used to facilitate persons to live outside of the approved centre on a continuous

basis through the continuing renewal of the detention order on the expiry of the earlier order. Tribunals have affirmed these orders. It is not clear if the practice is widespread.

Arguably discharge with leave on a continuous basis may be justifiable but it needs to be addressed and appropriate oversight be put in place. Its effect is to create a level of control beyond approved centres and into the community without any specific legislative basis for long-term use. Similar activity was found to be illegal under the Mental Health Act 1983 in England. (*R v Hallstrom* 1985 on the basis that there was no intention of admitting the person to the approved centre) There is a serious question as whether the statutory conditions for detention continue to apply if the person is in the community and a renewal order is continuously made.

This provision should be distinguished from Community Treatment Orders (CTOs) where the person is not detained but subject to a separate regime. The issue of Community Treatment Orders are frequently raised as a panacea for people who have frequent readmissions. In the context of poorly developed community support systems, this is merely a form of control that is oppressive rather than therapeutic and contrary to common law rights, and to human rights principles. The person's right to consent to treatment needs to be considered. Well-developed services community support services would eliminate the need to have such controls extending to the community. Evidence is very mixed on the outcome of the CTOs – see Inspectors report 2010) The English experience indicates a much greater use of CTO than originally planned.

Recommendations:

This provision should be linked with the individual care plan.

Clarification is required to define the purpose of the provision.

Discharge from involuntary admission: Section 28

The regrading of the person to voluntary status discharges the person from detention but not from the hospital. This issue of capacity to remain must be addressed in this context although recent decisions (*McN* 2009) might suggest that consent is not required to remain due to the broad reach of the definition of voluntary patient. Where the person is deemed not have capacity to make that decision they should be supported in enabling them to make decisions in keeping with the proposed Scheme of the Capacity Bill.

Consideration should be given to strengthening the individual care plan to incorporate a discharge plan and support following discharge in keeping with the Recovery ethos.

Recommendations:

The status of the person remaining in the centre following discharge needs to be considered.

The individual care plan should be included at the earliest point following admission and should provide a seamless approach towards discharge and support in the community.

Access to Justice: Section 73

Section 73 of the Mental Health Act 2001 on leave of the High Court to take civil proceedings is vulnerable to a legal challenge under the constitution and on the basis of human rights law. The judgment in *AL v Clinical Director of St Patrick's Hospital and MHC*[6] referred to the change from the previous provision in section 260 of the 1945 Act in which the burden of proof is now reversed and there is no requirement to show substantial grounds for the contentions underlying the proceedings as previously. Referring to *Blehein v Minister for Health*[7] and the finding that section 260 was inconsistent with the Constitution as it "confined an intended plaintiff to proceedings arising out of a lack of bona fides or a want of reasonable care," which was found to be disproportionate. "The fact that a similar restriction is to be found in S73 must, at least, raise some questions about the constitutional validity of the identical restriction contained in S73." [8]

Section 73 is completely at odds with the principles set out in Article 3 of the Convention on the Rights of Persons with Disabilities in particular non-discrimination and Article 12 on equal recognition before the law. Article 13 of the CRPD on the right to justice places an obligation on Ireland as it works towards ratification of the CRPD to repeal section 73. Article 13(1) states that States Parties to the Convention are required to ensure effective access to justice for persons with disabilities on an equal basis with others. Clearly, section 73 is an obvious restriction on the access to justice of persons with mental health problems that prevents access to the courts on an equal basis with all other persons in the State. In fact Article 13(1) goes further than simply requiring the removal of restrictions on accessing justice and expressly requires State Parties to provide

[6] 3 I.R. [2010] 537 delivered 11 March 2011, p 539.

[7] [2008] IESC 40 [2009] 1 IR 275.

[8] *Ibid*, at p 540.

"procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages." Article 13(2) of the Convention goes further in requiring State Parties to promote appropriate training for those working in the field of administration of justice, including police and prison staff to ensure that persons with mental health problems have effective access to justice. It is important to note that Article 13 of the Convention simply reiterates human rights norms that have long since been part of international human rights laws.[9]

Recommendation:

Section 72 should be repealed to reflect that persons with mental health problems are entitled to access to justice on an equal basis with everyone else.

Children

The review provides an opportunity to develop a human rights-based framework that will empower and safeguard the rights of children and adolescents with mental health problems. The Act needs to be revised to have a comprehensive and separate part relating to children, which should be positive in tone and highlight the visibility of the child/young person in the Act. This new part should be based on the principles discussed already as well as child/young person appropriate principles including supported decision-making. The emphasis should be on supporting the child young person to make their own decisions where possible, and the involvement, collaboration, contribution to their individual care plan. In particular the "best interests" principle should be refocused to be child centred and include a requirement that the participation of the child in decisions affecting him or her is a fundamental requirement. (Convention on the Rights of the Child) (See also Section 2)

The role of advocacy should be considered in relation to all children. Information must be given to the child as is required under the Act at present. Information should be provided to the parents also while respecting the right of confidentiality (s4 rights) of the child where appropriate.

The principles in the Child Care Act 1991 relating to the child and his/her family should be explicitly incorporated into the revised 2001 Act. The

[9] See for example Articles 6 to 11 of the Universal Declaration on Human Rights 14 to 16 of the International Covenant Civil Political Rights.

interface of these two Acts needs to be addressed to avoid the current dual standards and fragmented approach.

Recommendation:

This new part should be based on the principles discussed already as well as child/young person appropriate principles including supported decision-making.

Definition of child

The definition of child is one of the first considerations in a revised Act. Based on the principles and the LRC proposals, the revision of the age to 16 years should be considered while also recognising the risks associated with such a change. Allied to this possible age reduction must be a commitment to continue to provide specialist services to young adults up to 18 years. If this change is made then the next issue is the formal admission of the 16-18, whether it should be similar to adult admission with the same range of applicants, or if this age range should have a different approach. The admission of those under 16 should, as in general health care, continue to be consented to by parents/*loco parentis* with the child's wishes included in all decisions. This should not be called voluntary admission, as this is misleading, it is an informal admission. The formal admission or detention of the under 16 year old by the courts should continue with consideration of follow-up by a tribunal review as proposed in the LRC Report (2011). At present the review provisions applying to adults do not apply to those under 18 years.

Capacity and the Child

There is no recognition of the capacity of children to consent to or refuse admission and treatment under the *2001 Act*. Children admitted to psychiatric hospitals are usually admitted with the consent of a parent (355 in 2009), and therefore become so-called 'voluntary' patients. Such children do not even have the limited safeguards granted to children detained as involuntary patients (10 in 2009). The relationship between the *2001 Act* and the *Non-Fatal Offences Against the Person Act 1997*, and the differing ages of consent must be addressed. Using the status of age rather than capacity is at odds with the principles of the CRC and the CRPD. The Law Reform Commission has recommended that a person of 16 years of age or older should be presumed in law to have capacity to consent to health care and medical treatment. This recommendation would address the inconsistency in the law and comply with the human rights principle of non-discrimination as reiterated recently in the CRPD, and take into account the position in the proposed Scheme of Capacity Bill.

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 where admission to mental health care is subject to some independent oversight, particularly when transfer is from one branch of the HSE to the Child & Adolescent Mental Health Service (CAMHS). As a voluntary admission this over 16year old would have the right to consent to treatment provided he or she had capacity to do so.

Where a 16 year old lacks capacity in relation to a voluntary admission but is compliant this should be regarded as an informal admission and the proposed mental capacity law would presumably apply. The role of supported decision-making should be addressed in this context. (See Section 2)

The role of the mature minor should also be considered where they might have capacity to make decisions.

Recommendations:

To ensure adequate safeguards are present and meaningful in practice we need to amend the *2001 Act* to include a comprehensive and separate part relating to children, which should be positive in tone and highlight the visibility of children and adolescents in the Act.

This separate section should explicitly refer to a set of guiding principles and safeguards that will apply to all children admitted to approved centres for mental health care and treatment.

Voluntary admission

The definition of voluntary patient under the *2001 Act* is not a true representation of the position the majority of children find themselves in once admitted to an approved centre. The Law Reform Commission recommends a new category of intermediate admission for those admitted under the *Mental Health Act 2001* by way of the consent of persons having parental responsibilities for them.[10]

Involuntary admission

While section 25 of the *2001 Act* provides protection for those admitted involuntarily, these protections are inadequate and could be improved. The Law Reform Commission recommends a number of improvements in

[10] Law Reform Commission, *Children and the Law: Medical Treatment* (LRC 103 - 2011)

this regard.[11] There is no mechanism for a person detained under the section 25 to challenge a detention or seek a review of the detention. Significantly, there is a need for stronger and more definite protections than those imported from the *Child Care Act 1991*. The interface of these two Acts needs to be addressed to avoid the current dual standards and fragmented approach.

Recommendations:

The Act should be amended to provide that persons 16 years and over shall be presumed to have capacity to make decisions regarding admission and treatment unless that presumption is rebutted.

The definition of voluntary admission must be clarified to reflect the status of children admitted by those with parental responsibilities or a new category introduced as recommended by the Law Reform Commission.

Any category of admission should have all the safeguards currently provided for the admission of adults under the 2001 Act.

Treatment

The *2001 Act* does not engage with issues of capacity in relation to consent or refusal to treatment in respect of patients under 18 years of age. Patients under 18 years of age have no input into the treatment they are prescribed and can be prescribed medication for a three month period without a second opinion or their views on the treatment discussed (section 61); this represents a failure to respect the rights of children and adolescents who are patients under the *2001 Act.*

The principle of participation is of paramount importance here. There is a need to include a mechanism for participation in the *2001 Act*. Participation is a core right in the CRC, it is a general principle and all other provisions must be read with it in mind, such as the Article 13 right to receive and impart information and the Article 24 right to the highest attainable standard of health. However, the effectiveness of the participation principle in the CRC is limited if there is no implementation mechanism in legislation, this should be considered when reviewing the *2001 Act*.

Furthermore, health care professionals must be trained and educated to listen to children and to respect their needs for information; only through education and training will changes in thinking be achieved. We need a framework with a child-centred approach. A statutory-based code of practice could help to implement children's rights under mental health

[11] Law Reform Commission, (LRC 103- 2011) p 135-139.

legislation. The code should set out fundamental principles that must apply to children, such as: giving them age appropriate information regarding the proposed admission and treatment, providing an appropriate environment for their views to be heard, and compulsory recovery-orientated care plans drawn up. This would help underpin the recovery ethos in A Vision for Change. Each child or adolescent should have access to supports necessary for them to participate in all aspects of their care and treatment. (Article 12, CRPD). The role of advocacy should be considered here in relation to all children.

The *2001 Act* provides safeguards for adults who are involuntarily admitted by ensuring that all admission and renewal orders are subject to automatic and independent review by a Mental Health Tribunal. The Law Reform Commission has recommended that a Mental Health Tribunal (with an age appropriate focus) rather than the District Court should review the admission and treatment of children admitted as patients under the *Mental Health Act 2001*. This is a welcome amendment. The child should be integral to any review under the legislation.

Recommendations:

The Act should be amended to include a mechanism for the participation of the child in all aspects of their care and treatment.

The *Mental Health Act 2001* should be amended to provide a statutory-based code of practice to help implement children's rights under mental health legislation. The code should set out fundamental principles that must apply to children, such as: giving them age appropriate information regarding the proposed admission and treatment, providing an appropriate environment for their views to be heard, and requiring compulsory recovery-orientated care and treatment plans.

To ensure adequate safeguards are present and meaningful in practice we need to amend the *2001 Act* to include a comprehensive and separate part relating to children, which should be positive in tone and highlight the visibility of children and adolescents in the Act. This separate part should explicitly refer to a set of guiding principles and safeguards that will apply to all children admitted to approved centres for mental health care and treatment.

The Act should be amended to provide that persons 16 years and over shall be presumed to have capacity to make decisions regarding admission and treatment unless that presumption is rebutted.

The definition of voluntary admission must be clarified to reflect the status of children admitted by those with parental responsibilities or a new category introduced as recommended by the Law Reform Commission.

Any category of admission should have all the safeguards currently provided for the admission of adults under the 2001 Act.

This applies to all the procedures involved in the process of admission and treatment.

The Act should be amended to include a mechanism for the participation of the child in all aspects of their care and treatment.

Fundamentally the *2001 Act* requires amendments that affirm the principles of the CRPD.

In addition, the "best interests" principle should be refocused to be child centred and include a requirement that any "best interests" test must be assessed objectively by reference to the rights of the child.

Specific provisions on children

Should all the issues relating to adults including: consent to treatment, seclusion and restraint, absence on leave, regarding to formal admission, and regarding from formal to voluntary/informal status, now apply to those over 16 -18 years? Further consideration will be required here in any significant revision and the principles and recommendations above should be influential.

The interface with the Criminal Law (Insanity) Act 2006-2010 will also need to be addressed due to the admission of under 18 years to the CMH. There should be an equivalence of safeguards and the principles applying in this revised Act should apply to persons under the 2006-2010 Act.

Addressing the Operational Demarcation of Safeguards Contained in the *Mental Health Act 2001*

Since the drafting of the *Mental Health Act 2001* the Oireachtas enacted and commenced the *Criminal Law (Insanity) Act 2006*. The safeguards contained in the 2001 Act in relation to the involuntary detention and treatment of persons with mental health problems do not extend to persons detained in the Central Mental Hospital under the 2006 Act. This is a major operational deficiency with the 2001 Act and has been the subject of much criticism from the Committee on the Prevention of Torture. This is discussed in greater detail in section 3 of the submission below.

Under the *Mental Health 2001* an approved centre is defined as "a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder".[12] Section 3(1) of the *Criminal Law (Insanity) Act 2006* provides that the "… Central Mental Hospital is hereby designated as a centre (in this Act referred to as a "designated centre") for the reception, detention and care or treatment of persons or classes of persons committed or transferred thereto under the provisions of this Act." Judge Sheehan in his recent judgment in *DPP v B*[13] was critical of the 2006 Act as it constrained the choices available to a trial judge in relation to dealing with a defendant following a not guilty by reason of insanity verdict. Judge Sheehan stated "5(2) of the Act of 2006 suggests that a court has a discretion as to the type of treatment that a person in the defendant's position might be afforded."[14] However, he noted that after examining this provision and the other relevant legislative provisions, it is apparent "that the Court is constrained significantly by the terms of this legislation."[15] He noted as there was only one "designated centre" the Central Mental Hospital there was no available choice in relation "… deciding the nature or format of in-patient care or treatment that may be suitable in relation to this specific individual" and that the 2006 Act only envisaged inpatient treatment.[16]

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[12] See Part 5 section 62.

[13] Central Criminal Court, [2011], IECCC1. Available at: http://courts.ie/Judgments.nsf/09859e7a3f34669680256ef3004a27de/381f81f6c89de4c6802578a1003c6f36?OpenDocument.

[14] *Ibid*, at paragraph 5.4.

[15] *Ibid*.

[16] *Ibid*.

Recommendation:

The safeguards contained in the Mental Health Act 2001 should apply equally to persons involuntarily detained and treated under the Criminal Law (Insanity) Act 2006 to ensure an equivalence of human rights protections. Persons detained under the 2006 Act should be entitled to treatment on an equal basis with persons dealt with under the 2001 Act in other settings and in the community.

Section 2: The provisions of the Act having regard to the provisions of the UN Convention on the Rights of People with Disabilities

Article 12: Equal Recognition before the Law and Voluntary Admission

The interaction between legal capacity and mental health laws is a complex issue which is often underexplored. With the adoption of the UN Convention on the Rights of Persons with Disabilities, the debate about how repsect for individuals' capacities should be protected in the context of mental health treatment has intensified. This submission will seek to clarify some of the key issues in respect of the application of a presumption of legal capacity to mental health treatment, in light of Ireland's forthcoming legal capacity legislation and subsequent ratification of the UN Convention. This section will address the problem generally referred to as the 'incapable compliant patient' where a person is admitted as a voluntary patient but lacks legal capacity to consent to treatment.

The Convention reaffirms that the rights of people with mental health problems are protected as part of a broader group of people with disabilities. Article 1 of the Convention defines disability as follows:

> Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

This clearly includes people with mental health problems within the scope of the Convention, and does not diffrentiate them from other people with disabilities. It is also worth noting that people with mental health problems played an active role in the drafting of the Convention, through representative civil society organisations.

Although Ireland has not yet ratified the Convention, it is important to acknowledge the significance of Ireland's position as a signatory to the Convention – which implies a willingness to uphold the principles of the Convention, and not to take steps which would be contrary to the spirit and purpose of the Convention. Therefore, the recommendations in this submission are cognisant of Ireland's future obligations under the Convention, but implementation of these recommendations can take place independently of ratification.

Article 12 of the UN Convention[17] on equal recognition before the law sets out the position on legal capacity as follows:

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
2. States Parties shall recognize that **persons with disabilities enjoy legal capacity on an equal basis** with others in all aspects of life.
3. States Parties shall take appropriate measures to **provide access by persons with disabilities to the support they may require** in exercising their legal capacity.
4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity **respect the rights, will and preferences of the person,** are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.
5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

The commentary on Article 12 has reinforced the notion that a presumption of capacity should apply to each individual. This concept is already enshrined in the common law and applies in Ireland. It is also implicit in the Mental Health Act 2001, and could be strengthened, especially in light of the forthcoming legal capacity legislation in Ireland. In fact, commentary on the Convention goes beyond a mere presumption of capacity, to suggest that Article 12 posits the view that all human persons are capable of forming wills and preferences where the person has access to the correct supports, and that the decisions made based on will and preferences should in all cases be upheld and legally validated (except where to do so would constitute criminal or civil negligence).

If we accept this as our goal – to grant to all human persons the full enjoyment of legal capacity,[18] then this goal translates into ensuring that those seeking mental health treatment do so by choice, and have their

[17] UN Convention on the Rights of Persons with Disabilities, 2006. Emphasis added.

[18] Quinn "Rethinking Personhood: New Directions in Legal Capacity Law & Policy" (Vancouver: University of British Columbia, 29 April 2011).

decision to undergo treatment validly upheld and recognised as a voluntary decision. This would mean moving to a position in the Mental Health Act where only voluntary treatment was provided for. However, a number of steps need to be taken before this can be achieved, and the key measures needed to facilitate this are outlined below. Prior to outlining the necessary steps, it is important to clarify why this goal of dismantling the provision of involuntary treatment is being sought, and what 'voluntariness' would mean in a new capacity legislative regime which includes supported and facilitated decision making (replacing the ward of court system and reframing substituted decision-making or guardianship in a positive way which places the focus squarely on the will and preferences of the person.

The Victorian Law Reform Commission use the term 'clinical guardianship' to describe where a psychiatrist is given the legal power to involuntarily detain an individual for the purpose of treatment.[19] This makes involuntary detention analogous to a form of guardianship or substituted decision-making. The Victorian analogy equally applies to Ireland, as it extends to any jurisdiction where a mdeical professional can detain individuals for the purpose of mental health treatment. Arguably, as a form of clinical guardianship, it should be dismantled in line with Article 12, which requires capacity legislation to focus on supports rather than on deficits, and introduce a regime of supported and facilitated decision-making to replace paternalistic guardianship and wardship processes.

In the context of this submission, the term 'supported decision-making' means a formally recognised decision-making method that is based on the will and preference of the individual and upholds the autonomy of the individual as the guiding principle.[20] It may include one or more support people (a supported decision-making network) who are assisting the individual in gathering and understanding the relevant information, weighing the various choices, and communicating his or her will and preference. Representation agreements in British Columbia are an example of supported decision-making,[21] as they enable the person to retain full legal capacity, while sharing the task of decision-making (either in certain specified areas e.g. medical treatment, financial decisions, or in all aspects of life) with one or more trusted individuals who understand and can express the person's will and preferences. Beyond recognition of formal supported decision-making networks, the language of Article 12 also requires states to put in place a broader range of supports, including advance planning, advocacy support and reasonable accommodation in decision-making.

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[19] Victorian Law Reform Commission, *Guardianship Consultation Paper* (Melbourne, Victorian Law Reform Commission, 2011), part 9.

[20] Michael Bach and Lana Kerzner, "A New Paradigm for Protecting Autonomy and the Right to Legal Capacity," prepared for the Law Commission of Ontario (October 2010), at 7-8, available at http://www.lco-cdo.org/disabilities/bach-kerzner.pdf (last accessed 18 October 2011).

[21] Representation Agreement Act (RSBC 1996 Chapter 405).

By contrast, the term 'facilitated decision-making' means a system of last resort, which should only be used in the rare circumstances where supported decision-making is impossible. Many Article 12 scholars argue that this system should replace current substituted decision-making mechanisms including guardianship and wardship. The guiding principle of facilitated decision-making is the will and preference of the individual and the facilitated decision maker should strive to assist the individual in maintaining his or her autonomy in any way possible.[22]

Under a new legal capacity regime which encompasses supported and facilitated decision-making, a person does not necessarily lose her legal capacity. Instead, legal capacity is retained, and supports are provided to enable a person to exercise her legal capacity. Even facilitated decision-making, which in practical terms, seems close to substituted decision-making or guardianship, is viewed as an intensive form of support under this model, since its operating philosophy is based on will and preferences, rather than on 'best interests', which in practice, is often interpreted narrowly to mean 'best medical interests.' Assuming then, that an individual retains her legal capacity, the only kind of mental health treatment which can be provided is treatment as a voluntary patient. Clearly, a transition to this goal of treating everyone as voluntary can only be achieved through time, and by putting in place measures to address the needs of people in crisis who require urgent mental health treatment.

Recommendations:

Respect voluntariness: This requires safeguards to be included in the Mental Health Act 2001 to enable voluntary patients to leave an approved centre when this accords with their will and preferences. While there is currently a mechanism in place in the 2001 Act to prevent the arbitrary conversion of voluntary patients to involuntary patients, further safeguards could be put in place to make the decision to leave a more realistic possibility for voluntary patients.

Community supports: Supports in community should be provided as a realistic alternative to involuntary detention for people in crisis who urgently need mental health treatment. This reinforces the recovery model for mental health services as set out in A Vision for Change.1 Such supports would include access to information on treatment, reasonable accommodation in accessing services, recognition of supported decision-making networks (or circles of support) and the availability of facilitated decision-making as a last resort. Community supports would also include examples of best practice, which have been demonstrated internationally to enable more effective recovery for people with mental health problems, e.g. crisis peer support from other mental health service users.1

[22] Michael Bach and Lana Kerzner, "A New Paradigm for Protecting Autonomy and the Right to Legal Capacity," prepared for the Law Commission of Ontario (October 2010), at 7-8, available at http://www.lco-cdo.org/disabilities/bach-kerzner.pdf (last accessed 18 October 2011).

Safeguard those subject to facilitated decisions: In this new legal capacity regime of supported decision-making, safeguards should be put in place for individuals subject to facilitated decision-making where a decision to undergo mental health treatment is made. This is because facilitated decision-making will only apply to individuals who do not have the possibility of supported decision-making, and where it is extremely difficult to ascertain the person's will and preferences (e.g. if the person is communicating in a way which cannot be understood by others). These are situations where the 'voluntariness' of undergoing treatment could legitimately be called into question, and safeguards to validate the decision would exist for all facilitated decisions, including those relating to mental health treatment.

Best Interests Principle in the 2001 Act: The Need to Radically Reframe "Best Interests" to Pivot on the "Will and Preferences" of the Person

Section 4 of the *Mental Health Act 2001* enshrines the concept of "best interests" as the "principal consideration" in making decisions on the care and treatment of a persons under the Act. The "best interests" principle emerged from law and policy focused on children and it is increasingly considered inappropriate in relation to adults.[23] While section 4(3) provides that "due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy" the underlying philosophy of the mental health legislation is the concept of "best interests". It is clear that the UN Convention on the Rights of Persons with Disabilities (CRPD) requires a move away from the "best interests" principle.

Article 3 of the CRPD sets out that the principles underpinning the Convention, which include "respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons; non-discrimination; full and effective participation and inclusion in society; respect for difference and acceptance of persons with disabilities as part of human diversity and humanity; equality of opportunity; accessibility; equality between men and women; respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities." Nowhere does the CRPD refer to the "best interests" of adults

[23] For a discussion in the origin of the best interests principle see "The Best Interests of the Child: Towards a Synthesis of Children's Rights and Cultural Values" [Florence: UNICEF, Innocenti Studies, 1996]. Available at: http://www.unicef-irc.org/publications/pdf/is_best_interest_low_eng.pdf.

with disabilities and in fact the suggestion that the "best interests" be included in Article 12 were firmly rejected at the negotiations at the Ad Hoc Committee.[24] The paradigm shift in thinking required by the CRPD and in particular in Article 12 requires a interchange away from substitute decision making by third parties based on what is adjudicated to be in a persons "bests interests". A central aspect of Article 12 is the focus on the "will and preferences" of the person as the determining factor in decisions about their life and this requires moving away from a "best interests" approach, which brings with it the significant risk of paternalism.
The 2001 Act requires to be amended to remove the "best interests" principle and replacement with the principle of respecting the "will and preferences" of persons with mental health problems.

Recommendation:

The "best interests" principle enshrined in the 2001 Act needs to be reframed in light of the UN Convention on the Rights of Persons with Disabilities to reflect the "will and preferences" of persons subject to its provisions.

Best Interests under the 2001 Act in the context of Involuntary Admission

Section 4(1) of the 2001 Act requires that when decisions concerning the care or treatment of a person, including a decision to make an admission order, are taken under the Act "the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made."[25] Due regard must also be had to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy.[26] On its face, these latter principles appear to go some way towards echoing the requirements of equality and non-discrimination, which lie at the core of the UN Convention on the Rights of Persons with Disabilities (CRPD).

However, the absence of a statutory definition of the term 'best interests' from the 2001 Act has led to both difficulties in its interpretation and, more worryingly, differences of interpretation depending on which decision is examined and when the decision was made. While a degree of discrepancy and difference in emphasis is to be expected in the context of

[24] The only references to "best interests" inn the UN Convention on the Rights of Persons with Disabilities emerge in respect of children with disabilities (see Articles 7 and 23).

[25] It is interesting to note that the provision regarding 'best interests' was not contained in the original 1999 Bill.

[26] Section 4(3)

decisions delivered by a variety of judges, what is of great concern is the recent judicial trend towards defining the 'best interests' of an individual with a mental disability solely, or at least predominantly, in the context of clinical/medical best interests, something which has become more evident in the more recent judgments of the superior courts on this issue. The "best interests" requirement of section 4 has been interpreted to require compliance with the provisions of the Act but has not been extended beyond these procedural guarantees to encompass any requirement that the "best interests" of the person with the mental disability (i.e. substantive adherence to their right to liberty as well as their right to autonomy and non-discrimination) be the primary motivation for decision regarding a deprivation of liberty under the 2001 Act.[27] Even in the absence of a statutory definition of the principle, the concept of 'best interests' has, in the majority of instances, been used by the judiciary to find the involuntary admission of a person with a mental disability to be lawful based on a perceived need for treatment or on the basis of the 'harm' criterion. Given the manner in which the section 4 has been interpreted, it is arguable that it has become a de facto lynchpin for the paternalism, which was applied to pre-2001 Act cases, which is incompatible with the governing principles of autonomy, and non-discrimination, which are contained in the CRPD.

This continued distortion of 'best interests' raises the question of whether or not the principle is in fact of any assistance to persons with mental disabilities in vindicating their right to liberty or whether it should be removed entirely from the 2001 Act. If it is to be retained, it should, at the very least, be interpreted in a rights-based manner and consistent with the requirements of Article 14 of the CRPD. This would not stretch the limits of a valid interpretation of section 4, lacking as it does a precise definition of what comprises 'best interests'.

Recommendations:
"Best interests" should be defined so as to ensure a consistent, rights-based application of that principle in the context of involuntary admission. This definition should be based on the rights of persons with disabilities as they are contained in the CRPD.

Involuntary Admission and Article 14 of the CRPD

Article 14 of the CRPD lays down the international standard which all states parties should work towards meeting in respect of the right to

[27] See for example *M.D. v. Clinical Director of St. Brendan's Hospital & Ors* [2008] 1 I.R. 632, *A.M. v. Kennedy & Ors* [2007] 4 I.R. 667 and B.F. v. Clinical Director of Our Lady's Hospital Navan (Unreported, High Court, Peart J., 4th June 2010)

liberty of persons with mental health problems. There is therefore an obligation on Ireland as a signatory of the Convention to embark on a course of continuous progression towards reaching these standards. A great deal this can be achieved by implementing pre-existing government strategies regarding community-based services and supports for those people and their families. It is only be ensuring that those supports are put in place that it will be possible for countries such as Ireland to comply with Article 14.

Article 14(1) of the CRPD states that:

> "States Parties shall ensure that persons with disabilities, on an equal basis with others:
>
> a) Enjoy the right to liberty and security of person;
>
> b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty." (emphasis added)

Legislative provisions and governmental policies, which justify the involuntary admission of persons with mental health problems, must now be reviewed through the lens of the disability-neutral requirement of Article 14(1)(b). The United Nations High Commissioner for Human Rights (UNHCHR) has interpreted Article 14(1)(b) as prohibiting the removal of a person's liberty on the basis of the existence of a mental disability (i.e. including their involuntary detention under mental health legislation). The UNHCHR notes that proposals made during the drafting of the CRPD to limit the prohibition of detention to cases "solely" determined by disability were rejected. Therefore 'unlawful detention' under the CRPD even encompasses situations where the deprivation of liberty is grounded in the combination of factors such as a mental or intellectual disability and other elements such as dangerousness, or care and treatment. Since such measures are partly justified by the person's disability, they are to be considered discriminatory and in violation of the prohibition of deprivation of liberty on the grounds of disability contained in Article 14.[28] The UN's Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment has also endorsed this interpretation of Article 14 of the CRPD.[29]

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[28] Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary General, *Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities* (A/HRC/10/48, 26 January 2009), para 48

[29] UN General Assembly, Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak, A/63/175, July 28, 2008, para. 64

The UNHCHR has clarified that Article 14 of the CRPD should not be interpreted to mean that persons with disabilities cannot be lawfully subject to detention for care and treatment or to preventive detention, but that the legal grounds upon which restriction of liberty is determined must be de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis.[30] An example of a 'disability-neutral' basis upon which the law might provide for deprivation of liberty might be a finding of 'dangerousness to others', although the definition and application of such a criterion has the obvious potential to be problematic when put into practice at a domestic level by states parties to the CRPD.

This requirement that any legislation which seeks to restrict the liberty of an individual which is enacted by a state party to the CRPD be disability-neutral is supported by the aforementioned centrality which the CRPD places on the overarching concept that the rights to equality[31], non-discrimination[32] and autonomy[33] inhere in persons with disabilities as fully as they do in persons without disabilities. Of further support for the proposition that involuntary admission based on the existence of a mental health problem is contrary to the CRPD is Article 19 which states the right to live independently and to be included in the community and requires states parties to "take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community...". Not only does this provision clearly place an obligation on states parties to take measures to ensure the vindication of persons with mental disabilities right to independence and a life in the community, it could arguably be said to require states parties to cease funding any public policy or project which would impede the achievement of full community living (e.g. the construction or renovation of psychiatric institutions).

The Committee on the Rights of Persons with Disabilities conclusively resolved this issue in April 2011, when it made it adopted its first Concluding Observation[34] – a response to the first Country Report that was submitted to them by Tunisia.[35] It stated that:

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[30] *Ibid*, para. 49

[31] Article 5 of the CRPD

[32] Article 3(b) of the CPRD

[33] Article 3(a) of the CRPD

[34] Consideration of reports submitted by states parties under article 35 of the Convention - Concluding observations of the Committee on the Rights of Persons with Disabilities – Tunisia. Adopted by the Committee on the Rights of Persons with Disabilities on 15 April 2011. Available at www2.ohchr.org//SPdocs/CRPD/5thsession/CRPD-C-TUN-CO-1_en.doc (last accessed 29 August 2011).

[35] The attitude of the Committee towards Article 14(1)(b) was somewhat predictable given the initial List of Issues which it published on foot of Tunisia's report at their Fourth Session which was held from the 4th-8th of October 2010. At paragraph 15 of this document they ask Tunisia to "indicate whether having disabilities, including intellectual, mental and psychosocial disabilities, constitute a basis for the deprivation of liberty under current legislation, either alone or in combination with other grounds. If so, please explain: whether steps are taken to repeal or amend this legislation..." (both Tunisia's Periodic

> "With reference to article 14 of the Convention, the Committee is concerned that having a disability, including an intellectual or psychosocial disability, can constitute a basis for the deprivation of liberty under current legislation."[36]

The Committee went on to recommend that Tunisia:

> "…repeal legislative provisions which allow for the deprivation of liberty on the basis of disability, including a psychosocial or intellectual disability. The Committee further recommends that until new legislation is in place, all cases of persons with disabilities who are deprived of their liberty in hospitals and specialized institutions be reviewed, and that the review include the possibility of appeal."[37]

The Committee made similar recommendations in September 2011 in its Concluding Observations[38] of Spain's country report where it stated:

> "The Committee recommends that the State party: review its laws that allow for the deprivation of liberty on the basis of disability, including mental, psychosocial or intellectual disabilities; repeal provisions which authorise involuntary internment linked to an apparent or diagnosed disability …"[39]

It therefore falls to states parties who have ratified the CRPD to act in accordance with its recommendations and initiate a programme of structuring its mental health supports in such a way as to ultimately enable the repeal legislative provisions, which allow for the deprivation of liberty on the basis of a mental health problem. Ireland will be amongst those countries once it ratifies the CRPD and must therefore take the implications of Article 14 seriously during its statutory review of the Mental Health Act 2001.

Report and the Committee's response by way of its List of Issues are available at www.ohchr.org/EN/HRBodies/CRPD/Pages/Session4.aspx - last accessed 29 August 2011)

[36] *Ibid*, para 24

[37] *Ibid*, para 25

[38] Consideration of reports submitted by States parties under article 35 of the Convention - Concluding observations of the Committee on the Rights of Persons with Disabilities – Spain. Adopted by the Committee on the Rights of Persons with Disabilities on 23 September 2011. Available at http://www2.ohchr.org/SPdocs/CRPD/6thsession/CRPD-C-ESP-CO-1%20.doc (last accessed 19th October 2011)

[39] *Ibid*, para. 36

Recommendations:

A Vision for Change should be implemented so as to ensure that sufficient community supports are put in place to minimise the number of involuntary admissions to approved centres under the Act.

Amendments to the 2001 Act must be made in a manner consistent with a progressive move towards compliance with the disability-neutral requirements of Article 14 of the CRPD.

Article 19 of the CRPD: Living independently and being included in the community

Article 19 of the CRPD also supports the proposition that involuntary admission can no longer be viewed as being in accordance with international law. Article 19 states that:

> "States Parties to this Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:
>
> (a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;
>
> (b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
>
> (c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs."

States parties to the CRPD are therefore required to ensure that there is a progressive transition from institutional frameworks to care and treatment options that are based in the community. Applying Article 19 in accordance with the principles contained in Articles 3, 4 and 5 of the CRPD, states parties are required to modify their laws so as to ensure such a progression towards a rights based, person-centred and user-led system of community living and supports for persons with mental

disabilities and those connected with them. This requirement clearly requires a move away from the focus on the detention of persons with mental disabilities in an institutional framework for the purposes of treatment, which is at the core of the 2001 Act.

A Vision for Change places at its centre a move towards community-based supports for persons with mental health problems and that "interventions should be aimed at maximising recovery from mental illness, and building on the resources within service users and within their immediate social networks to allow them to achieve meaningful integration and participation in community life."[40] Government policy in this area is therefore consistent with the requirements of Article 19. A Vision for Change should be implemented in line with government's commitments in this area in its programme for government.

A holistic reading of Articles 14 and 19 requires Ireland to move away from high-volume involuntary admissions towards community-based services for people with mental health problems.

Recommendation:

The Act must place at its centre a commitment to services and supports in the community and promote the inclusion of people with mental health problems in all aspects of life.

[40] A Vision for Change, p. 8

Children and the CRPD

The United Nations Convention on the Rights of the Child (CRC) and the UN Convention on the Rights of Persons with Disabilities (CRPD), provide benchmarks against which Irish mental health law and practice can be measured. Article 7 of the CRPD states that children with disabilities (including mental disability, Article 1) shall have equal enjoyment of all human rights. Both the CRC and the CRPD provide that children have a right to express their views, to participate in all matters affecting them, and to enjoy legal capacity on an equal basis with others. Human rights law requires us to look at children as individual rights holders. In *Glass v United Kingdom* the European Court of Human Rights affirmed the child's independent right to respect for his private and family life in the context of medical treatment.

Children's rights are invisible in the *2001 Act*. The CRPD recognises the importance of individual autonomy and independence. Children with mental health problems should have the opportunity to be actively involved in decision-making processes that directly concern them. The new thinking reflected in the CRPD will be challenging for Ireland; however, we must reconsider our approach to children and human rights in this context.

Fundamental to the CRPD is that people with disabilities, including mental health problems, are to enjoy all human rights and fundamental freedoms on an equal basis with others. The State is obliged to give children the protection they are given under international instruments to which Ireland is a party. The government must engage with the CRPD when reviewing the *Mental Health Act 2001*. The CRPD provides for an autonomy-based approach to "best interests" in its general principles (Article 3, 12 and 25). Article 12 of the CRPD requires that people with mental health problems be presumed legally capable of making their own decisions and having their right to self-determination respected on an equal basis with people in general health care settings.

Article 12 also places an obligation on State Parties to "take all appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity." Article 12 involves a move away from the paternalism that surrounds "best interests" to respecting the will and preference of the person. The best interest principle came from law and policy focused on children and is criticised as being inappropriate in relation to adults.[41] If the use of the best interests test is to remain in the *2001 Act*, it must be defined and its application in practice made clear. The Law Reform Commission suggests

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[41] For a discussion on the origin of the best interests principle see "The Best Interests of the Child: Towards a synthesis of Children's Rights and Cultural Values" [Florence: UNICEF, Innocenti Studies, 1996] Available at: www.nicef-irc.org

that the best interests principle is more than just a paternalistic test of "parents know best" or "doctor knows best". The Commission states that best interests viewed with a rights-based approach has an "objective aspect that ensures an appropriate level of protection against outcomes that would be inconsistent with the rights of children."[42] Any best interests principle in the *2001 Act* must be assessed objectively by reference to the rights of the child. There is also a need for specialist child and adolescent advocates in this context.

Recommendations:

Fundamentally the *2001 Act* requires amendments that affirm the principles of the CRPD.

In addition, the "best interests" principle should be refocused to be child centred and include a requirement that any "best interests" test must be assessed objectively by reference to the rights of the child.

Addressing the Demarcation of the Criminal Law (Insanity) Act 2001 & Mental Health Act 2001

The Committee on the Prevention of Torture in its 2006 report on Ireland, stated that a comparative reading of both the *Mental Health Act 2001* and *Criminal Law (Insanity) Act 2006* indicates that patients placed under the 2006 Act potentially benefit from considerably fewer safeguards than those placed under the *Mental Health Act 2001*.[43] It noted that the *Criminal Law (Insanity) Act 2006* lacks provisions on the use of physical restraint, seclusion and inspection. Similarly, the mandate of the Mental Health (Criminal Law) Review Board is limited when compared with that of the Mental Health Board under the civil mental health system. This criticism was reiterated in its most recent Report where the Committee noted that the Central Mental Hospital voluntarily applies the *Mental Health Act 2001* provisions "… as regards consent to treatment and use of means of restraint and seclusion, to patients placed under the 2006 Criminal Law (Insanity) Act."[44] The CPT recommended that the Irish

[42] Law Reform Commission, (LRC 103- 2011) p 23

[43] "Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 2 to 13 October 2006" (Strasbourg: Council of Europe, 2007 at paragraph 106).

[44] "Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 25 January to 5 February 2010" (Strasbourg: Council of Europe, CPT/Inf (2011) 3) at page 68.

government "… introduce legally binding safeguards, including as regards consent to treatment and use of means of restraint and seclusion, for patients detained under the 2006 Criminal Law (Insanity) Act."[45]

With regards to review of detention under the 2006 Act the CPT was critical of the Mental Health (Criminal Law) Review Board on that the basis that since its establishment in 2006 "only one patient hospitalised after a verdict of "not guilty by reason of insanity" has been discharged from the Central Mental Hospital on the Board's initiative."[46] The reason suggested to the Committee for the low number of discharges by the Board was that the Act did not contain a power to recall patients if the conditions of discharge are breached.[47] This position has been resolved somewhat by the *Criminal Law (Insanity) Act 2010* whose main purpose was to address this deficiency.[48] The 2010 Act provides greater power to the Mental Health (Criminal Law) Review Board in respect of the conditional discharge of patients detained by order of a court in the Central Mental Hospital (a designated centre) having been found unfit to be tried or not guilty by reason of insanity under the *Criminal Law (Insanity) Act 2006.*[49] Despite the amendments to the 2006 Act the core deficit remains in terms of the lack of safeguards afforded to persons detained under the 2006 Act when compared to persons detained under the 2001 Act.

Section 5(2) of the Criminal *Law (Insanity) Act 2006* states that a person found not guilty by reason of insanity if "suffering from a mental disorder (within the meaning of the Act of 2001) and is in need of in-patient care or treatment in a designated centre, the court shall commit that person to

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[45] *Ibid*.

[46] *Ibid*, at page 67.

[47] *Ibid*.

[48] The case *J.B. v Mental Health (Review Board) & Others* was on going as the time this amending piece of legislation was passed. See See the Irish Human Rights Commission website at: http://www.ihrc.ie/home/wnarticle.asp?NID=238&T=N. The case raised important issues about the extent to which aspects of the *Criminal Law (Insanity) Act 2006* respects human rights principles. That case concerned the continuing detention of the appellant who had been found not guilty of murder by reason of insanity in the Central Mental Hospital. The Mental Health (Criminal Law) Review Board were under an obligation under the *Criminal Law (Insanity) Act 2006* to review the applicants detentions, but determined that the person should be released subject to a number of conditions, but where the conditions could not be legally enforced. (The proceedings are entitled *J.B. v The Mental Health (Criminal Law) Review Board, the Minister for Justice, Equality and Law Reform, Ireland and The Attorney General*.) The Human Rights Commission's submission addressed circumstances where a person originally convicted of murder but now deemed to be "not guilty by virtue of insanity" can continue to be detained by the State. It is unfortunate that this case was settled in that the Supreme Court were required to consider the important issues around the Mental Health (Criminal Law) Review Board obligations in assuming the State's functions in taking decisions on the detention of citizens, is bound by provisions of the Irish Constitution and European Convention on Human Rights.

[49] Under the *Criminal Law (Insanity) Act 2006* the Mental Health (Criminal Law) Review Board is empowered to grant patients conditional discharge where it considers the patient suitable for discharge. The Act amended the 2006 Act to make provision for a patient to be returned to the "approved centre" in circumstances where they are in material breach of the conditional discharge order.

a specified designated centre". The rationale for the "insanity defence" is that it avoids the application of punishment for conduct that a person was not responsible for at the time of the commission of the offence. It is clear from the 2006 Act that the detention is for the purposes of treatment. It is on this basis that the provisions of the 2001 Act including any amendments extending human rights protections should apply equally to persons detained under the 2006 Act.

Recommendation:

The Mental Health Act 2001 should be amended to extend its safeguards including any future safeguards to persons detained under the Criminal Law (Insanity) Act 2006.

Section 3: The extent to which the Recommendations of *A Vision for Change* could or should be underpinned by legislation

One of the key recommendations in VFC is that it proposes a "holistic view of mental illness and recommends and integrated multidisciplinary approach to addressing the biological, psychological and social factors that contribute to mental health problems. It proposes a person-centred approach which addresses each of these elements through an integrated care plan reflecting best practice, and evolved and agreed with service users and their carers." It emphasizes the need to involve service users and carers at every level of service provision. A particular emphasis is placed on maximizing recovery, building on personal resources and social networks towards participation in community life.

One of the key elements in advancing the strategy in VFC was the appointment of a National Directorate of Mental Health Services with budgetary power. This has not happened and has been recommended and emphasized in all key reports that review the operation of the Act.[50] It is illogical not to do so when the key area to be developed is the community network of support. The Act should be amended to provide for this role in the same way that the Mental Health Commission, the Inspectorate of Mental Health Services, and the Mental Health Tribunals are recognized as essential. Otherwise, the services will not advance and may even regress. The avoidance of fragmentation in the system is so critical at this time of constraints and a dynamic and creative directorate could lead in an imaginative way.

In line with the above recommendation, the title of the Act should be inclusive of the focus towards community care. This would strengthen the orientation and recognize the Recovery ethos. Otherwise the revision will not progress beyond the current status quo. As an adjunct to the above recommendation on the title, the definition of mental health services should be expanded to reflect the catchment area and the Inspectorate and Regulatory system extended to underpin this element. If this development were successful, one would expect to see far more community activity and less concentration on the approved centres.

The Act already includes service users in the monitoring bodies and the success of this development needs to be recognized and expanded. The formal statutory involvement includes the Mental Health Commission, the Inspectorate of Mental Health Services and the Mental Health Tribunals. In addition collaboration with key service user stakeholder groups is embedded in some HSE policies. The role of the peer advocate is established but is in need of expansion. This foundation needs to be build

[50] See for example the Independent Monitoring Group Annual Reports.

upon "at every level", further underpinned in the legislation as a key element of future sustainability in the community.

The individual care plan is another element of VFC. Many recommendations on this are made in Section 1 of this report. Please note that the Principles from VFC recommendations are included also in Section 1.

Recommendations:

The Act should be amended to provide for that the role of the National Directorate of Mental Health Services (with budgetary power) in the same way that the Mental Health Commission, the Inspectorate of Mental Health Services, and the Mental Health Tribunals are recognized as essential.

The title of the Act should be inclusive of the focus towards community care.

The definition of mental health services should be expanded to reflect the catchment area and the Inspectorate and Regulatory system extended to underpin this element.

The role of the peer advocate is established but is in need of expansion within the monitoring mechanisms of the Act.

Section 4: The Current Economic Environment

Although there is an increasing prevalence of mental health issues due to the economic downturn, positive initiatives exist in many communities, which support people through crisis situations. Ireland has long been rich in social capital and it is important to draw on the existing resources in our communities to ensure that the recovery approach to mental health services can be realised. However, an injection of capital is needed in order to achieve the structural change required in the delivery of mental health services as a VFC was predicated on increased funding. The neglect of mental health services and failing to implement a recovery-based approach to mental health treatment conflicts with the CRPD. Article 25 of the CRPD requires Ireland as a States Party to recognise that "… persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability." These obligations in Article 25(c) include an obligation to provide services "… as close as possible to people's own communities, including in rural areas".

It is important to be mindful of Ireland's obligations in providing mental health services under international human rights law. The Convention on the Rights of Persons with Disabilities includes a broad array of civil and political rights and economic, social and cultural rights and retains applies the traditional distinction between civil and political and socio-economic rights. It is important to note that State Parties to the Convention are required to immediately implement civil and political rights. However, State Parties to the Convention are required to progressively achieve or implement rights that are socio-economic in nature. In this regard Article 4(2) of the CRPD adopts the concept of progressive realisation of economic social and cultural rights. Article 4(2) states that "with regard to economic, social and cultural rights, each State Party undertakes to take measures to the maximum of its available resources and, where needed, within the framework of international cooperation, with a view to achieving progressively the full realization of these rights, without prejudice to those obligations contained in the present Convention that are immediately applicable according to international law." It is important to note that this does not mean that State Parties to the CRPD are not required to take any measures in respect of its obligations in providing appropriate mental health services. The UN Committee on Economic, Social and Cultural Rights in its General Comment No. 3 below is very instructive:

> "Thus while the full realization of the relevant rights may be achieved progressively, steps towards that goal must be taken within a reasonably short time after the Covenant's entry into force for the States concerned. Such steps should be deliberate, concrete and targeted as clearly as possible towards meeting the obligations recognized in the Covenant. The means which should be used in order to satisfy the obligation to take steps are stated in article 2 (1) to be "all appropriate means, including particularly the adoption of legislative measures". The Committee recognizes that in many

instances legislation is highly desirable and in some cases may even be indispensable."[51]

The Committee on the Rights of Persons with Disabilities will adopt the approach taken by the UN Committee Economic, Social and Cultural Rights. However, it is important to note that Article 4(2) of the CRPD on progressive realisation is expressly "without prejudice to those obligations contained in the present Convention that are immediately applicable according to international law" meaning that rights are to be expressed without discrimination. The right to appropriate mental health services in the community arguably goes beyond economic social and cultural rights, as there are civil and political dimensions to the right – most obviously the right to liberty. This is of particular relevance to persons placed in psychiatric institutions as a direct result of a lack of choices in terms of community based supports.[52]

The CRPD requires State Parties to move away from guardianship to supported decision-making and requiring State Parties to support people to live in the community. The experience of supported decision-making in British Columbia through representation agreements has demonstrated that supported decision-making models do not have to be resource intensive.[53] Similarily, there is evidence that advance directives have been shown to decrease costs and reduce hospital readmission rates in mental health care.[54] The potential economic benefits resulting from the therapeutic impact of advance directives is significant. For example, an economic valuation of joint crisis plans found a 78 per cent probability that they were more cost effective than standard service information in preventing admissions.[55] As such Ireland as a State Party to the CRPD could be held to be in violation of the Convention if it fails to provide a range of community based mental health services particularly where restrictions on legal capacity and institutionalisation result.

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[51] General Comment 3 (Office of the High Commissioner for Human Rights, 14/12/90) at paras 2-3. Available at: http://www.unhchr.ch/tbs/doc.nsf/0/94bdbaf59b43a424c12563ed0052b664?Opendocument.

[52] This perspective is shared in relation to Article 19 on the right to independent living see Parker & Clements "The UN Convention on the Rights of Persons with Disabilities: A New Right to Independent Living?" (*European Human Rights Law Review*: 2008, 4, 508) at page 514.

[53] See in particular, NIDUS (a not for profit group set up to support personal networks) at:

http://www.nidus.ca/.

[54] Henderson et al., "Effect of Joint Crises Plans on Use of Compulsory Treatment in Psychiatry: Single Blind Randomised Controlled Trial" (2004) 329 *British Medical Journal* 136.

[55] Flood et al., "Joint Crisis Plans for People with Psychosis: Economic Evaluation of a Randomised Controlled Trial" (2006) 333 *British Medical Journal* 729.

Recommendation:

The progressive realisation of socio-economic rights defence for failure to provide appropriate community based supports for persons with mental health problems is vulnerable to challenge given the resultant restriction on civil and political rights.

Summary of Recommendations

Recommendations: Section 1 General Operation since commencement of the Act

Guiding Principles: Section 4

- The autonomy principle, as well as the other principles, in section 4(3) should be set out at the start of the Guiding Principles section. Consideration should be given to including principles from the Report of the Expert Group on Mental Health Policy, *A Vision for Change*, 2006 (VFC) particularly the principle of Recovery which "should inform every level of the service provision..." (VFC 2006, p5).

- The presumption of capacity, as a logical adjunct to the above principles, should be included in order to have the highest level of compatibility with proposed mental capacity law.

- The current best interests principle needs to be defined, and consideration should be given to adopting a principle in accordance with the CRPD.

- The principle, in section 4(2), of consultation and active participation of the person in decisions should be strengthened as a key underpinning principle of VFC. Consideration should be given to see how this can link with the revised principles and can enhance autonomy along with the inclusion of support in situations where capacity issues arise.

- The principle of supported decision making to enable people to make their own decisions is a key element in advancing all other principles.

Criteria for detention: Sections 3, 8

- The Act should be amended so as to expressly require involuntary admission to be a practice of last resort and only where voluntary admission or support in the community is no longer possible.

- The definition of persons who are capable of being admitted involuntarily should be more precisely defined and the term 'mental disorder' replaced with less stigmatising label.

- In line with international best practice, persons with intellectual disabilities should be excluded from the provisions of the Act.

Voluntary admission: Sections 29 and 23

- The Act needs to include the principle of the least restrictive alternative and therefore should include a strong enabling provision around voluntary admission.

- The presumption of capacity must apply to all voluntary admissions and this needs to be stated in the Act.

- The role of supported decision-making and safeguards for people whose decision-making capacity may be reduced should be recognised to ensure compatibility with proposed mental capacity law.

- Voluntary patients should be informed of the range of common law rights associated with that status including informed consent to treatment.

Prevention of voluntary person from leaving: Section 23

- The Act needs to have positive statements supporting voluntary admission and deter efforts to undermine any voluntary admission.

Part 4 Consent to treatment: Section 56

- The importance of informed consent and patient participation, as elements of autonomy and treatment decision-making should be recognised in the revised Act

- Regular review of capacity is required and should include an independent assessment that would include a multi-disciplinary element.

Treatment not requiring consent: Section 57

- Consideration should be given to support to enable people to choose their treatment and to narrow the broad range of exceptions.

ECT treatment: Section 59

- Informed consent is essential for this treatment and any departure should be subject to oversight and include independent opinion and multidisciplinary team.

Administration of medicine: Section 60

- Informed consent and collaboration in the treatment plan.

- Departure from this principle should be subject to independent opinion and multidisciplinary team.

Advance Directives

- The revised Act should introduce advance directives to:

- Reinforce the supported decision making model and the assumption of capacity.

- Assist in the implementation of the person's wishes and preferences

- Preserve decision-making autonomy during periods when deficits in capacity may occur.

- Reduce the need for involuntary treatment by involving individuals in decisions about their mental health treatment and recovery.

Seclusion and Restraint: Section 69

- Encourage patient participation in decisions about future mental health treatment.

- The scope of the provision is too wide as it applies to voluntary patients and to children.

Absence on Leave: Section 26

- This provision should be linked with the individual care plan.

- Clarification is required to define the purpose of the provision.

Discharge from involuntary admission: Section 28

- The status of the person remaining in the centre following discharge needs to be considered.

- The individual care plan should be included at the earliest point following admission and should provide a seamless approach towards discharge and support in the community.

Access to Justice: Section 73

- Section 72 should be repealed to reflect that persons with mental health problems are entitled to access to justice on an equal basis with everyone else.

Children

- This new part of the Act on Children should be based on the principles discussed already as well as child/young person appropriate principles including supported decision-making.

- To ensure adequate safeguards are present and meaningful in practice we need to amend the *2001 Act* to include a

comprehensive and separate part relating to children, which should be positive in tone and highlight the visibility of children and adolescents in the Act.

- This separate section should explicitly refer to a set of guiding principles and safeguards that will apply to all children admitted to approved centres for mental health care and treatment.

- The Act should be amended to provide that persons 16 years and over shall be presumed to have capacity to make decisions regarding admission and treatment unless that presumption is rebutted.

- The definition of voluntary admission must be clarified to reflect the status of children admitted by those with parental responsibilities or a new category introduced as recommended by the Law Reform Commission.

- Any category of admission should have all the safeguards currently provided for the admission of adults under the 2001 Act.

- The Act should be amended to include a mechanism for the participation of the child in all aspects of their care and treatment.

- The *Mental Health Act 2001* should be amended to provide a statutory-based code of practice to help implement children's rights under mental health legislation. The code should set out fundamental principles that must apply to children, such as: giving them age appropriate information regarding the proposed admission and treatment, providing an appropriate environment for their views to be heard, and requiring compulsory recovery-orientated care and treatment plans.

- To ensure adequate safeguards are present and meaningful in practice we need to amend the *2001 Act* to include a comprehensive and separate part relating to children, which should be positive in tone and highlight the visibility of children and adolescents in the Act. This separate part should explicitly refer to a set of guiding principles and safeguards that will apply to all children admitted to approved centres for mental health care and treatment.

- The Act should be amended to provide that persons 16 years and over shall be presumed to have capacity to make decisions regarding admission and treatment unless that presumption is rebutted.

- The definition of voluntary admission must be clarified to reflect the status of children admitted by those with parental responsibilities or a new category introduced as recommended by the Law Reform Commission.

- Any category of admission should have all the safeguards currently provided for the admission of adults under the 2001 Act.
- This applies to all the procedures involved in the process of admission and treatment.

- The Act should be amended to include a mechanism for the participation of the child in all aspects of their care and treatment.

- Fundamentally the *2001 Act* requires amendments that affirm the principles of the CRPD.

- In addition, the "best interests" principle should be refocused to be child centred and include a requirement that any "best interests" test must be assessed objectively by reference to the rights of the child.

Addressing the Operational Demarcation of Safeguards Contained in the *Mental Health Act 2001*

- The safeguards contained in the Mental Health Act 2001 should apply equally to persons involuntarily detained and treated under the Criminal Law (Insanity) Act 2006 to ensure an equivalence of human rights protections. Persons detained under the 2006 Act should be entitled to treatment on an equal basis with persons dealt with under the 2001 Act in other settings and in the community.

Recommendations: Section 2: The provisions of the Act having regard to the provisions of the UN Convention on the Rights of People with Disabilities

Article 12: Equal Recognition before the Law and Voluntary Admission

- **Respect voluntariness:** This requires safeguards to be included in the Mental Health Act 2001 to enable voluntary patients to leave an approved centre when this accords with their will and preferences. While there is currently a mechanism in place in the 2001 Act to prevent the arbitrary conversion of voluntary patients to involuntary patients, further safeguards could be put in place to make the decision to leave a more realistic possibility for voluntary patients.

- **Community supports:** Supports in community should be provided as a realistic alternative to involuntary detention for people in crisis who urgently need mental health treatment. This reinforces the recovery model for mental health services as set out in A Vision for Change.1 Such supports would include access to information on treatment, reasonable accommodation in accessing

services, recognition of supported decision-making networks (or circles of support) and the availability of facilitated decision-making as a last resort. Community supports would also include examples of best practice, which have been demonstrated internationally to enable more effective recovery for people with mental health problems, e.g. crisis peer support from other mental health service users.1

- **Safeguard those subject to facilitated decisions:** In this new legal capacity regime of supported decision-making, safeguards should be put in place for individuals subject to facilitated decision-making where a decision to undergo mental health treatment is made. This is because facilitated decision-making will only apply to individuals who do not have the possibility of supported decision-making, and where it is extremely difficult to ascertain the person's will and preferences (e.g. if the person is communicating in a way which cannot be understood by others). These are situations where the 'voluntariness' of undergoing treatment could legitimately be called into question, and safeguards to validate the decision would exist for all facilitated decisions, including those relating to mental health treatment.

Best Interests Principle in the 2001 Act: The Need to Radically Reframe "Best Interests" to Pivot on the "Will and Preferences" of the Person

- The "best interests" principle enshrined in the 2001 Act needs to be reframed in light of the UN Convention on the Rights of Persons with Disabilities to reflect the "will and preferences" of persons subject to its provisions.

- "Best interests" should be defined so as to ensure a consistent, rights-based application of that principle in the context of involuntary admission. This definition should be based on the rights of persons with disabilities as they are contained in the CRPD.

Involuntary Admission and Article 14 of the CRPD

- A Vision for Change should be implemented so as to ensure that sufficient community supports are put in place to minimise the number of involuntary admissions to approved centres under the Act.

- Amendments to the 2001 Act must be made in a manner consistent with a progressive move towards compliance with the disability-neutral requirements of Article 14 of the CRPD.

Article 19 of the CRPD: Living independently and being included in the community

- The Act must place at its centre a commitment to services and supports in the community and promote the inclusion of people with mental health problems in all aspects of life.

Children and the CRPD

- Fundamentally the *2001 Act* requires amendments that affirm the principles of the CRPD.

- In addition, the "best interests" principle should be refocused to be child centred and include a requirement that any "best interests" test must be assessed objectively by reference to the rights of the child.

Addressing the Demarcation of the Criminal Law (Insanity) Act 2001 & Mental Health Act 2001

- The Mental Health Act 2001 should be amended to extend its safeguards including any future safeguards to persons detained under the Criminal Law (Insanity) Act 2006.

Recommendations: Section 3: The extent to which the Recommendations of *A Vision for Change* could or should be underpinned by legislation

- The Act should be amended to provide for that the role of the National Directorate of Mental Health Services (with budgetary power) in the same way that the Mental Health Commission, the Inspectorate of Mental Health Services, and the Mental Health Tribunals are recognized as essential.

- The title of the Act should be inclusive of the focus towards community care.

- The definition of mental health services should be expanded to reflect the catchment area and the Inspectorate and Regulatory system extended to underpin this element.

- The role of the peer advocate is established but is in need of expansion within the monitoring mechanisms of the Act.

Recommendation: Section 4: The Current Economic Environment

- The progressive realisation of socio-economic rights defence for failure to provide appropriate community based supports for

persons with mental health problems is vulnerable to challenge given the resultant restriction on civil and political rights.