Coimisiún na hÉireann um Chearta
an Duine agus Comhionannas
Irish Human Rights and Equality Commission

IHREC
Monitoring Mechanism
Independent Monitoring Mechanism
under the United Nations Convention on
the Rights of Persons with Disabilities

Mary Butler, T.D., Minister of State for Mental Health,

Department of Health,

Miesian Plaza,

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10 November 2025

Re: Mental Health Bill

Minister Butler, a chara

The Irish Human Rights and Equality Commission, in our statutory mandate as the Independent Monitoring Mechanism for the UN Convention on the Rights of Persons with Disabilities ('UNCRPD'), have been following the Mental Health Bill as it progresses through the legislative process. We stress that people with psychosocial disabilities must be regarded as rights holders under UNCRPD.

We are concerned that these UNCRPD rights are not explicitly or fully considered within current mental health legislative reform, policy, provision and practice. The issues addressed in this correspondence are longstanding, evidenced in our UNCRPD List of Issues Prior to Reporting Report (July 2025) and IHREC publications referenced below.

We have consistently expressed concern with the delay in progress of reforming Irish mental health legislation, noting the impact that this delay has on the rights of persons with psychosocial disabilities who have spent years advocating for reform of mental health legislation. We welcome that the Programme for Government sets out that it is a Government priority to enact the Mental Health Bill. We also acknowledge the Government's

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commitments in the Programme for Government to advance the rights and improve the lives of disabled people, and to advance the implementation of the UNCRPD. The paradigm shift required by Ireland's ratification of the UNCRPD needs to be evident in this legislation.

With the Mental Health Bill now in Seanad Éireann, after being passed by Dáil Éireann, we consider that it is important to ensure timely enactment of legislation that is consistent with human rights standards, as set out below, and includes appropriate and effective safeguards and protections for the rights of persons with psychosocial disabilities.

As you may be aware, in April 2022, we published legislative observation on the General Scheme of the Mental Health (Amendment) Bill. In this submission, we emphasised the need for reform of the *Mental Health Act 2001* and set out recommendations to align the legislation with the UNCRPD, the United Nations Convention on the Rights of the Child ('UNCRC') and other human rights standards. Key substantive issues remain unaddressed in the legislation, and we set out several points below which should be considered in progressing and enacting this legislation.

- **Definition of 'mental disorder'**: The term 'mental disorder' in the Mental Health Bill should be replaced with 'persons of psychosocial disabilities', in line with UNCRPD and the human rights model of disability.[1]
- **Provisions governing the use of chemical restraint**: The Mental Health Bill has removed provisions concerning the use of chemical restraint which were included in the general scheme of the Bill. The absence of statutory safeguards is

[1] IHREC, Submission on the General Scheme of the Mental Health (Amendment) Bill (2022) p. 24.

concerning as chemical restraint is not covered in the current Rules or codes of practice in place. The Bill must include provisions concerning the use of chemical restraint, with appropriate safeguards in place.[2]

- **Absence of an independent complaints mechanism**: The Mental Health Bill should provide for the creation of an independent complaints mechanism to receive, investigate and determine complaints from adults and children about mental health services.[3]

In the appendix below we include several other considerations for this legislation. Since our submission on the General Scheme in 2022, there have been several recommendations made by United Nations and Council of Europe human rights mechanisms to Ireland on reform of mental health law. We include these recommendations below, which should be considered in progressing, implementing and monitoring the legislation. It is critical to ensure that the UNCRPD and UNCRC rights of adults and children with psychosocial disabilities are protected and fulfilled under this legislation.

In accordance with our mandate, we will continue to monitor the Bill as it progresses through the legislative process. IHREC believes that the present Bill presents a historic opportunity to

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[2] IHREC, Submission on the General Scheme of the Mental Health (Amendment) Bill (2022) pp. 61-62. See also IHREC, Ireland and the United Nations Convention on the Rights of Persons with Disabilities: Submission to the Committee on the Rights of Persons with Disabilities for the List of Issues Prior to Reporting (2025) pp. 56-57; IHREC, Ireland and the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2024) p. 49.

[3] IHREC, Submission on the General Scheme of the Mental Health (Amendment) Bill (2022) p. 72. See also IHREC, Ireland and the United Nations Convention on the Rights of Persons with Disabilities: Submission to the Committee on the Rights of Persons with Disabilities for the List of Issues Prior to Reporting (2025) p. 43; IHREC, Policy brief on Access to Justice: Implementation of Article 13 of the UN Convention on the Rights of Persons with Disabilities (2024) pp. 26, 36-27; IHREC, Ireland and the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2024) pp. 52-53.

finally put in place a legal framework for mental health in Ireland which is fully consistent with Ireland's obligations under the UNCRPD and other relevant human rights standards. We recognise the extensive work that has been undertaken by you and by your Department to bring the Bill to this point. However, we are concerned that a number of aspects of the legislation continue to present significant divergence from human rights standards.

As Ireland's National Human Rights Institution and as the Independent Monitoring Mechanism under CRPD, IHREC is committed to supporting both you as Minister and the Oireachtas in ensuring the strongest possible legal framework is in place in this area, mindful of the urgency of enacting this legislation for all those individuals and families who are affected.

The IHREC team and I are available to meet with you or your officials to discuss this legislation at any time.

Le dea-mhéin,

Liam Herrick
Chief Commissioner
Irish Human Rights and Equality Commission

In line with our publications policy, this letter will be published on our website. This policy only pertains to IHREC-issued communications, and not to correspondence received by us.

Appendix

Relevant human rights and equality standards

The Mental Health Bill engages with several fundamental rights protected under the Constitution, the Charter of Fundamental Rights of the European Union, the European Convention on Human Rights, the UNCRPD, other treaties of the United Nation system, and other sources of international human rights law.[4]

- The right to exercise legal capacity
- The right to consent to medical treatment
- Deprivation of liberty safeguards
- De facto detention for treatment
- Restraint and seclusion
- The rights of the child

The legislation needs to be aligned with Ireland's human rights and equality obligations.

Alignment with relevant legislation

Along with delays in the reform of the Mental Health Act 2001, we have repeatedly raised concerns with the delay of legislation adequately safeguards individuals at risk and/or deprived of their liberty, including the Protection of Liberty Safeguards Bill and the Inspection of Places of Detention Bill. It is important that the provisions of the Bills be carefully aligned to ensure there is no difference in standards or treatment of individuals under the respective legislation.[5]

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[4] IHREC, Submission on the General Scheme of the Mental Health (Amendment) Bill (2022) pp. 4-18.
[5] IHREC, Submission on the General Scheme of the Mental Health (Amendment) Bill (2022) p. 2. See also IHREC, Ireland and the United Nations Convention on the Rights of Persons with Disabilities: Submission to the Committee on the Rights of Persons with Disabilities for the List of Issues Prior to Reporting (2025) pp. 44-45; IHREC, Policy brief on Access to Justice: Implementation of Article 13 of the UN Convention on the Rights of Persons with Disabilities (2024) pp. 26-27; IHREC, Ireland and the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2024) pp. 42-43.

Capacity to consent to treatment

Non-consensual use of psychiatric medication in mental health services should be generally prohibited and only used in exceptional circumstances as a measure of last resort.[6] People should be informed on admission of their right to refuse treatment.

Initial involuntary detention period

Procedural safeguards governing involuntary admission are currently inadequate and not human rights compliant.[7] We are concerned about the procedure by which involuntary admission arises. The Mental Health Bill proposes to reform the involuntary admission procedure, including by enhancing the role of the Authorised Officer. This service must be adequately and appropriately resourced.

The State must strengthen the procedural safeguards governing involuntary admission. To minimise interference with rights under UNCRPD, any involuntary admissions must apply a rights-based threshold for admission, provision of community-based mental health services as an alternative to involuntary detention, and a strengthened process around review of detention.

Review of the definition of 'voluntary' admission is required, which does not address whether the individual has consented to admission or whether they have the capacity to consent, heightening the risk for deprivation of liberty in the absence of appropriate safeguards such as an independent review of the detention. We note the absence of robust procedural

[6] IHREC, Submission on the General Scheme of the Mental Health (Amendment) Bill (2022) pp. 45-51. See also IHREC, Ireland and the United Nations Convention on the Rights of Persons with Disabilities: Submission to the Committee on the Rights of Persons with Disabilities for the List of Issues Prior to Reporting (2025) pp. 70-71.
[7] IHREC, Submission on the General Scheme of the Mental Health (Amendment) Bill (2022) pp. 25-45. See also IHREC, Ireland and the United Nations Convention on the Rights of Persons with Disabilities: Submission to the Committee on the Rights of Persons with Disabilities for the List of Issues Prior to Reporting (2025) pp. 48-49, 55; IHREC, Ireland and the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2024) pp. 44-46.

safeguards governing the reclassification of patients from voluntary to involuntary status, and the potentially coercive nature of the measures employed.

Restrictive practices

We remain concerned about the ongoing use of restrictive practices in Ireland, including the use of seclusion and restraint.[8] This legislation should be aimed at ensuring less restrictive forms of treatment in the community are available and the ultimate eradication of coercion in the treatment of people with psychosocial disabilities. The use of restrictive practices should be limited to exceptional circumstances, where it is the only means available to prevent immediate or imminent harm to the individual or others, and its use should not be prolonged beyond what is necessary for this purpose. The State must provide proactive measures to reduce the use of restrictive practices, to develop strategies which promote less restrictive alternatives consistent with UNCRPD and Council of Europe's Committee for the Prevention of Torture standards, and to provide for access to justice. There should also be provision for people subject to restrictive practices to have access to independent advocacy, legal representation and accessible information about their rights.

Independent advocacy

Access to an independent advocate may be critical to a person in exercising their rights under this legislation.[9] We recommend that the right to an advocate be put on a statutory footing and independent advocacy services be provided, including for children.

[8] IHREC, Submission on the General Scheme of the Mental Health (Amendment) Bill (2022) pp. 19-20, 51-62. See also IHREC, Ireland and the United Nations Convention on the Rights of Persons with Disabilities: Submission to the Committee on the Rights of Persons with Disabilities for the List of Issues Prior to Reporting (2025) pp. 56-60; IHREC, Ireland and the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2024) pp. 48-50.
[9] IHREC, Submission on the General Scheme of the Mental Health (Amendment) Bill (2022) pp. 24-25..

Admission of children to approved inpatient facilities

We continue to call for the Mental Health Bill to explicitly prohibit children from being admitted to an adult inpatient facility.[10] This legislative measure should be accompanied by the increased resourcing of community and age-appropriate treatments.

Recommendations from international human rights mechanisms

United Nations Human Rights Committee – Concluding Observations on the fifth periodic report of Ireland (2023) CCPR/C/IRL/CO/5

Coercive measures in psychiatric institutions

33. The Committee notes the information provided in regard to the ongoing review of the Mental Health Act 2001 with a view to providing safeguards against coercive treatments in psychiatric institutions that are aligned with the principles of the Assisted Decision-Making (Capacity) Act 2015, and welcomes the State party's commitment to age-appropriate treatment and to reducing the number of children admitted to adult psychiatric institutions. It is, however, concerned about the significant delays in the commencement and reform of enacted legislation concerning legal capacity and persons with psychosocial disabilities. The Committee is also particularly concerned that the State party has asserted that children will likely continue to be admitted to adult psychiatric institutions in situations in which there is an issue with institutional capacity. Furthermore, recalling its previous concerns, the Committee regrets the reports of ongoing use of, inter alia, seclusion, physical restraint, electroconvulsive therapy and involuntary administration of medication (arts. 2, 7 and 14).

34. The State party should ensure the prompt and full commencement and reform of legislation concerning capacity and psychosocial disabilities, guaranteeing a human

[10] IHREC, Submission on the General Scheme of the Mental Health (Amendment) Bill (2022) pp. 70-72. See also IHREC, Ireland and the United Nations Convention on the Rights of Persons with Disabilities: Submission to the Committee on the Rights of Persons with Disabilities for the List of Issues Prior to Reporting (2025) pp. 50, 53; IHREC, Ireland and the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2024) p. 47.

rights-based approach that endorses non-discrimination in line with international standards. The Committee urges the State party to implement the necessary measures with a view to guaranteeing age-appropriate treatment, eliminating the practice of admitting children into adult psychiatric facilities. The State party should also:

(a) Take effective measures to ensure full implementation of legal provisions related to the use, in compliance with the Covenant and other international instruments, of physical restraint and coercive force, ensuring that any decision to use restraints or involuntary seclusion in such institutions be made after a thorough and professional medical assessment to determine the amount of restraint or coercive force to be applied, and that any restrictions be legal, necessary and proportionate to the individual circumstances and include guarantees of an effective remedy;

(b) Ensure that non-consensual use of psychiatric medication, electroconvulsive therapy and other restrictive and coercive practices in mental health services is prohibited. Non-consensual psychiatric treatment may only be applied, if at all, in the most exceptional cases as a measure of last resort, where absolutely necessary for the benefit of the persons concerned, provided that they are unable to give consent, for the shortest possible time, without any long-term impact and under independent review;

(c) Offer adequate community-based or alternative social care services for persons with intellectual or psychosocial disabilities to provide less restrictive alternatives to forcible confinement;

(d) Ensure an effective and independent monitoring and reporting system for mental and social care institutions, aimed at effectively investigating and sanctioning abuses and providing redress to victims and their families.

United Nations Committee on the Rights of the Child – Concluding observations on the combined fifth and sixth periodic reports of Ireland (2023) CRC/C/IRL/CO/5-6

Mental health

31.The Committee welcomes the adoption of a mental health policy in 2020 but is seriously concerned about:

(a)Insufficient and inadequate mental health services for children;

(b)Long waiting lists for children seeking mental health services, with some waiting for more than a year for an appointment;

(c)The placement of children with mental health issues in adult psychiatric wards;

(d)The identification of racism and discrimination as having the most detrimental impact on the mental health of children of ethnic minority groups;

(e)Insufficient progress in adopting a Traveller and Roma mental health action plan, despite commitments in this regard.

32. The Committee urges the State party:

(a) To ensure the availability of therapeutic mental health services and programmes for children, including by:

(i) Significantly increasing the resources allocated for the implementation and monitoring of the mental health policy;

(ii) Providing comprehensive mental health promotion, screening for mental health issues and early intervention services in schools at all levels and in communities;

(iii) Ensuring that the number of qualified professionals, including child psychologists and psychiatrists, is sufficient to meet children's mental health needs in a timely manner;

(iv) Ensuring regular follow-up of children in treatment beyond the initial consultation and that the status of children under medication is adequately monitored;

(b) To ensure that the revisions of the Mental Health Act and the Assisted Decision-Making (Capacity) Act include:

(i) An explicit prohibition of the practice of placing children with mental health issues in adult psychiatric units;

(ii) A recognition of children's right to be heard in decisions regarding their mental health care and assistance from an independent advocate;

(c) To progress the Traveller and Roma mental health action plans and develop a designated mental health support service for children of minority ethnic groups, with a focus on providing support to those who have experienced racial discrimination and related trauma;

(d) To invest in preventive measures, address the underlying causes of suicide and poor mental health among children and ensure that children's perspectives are included in the development of response services;

(e) To allocate sufficient resources for the expansion of the mental health advocacy and information service for children.

United Nations Committee on Economic, Social and Cultural Rights – Concluding Observations on the fourth periodic report of Ireland (2024) E/C.12/IRL/CO/4

48.The Committee is concerned about the low budget allocated to mental health compared with total government health spending. It is also concerned about reports of problems with the availability, accessibility and quality of mental health care and services, in particular for disadvantaged and marginalized individuals and groups (art. 12).

49. The Committee recommends that the State party intensify its efforts to ensure that mental health care is available, accessible and provided in a timely fashion and

guarantee the quality of professional mental health-care services, including community-based services, in particular for disadvantaged and marginalised groups and individuals.

United Nations Committee on the Elimination of Discrimination against Women – Concluding observations on the eighth periodic report of Ireland (2025) CEDAW/C/IRL/CO/8

Health

39. The Committee notes with concern:

(f) The limited availability of gender-sensitive, community-based public mental health services, particularly for women and girl victims of gender-based violence and trafficking and for women with psychosocial disabilities.

40. The Committee recommends that the State Party:

> **(g) Integrate gender-sensitive, community-based mental health services into public health services, with special support for women and girl victims of gender-based violence and trafficking and for women with psychosocial disabilities.**

European Committee for the Prevention of Torture (CPT) – Report to the Irish Government on the visit to Ireland carried out from 21 to 31 May 2024, CPT/Inf (2025) 22

Preliminary remarks

325. The legislative framework governing mental healthcare was undergoing a reform process, as the Government published a bill in July 2024 to radically amend the Mental Health Act 2001. The bill is intended to substantially revise many key areas, such as the criteria for involuntary admission and detention, consent to treatment and the use of means of restraint (see paragraphs 345 and 354). **The Committee would like to be kept informed of the progress of the reform on a regular basis.**

Seclusion and means of restraint

345. Section 69 of the Mental Health Act 2001 constitutes the legal basis for the resort to seclusion and means of mechanical restraint in psychiatric settings. It authorises the Mental

Health Commission to issue rules for the application of the said restrictive measures which are legally binding on 'approved centres' under the Mental Health Act, including the Central Mental Hospital. In contrast, as the law is silent on physical restraint, the Mental Health Commission only issued in this area a 'code of practice', which does not as such entail a legal duty to comply. In addition, the hospital's relevant policy mentions 'common law powers' to apply physical restraint to certain categories of patients, without any further specification. The CPT considers it to be good practice that a specialised and autonomous body, like the Mental Health Commission, be vested with the authority to develop and review rules on restrictive practices. However, **the Committee recommends that the Irish authorities clarify, by amending relevant legislation if necessary, the legal basis for the use of means of physical restraint and the related power to regulate it**.

346. The Mental Health Commission in September 2022 published revised rules governing the use of seclusion and mechanical restraint, which came into effect on 1 January 2023. The rules enshrine, among others, the key principles that seclusion and means of mechanical restraint may only be used in exceptional circumstances and must be the safest and least restrictive option of last resort vis-à-vis the prevailing situation, applied for the shortest possible duration and following reasonable attempts to use alternative means of de-escalation. They shall not be used as a punitive action or to confront operational difficulties including staff shortages. They introduce a ban on the use of mechanical means of restraint for young persons, including the use of hand and leg cuffs. The rules stipulate various legal and medical safeguards, including in relation to the procedure for initiation and review, recording of instances and notification to the Mental Health Commission, and they largely align with the relevant CPT standards. The rules now also require that, when seclusion or mechanical restraint is initiated by a registered nurse, a medical practitioner be informed immediately and carry out a medical examination of the patient no later than two hours following the application of the measure, thus implementing a recommendation made by the CPT in its last visit report.

However, the rules on the use of seclusion are silent on the possibility of secluded patients taking at least one hour of outdoor exercise on a daily basis, if their medical condition so

permits. As regards mechanical restraint, the applicable rules do not dictate that a qualified member of staff be permanently present in the room; video surveillance is not a substitute for personal direct monitoring. Moreover, the requirement that persons should be mechanically restrained out of the view of other patients should be explicitly specified. **The CPT recommends that the Rules Governing the Use of Seclusion and the Rules Governing the Use of Mechanical Means of Bodily Restraint be amended accordingly, and the necessary revisions reflected in all relevant policies and procedures adopted by the National Forensic Mental Health Service.**

347. Regarding the actual resort to seclusion and means of restraint at the Central Mental Hospital, the delegation positively noted the effective implementation of a last resort policy, meaning that, as attested by documentary evidence and interviews, seclusion was applied after other alternative options were explored including de-escalation techniques. While no excessive recourse to seclusion in terms of the number of episodes was noted, seclusion appeared to be applied for lengthy periods of time. Of the 108 instances of seclusion recorded since 2023, only ten lasted for less than 24 hours, while 38 were longer than ten days and 14 extended beyond one month. The CPT has doubts as to whether the seclusion of patients for such lengthy periods is justifiable.

In this context, the delegation examined the case of a patient who had been in uninterrupted seclusion for years on end, first at the hospital's previous premises in Dundrum and then at its current location. There was overall good quality care delivered, including a comprehensive individual care plan and capacity assessments, along with opportunities provided for some human interaction, family visits and access to fresh air. However, the move to the new premises had potentially been detrimental to this patient's quality of life, since he previously had access to a small suite of rooms, which allowed for a less restrictive environment.

In light of the lengthy duration of many instances of seclusion at the Central Mental Hospital, and in particular with reference to this case of extremely long seclusion, **the Committee invites the authorities to consider the development of a Long Term Segregation policy, which would allow for patients to be secluded in the ward, under specific arrangements**

regarding risk management and individualised levels of restriction. This policy should make sure that a range of strong safeguards are guaranteed (see following paragraph), an appropriate programme of therapeutic activities developed (including access to fresh air and, possibly, leave outside the hospital), and meaningful human contact ensured.

348. Seclusion was practically always initiated by a nurse, with subsequent medical examinations carried out by a registrar (psychiatrist in training). Approvals and reviews by a consultant psychiatrist, medical examinations by a registered medical practitioner, and observations by a nurse generally took place within the statutory timeframes. The relevant documentation, which comprised a seclusion care plan, was detailed and recorded in the electronic system. Nevertheless, the reasons for longer seclusion periods – that is, why seclusion should continue – and the performance of de-briefing sessions with the patient were not always clearly documented. This led to the delegation's impression, confirmed in interviews with patients, that patients were not made aware of what was required of them in order to be released from seclusion, and after release, were not always involved in a de-briefing.

Further, seclusion forms subsequent to the initial one were rarely fully completed and the nurses' observation records appeared to be a box-ticking exercise, with no indication as to whether the nurse had meaningfully engaged with the patient or had only performed passive observation. Also, it further transpired from the documents that secluded patients were not routinely offered psychological or occupational therapy sessions.

The CPT recommends that records be properly maintained, with reasons for the initiation and continuation of seclusion exhaustively expressed. Adequate information should be provided to patients, in a manner adapted to their condition, about the reasons underlying the continuation of seclusion and, consequently, the conditions that patients need to satisfy in order for the measure to be ended. Furthermore, secluded patients should receive regular visits from psychologists or occupational therapists.

349. There were 11 seclusion rooms in the hospital wards that were operational at the time of the visit. They all were of reasonable size and in a good state of repair, with sufficient access

to natural light and adequate ventilation. They were fitted with a mattress on the floor, a call bell, a clock displaying the hour and date, and a beanbag, and had a toilet area with a washbasin. A water jet from the ceiling served as a shower. No means of distraction were present in the room. An adjacent nurses' room with glass panel allowed observation, including through CCTV monitoring that ensured the privacy of patients was respected. Nurses and patients could communicate via microphone and speaker, but a significant echo effect in the seclusion room prevented clear comprehension, therefore staff explained that they often had to go to the garden and speak through the open window. The ward's seclusion wing also contained a de-escalation/relaxation area with sofa and TV for use on a case-by-case basis and a secure outdoor exercise yard. **The CPT recommends that measures are taken to improve the way in which secluded patients and nurses in the observation room can engage in meaningful communication. The CPT further recommends that more distractions be offered to patients kept in seclusion for long periods of time**.

350. Resort to means of mechanical restraint – notably, at the Central Mental Hospital, metal or fabric handcuffs – had to be authorised in advance by a consultant psychiatrist (or, in certain cases, by the executive clinical director and the area director of nursing) following a risk assessment, as per the hospital's policy. According to the records, there had been eight applications of mechanical restraint in 2023, and seven in the first four months of 2024, mostly for the purpose of transferring patients to court or external hospitals. The longest instances ranged from three to six and a half hours, all related to escorts to external hospitals. In a recent case, it appeared that a patient who had not been restrained during transportation to an external hospital had been handcuffed during the medical examination there, reportedly due to risk of absconding. **The Committee trusts that the use of means of restraint such as handcuffs when transporting a patient to an external hospital or during a medical examination is only resorted to as a last resort option, when no lesser form of control is deemed effective to address the risks posed by unrestricted movement, and that this is assessed on a case-by-case basis**.

351. As regards physical restraint, various types of possible manual holds were set out in a policy adopted at the Central Mental Hospital, which specified key principles such as use on

a last resort basis, prohibition of pressure being applied to certain body parts including neck, thorax and back, and that the prone position should only be applied when it has become unavoidable. Since 2023, there had been 115 recorded applications of physical restraint at the Central Mental Hospital, principally consisting of holding patients in prone and upright positions. Their reported duration never exceeded 10 minutes, and was often shorter. Reasons adduced included aggressive or threatening behaviour towards staff or other patients and administration of treatment. Staff explained that, as a way to avoid the resort to more restrictive forms of restraint, patients would at times be cornered using a beanbag for a short period while they calm down. While the Committee considers this to be a potentially good and promising practice, it emphasises it being nonetheless a restriction on the patients' freedom of movement, which must be surrounded by adequate safeguards, including notification to a doctor, approval and recording. **The CPT recommends the consistent application of the policy on the use of physical restraints to all forms of restriction on the patients' freedom of movement**.

352. Rapid tranquillisation ('titration'), whether administered orally or by injection, was prescribed by doctors at the Central Mental Hospital in response to patients' potentially harmful, agitated or aggressive behaviour (see paragraph 333). However, as in the past, the administration of medication to calm or sedate a patient to reduce risk of harm, agitation or aggression did not qualify under the Irish legal framework as a form of restraint ("chemical restraint"), and therefore was not subject to the same legal and medical safeguards as other forms of restraint. **The CPT recommends that use of chemical restraint be regulated by clear rules and subjected to the same safeguards applying in Ireland to other means of restraint, including medical approval, review and oversight, recording in a centralised register, and reporting to an outside monitoring body**.

Legal safeguards

353. Concerning legal safeguards, the delegation analysed the situation of legally incapacitated patients ('wards of court') and forensic patients, both categories being involuntary detained at the Central Mental Hospital.

354. In Ireland, the legal framework governing the deprivation of legal capacity has been for many decades primarily based on the 1871 Lunacy Regulation (Ireland) Act, the main axes of which the CPT has already criticised for lacking the necessary minimum safeguards. In short, the Lunacy Regulation allowed the President of the High Court to legally incapacitate any person found to be "of unsound mind and incapable of managing himself or his affairs" (thus making them a 'ward of court'), and also to detain such a person in a mental hospital. To overhaul this outdated system of wardship, the Assisted Decision-Making (Capacity) Act 2015 was passed, which for the most part entered into force on 16 April 2023.

The 2015 Capacity Act, as amended, aims to minimise any restriction on a person's rights, abiding by the principles of proportionality and least intrusive measure. It envisages a tiered system of decision support arrangements, depending on a person's level of capacity at the time a specific decision has to be made. For example, applications to a court may be lodged to seek the appointment of decision-making representatives or the approval of co-decision making arrangements entered into by the person lacking capacity. Over a three-year transitionary period, a comprehensive review of the situation of existing wards of court should take place. However, the delegation learnt that the projected review process was far behind schedule, due to insufficient resources. Furthermore, the scope of the 2015 Capacity Act does not encompass all patients involuntarily detained in a psychiatric facility, especially as regards consent to treatment. In particular, (i) it does not apply to young persons; (ii) it does not fully apply to patients detained under the Criminal Law (Insanity) Act 2006; and (iii) it does not apply to all categories of involuntary patients under the Mental Health Act 2001 (notably, patients detained on the grounds of risk). The CPT considers that the ongoing reform of the Mental Health Act 2001 could be the opportunity to extend the safeguards under the Assisted Decision-Making (Capacity) Act 2015 to all patients detained in psychiatric settings, irrespective of the legal basis for their detention.

The CPT wishes to receive updated information on the ongoing reform progress, in particular in respect of the scope of applicability of the Assisted Decision-Making (Capacity) Act 2015 for issues of consent to treatment. It also wishes to be kept informed

of the progress of the transitional review of the situation of the persons who had been deprived of their capacity under the system of wardship.

355. At the time of the visit, the Central Mental Hospital was accommodating eight patients qualifying as wards of court and two patients detained under the inherent jurisdiction powers of the High Court. The Committee is concerned about the legal framework applicable to those patients, who enjoyed limited safeguards compared to persons detained under the Mental Health Act 2001 or the Criminal Law (Insanity) Act 2006.

For instance, unlike in proceedings before the Mental Health Tribunal or the Criminal Law Review Board, patients and psychiatrists rarely appeared in person before the High Court and judges were not necessarily specialised in the field of mental health. Judicial decisions were stereotyped and lacked adequate reasoning enabling the patients concerned (and other potential interested persons) to grasp the significance of the decisions and, where appropriate, avail themselves of avenues of appeal. As in the past, decisions mandated a consultant psychiatrist to treat the patient "in his best interest" and medical staff would only seldom consult with the Office of Wards of Court. In the few recent cases to which the new Assisted Decision-Making (Capacity) Act 2015 was applied, the procedure and safeguards have not significantly improved, including the quality of judicial reasoning and patients' involvement in the process. It was positive, however, that reviews took place regularly on a six-month basis.

356. Several patients with whom the delegation spoke expressed frustration with the system, especially the indeterminate length of their detention. Most of them mentioned having little understanding of the legal decisions and the reasons why they were still detained, had no knowledge of possible ways to challenge them and, in some cases, complained of their inability to choose their legal representative. As courts' decisions deprived them of any say, patients found themselves without agency. Some patients wished to be transferred to a facility closer to home or family, but seemed unaware of whether and how this could be formally requested or obtained. Overall, the delegation gained the impression that nobody

had been assigned to truly assist these patients in navigating the system, and had misgivings about whether there was sufficient engagement from the Office of the Wards of Court.

357. In addition, the delegation found that in certain cases the system of wardship (and the court's inherent jurisdiction) was resorted to in order to continue the detention of patients whose admission or renewal orders had been revoked by the Mental Health Tribunal, or whose sentences had expired years prior.

For example, the delegation examined the case of a patient whose detention order was revoked in 2021 by the Mental Health Tribunal, which found him not to be suffering from a mental disorder within the meaning of the Mental Health Act 2001. On the same day, an application was lodged to, and granted by, the High Court to make him a ward of court and detain him at the Central Mental Hospital. In another case, dating to 2024, the Mental Health Tribunal revoked the renewal order due to a procedural error. On the same day, the High Court ordered the patient's (continued) detention based on its inherent jurisdiction powers.

The Committee is highly critical of this situation, which not only tarnishes the credibility of the review systems in place for involuntarily detained patients, but also raises questions about compliance with the requirements of legal certainty and effective judicial review. The CPT does appreciate the complexities of those situations, including the patients' state of health and need for a high level of support. However, from a clinical and therapeutic perspective, it believes that long-term, low-risk patients should be given the opportunity to live under less restrictive conditions, with a focus on their quality of life, and that a highly secure hospital setting may not be suitable for them. The delegation learnt that the wardship system has also been used to admit 'civil' patients directly into the Central Mental Hospital, an avenue not envisaged under the Mental Health Act 2001. This is another lacuna that the Irish authorities should fill without further delay.

The CPT calls upon the Irish authorities to review, as a matter of urgency, the legal basis for detention and the safeguards afforded to patients detained under the provisions of the 1871 Lunacy Regulation (Ireland) Act (wards of court) and the inherent jurisdiction powers of the High Court. New mental capacity legislation should follow the principles

outlined in Recommendation R (99) 4 of the Committee of Ministers of the Council of Europe, ensuring that the personal autonomy of patients is respected to the extent possible.

358. A related legal issue regards consent to treatment for patients who are incapable or refuse to consent. Consent to treatment is governed by Part 4 of the Mental Health Act 2001. Consent of a patient is required for treatment except where, in the opinion of the treating psychiatrist, the treatment is necessary (i) to safeguard the life of the patient, (ii) to restore their health, (iii) to alleviate their condition, or (iv) to relieve their suffering, and by reason of their mental disorder the patient concerned is incapable of giving such consent.

An opinion from a second consultant psychiatrist is required by law within three months of the commencement of the involuntary treatment. It remained unclear whether Part 4 of the Mental Health Act 2001 also applies to patients detained under the Criminal Law (Insanity) Act 2006.

The delegation appreciated that it was common practice at the Central Mental Hospital to request an opinion from a second consultant psychiatrist within days of starting the treatment. However, the Committee considers that the three-month statutory deadline for the independent assessment of the necessity and appropriateness of the involuntary treatment is excessively long. An involuntary placement order should not automatically enable the administration of treatment without consent.

In addition, having reviewed several 'second' psychiatric opinions, the delegation often found them lacking in adequate depth of analysis and specificity. **The CPT recommends, once again, that the Irish authorities amend the legislation and practice on consent to treatment accordingly, including by introducing appropriate procedures and safeguards for patients detained under the Criminal Law (Insanity) Act 2006.**