SUBMISSION

Submission on the General Scheme of the Mental Health (Amendment) Bill

Irish Human Rights and Equality Commission

April 2022

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

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The Irish Human Rights and Equality Commission was established under statute on 1 November 2014 to protect and promote human rights and equality in Ireland, to promote a culture of respect for human rights, equality and intercultural understanding, to promote understanding and awareness of the importance of human rights and equality, and to work towards the elimination of human rights abuses and discrimination.

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Introduction

The Irish Human Rights and Equality Commission ('the Commission') is both the national human rights institution and the national equality body for Ireland, established under the *Irish Human Rights and Equality Commission Act 2014* (the '2014 Act'). The Commission has a statutory mandate to keep under review the adequacy and effectiveness of law and practice in the State relating to the protection of human rights and equality, and to examine any legislative proposal and report its views on any implications for human rights or, equality.[1]

The Commission welcomes the opportunity to provide the Joint Sub-Committee on Mental Health with its submission on the General Scheme of the *Mental Health (Amendment) Bill* (the 'General Scheme').[2] The Commission welcomes reform in this area as it has consistently called for mental health law and policy to be aligned with Ireland's human rights and equality obligations, in particular the United Nations Convention on the Rights of Persons with Disabilities (the 'UNCRPD').[3] The Commission has exercised its *amicus curiae* function in a number of cases concerning the rights of persons in mental health establishments.[4] The Commission remains available to assist the Committee if further scrutiny of the General Scheme is required and on any specific issue which may arise.

The Commission notes that the development of this legislation is informed by the 2014 Report of the Expert Group on the Review of the *Mental Health Act 2001* (the 'Expert Group

[1] Section 10(2)(c) of the Irish Human Rights and Equality Commission Act 2014.
[2] See General Scheme of the Mental Health (Amendment) Bill.
[3] IHREC, Ireland and the International Covenant on Economic, Social and Cultural Rights: Report to UN Committee on Economic, Social and Cultural Rights on Ireland's third periodic review (May 2015) p. 79; IHREC, Comments on Ireland's 14th National Report on the Implementation of the European Social Charter (April 2017) pp. 8–9; IHREC, Ireland and the Convention against Torture: Submission to the United Nations Committee against Torture on Ireland's second periodic report (July 2017) pp. 41–51; IHREC, Submission to the public consultation on Deprivation of Liberty: Safeguard Proposals (March 2018); IHREC, Submission to the UN Committee against Torture on the List of Issues for the Third Examination of Ireland (January 2020) pp. 6–7, 16–20; IHREC, Submission to the United Nations Human Rights Committee on the List of Issues for the Fifth Periodic Examination of Ireland (August 2020) pp. 8, 35–36; IHREC, Submission to the Mental Health Commission's Public Consultation on the Rules and Code of Practice governing the use of seclusion and restraint (November 2021).
[4] See Amicus curiae submission in AB v Clinical Director of St Loman's Hospital (March 2018) and Amicus curiae submission in PL v the Clinical Director of St Patrick's University Hospital (December 2017). See also Press release re Court of Appeal judgment in AB and Press release re Court of Appeal judgment in PL.

Review').[5] While the Expert Group Review report is a key resource in the reform of the *Mental Health Act 2001*, it did not substantially engage with human rights and equality standards. The report also predates the ratification of the UNCRPD, and therefore its recommendations should be considered in line with the requirements of compliance with the UNCRPD. The paradigm shift required by Ireland's ratification of the UNCRPD needs to be evident in the revised Act.

The Commission observes that there has been significant legislative activity in this area in recent years with the enactment of the *Assisted Decision Making (Capacity) Act 2015* and the *Mental Health (Amendment) Act 2018*. However, neither of these acts have been fully commenced, which has substantial implications for the realisation of the rights of individuals. The Commission also notes that this legislation is being progressed at the same time as legislation is being brought forward to amend the Assisted Decision Making (Capacity) Act,[6] ratify the Optional Protocol to the United Nations Convention Against Torture ('OPCAT'),[7] and to put in place safeguards protecting the liberty of persons with capacity issues in certain facilities.[8] In developing these legislative proposals, 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. Moreover, as the designate Independent Monitoring Mechanism for UNCRPD,[9] and anticipating that the Commission may be the Co-ordinating Body for the OPCAT National Preventive Mechanism,[10] the Commission is of the view that it is essential that the human rights

[5] The Expert Group Review made 165 recommendations to reform mental health law; see Department of Health, Report of the Expert Group on the Review of the Mental Health Act 2001 (2014).
[6] The General Scheme of the Assisted Decision-Making (Capacity) (Amendment) Bill 2021. The Commission appeared before the Joint Committee on Equality, Disability, Integration and Youth on the Pre-legislative scrutiny of the General Scheme of the Assisted Decision-Making (Capacity) (Amendment) Bill 2021 on 16 February 2022; see Opening statement by Adam Harris, Commission Member, Irish Human Rights and Equality Commission.
[7] The Inspection of Places of Detention Bill. The Minister for Justice has advised that the General Scheme of the Bill is currently being drafted, and she expects to submit it to Government in the first quarter of 2022. See International Agreements – Dáil Éireann Debate, 10 February 2022: Question 371.
[8] The Protection of Liberty Safeguards Bill. The Department of Health carried out a public consultation on a general scheme of the Deprivation of Liberty Safeguards Bill in December 2017. The draft Bill has not yet been published and there does not appear to be a clear timeframe for its publication. See comments made by the Minister for Health in Proposed Legislation – Dáil Éireann Debate, 19 January 2022: Question 1866.
[9] Under the Assisted Decision-Making (Capacity) (Amendment) Bill.
[10] Under the Inspection of Places of Detention Bill.

standards contained in both instruments are reflected in the reform of the *Mental Health Act 2001* and other relevant legislative proposals.

Relevant human rights and equality standards

The General Scheme engages and interferes with a number of fundamental rights protected under the Constitution, the Charter of Fundamental Rights of the European Union ('the Charter'), the European Convention on Human Rights ('the ECHR'), treaties of the United Nation system,[11] and other sources of international human rights law.

The right to exercise legal capacity

Article 12(2) of the UNCRPD recognises that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.[12] To support persons with disabilities in exercising their legal capacity, states must take appropriate measures to provide access to supports they may require.[13] All measures which relate to the exercise of legal capacity must be accompanied by appropriate and effective safeguards to prevent abuse:

> "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."[14]

The European Court of Human Rights (the 'ECtHR') has held that the deprivation of legal capacity constitutes an interference with the right to private life under Article 8(1) of the ECHR.[15] Any interference with the right to private life amounts to a breach of Article 8(1) unless it "is in accordance with the law" and "is necessary in a democratic society" for one

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[11] Including UNCRPD; United Nations Convention against Torture and Other Cruel, Inhuman and Degrading Treatment; United Nations Convention on the Rights of the Child; International Covenant on Civil and Political Rights; and International Covenant on Economic, Social and Cultural Rights.

[12] The Commission notes that Ireland has made a Declaration and Reservation to Article 12 of the UNCRPD to permit substitute decision-making arrangements in appropriate circumstances. See Convention on the Rights of Persons with Disabilities

[13] Article 12(3) of the UNCRPD.

[14] Article 12(4) of the UNCRPD.

[15] *Shtukaturov v. Russia*, 44009/05, Judgment of 27 March 2008, para. 83. Article 8(1) of the ECHR provides that: "Everyone has the right to respect for his private and family life, his home and his correspondence."

of the legitimate aims under Article 8(2).[16] Any interference must be proportionate to the legitimate aims pursued.[17] In determining the proportionately of the interference, the ECtHR will assess whether adequate and effective safeguards are in place to protect against abuse.[18] In interpreting the obligations of Article 8 and Article 6.1, which lays down the guarantees for a fair hearing, the ECtHR have held that any interference with the right to exercise legal capacity must be subject to the requirement of regular, or periodic review by a competent, independent and impartial authority or judicial authority.[19] Individuals should also have direct access to a court to seek restoration of their legal capacity.[20] Individuals should have the opportunity to be heard in person, or where necessary, through some form of representation.[21]

The ECtHR have said that:

> "Mental illness may entail restricting or modifying the manner of exercise of such a right … but it cannot justify impairing the very essence of the right. Indeed, special procedural safeguards may prove called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves."[22]

In the Supreme Court judgment in *A.C v Cork University Hospital*, O' Malley J. remarked that there is no significant difference in approach between the jurisprudence of the Irish courts and the ECtHR in relation to the exercise of legal capacity.[23] O'Malley set out a range of safeguards which apply when considering a person's capacity to make a decision, including:

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[16] Article 8(2): "In the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."
[17] *Silver and Others v. The United Kingdom*, Judgment of 25 March 1983, (1983) 5 EHRR 347, para. 97.
[18] See *Camenzind v. Switzerland*, Judgment of 16 December 1997, (1997) paras. 45–47; *Klass and Others v. Germany*, Judgment of 6 September 1978, (1994) 18 EHRR 305, para. 50.
[19] *Stanev v Bulgaria* App 36760/06, 17 January 2012, para. 244–245; *Shakulina & Ors v Russia* 2018 E.C.H.R. 464.
[20] *Stanev v Bulgaria* App 36760/06, 17 January 2012, para. 245.
[21] *Winterwerp v. The Netherlands*, Judgment of 24 October 1979, (1979) 2 EHRR 387, para. 60. See also Principle 13 of the Council of Europe Committee of Ministers, Recommendation No. R (99) 4 on principles concerning the legal protection of incapable adults, adopted by the Committee of Ministers on 23 February 1999.
[22] *Winterwerp v. The Netherlands*, Judgment of 24 October 1979, (1979) 2 EHRR 387, para. 60.
[23] *A.C v Cork University Hospital* [2019] IESC 73, para. 319.

- A person has a right to have their voice heard or represented in any process concerning them.

- If a person cannot speak for themselves, they must have a legal representative or other advocate who is otherwise not involved in the dispute appointed to hear their voice and represent it to the court.[24]

The right to consent to medical treatment

The right to consent to medical treatment is a key element in the exercise of legal capacity. The Irish Supreme Court has recognised that the loss of capacity does not lead to a diminution of an individual's rights, including their right to refuse medical care or treatment.[25] The UN Committee on the Rights of Persons with Disabilities has said that States have an obligation to require all health and medical professionals, including psychiatric professionals, to obtain free and informed consent before any treatment.[26]Article 3(2)(a) of the Charter provides that in the field of medicine and biology, the free and informed consent of the person concerned must be respected.

The European Convention on Human Rights and Biomedicine (the Oviedo Convention) provides that:

> "[a]n intervention in the health field may only be carried out after the person concerned has given free and informed consent to it."[27]

The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has stated:

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[24] *A.C v Cork University Hospital* [2019] IESC 73, paras. 366, 393.
[25] Per Hamilton CJ, *In the matter of A Ward of Court* (withholding medical treatment) (No. 2) [1995] 2 IR 100, p. 126.
[26] This is an aspect of the right to the enjoyment of the highest attainable standard of health under Article 25 of the UNCRPD; see Committee on the Rights of Persons with Disabilities, General Comment No.1 (2014) – Article 12: Equal recognition before the law, CRPD/C/GC/1 (19 May 2014) para. 41.
[27] Article 5 of Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, Oviedo, 4.IV.1997. See also the 1994 World Health Organization Amsterdam Declaration on Patients' Rights, which requires informed consent as a prerequisite for any medical intervention, guaranteeing also the right to refuse or halt medical interventions. Also, the Universal Declaration on Bioethics and Human Rights, adopted by UNESCO's General Conference on 19 November 2005, confirming at Article 6 the requirement for free and informed consent in relation to any "preventive, diagnostic and therapeutic medical intervention."

> "Considering that the right to health is now understood within the framework of the Convention on the Rights of Persons with Disabilities, immediate action is required to radically reduce medical coercion and facilitate the move towards an end to all forced psychiatric treatment and confinement. In that connection, States must not permit substitute decision-makers to provide consent on behalf of persons with disabilities on decisions that concern their physical or mental integrity; instead, support should be provided at all times for them to make decisions, including in emergency and crisis situations."[28]

The Committee on the Rights of Persons with Disabilities has stated that:

"substitute decision-making regimes such as guardianship, conservatorship and mental health laws that permit forced treatment" have been used to deny people their right to legal capacity in a discriminatory manner.[29] The Committee have called for these practices to be abolished to ensure legal capacity can be exercised on an equal basis.[30]

While not adopting the absolutist position of the Committee, the ECtHR have said that legislative frameworks should, as far as possible, recognise that different degrees of decision-making may exist from time to time;[31] relying on Principle 3.1 of the Council of Europe *Principles concerning the legal protection of incapable adults*.[32]

Principle 3.2 provides that measures of protection:

> "should not automatically deprive the person concerned of the right to … consent or refuse consent to any intervention in the health field."[33]

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[28] United Nations Human Rights Council, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/35/21 (28 March 2017) para. 65.
[29] Committee on the Rights of Persons with Disabilities, General Comment No.1 (2014) – Article 12: Equal recognition before the law, CRPD/C/GC/1 (19 May 2014) para. 7.
[30] Committee on the Rights of Persons with Disabilities, General Comment No.1 (2014) – Article 12: Equal recognition before the law, CRPD/C/GC/1 (19 May 2014) para. 7. See also Committee on the Rights of Persons with Disabilities, Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities, Adopted during the Committee's 14th session (September 2015) para. 11.
[31] *Shtukaturov v. Russia*, App. No. 44009/05) (2012) 54 E.H.R.R. 27.
[32] Council of Europe Committee of Ministers, Recommendation No. R (99) 4 on principles concerning the legal protection of incapable adults, adopted by the Committee of Ministers on 23 February 1999.
[33] Council of Europe Committee of Ministers, Recommendation No. R (99) 4 on principles concerning the legal protection of incapable adults, adopted by the Committee of Ministers on 23 February 1999.

The ECtHR have laid down principles[34] to examine whether involuntary confinement and forced administration of medication in an inpatient facility following psychiatric examination breached ECHR rights.

These include:

- Any measure which interferes with the right to consent to treatment must be based on law which guarantees proper safeguards against arbitrariness;
- A decision which interferes with the right to consent and which allows for the forcible administration of treatment must not rest solely with the treating doctors;
- Evidence on which a decision for treatment is based should be sufficiently independent;[35]
- A decision to forcibly administer treatment must be subject to judicial scrutiny; and
- An individual must have a remedy available whereby they could require a court to rule on the lawfulness, including proportionality, of the forced administration of medication and to have it discontinued.

Deprivation of liberty safeguards

The right to liberty is guaranteed under Article 40.4 of the Constitution, Article 6 of the Charter, Article 5 of the ECHR, Article 9 of the International Covenant on Civil and Political Rights ('ICCPR') and Article 14 of the UNCRPD.

In *R.T. v Director of the Central Medical Hospital*, Costello P emphasised that any measure which interferes with a person's liberty must accord with the fundamental norms of legal order postulated by the Constitution, and the State must defend and vindicate a person's right to liberty.[36]

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[34] *X v Finland* (App. No. 34806/04) [2012] 1 M.H.L.R. 318, para. 220.
[35] See *Sykora v Czech Republic* [2012] E.C.H.R 1960; where the ECtHR found that the procedures, on the basis of which the national court had deprived the applicant of legal capacity, suffered from serious deficiencies, and that the evidence on which the decision was based was not sufficiently reliable and conclusive. The interference with the applicant's private life was thus disproportionate to the legitimate aim pursued and was in violation of Article 8.
[36] *R.T. v Director of the Central Mental Hospital* [1995] 2 I.R. 65, p. 78.

Costello P stated that this requires the Oireachtas:

> "[T]o be particularly astute when depriving persons suffering from mental disorder of their liberty and that it should ensure that such legislation should contain adequate safeguards against abuse and error in the interests of those who welfare the legislation is designed to support. And in considering such safeguards, regard should be had to the standards set by the Recommendations and Conventions of International Organisations of which this country is a member."[37]

In the Supreme Court case of *HSE v A.M.*,[38] which considered the detention of a person deemed to lack capacity, pursuant to the wardship jurisdiction, MacMenamin J noted the importance of a number of safeguards that are already in place to vindicate the rights of wards. These include that the detention of a ward is reviewed every six months and often much more frequently and that the parties have liberty to apply to the court at any time, and to be heard without delay.

MacMenamin J held:

> "That these protections to vindicate the rights of wards are now in place is important. But I would go further and say that without the range of such protection and those others necessary in each case, questions might arise as to constitutional and Convention compliance. … for Constitution and Convention compliance, any law in this area which has the effect of a deprivation of liberty must be precise. It must be clear in its application. That clarity must be such that a citizen, or other person, can ascertain what will be the circumstances in which a procedure will be invoked and how that procedure will be applied. An individual who is to be subject to an order must reliably be shown to be of unsound mind. The continued validity of any such a person's detention must depend upon it being shown that the situation which warranted involuntary detention continues. There must be available a speedy,

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[37] *R.T. v Director of the Central Mental Hospital* [1995] 2 I.R. 65, pp. 78–79. See also *Croke v Smith* (No. 2) [1998] 1 I.R. 101, p. 118, where Hamilton CJ stated that: "The obligation which rested and rests on the Oireachtas is to ensure that a citizen, who is of unsound mind and requiring treatment and care, is not unnecessarily deprived, even for a short period, of his liberty and to ensure that legislation which permits the deprivation of liberty contains adequate safeguards against abuse and error in the continued detention of such citizens".

[38] *HSE v A.M.* [2019] IESC 3.

effective and periodic system of review. … Needless to say, also, any order must be proportionate. Fair procedures must be observed."[39]

The Irish courts have looked to the ECtHR and other international instruments for guidance on the proper interpretation of necessary safeguards.[40] The ECtHR has stressed that there must be adequate legal protection against arbitrary deprivation of liberty.[41] The ECtHR has emphasised the requirement of objective medical evidence where a person is to be detained on grounds of mental disorder.[42]

The ECtHR has found that the provision of a second psychiatric opinion independent to the hospital is:

> "an important safeguard against possible arbitrariness in the decision-making when the continuation of confinement to involuntary care is concerned."[43]

The ECtHR has recognised that the right under Article 6 of the ECHR to a fair and public hearing, within a reasonable time, by an independent and impartial tribunal established by law applies to persons detained under mental health legislation.[44] An individual who has been deemed to lack capacity, but is capable of expressing their view must be heard in proceedings, either in person or where necessary, through some form of representation.[45] Where a person who is capable of expressing a view, despite having been deprived of legal capacity, is deprived of their liberty at the request of their guardian, they must be accorded an opportunity of contesting that confinement before a court, with separate legal representation.[46]

Special procedural safeguards may need to be called for:

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[39] *HSE v A.M.* [2019] IESC 3, paras. 101–103.
[40] See for example, *A.B v St Lomans* [2018] IECA 123; *HSE v A.M.* [2019] IESC 3.
[41] *Winterwerp v. The Netherlands*, Judgment of 24 October 1979, (1979) 2 EHRR 387*,* para. 45; *H.L. v. United Kingdom*, App No. 45508/99, paragraph 115.
[42] See for example, *Winterwerp v. The Netherlands*, Judgment of 24 October 1979, (1979) 2 EHRR 387 and *Pleso v Hungary*, App no. 41242/08 2nd October 2012.
[43] *X v. Finland*, App. No. 34806/04, para. 169.
[44] See *Aerts v Belgium*, App no 61/1997/845/1051 30 July 1998 confirming that the right to liberty is a civil right for the purposes of Article 6.
[45] *D.D. v Lithuania*, App No. 13469/06, 14 February 2012, para. 118.
[46] *D.D. v Lithuania*, App No. 13469/06, 14 February 2012, para. 126.

> "in order to protect the interests of persons who, on account of their mental health issues, are not fully capable of acting for themselves".[47]

The Committee on the Rights of Persons with Disabilities have stated that the detention of persons on the grounds of their actual or perceived impairment[48] is discriminatory in nature and amounts to arbitrary deprivation of liberty and is therefore the practice is incompatible with Article 14 of the UNCRPD.[49] Involuntary commitment of persons with disabilities on health-care grounds also contradicts the principle of free and informed consent to healthcare under Article 25 of the UNCRPD.[50]

The Committee have also stated in its General Comment No.1 on Article 12 that:

> "States parties should refrain from the practice of denying legal capacity of persons with disabilities and detaining them in institutions against their will, either without the free and informed consent of the persons concerned or with the consent of a substitute decision-maker, as this practice constitutes arbitrary deprivation of liberty and violates articles 12 and 14[51] of the Convention."[52]

Article 25 of the Council of Europe's *Recommendation concerning the protection of the human rights and dignity of persons with mental disorders* requires Member States to

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[47] *D.D. v Lithuania*, App No. 13469/06, 14 February 2012, para. 118.

[48] Impairment in these guidelines is "understood as a physical, psycho-social, intellectual or sensory personal condition which may or may not come with functional limitations of the body, mind or senses. Impairment differs from what is usually considered the norm. Disability is understood as the social effect of the interaction between individual impairment and social and material environment as described in article 1 of the Convention." See Committee on the Rights of Persons with Disabilities, Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities, Adopted during the Committee's 14th session (September 2015) para. 6.

[49] Committee on the Rights of Persons with Disabilities, Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities, Adopted during the Committee's 14th session (September 2015) para. 6.

[50] Committee on the Rights of Persons with Disabilities, Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities, Adopted during the Committee's 14th session (September 2015) para. 10.

[51] The Commission notes that the State has made a Declaration in respect of Articles 12 and 14 that "Ireland recognises that all persons with disabilities enjoy the right to liberty and security of person, and a right to respect for physical and mental integrity on an equal basis with others. Furthermore, Ireland declares its understanding that the Convention allows for compulsory care or treatment of persons, including measures to treat mental disorders, when circumstances render treatment of this kind necessary as a last resort, and the treatment is subject to legal safeguards." See Convention on the Rights of Persons with Disabilities

[52] Committee on the Rights of Persons with Disabilities, General Comment No.1 (2014) – Article 12: Equal recognition before the law, CRPD/C/GC/1 (19 May 2014) para. 40.

ensure that persons subject to involuntary placement or involuntary treatment can effectively exercise the right:

- To appeal against a decision;

- To have the lawfulness of the measure, or its continuing application, reviewed by a court at reasonable intervals – regardless of whether the person, their personal advocate or their representative requests such a review; and

- To be heard in person or through a personal advocate or representative at such reviews or appeals.[53]

The decision of the court should be delivered promptly, and there should be a procedure to appeal the court's decision.[54]

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment ('the CPT') have stated that in relation to initial placement in detention:

> "[A] person who is involuntarily placed in a psychiatric establishment by a non-judicial authority must have the right to bring proceedings by which the lawfulness of his detention shall be decided speedily by a court."[55]

In relation to discharge, the CPT have stated that:

> "Involuntary placement in a psychiatric establishment should cease as soon as it is no longer required by the patient's mental state. Consequently, the need for such a placement should be reviewed at regular intervals.
>
> …

[53] Council of Europe Committee of Ministers, Recommendation No. REC(2004)10 concerning the protection of the human rights and dignity of persons with mental disorders, adopted by the Committee of Ministers on 22 September 2004.
[54] Article 25 of the Council of Europe Committee of Ministers, Recommendation No. REC(2004)10 concerning the protection of the human rights and dignity of persons with mental disorders, adopted by the Committee of Ministers on 22 September 2004. See also Article 5(4) of the ECHR which provides that "Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful."
[55] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, CPT Standards, CPT/Inf/E (2002) 1 – Rev. 2015, p. 55.

> If the period of involuntary placement is unspecified, there should be an automatic review at regular intervals of the need to continue the placement.
>
> In addition, the patient himself should be able to request at reasonable intervals that the necessity for placement be considered by a judicial authority."[56]

De facto detention for treatment

In determining whether a measure amounts to detention, even if it is not described as such in national law, the ECtHR will consider the type, duration, effect and manner of the measures.[57] A key factor in assessing whether a person has been deprived of their liberty is whether they have consented to their detention.

The ECtHR have recognised that deprivation has both an objective and subjective element:

> "[T]he notion of deprivation of liberty within the meaning of Article 5 § 4 does not only comprise an objective element of a person's confinement to a particular restricted place for a non negligible period of time. A person can only be considered to have been deprived of his liberty if, as an additional subjective element, he has not validly consented to the confinement in question."[58]

The ECtHR have held that a person must have capacity in order to consent to confinement otherwise it will amount to detention.[59] In circumstances where a guardian has consented to the confinement, it will amount to detention if an individual who is deemed to lack capacity objects to the confinement.[60]

In *PL v The Clinical Director of St Patrick's University Hospital*, the Court of Appeal held that it was not permissible to prevent a voluntary patient who expresses a desire to leave from leaving an approved centre save in accordance with the provisions of section 23 and section

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[56] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, CPT Standards, CPT/Inf/E (2002) 1 – Rev. 2015, pp. 55–56.
[57] See *Guzzardi v Italy*, App No 736/76, 6th November 1980; *Engel v The Netherlands* (No.1) (1976) 1 EHRR 647 paras. 58-59; *Storck v Germany*, App no 616/03, ECHR 2005-V, para. 71; *Stanev v Bulgaria* App 36760/06, 17 January 2012 [2012] 55 EHRR 22.
[58] *Storck v Germany*, App no 616/03, ECHR 2005-V, para. 71.
[59] *H.L v United Kingdom*, App no 45508/99, 5th January, 2005.
[60] *Shtukaturov v. Russia*, App no. 44009/05 27 March 2008; *D.D. v Lithuania* App no. 13469/06, 9 July 2012.

24 of the *Mental Health Act 2001*.[61] Hogan J, delivering the judgment of the Court, held that if a person was detained, other than accordance with the Act, it would:

> "[L]ead to a state of affairs which the Oireachtas could scarcely have contemplated, since it would mean that a voluntary patient could effectively be detained within an approved centre without any of the protections provided for by the 2001 Act for persons detained under that Act."[62]

In *AC v Cork University Hospital*, the Supreme Court held that it was possible for a hospital to detain a person for a brief period to assess their capacity where there is a real risk to their health or welfare as part of the doctrine of necessity.[63] However, an agreement to stay on the part of the patient who lacks capacity will not on its own amount to justification for detention:

> "since if the patient cannot give a valid consent then some other lawful authority is necessary if other persons are to make decisions for her."[64]

O'Malley J, giving judgment for the Court, noted that the paternalistic approach to persons with disabilities, including making decisions for persons with impaired capacity, is:

> "increasingly under attack as failing to afford sufficient importance to the right of individuals to make their own decisions."[65]

Restraint and seclusion

The Committee on the Rights of Persons with Disabilities has called upon states:

> "[T]o protect the security and personal integrity of persons with disabilities who are deprived of their liberty, including by eliminating the use of seclusion and various methods of restraint in medical facilities, including physical, chemical and mechanic restraints. The Committee has found that these practices are not consistent with the prohibition of torture and other cruel, inhumane or degrading treatment or

[61] [2018] IECA 29, para. 60.
[62] *PL v The Clinical Director of St Patrick's University Hospital* [2018] IECA 29, para. 46.
[63] *A.C v Cork University Hospital* [2019] IESC 73.
[64] *A.C v Cork University Hospital* [2019] IESC 73, para. 393.
[65] *A.C v Cork University Hospital* [2019] IESC 73, para. 244.

punishment against persons with disabilities pursuant to article 15 of the Convention."[66]

The CPT's Revised Standards for Means of restraint in psychiatric establishments for adults provides that:

> "[T]he ultimate goal should always be to prevent the use of means of restraint by limiting as far as possible their frequency and duration. To this end, it is of paramount importance that the relevant health authorities and the management of psychiatric establishments develop a strategy and take a panoply of proactive steps, which should inter alia include the provision of a safe and secure material environment (including in the open air), the employment of a sufficient number of health-care staff, adequate initial and ongoing training of the staff involved in the restraint of patients, and the promotion of the development of alternative measures (including de-escalation techniques)."[67]

The CPT's Revised Standards for Means of restraint in psychiatric establishments for adults provides that:

> "All types of restraint and the criteria for their use should be regulated by law."[68]

Principle 11.11 of the United Nations Principles for the protection of persons with mental illness and the improvement of mental health care provides that:

> "Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the

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

[67] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), Means of restraint in psychiatric establishments for adults (Revised CPT standards), CPT/Inf(2017)6 (21 March 2017) p. 2.

[68] General Principle 1.3 of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), Means of restraint in psychiatric establishments for adults (Revised CPT standards), CPT/Inf(2017)6 (21 March 2017) p. 2.

patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient."[69]

The rights of the child

Article 24 of the United Nations Convention on the Rights of the Child ('the UNCRC') provides that states should recognise the rights of the child to the enjoyment of the highest attainable standard of mental health and to facilities for the treatment of illness and rehabilitation of health.[70] States should strive to ensure that no child is deprived of access to such mental health care services.[71] States should also protect a child from all forms of discrimination, including based on a psychosocial disability.[72] Article 23(4) of the UNCRPD provides that a child should not be separated from their parents on the basis of their disability.

The Committee on the Rights of the Child have cautioned against the over-medicalisation and institutionalisation, and has urged:

> "States to undertake an approach based on public health and psychosocial support to address mental ill-health among children and adolescents and to invest in primary care approaches that facilitate the early detection and treatment of children's psychosocial, emotional and mental problems."[73]

Measures should be in place to ensure that a child, who is capable of forming their own views, has the right to express those views freely in all matters affecting the child.[74] The views of the child should be given due weight in accordance with the age and maturity of

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[69] United Nations, Principles for the protection of persons with mental illness and the improvement of mental health care, Adopted by General Assembly resolution 46/119 of 17 December 1991.
[70] Article 24 of the UNCRC.
[71] Article 24 of the UNCRC.
[72] Article 2 of the UNCRC.
[73] United Nations Committee on the Rights of the Child, General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), CRC/C/GC/15 (17 April 2013) para. 38.
[74] Article 42A.4.2° of the Constitution and Article 12(1) of the UNCRC.

the child.[75] A child should be provided with the opportunity to be heard in in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body.[76] Article 42A.4.1° of the Constitution provides that in the resolution of all proceedings brought by the State for the purpose of preventing the safety and welfare of any child from being prejudicially affected, the best interests of the child shall be the paramount consideration.[77] A child will need appropriate legal representation when their best interests are to be formally assessed and determined by courts and equivalent bodies under mental health legislation.[78] Where there is an administrative or judicial procedure involving the determination of a child's best interests, the child should be provided with a legal representative, in addition to a guardian or representative of their views, when there is a potential conflict between the parties in the decision.[79]

If a child is detained under mental health legislation, they should be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of their age.[80] The child should be separated from adults unless it is considered in the best interests of the child.[81] The ECtHR has held that detaining children together with adults may amount to a breach of Article 3 or Article 5 of the ECHR.[82] The Committee on the Rights of the Child have stated that institutions which provide care for children with disabilities should be:

[75] Article 42A.4.2° of the Constitution and Article 12(1) of the UNCRC.
[76] Article 12(2) of the UNCRC.
[77] Article 42A.4.1° of the Constitution. See also Article 3(1) of the UNCRC and Article 7(2) of the UNCRPD.
[78] United Nations Committee on the Rights of the Child, General comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1), CRC/C/GC/14 (29 May 2013) para. 96.
[79] United Nations Committee on the Rights of the Child, General comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1), CRC/C/GC/14 (29 May 2013) para. 96.
[80] Article 37(c) of the UNCRC.
[81] Article 37(c) of the UNCRC.
[82] See for example ECtHR, *Güveç v. Turkey*, No. 70337/01, 20 January 2009; *Nart v. Turkey*, No. 20817/04, 6 May 2008.

> "staffed with specially trained personnel, subject to appropriate standards, regularly monitored and evaluated, and have accessible and sensitive complaint mechanisms."[83]

A child who has been detained for the purposes of care, protection, or treatment of their mental health has a right to a periodic review of the treatment provided to them, and all other circumstances relevant to their placement.[84]

In relation to parental consent for treatment for a child, the Irish courts have held that parents of a child under 16 years of age may agree, on their behalf, to a course of treatment proposed or to withhold treatment.[85] In circumstances where there is clear and convincing evidence that the decision of the parents prejudicially affects the safety or welfare of the child, the court can "supply the place" of the parent to authorise treatment.[86] However, any intervention by the Court must be proportionate.[87] *In the matter of J.J.*, the Supreme Court set out a test for considering the best interests of the child, where there is a disagreement in relation to the best interests of the child between a parent and the treating doctor:

> "[T]he test is to consider what a loving and considerate parent would do once apprised of all the relevant information. Such a parent would take into account the views of the child, if expressed, and the character of the child, and would make a decision as to the best interests of the child in that context."[88]

The Supreme Court stated that the introduction of Article 42A and the text within "crystallises and endorses a developing trending in the case law" as the rights of the child have been acknowledged more fully.[89]

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[83] United Nations Committee on the Rights of the Child, General Comment No. 9 (2006) The rights of children with disabilities, CRC/C/GC/9 (27 February 2007) para. 43(f).
[84] Article 25 of the UNCRC.
[85] See for example, *In the matter of J.J.* [2021] IESC 1, para. 177.
[86] *In the matter of J.J.* [2021] IESC 1, para. 177.
[87] *In the matter of J.J.* [2021] IESC 1, para. 177.
[88] *In the matter of J.J.* [2021] IESC 1, para. 176.
[89] *In the matter of J.J.* [2021] IESC 1, para. 126. Citing Denham J in *NHWB*.

General observations on mental health law

Elimination of the use of detention and coercion for the treatment of persons with psychosocial disabilities

As noted above, the Committee on the Rights of Persons with Disabilities has stated that Article 14 of the UNCRPD prohibits the detention of persons with disabilities on the grounds of their actual or perceived impairment.[90] The Committee has repeatedly called for State parties to repeal provisions that permit involuntary detention of:

> "persons with disabilities in mental health institutions based on actual or perceived impairments".[91]

The State has made a Declaration in respect of Article 12 and Article 14 that it understands that the UNCRPD:

> "allows for compulsory care or treatment of persons, including measures to treat mental disorders, when circumstances render treatment of this kind necessary as a last resort, and the treatment is subject to legal safeguards."[92]

Notwithstanding this Declaration, the Commission considers that in order to comply with its obligations under the UNCRPD, the State will need to take positive measures to eradicate the use of detention and coercion for the treatment of persons with psychosocial disabilities. The Commission is aware that the General Scheme is unlikely to prohibit involuntary detention and coercion; however, the Heads of the Bill need to be considered in light of the State's obligation to eradicate measures which permit detention and forced treatment of persons with psychosocial disabilities.

The Commission recommends that the reform of mental health legislation must be accompanied by State measures, including legislation, aimed at ensuring less restrictive

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[90] Committee on the Rights of Persons with Disabilities, Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities, Adopted during the Committee's 14th session (September 2015) para. 6.

[91] Committee on the Rights of Persons with Disabilities, Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities, Adopted during the Committee's 14th session (September 2015) para. 10.

[92] See Convention on the Rights of Persons with Disabilities

forms of treatment in the community are available and the ultimate eradication of coercion in the treatment of persons with psychosocial disabilities. This includes investment in community based support and services for persons with psychosocial disabilities and through assisting persons to utilise the Assisted Decision Making (Capacity) Act 2015 to exercise their capacity.

Alignment with Assisted Decision Making (Capacity) Act 2015 and the Mental Health (Amendment) Act 2018

The Commission notes that a number of the Heads rely on provisions within the Assisted Decision Making (Capacity) Act 2015 (the '2015 Act'). For example, Head 3 – Section 2 'Interpretation' subsection 22 provides a "person who lacks capacity" has the same meaning as section 3 of the 2015 Act. However, the 2015 Act provides for a functional assessment of mental capacity which can be used to restrict or deny legal capacity, in contravention to the requirements of the UNCRPD.[93] The 2015 Act provides that, as a last resort, a person can be deemed to lack capacity and have a substitute decision maker appointed to make decisions on their behalf. The State has justified the substitute decision-making provisions based on its understanding of Article 12 of the UNCRPD.[94] However, this is contrary to the position of the Committee on the Rights of Persons with Disabilities who have stated that the:

> "[D]evelopment of supported decision-making systems in parallel with the maintenance of substitute decision-making regimes is not sufficient to comply with article 12 of the Convention."[95]

In order to comply with international human rights obligations, consideration will need to be given to abolishing substitute decision-making arrangements and how better to reflect

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[93] See IHREC, Submission to the United Nations Human Rights Committee on the List of Issues for the Fifth Periodic Examination of Ireland (August 2020) p. 35.

[94] In Ireland's Declaration and Reservation to Article 12 of the UNCRPD: "Ireland recognises that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. Ireland declares its understanding that the Convention permits supported and substitute decision-making arrangements which provide for decisions to be made on behalf of a person, where such arrangements are necessary, in accordance with the law, and subject to appropriate and effective safeguards. To the extent article 12 may be interpreted as requiring the elimination of all substitute decision making arrangements, Ireland reserves the right to permit such arrangements in appropriate circumstances and subject to appropriate and effective safeguards." See Convention on the Rights of Persons with Disabilities

[95] Committee on the Rights of Persons with Disabilities, General Comment No.1 (2014) – Article 12: Equal recognition before the law, CRPD/C/GC/1 (19 May 2014) para. 28.

this obligation in the General Scheme. The General Scheme should also implement a coordinated approach with the 2015 Act to ensure there are no gaps in the protections and safeguards afforded to persons in exercising their legal capacity on an equal basis with others.[96]

The Commission recommends that the reform of mental health legislation must ensure that the use of substitute decision-making arrangements complies with human rights and equality standards.

The General Scheme, the Mental Health (Amendment) Act 2018 and the Assisted Decision-Making (Capacity) Act 2015 must be read in conjunction with each other and must not be considered in isolation. The 2015 Act aligns with the principles of the UNCRPD and embraces the social model of disability.[97] In order to align with the 2015 Act and the UNCRPD, Head 5 proposes that the 'best interest' principle in the Mental Health Act is replaced by the 'will and preferences' principle.[98] The move away from the 'best interest' principle is significant in terms of strengthening the protection of the right of individuals who receive inpatient treatment and it is required to comply with Ireland's obligations under both the ECHR and the UNCRPD. As noted above, the courts have often interpreted this principle in a paternalistic manner, to the detriment of the individual. The Guiding Principles, under Head 5, will prove invaluable and assist the courts when making or assisting with difficult decisions. It reflects an autonomy-based approach that the person's will and preferences are respected and that support must be provided, where necessary, in the decision-making process. As mentioned, it is important that the proposed legislation aligns with Ireland's capacity legislation and other legislative reform that is occurring in this area, to move Ireland further towards compliance with the provisions of the UNCRPD.

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[96] See Dr Mary Keys, Dr Catriona Moloney, Dr Fiona Morrissey and Dr Charles O'Mahony, Submission to the Department of Health Public consultation on draft legislation to update the Mental Health Act 2001 (School of Law NUI Galway, March 2021) p. 4. The authors recommended that "[t]he Mental Health Act should seek to implement a coordinated approach with the 2015 Act to ensure a comprehensive system of supports and alternatives to coercion for persons admitted under the Mental Health Act and otherwise to ensure they are able to exercise their legal capacity and are free from coercion and non-consensual treatment on an equal basis with others."

[97] United Nations General Assembly, Report of the Special Rapporteur on the Rights of Persons with Disabilities, A/70/297 (7 August 2015). See also Catalina Devandas Aguilar, Social Protection and Persons with Disabilities (Wiley Online Library, 2017).

[98] This is also the approach taken in section 3 of the Mental Health (Amendment) Act 2018 and it references the Assisted Decision-Making (Capacity) Act 2015 and its guiding principles.

One of the key guiding principles which is cross-referenced in all three Acts is the inclusion of the presumption of capacity for all adults.[99] It is to be welcomed that a coherent approach has been taken in respect of the guiding principles and that they align with the principles of the UNCRPD, signifying that Ireland is embracing the paradigm shift and a more human rights based approach. Alignment between all three Acts is extremely important, as they will operate closely together in practice. While the 2015 Act has brought Irish capacity legislation closer towards UNCRPD compliance and international human rights standards, full compliance with the UNCRPD has not been achieved. The 2015 Act permits the use of a substitute decision-making regime, in breach of article 12 of the UNCRPD.[100]

The Commission recommends that emphasis should be placed on ensuring close alignment between the relevant mental health legislation, in compliance with the standards of the UNCRPD.

Consultation with persons with psychosocial disabilities

The right to participate in public life is recognised under international law.[101] The principle of participation requires the active and informed participation of individuals in the development, implementation, monitoring and reviewing of legislative, executive and administrative decisions that concern them.[102]

Article 4.3 of the UNCRPD requires that:

> "In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult with and

[99] Head 5(2) of the General Scheme and section 3(3) of the Mental Health (Amendment) Act 2018 reference the presumption of capacity set out in section 3 of the Assisted Decision-Making (Capacity) Act 2015.
[100] Committee on the Rights of Persons with Disabilities, General Comment No.1 (2014) – Article 12: Equal recognition before the law, CRPD/C/GC/1 (19 May 2014) para. 7.
[101] Article 25 of the ICCPR, Article 5 (c) of the CERD, Article 7 of the Convention on the Elimination of All Forms of Discrimination against Women, Articles 12 and 23 (1) of the Convention on the Rights of the Child, and Article 4 (3) and Article 33 (3) of the Convention on the Rights of Persons with Disabilities. See also United Nations Office of the High Commissioner for Human Rights, Guidelines for States on the effective implementation of the right to participate in public affairs (2018).
[102] United Nations Office of the High Commissioner for Human Rights, Guidelines for States on the effective implementation of the right to participate in public affairs (2018).

actively involve persons with disabilities, including children with disabilities, through their representative organizations."

All persons with disabilities, including psychosocial disabilities, should be able to effectively and fully participate in public life, without discrimination, on an equal basis with others.[103] States have an obligation to ensure the transparency of the consultation processes, the provision of appropriate and accessible information and early and continuous involvement.[104] The Commission has called for the State to actively engage with Disabled Persons Organisations ('DPOs') on matters relating to disabled persons, and to actively support their further development and involvement by providing sustainable core funding, capacity building and training.[105] The meaningful participation of disabled persons in processes involving them is beneficial to the decision-making processes due to their lived experience and their knowledge of the rights to be implemented.[106]

The Commission recommends the meaningful consultation with, and involvement of, persons with psychosocial disabilities, through their representative organisations, including those representing children, in the development, implementation, monitoring and reviewing of the General Scheme and other relevant mental health legislation.

[103] Committee on the Rights of Persons with Disabilities, General comment No. 7 (2018) on the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention, CRPD/C/GC/7 (9 November 2018) para. 16.
[104] Committee on the Rights of Persons with Disabilities, General comment No. 7 (2018) on the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention, CRPD/C/GC/7 (9 November 2018) para. 43.
[105] IHREC, Consultation on Terms of Reference and Work Programme for the Joint Oireachtas Committee on Disability Matters (November 2020) p. 6.
[106] Committee on the Rights of Persons with Disabilities, General comment No. 7 (2018) on the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention, CRPD/C/GC/7 (9 November 2018) para. 9.

Specific observations on the General Scheme

Part 1 – Preliminary and General

Definition of 'mental disorder' (Head 4)

Head 4 provides that a:

> "'mental disorder' means any mental disorder, illness or disability, whether of a continuous or intermittent nature, which affects the person's thinking, perceiving, emotion, mood or judgment and impairs the mental function of the person."

The separation of the definition of a mental disorder from the criteria for detention and the fact that references to 'significant intellectual disability' and 'severe dementia' have been removed in the General Scheme is to be welcomed. However, it is noted that the Expert Group Review recommended that mental disorder should not be defined in mental health legislation and instead a definition of mental illness should be included as the definition of mental disorder reflected:

> "a strongly medical model approach to mental illness".[107]

While the term 'mental disorder' is retained in the General Scheme, the Commission is of the view that both terms are reflective of the medical model approach to disability. The term 'mental disorder' should be replaced by 'persons with psychosocial disabilities' in line with the UNCRPD and the social model of disability.[108]

The Commission recommends that the General Scheme be amended to remove references to the term 'mental disorder' and replace it with 'persons with psychosocial disabilities' in line with the UNCRPD and the social model of disability.

The right of persons to an advocate (Head 5)

The Commission notes that Head 5 – Section 4(3) of the 'Guiding Principles' provides that:

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[107] Department of Health, Report of the Expert Group on the Review of the Mental Health Act 2001 (2014) pp. 15–17.

[108] The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health employs the term 'persons with psychosocial disabilities'; see United Nations Human Rights Council, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/35/21 (28 March 2017).

> "A person shall not be considered as unable to make a decision affecting himself or herself unless all practicable steps have been taken, without success, to help him or her to do so, including giving the person concerned an opportunity, if he or she so wishes, to consult with a person or persons of his or her choosing prior to making a decision, including an advocate."

There are several provisions under the General Scheme which provide for a person to engage with an advocate. Access to an advocate may be of critical importance to the rights of an individual as it may assist them in exercising their right to consent and prevent the presumption of capacity being displaced. Advocates are envisaged to play a crucial role under this legislation in assisting individuals exercise their legal capacity and to give effect to the 'Guiding Principles'. The requirement under Article 12.3 of the UNCRPD for States to "take appropriate measures to provide access by persons with disabilities to support they may require in exercising legal capacity" supports access to advocates for persons with disabilities. Therefore, the Commission considers that the right of persons, including children, receiving treatment under this Act to advocates should exist as an explicit provision under the General Scheme.

The Commission recommends that the right to access an advocate be placed on a statutory footing. This right should be accompanied by the provision of independent advocacy services.

Part 2 – Admission of Involuntary and Intermediate Persons to Approved Inpatient Facilities

The criteria for involuntary admission (Head 9)

Head 9 – Section 8 provides for the involuntary admission of persons, if certain conditions are met. Section 8 implements a number of the Expert Group Review recommendations in respect of involuntary admission. As noted above, the Expert Group Review recommendations predate the ratification of the UNCRPD and as a result, they did not sufficiently consider the implications of Ireland's obligations under the Convention. Although the Expert Group Review recommended that the term 'mental illness' be

separated from the criteria for detention,[109] it is still included within a category needed to fulfil the criteria for detention.[110] This is problematic, as a 'mental disorder' appears to be a necessary element for the criteria for detention where it is of such a 'nature and degree[111] of severity' which makes it necessary for a person to be involuntarily detained.

A person may be detained on the basis that treatment is immediately necessary to protect the life of the person, or to protect the health of the person from the threat of serious harm, or for the protection of other persons.[112] The Commission considers that the phrase 'for the protection of others' is vague and it needs to be defined in the General Scheme or amended, as it appears to represent a low threshold for admission. The General Scheme appears to permit the involuntary detention of person with a psychosocial disability who has capacity to refuse treatment where there is a serious risk to the health of the person. The General Scheme should set out the rational for permitting a person to be detained in such circumstances.

The Commission is concerned about the lack of parity of esteem between the treatment for mental health and physical health. By allowing detention on the basis that it would protect the 'health of the person from the threat of serious harm' the proposed legislation treats people with psychosocial disabilities differently from those with a physical disability, which potentially contravenes the UNCRPD. The UN Special Rapporteur on Health has noted that the:

> "proliferation of paternalistic mental health legislation and lack of alternatives has made coercion commonplace."[113]

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[109] Department of Health, Report of the Expert Group on the Review of the Mental Health Act 2001 (2014) p. 17.
[110] The new section 8(1)(a) under Head 9.
[111] According to the explanatory notes of the draft heads of Bill, the Department decided to use the term 'nature and degree' to provide greater clarity to persons operating under this Act as significant case law on the term 'nature and degree' in mental disorders has developed in the UK and can be referred to for guidance.
[112] The new section 8(1)(b) under Head 9.
[113] United Nations Human Rights Council, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/35/21 (28 March 2017) para. 63.

The justification for the use of coercion is often based on 'medical necessity' and 'dangerousness'.[114] The Commission is of the view that these justifications are subjective and there is a lack of research to support their application, which can often result in grave violations of human rights, such as the denial of legal capacity or the deprivation of liberty.[115]

The ECtHR have stated that one of the minimum conditions which must exist to justify detention on the grounds of mental disorder is that the mental disorder must be of the kind and degree warranting compulsory confinement.[116] Case law of the ECtHR illustrates that the Court has identified that there are two circumstances where detention on the grounds of mental illness may be necessary:

1. Where the person requires treatment to alleviate his or her condition.

2. Where the person needs control and supervision to prevent harm to himself or herself or others.[117]

Article 17 of the Council of Europe's *Recommendation concerning the protection of the human rights and dignity of persons with mental disorders* provides that a person may be subject to involuntary placement if all the following conditions are met:

1. the person has a mental disorder;

2. the person's condition represents a significant risk of serious harm to his or her health or to other persons;

3. the placement includes a therapeutic purpose;

4. no less restrictive means of providing appropriate care are available; and

[114] United Nations Human Rights Council, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/35/21 (28 March 2017) para. 64.
[115] United Nations Human Rights Council, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/35/21 (28 March 2017) para. 64.
[116] *Winterwerp v. The Netherlands*, Judgment of 24 October 1979, (1979) 2 EHRR 387.
[117] *Hutchison Reid v United Kingdom*, App no 50722/99, ECHR 2003-IV, para. 52.

5. the opinion of the person concerned has been taken into consideration.[118]

The Commission recommends that Head 9 – Section 8(1) be amended to ensure compliance with international human rights standards.

The Commission recommends that Head 9 – Section 8(1)(b) be amended to provide that a person fulfils the criteria for involuntary admission 'where such treatment is immediately necessary to protect the life of the person, or to protect the health of the person from the threat of serious harm, or for the protection of other persons *from such harm*'.

Given the importance of community based mental health services under the UNCRPD, the Commission is concerned that Head 9 – Section 8 does not explicitly refer to community based mental health services as an alternative to involuntary detention in an approved inpatient facility. This would help to reinforce the move towards a more human rights based approach to mental health services in Ireland. It is important to ensure that alternatives to inpatient services are available and assist in the move towards the eventual elimination of coercion in mental health services, as required under the UNCRPD.

The Commission recommends that Head 9 – Section 8 be amended to refer to community based mental health services as an alternative to involuntary detention.

Enhanced role for an authorised officer (Head 10)

Head 10 provides for the enhanced role of an Authorised Officer ('AO') and only an AO may make an application for an admission. They should consult and meet with the person who is the subject of the order and consult with family members and carers, where appropriate. Head 10 – Section 9(5) provides that the application for a recommendation that the person may be admitted to an approved inpatient facility remains in force for a period of seven days and then expires. The Commission is concerned about the seven-day period, as it may mean that the AO might delay in their application to the registered medical practitioner. The legislation contains a number of safeguards to ensure that a person has been observed and examined before they are admitted. However, these safeguards may be eroded if there

[118] Council of Europe Committee of Ministers, Recommendation No. REC(2004)10 concerning the protection of the human rights and dignity of persons with mental disorders, adopted by the Committee of Ministers on 22 September 2004.

is a delay between the observations of the AO and the registered medical practitioner.[119] Section 9(3) sets out that an AO:

> "must take account of whether the care and treatment required by the person can be given other than in an approved inpatient facility, with a view to ensuring an application for involuntary admission is only made as a last resort."

If the view of the AO is that is necessary for an individual to be admitted, then the application should be done without delay.

The Commission recommends that Head 10 – Section 9(5) be amended to reduce the period for an application to be in force to require that Authorised Officers make an application to the registered medical practitioner without delay.

Furthermore, to reduce delays in the admission process, the Commission recommends that Head 11 – Section 10(5)[120] be amended to provide that a registered medical practitioner shall send a recommendation to a clinical director without delay and at the latest within 24 hours.

According to the Explanatory Notes for Head 10:

> "[F]or this is to operate effectively and in a timely manner, the HSE will need to guarantee that there are enough trained authorised officers available in all areas on a 24/7 basis. It would also mean that should the HSE require more time and resources to build up the authorised officer service, then this new provision could not come into effect until the full service is in place, so this section may need to be commenced at a later date to the rest of the Act."[121]

[119] Head 10 – Section 9(6) provides that an AO shall not make an application unless they have met with, spoken to and observed the person the subject of the application not more than 24 hours before the date of making the application. Section 10(2), under Head 11, provides that the registered medical practitioner shall carry out an examination within 24 hours of receiving the application.
[120] Head 11 – Section 10(5) provides that a recommendation under subsection (1) shall be sent within 24 hours by the registered medical practitioner concerned to the clinical director of the approved inpatient facility concerned and a copy of the recommendation shall be given to the applicant concerned within 24 hours.
[121] Explanatory Notes for Head 10.

The number of AOs has remained low and inconsistent throughout the country.[122] This is unfortunate, as it would alleviate pressure on family members having to make an application for admissions. The AO could provide information and support to the family and would be able to make the decision to make an admission order where no alternative is available. More focus could be put on community resources which would help to ensure that an involuntary admission was made as a last resort.

The Commission recommends that the Authorised Officer service be adequately and appropriately resourced to ensure the effective implementation of the safeguards within this legislation.

Powers of An Garda Síochána (Head 13)

Head 13 sets out the powers of An Garda Síochána to take a person, believed to fulfil the criteria, for involuntary detention into custody. The Commission is concerned that this Head appears to lower the threshold for members of An Garda Síochána to exercise coercive powers on persons with psychosocial disabilities in comparison to the powers under Section 12(1) of the *Mental Health Act 2001*.[123]

The new section 12, under Head 13, provides that these powers can be exercised where a member of An Garda Síochána has reasonable grounds for believing that a person fulfils the criteria for detention under Head 9 – section 8. Under section 8(1)(b), a person fulfils the criteria for involuntary admission where treatment is immediately necessary to protect the life of the person, or to protect the health of the person from the threat of serious harm, or for the protection of other persons. As noted above, the 'protection of other persons' is a low threshold; and could provide members of An Garda Síochána with wide-ranging powers to detain people with psychosocial disabilities. The Commission is of the view that the use of coercive powers should be a measure of last resort. An arrest can be a traumatic experience

[122] See Dr Mary Keys, Dr Catriona Moloney, Dr Fiona Morrissey and Dr Charles O'Mahony, Submission to the Department of Health Public consultation on draft legislation to update the Mental Health Act 2001 (School of Law NUI Galway, March 2021) p. 8.

[123] Section 12(1) of the 2001 Act provides that: "Where a member of the Garda Síochána has reasonable grounds for believing that a person is suffering from a mental disorder and that because of the mental disorder there is a serious likelihood of the person causing immediate and serious harm to himself or herself or to other persons, the member may either alone or with any other members of the Garda Síochána—(*a*) take the person into custody, and (*b*) enter if need be by force any dwelling or other premises or any place if he or she has reasonable grounds for believing that the person is to be found there."

for someone with psychosocial disabilities. The Commission is concerned that in 2020, the largest proportion of applications for recommendations for involuntary admission of persons to approved centres came from An Garda Síochána.[124]

The Commission reiterates its recommendation that Head 9 – Section 8 be amended to provide that treatment musty be immediately necessary to protect the life of the person, or to protect the health of the person from the threat of serious harm, or for the protection of other persons from such harm. Accordingly, a member of An Garda Síochána can only exercise section 12 powers where they have reasonable grounds for believing that the person fulfils the criteria for detention under the amended Head 9 – Section 8. Detention in a Garda Station significantly interferes with the dignity of an individual, and is stigmatising and discriminatory.[125] It may also pose a risk to the health of a person due to the traumatic effect. Detention in custody should only be a measure of last resort for persons whom it is believed immediately require admission. In this regard, the Commission notes that in England and Wales, the *Mental Health Act 1983* provides that it is lawful for a police officer to detain a person temporarily in a place of safety for the purpose of assessment for admission for treatment. While the definition of a 'place of safety' under the Act includes any police station,[126] the Code of Practice for the *Mental Health Act 1983* provides that:

> "A police station should not be used as a place of safety except in exceptional circumstances, for example it may be necessary to do so because the person's behaviour would pose an unmanageably high risk to other patients, staff or other users if the person were to be detained in a healthcare setting."[127]

The Garda Síochána Inspectorate has recommended the enactment of legislation and development of arrangements to provide that persons to whom section 12 of the *Mental*

[124] 32% of 1919 admission orders were initiated by An Garda Síochána. See Mental Health Commission, Annual Report 2020 (2021) p. 5.
[125] Garda Síochána Inspectorate, Delivering Custody Services: A Rights-Based Review of the Treatment, Safety and Wellbeing of Persons in Custody in Garda Síochána Stations (July 2021) pp. 24, 26.
[126] Section 55 of the Mental Health Act 1983.
[127] Department of Health, Mental Health Act 1983: Code of Practice (2015) p. 146.

Health Act 2001 applies can be brought directly to a suitable medical facility rather than only to a Garda Station.[128]

The Commission recommends that the General Scheme should explicitly provide that the detention of a person in a Garda Station should only happen in exceptional circumstances.

The Commission considers that there should be a system of supports available to assist a person in exercising legal capacity when they are arrested. Article 33 of the Council of Europe's *Recommendation concerning the protection of the human rights and dignity of persons with mental disorders* provides that:

> "If a person whose behaviour is strongly suggestive of a mental disorder is arrested … the person should have the right to assistance from a representative or an appropriate personal advocate during the procedure".[129]

Such a system is in line with the State's obligation to protect the rights and dignity of a person deprived of liberty. Having a system of appropriate supports in place at the time of being arrested may reduce the likelihood of the use of restrictive practices when a person is transferred to an approved facility or even the involuntary admission in the first place. The Guiding Principles, particularly section 4 (4),[130] (6),[131] (7)[132] and (8),[133] as well as the

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[128] Garda Síochána Inspectorate, Delivering Custody Services: A Rights-Based Review of the Treatment, Safety and Wellbeing of Persons in Custody in Garda Síochána Stations (July 2021) p. 26.

[129] Council of Europe Committee of Ministers, Recommendation No. REC(2004)10 concerning the protection of the human rights and dignity of persons with mental disorders, adopted by the Committee of Ministers on 22 September 2004.

[130] Section 4(4) provides that "A person shall not be considered as unable to make a decision merely by reason of making, having made, or being likely to make, an unwise decision."

[131] Section 4(6) provides that: "Where it is proposed to make a decision in respect of a person under this Act— (i) the person shall be notified of the proposed decision in a form and language that may be understood by him or her, (ii) the person notified shall be entitled to make representations in relation to the proposed decision, (iii) the person notified shall be encouraged and facilitated to participate, or to improve his or her ability to participate, as fully as possible, in the decision, and (iv) all representations made by the person shall be taken into account before any decision is made."

[132] Section 4(7) provides that: "In making a decision, the person making the decision— (a) shall act at all times in good faith, (b) may, with the consent of the person concerned, consider the views of— (i) any person engaged in caring for the person, and (ii) any other mental healthcare professional, (c) shall not seek to obtain information that is not reasonably required for the making of the decision, (d) shall not use information for a purpose other than in relation to the proposed decision, and (e) shall take all necessary steps to ensure that information— (i) is kept secure from unauthorised access, use or disclosure, and (ii) is safely disposed of when he or she believe it is no longer required."

[133] Section 4(8) provides that: "A decision made in respect of a person shall— (a) be made in a manner that minimises any restrictions of the person's rights and freedoms, (b) respect the right of the person to dignity, bodily integrity, privacy and autonomy, (c) be proportionate to the significance and urgency of the matter the subject of the decision, (d) be limited in duration, in so far as is practicable, after taking into account the

requirement under section 9(3) that an AO considers whether care and treatment can be given in a setting other than an approved inpatient facility may also assist in reducing the coercive practices in the admission process. Furthermore, to ensure the rights of persons with psychosocial disabilities are protected when they engage with members of An Garda Síochána, provision should be made for members to be trained on the use of section 12 and on the rights of persons with psychosocial disabilities.

The Commission recommends that persons detained under section 12 should have reasonable access to suitably trained support persons, and they should be provided with notification of their rights. The Commission further recommends that the Mental Health Commission should be responsible for devising a notification which must be provided to a person detained in Garda custody.

The Commission recommends that initial and ongoing training be provided to members of An Garda Síochána on the use of section 12, on the rights of persons with psychosocial disabilities, and on de-escalation techniques and alternatives to coercion.

Notification of basis for detention (Head 17)

Head 17 – Section 14(3) provides for the detention of a person for a period of up to 24 hours for carrying out an examination. There is no requirement to notify the person concerned of the basis for their detention and their rights. This period of detention could be greater if they have been brought into custody under section 12 and have been detained in a Garda Station for a 12-hour period before being brought to an approved inpatient facility. The Commission considers that to strengthen the safeguards for the fundamental rights of individuals, an individual should be provided with notification which would inform the person of their rights and the basis of their detention.[134] The Commission suggest the notification could be called the 'Detention for the Purposes of Examination Form' (the 'DPE form'). This name for the notification would make it clear the purpose for detention is for examination, and not for treatment prior to admission. Persons should be provided with

particular circumstances of the matter the subject of the decision, (e) be made in a manner that promotes the highest attainable standard of mental health, and (f) with due regard to the persons will and preferences in relation to the decision."

[134] The provision of a Patient Notification Form is already provided for under Head 20 – Section 16(1).

appropriate support and assistance to understand the information proved to them.[135] The Commission further considers that the Mental Health Commission should be notified of the detention.

The Commission recommends that Head 17 – Section 14(3) be amended to require that an individual is provided with a Detention for the Purposes of Examination Form (the 'DPE form') and that the Mental Health Commission be notified in regards to the detention.

The Commission recommends that Head 17 – Section 14(3) be amended to provide for a shorter period for carrying out an examination.

The Commission recommends Head 17 – Section 14(5)[136] be amended to provide for when an admission order can be signed and that an examination must take place within 24 hours of the making of the order. Moreover, the application for an admission order should be made by an Authorised Officer, with all the necessary safeguards in place.

'Intermediate person' (Head 18)

Head 3 – Section 2 provides for the creation of the category of 'intermediate patient' meaning a person "who lacks capacity (within the meaning of section 3 of the Act of 2015) and does not meet the criteria for involuntary detention in section 8, but requires treatment in an approved inpatient facility",[137] and the procedure for an intermediate admission order is provided for under Head 18 – Section 14A. This extends safeguards usually provided to

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[135] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), 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 23 September to 4 October 2019 (24 November 2020) p. 65.

[136] Head 17 – section 14(5) provides that: "Where a person, who has been detained in the Central Mental Hospital under any provision of the *Criminal Law (Insanity) Act 2006*, nears or comes to the expiration of his or her sentence or when his or her period of lawful custody is ending or has otherwise come to an end, and where the clinical director of the designated centre in consultation with the consultant psychiatrist responsible for the person's care and treatment have examined the person and satisfied themselves that the person fulfils the criteria for detention under *section 8* and that the person requires the special treatment provided by the Central Mental Hospital, an admission order to admit such a person directly to the Central Mental Hospital under this Act may be made prior to the end of his or her period of lawful detention under the *Criminal Law (Insanity) Act 2006*."

[137] "intermediate person" means a person (other than a child) who lacks capacity (within the meaning of section 3 of the Act of 2015) and does not meet the criteria for involuntary detention in section 8, but requires treatment in an approved inpatient facility; or in the case of a child over 16 years of age, means a child who lacks capacity to consent to his or her admission and has been admitted with the consent of his or her parents, or either of them, or person or persons acting in loco parentis.

those involuntarily detained to this group. The Commission emphasises the importance of ensuring that the provisions in relation to 'intermediate persons' comply with human rights principles and carefully align with the relevant legislation and legislative proposals including the 2015 Act, the Assisted Decision-Making (Capacity) (Amendment) Bill and the Protection of Liberty Safeguards Bill. It is important that the procedures in relation to capacity in the different legislation support each other.

The Commission recommends provisions in relation to the category of 'intermediate person' take account of the provisions under the Assisted Decision Making (Capacity) Act 2015, the Assisted Decision-Making (Capacity) (Amendment) Bill and the Protection of Liberty Safeguards Bill.

Right to initiate review of detention (Head 19 and Head 26)

The Commission is concerned that Head 19 – Section 15 may not fully comply with the requirement that a detained person has the right to initiate a review of detention by a judicial authority, at reasonable intervals. The Court of Appeal decision in *A.B. v St Loman's Hospital*[138] led to an amendment to the *Mental Health Act 2001*,[139] introducing the right for a detained person to initiate a first instance review of their detention. However, this right may not comply with the requirements of Article 5(4) of the ECHR,[140] as the right to initiate review is only provided for where a renewal order is made for a period in excess of three months and only after a three-month period has expired.

Head 25 – Section 18(3) provides that the Review Board will review a renewal order or an intermediate renewal order not later than 14 days after the making of an order. A person then has a right to appeal the decision of the Review Board to the Circuit Court within 28 days under Head 26 – Section 19. This provision may raise concern in circumstances where a person chooses not to appeal a renewal order in excess of three months, as they still fulfil the criteria for involuntary detention under section 8 during the time for them to make an appeal. They will have no right to initiate a review until the three-month mark,

[138] *A.B v St Lomans* [2018] IECA 123.
[139] By the Mental Health (Renewal Orders) Act 2018.
[140] Article 5(4) of the ECHR provides that: "Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful."

notwithstanding that their individual circumstances justifying their detention may have changed or no longer exist. The original Review Board hearing and the possibility of appeal to the Circuit may be used to justify the absence of a right to initiate a review. However, the ECtHR have held that:

> "surplus guarantees do not negate the requirement for fundamental ones."[141]

The ECtHR have found breaches of Article 5(4) of the ECHR where there have been delays of 24 days,[142] five weeks,[143] eight weeks[144] and five months[145] in deciding the lawfulness of detention. While the possibility of allowing a detained person to initiate a further review would have an effect on resources; Lord Phillips in the English Court of Appeal, relying on ECtHR case law, said that in ensuring cases are determined as "speedily as their individual circumstances reasonably permit" the ECtHR "would not have regard to any alleged constraint of resources."[146]

The Commission recommends that Head 19 – Section 15 be amended to ensure that a person detained for treatment can initiate a review of their detention at reasonable intervals in compliance with Article 5(4) of the ECHR.

The Commission recommends that Head 26 – Section 19 be amended to extend the time limit permitted for an appeal to the Circuit Court.

Provision of information for involuntary and intermediate persons admitted to approved centres (Head 20)

The Commission welcomes that Head 20 – Section 16(1) provides that a notice of an admission order or renewal order should be given to the person concerned by the consultant psychiatrist as soon as practicable, but not later than 24 hours thereafter. The Commission considers that this provision could be strengthened by shortening the period for which the notice should be provided to the person. It is welcomed also that all

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[141] *Rakevich v Russia* 58973/00 [2003] ECHR 558.
[142] *L.R. v. France*, 33395/96, ECHR June 27, 2002.
[143] *Laidin v. France*, 43191/98, ECHR November 5.
[144] *E v. Norway* (1994) 17 E.H.R.R. 30.
[145] *Van der Leer v. The Netherland* (1990) 12 E.H.R.R. 567.
[146] R*. v MHRT London South & West Region exparte C.* [2001] E.W.C.A. Civ. 1110; [2002] 1 W.L.R. 176.

information provided to the person shall be in a form and language understood by them.[147] Section 16(6) provides that where the person concerned has an enduring power of attorney in place, or is a ward of the court, information should be given to any person, empowered by law, to give consent, or exercise a legal power on behalf of the person. The Commission is of the view that the category of persons which the information is provided to should be expanded to include a Decision Making Representative, or any person appointed as proxy decision maker under an Advanced Health Care Directive.

The Commission recommends that Head 20 – Section 16(1) be amended to provide that the notice be given to an individual without delay and no later than 12 hours thereafter, and that the Mental Health Commission be notified without delay and no later than 12 hours after the making of an order.

The Commission recommends that Head 20 – Section 16(6) be amended to expand the category of persons to which information should be given to, so as to include a Decision Making Representative or any person appointed as proxy decision maker under an Advanced Health Care Directive. In circumstances where a substitute decision maker has been appointed, it is important that both the individual and the substitute decision maker be provided with the necessary information.

Mental Health Review Boards (Head 22)

Mental Health Review Boards should be designed and function in line with human rights and equality principles. A key component of a human rights compliant Mental Health Review Board is providing reasons for its decisions. The Supreme Court has recognised that the requirement for a mental health tribunal to provide reasons for its decision arises:

> "both in natural justice and in Statute".[148]

The ECtHR have held that the right to a fair trial under Article 6.1 includes the obligation on a court or tribunal to give sufficient reasons for its decisions.[149] The Commission is of the

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[147] Section 16(5) of the General Scheme.
[148] See also *MD v Clinical Director of St Brendan's Hospital* [2008] 1 I.R 632. Hardiman J. (at 644, paras. 16 - 18) where the Supreme Court held that the giving of reasons was an "absolutely essential part of the Tribunal's functions and is necessary in the law because of the Tribunal's very considerable powers to affect directly the rights of the patient, including his right to liberty".
[149] *H v Belgium*, Application No. 8950/80, 30 November 1987, para. 53.

view that further guidance is needed in Head 22 – Section 16B on what is required of the Mental Health Review Board when giving reasons for a decision. A particular focus should be on recording the will and preferences of the person concerned and addressing the issue of the suitability of less restrictive forms of treatment.

Article 8 of the Council of Europe's *Recommendation concerning the protection of the human rights and dignity of persons with mental disorders* provides that persons should have:

> "[T]he right to be cared for in the least restrictive environment available and with the least restrictive or intrusive treatment available, taking into account their health needs and the need to protect the safety of others."[150]

The Commission considers that the Review Board should have a more explicit role in considering the alternatives to detention in order to protect the right to the least restrictive form of treatment.

The Commission recommends that Head 22 – section 16B(6)(k) should be amended to include a requirement that the recording of a sufficient record of the proceedings of the Review Board include:

- **a record of the will and preferences of the person the subject of the review;**
- **a summary of the key submissions made; and**
- **the evidence given in respect of the availability or suitability of less restrictive forms of treatment – treatment as voluntary patient or treatment in the community.**

The Commission recommends that Head 22 – Section 16B(12) be amended to provide that a decision of a Review Board shall be set out in writing, with reference to the evidence given, and the reasons for each matter which it is required to consider including that it address key submissions made by or on behalf of the person the subject of the review.

[150] Council of Europe Committee of Ministers, Recommendation No. REC(2004)10 concerning the protection of the human rights and dignity of persons with mental disorders, adopted by the Committee of Ministers on 22 September 2004.

Compliance with Section 12 (Head 25, Head 26 and Head 36)

As noted above, section 12 significantly interferes with the fundamental rights of an individual including the right to liberty. The Commission is of the view that compliance with this provision should be subject to heightened scrutiny by the Mental Health Review Board [under Head 25 – Section 18(1)(b) and Head 36 – Section 28(9)(b)(i)] – and the Circuit Court [under Head 26 – Section 19(5)(b)]. There may be circumstances where unlawfulness in an earlier period of detention would affect the validity of an admission order due to a gross abuse of power or a default in fundamental requirements.[151]

The Commission recommends that Head 25 – Section 18(1)(b) be amended to include section 12 as one of the provisions which the Mental Health Review Board has regard to in assessing compliance.

The Commission recommends that Head 26 – Section 19(5)(b) be amended to include section 12 as one of the provisions which the Circuit Court has regard to in assessing compliance.

The Commission recommends that Head 36 – Section 28(9)(b)(i) be amended to include section 12 as one of the provisions which the Mental Health Review Board has regard to in assessing compliance.

Transfer of a person (Head 27, Head 28 and Head 29)

Head 27, Head 28 and Head 29 provide for transfers of a person to another approved inpatient facility or the Central Mental Hospital. When a person is transferred to another approved inpatient facility, it is important that they be provided with information on their rights and on the complaints procedure as set out under section 16. The Commission considers that the language in Head 27 – section 20 should be reassessed to make it explicit that a person can apply for a transfer.[152] As currently drafted, the language is focused on

[151] *S.O. v Clinical Director Adelaide and Meath Hospital of Tallaght* (Unreported, Hogan J. 25th March 2013).
[152] Head 27 – Section 20 provides that: "Where a person applies to the clinical director of the approved inpatient facility for a transfer to another approved inpatient facility, the clinical director of the approved inpatient facility may, having consulted with the person's multi-disciplinary team, arrange for the transfer of the person to the approved inpatient facility with the consent of the clinical director of the second-mentioned approved inpatient facility and, if the clinical director declines the request he or she shall set out the reasons

the role and responsibilities of the Clinical Director rather than the right of a person to apply for a transfer. The Commission also considers that a person should be able to apply for a transfer to the Central Mental Hospital. There seems to be no objective justification for why a patient can apply to transfer to another approved inpatient facility but cannot apply to transfer to the Central Mental Hospital. The Commission is also of the view that persons who remain in the Central Mental Hospital after the expiration of their prison sentence should be entitled to apply to transfer to an approved inpatient facility.

The Commission notes that under Head 29 – Section 21, the Review Board will review the proposal for a transfer of a person to the Central Mental Hospital, which can be appealed to the Circuit Court. This provision raises concern as once a person is transferred the detention in the Central Mental Hospital will continue if every three months if certain conditions are met. The detention will continue if the clinical director of the approved inpatient facility from which the person was transferred approves the further detention and the clinical director of the Central Mental Hospital has consented in writing to the further detention. This lack of external oversight of the appropriateness of treatment has profound implications for the rights of persons detained in the Central Mental Hospital.

The Commission recommends that Head 27 – Section 20 be amended to make it explicit that a person can apply for a transfer to another approved inpatient facility.

The Commission recommends that Head 29 – Section 21 be amended to provide that a person can apply to transfer from an approved inpatient facility to the Central Mental Hospital.

The Commission recommends that the Heads be amended to provide that pursuant to the revised Act, a person who has been detained in the Central Mental Hospital can apply to transfer from the Central Mental Hospital to an approved inpatient facility.

The Commission recommends that Head 29 – Section 21 be amended to provide that the decision to continue the placement in the Central Mental Hospital after three months is

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for this decision in writing within 7 days of receipt of the request. All such decisions shall be made in accordance with *section 4*."

subject to the periodic external oversight of the Mental Health Review Board, and that the person concerned has the right to appeal that decision to the Circuit Court.

The Commission recommends that Heads 27, 28 and 29 be amended to set out the information which should be provided to a person when they transfer to another approved inpatient facility or to the Central Mental Hospital.

Change of status from voluntary to involuntary (Head 31)

The provisions within Head 31 – Section 23 pose significant human rights and equality concerns, as they are coercive measures which could potentially place a voluntary patient in a form of de facto detention. The Commission has previously recommended that the process of reclassifying a patient from voluntary to involuntary status should incorporate safeguards to ensure that the power to reclassify patients is invoked in exceptional circumstances.[153] The powers under section 23 and section 24 of the *Mental Health Act 2001* have been viewed as coercive, whereby persons have been persuaded to remain as a voluntary patient in an approved centre due to fear that the provisions of sections 23 and 24 will be utilised to formally detain them or similar.[154] In *PL v the Clinical Director of St Patrick's University Hospital*,[155] where the Commission appeared as *amicus curiae*, the Court found that voluntary patients cannot be prevented from leaving an approved centre except pursuant to section 23 and only for the purposes of examination and assessment where a consultant psychiatrist, registered medical practitioner or registered nurse on staff is of the opinion that the person fulfils the criteria for detention under the Act.

The Commission welcomes the amendment to section 23 under Head 31 which provides that it will no longer be necessary for a voluntary person to express a wish to leave before the provisions can be activated. Once it is decided that a person does not fulfil the criteria for detention, he or she must be notified immediately of the decision and informed of his or her right to leave, or stay as a voluntary patient. However, section 23 now provides that a consultant psychiatrist, registered medical practitioner or mental healthcare professional

[153] IHREC, Ireland and the Convention against Torture: Submission to the United Nations Committee against Torture on Ireland's second periodic report (July 2017) p. 45.
[154] Dr Charles O'Mahony and Dr Fiona Morrissey, A Human Rights Analysis of the Draft Heads of a Bill to Amend the Mental Health Act 2001 (Mental Health Reform, October 2021) pp. 31–32.
[155] *PL v St Patricks Hospital* [2012] IEHC 15, [2014] 4 IR 385.

responsible for or involved in the care and treatment of a voluntary person in an approved inpatient facility may detain the person if they are of the opinion that the voluntary person now fulfils the criteria for detention as set out in section 8. The revised section 23 may now mean that any person who is admitted to an approved centre is not truly a voluntary person, as they can be detained if they express a wish to leave, and even in circumstances where they do not express a wish to leave.[156] This amendment has been criticised for potentially widening the net of coercion even further and it has been recommended that the power to detain under section 23:

> "should not be used outside of very narrowly defined emergency circumstances where there is an imminent threat to life."[157]

The Commission is of the view that whenever a consultant psychiatrist, registered medical practitioner or mental healthcare professional is of the opinion that a person fulfils the criteria for detention under section 8, then they should contact an AO to observe the person and consider whether to make an application, following the steps outlined under section 9(3).[158] If the current section 23 model is retained, possibly because of a shortage of AOs, there should be a number of strengthened safeguards within the section. In particular, a person should have access to an advocate. The detention aspect of section 23(1) should be moved to the end of the section to illustrate that detention should be a measure of last resort. In examining a voluntary person under section 23(2), the responsible consultant psychiatrist should speak with the person, and where appropriate, with the person's family or carer. To ensure that involuntary admission is a measure of last resort, the consultant psychiatrist should take into account whether the care and treatment required by a person can be provided to the person other than as involuntary patient.

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[156] Dr Charles O'Mahony and Dr Fiona Morrissey, A Human Rights Analysis of the Draft Heads of a Bill to Amend the Mental Health Act 2001 (Mental Health Reform, October 2021) p. 32.
[157] Dr Charles O'Mahony and Dr Fiona Morrissey, A Human Rights Analysis of the Draft Heads of a Bill to Amend the Mental Health Act 2001 (Mental Health Reform, October 2021) p. 32.
[158] Section 9(3) provides that "[i]n considering whether or not to make an application [for involuntary admission] the authorised officer shall meet with, speak to and observe the person, and consult where possible and appropriate with the person's family or carer, and must take account of whether the care and treatment required by the person can be given other than in an approved inpatient facility, with a view to ensuring an application for involuntary admission is only made as a last resort. When an application is made under *subsection (1)*, the application shall contain a statement of the reasons why it is so made, and of the circumstances in which the application is made."

Section 23(b) provides that:

> "the responsible consultant psychiatrist shall arrange for the voluntary person to be examined by another consultant psychiatrist, who is independent of the approved inpatient facility where the voluntary person is being detained at that time and who is not the spouse or a relative of the person concerned."

Due to the implications of involuntary detention on the rights of individuals, providing for the consultant psychiatrist to choose another independent consultant psychiatrist is a low level of protection. This could be strengthened by requiring the independent consultant psychiatrist to be selected from a panel of independent consultant psychiatrists, maintained by the Mental Health Commission.

Section 23(6) provides that:

> "[f]or the purposes of carrying out the examinations under this section, the responsible consultant psychiatrist shall be entitled to take charge of the person concerned for the relevant period".

This language differs from section 14(3), which provides that a consultant psychiatrist:

> "shall be entitled to take charge of the person concerned and detain him or her for a period not exceeding 24 hours from the time of that person's arrival at the approved inpatient facility for the purpose of carrying out the examination and the assessment".

To ensure there is no ambiguity around the meaning of 'take charge' the language in section 23(6) should align with section 14(3).

The Commission recommends that Head 31 – section 23 be revised to ensure that it should only be used where there is an immediate risk of harm to the health of the person or others.

The Commission recommends that consideration be given to amending Head 31 – section 23 to provide that when a consultant psychiatrist, registered medical practitioner or mental healthcare professional is of the opinion that a person fulfils the criteria for detention under section 8 they should request an authorised officer to observe the person and the authorised officer should make the application.

The Commission recommends that Head 31 – section 23 be amended to provide that a person can engage with an advocate.

The Commission recommends that Head 31 – section 23(1) be moved to the end of the section to highlight that detention should not happen as a matter of course and should only occur where absolutely necessary.

The Commission recommends that Head 31 – section 23(2) be amended to provide that the responsible consultant psychiatrist speak to and examine the person concerned, and consult where possible and appropriate with the person's family, carer or any decision-making assistant, co-decision maker or decision-making representative. They must take account of whether the care and treatment required by the person can be given other than as an involuntary patient in approved inpatient facility.

The Commission recommends that Head 31 – section 23(2)(b) be amended to provide that the independent consultant psychiatrist should be drawn from a panel maintained by the Mental Health Commission.

The Commission recommends that Head 31 – section 23(6) be amended to 'The responsible consultant psychiatrist shall be entitled to take charge of the person concerned for the relevant period, for the purposes of carrying out the examinations under this section', to align with the provision under section 14(3).

The Commission further recommends that the person should be expressly informed that he or she is being detained for the purposes of examination under section 23 and they should be provided with written notification of the basis of that detention. The person should have the assistance of an advocate.

Status of a person if an admission order is revoked but they fulfil the criteria as an involuntary person

The Commission is concerned that the General Scheme fails to address circumstances where a Mental Health Review Board revokes an admission order for failing to comply with one of the provisions relating to admission but the consultant psychiatrist, registered medical practitioner or mental healthcare professional is of the opinion that a person fulfils the

criteria for detention as an involuntary person. With the order revoked, the person is no longer a voluntary or intermediate person so they are not covered by the provisions of section 23. The Commission is of the view that this scenario should be addressed within the provisions of the General Scheme rather than leaving it to the approved inpatient facility to detain the person without the necessary safeguards in place.

The Commission recommends the General Scheme be amended to address the circumstances where an admission order has been revoked but the person fulfils the criteria for detention as an involuntary person.

Part 4 – Requirements for Consent to Treatment

Part 4 sets out a number of provisions in relation to the requirements for consent to treatment. Provisions in relation to consent to treatment are controversial, as they interfere with fundamental rights.[159] Therefore, consideration needs to be given to ensuring adequate safeguards exist within Part 4 and that Part 4 complies with human rights principles.

The UN Special Rapporteur on the Right to Health has noted that decisions:

> "[T]o use coercion are exclusive to psychiatrists, who work in systems that lack the clinical tools to try non-coercive options. The reality in many countries is that alternatives do not exist and reliance on the use of coercion is the result of a systemic failure to protect the rights of individuals."[160]

Given that the right to health is now understood within the framework of the UNCRPD, immediate action is required to:

> "radically reduce medical coercion and facilitate the move towards an end to all forced psychiatric treatment and confinement".[161]

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[159] Dr Charles O'Mahony and Dr Fiona Morrissey, A Human Rights Analysis of the Draft Heads of a Bill to Amend the Mental Health Act 2001 (Mental Health Reform, October 2021) p. 56.
[160] United Nations Human Rights Council, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/35/21 (28 March 2017) para. 64.
[161] United Nations Human Rights Council, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/35/21 (28 March 2017) para. 65.

In 2014, the Human Rights Committee recommended that Ireland ensure that non-consensual use of psychiatric medication, electroconvulsive therapy, and other restrictive and coercive practices in mental health services is generally prohibited. The Committee recommended that such measures should only be used in exceptional circumstances, as a measure of last resort; where absolutely necessary for the benefit of the person concerned, provided that they are unable to give consent; for the shortest possible time without any long-term impact; and under independent review.[162] The Human Rights Committee will review Ireland's Fifth Periodic Report in 2022; and the Commission will update it on the extent to which the legislation adheres to human rights standards and has implemented its 2014 recommendations.

In its recommendations to Ireland after its 2019 visit, the CPT stated that the involuntary admission order should not automatically enable the administration of treatment without consent.[163] The CPT recommended that:

> "the involuntary administration of medicine should be subject to a separate decision with the possibility of appeal and an independent second opinion."[164]

The CPT highlighted concerning practices in communicating to persons upon admission their right to refuse treatment.[165]

The CPT noted that several persons stated that they:

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[162] United Nations Human Rights Committee, Concluding observations on the fourth periodic report of Ireland, CCPR/C/IRL/CO/4 (19 August 2014) para. 12.
[163] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), 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 23 September to 4 October 2019 (24 November 2020) p. 63.
[164] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), 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 23 September to 4 October 2019 (24 November 2020) p. 63.
[165] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), 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 23 September to 4 October 2019 (24 November 2020) p. 63.

> "consented to treatment, even though they did not want it, either because they did not think they could refuse, or because they did not wish to be forcibly medicated."[166]

The Commission recommends that the Heads under Part 4 be revised to comply with Ireland's international human rights obligations under the UNCRPD and the International Covenant on Civil and Political Rights, and the recommendations of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT).

Capacity to consent to treatment (Head 63)

The Commission notes that Heads 63 and 64 are to be read in conjunction with the 2015 Act; however, as noted above, the 2015 Act is not in full compliance with the UNCRPD. Therefore, the provisions need to be revised with the UNCRPD and other human rights standards in mind, to ensure adequate safeguards are in place. The Commission notes that Head 63 – section 56(5) and (6) provides that a capacity assessment can be conducted by a consultant psychiatrist and another mental healthcare professional from the same hospital who is chosen by the consultant psychiatrist. To strengthen the safeguards for the exercise of a person's capacity, the Commission considers that the second assessment of capacity should be carried out by an independent psychiatrist on the panel maintained by the Mental Health Commission.

The Commission recommends that Head 63 – section 56 be amended to require that the secondary assessment of capacity be carried out by an independent psychiatrist on the panel maintained by the Mental Health Commission.

Advance healthcare directive (Head 64)

Head 64 – section 57 provides that where a person is found to lack capacity, following a capacity assessment, treatment may be administered if the person has an advance

[166] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), 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 23 September to 4 October 2019 (24 November 2020) p. 63.

healthcare directive, as defined in Part 8 of the 2015 Act,[167] which includes a provision on specific treatment proposed.[168] The entitlement to make an advance healthcare directive is an important aspect of the exercise of legal capacity and the right to consent to treatment. States have an obligation to support persons in exercising legal capacity.[169] Principle 1 of the Council of Europe's *Recommendation concerning continuing powers of attorney and advance directives for incapacity* provides that:

> "1. States should promote self-determination for capable adults in the event of their future incapacity, by means of continuing powers of attorney and advance directives
>
> 2. In accordance with the principles of self-determination and subsidiarity, states should consider giving those methods priority over other measures of protection."[170]

Principle 14 provides that:

> "[A]dvance directives may apply to health, welfare and other personal matters, to economic and financial matters, and to the choice of a guardian, should one be appointed."[171]

Principle 15 provides that:

> "States should decide to what extent advance directives should have binding effect. Advance directives which do not have binding effect should be treated as statements of wishes to be given due respect.

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[167] Section 82 of the *Assisted Decision-Making (Capacity) Act 2015* defines an advance healthcare directive "in relation to a person who has capacity, means an advance expression made by the person, in accordance with section 84, of his or her will and preferences concerning treatment decisions that may arise in respect of him or her if he or she subsequently lacks capacity".

[168] According to the Explanatory Notes for Head 64, this provision reflects the Expert Group Review recommendations 126–131 that advance healthcare directives should apply to persons receiving treatment under the Mental Health Act.

[169] See Article 12 of the UNCRPD and Principle 2.7 of the Council of Europe Committee of Ministers, Recommendation No. R (99) 4 on principles concerning the legal protection of incapable adults, adopted by the Committee of Ministers on 23 February 1999.

[170] Council of Europe Committee of Ministers, Recommendation CM/Rec(2009)11: Principles concerning continuing powers of attorney and advance directives for incapacity, adopted by the Committee of Ministers of the Council of Europe on 9 December 2009.

[171] Council of Europe Committee of Ministers, Recommendation CM/Rec(2009)11: Principles concerning continuing powers of attorney and advance directives for incapacity, adopted by the Committee of Ministers of the Council of Europe on 9 December 2009.

> States should address the issue of situations that arise in the event of a substantial change in circumstances."[172]

In making provision for advance healthcare directives, it is important to ensure that any measures relating to advance healthcare directives apply equally to persons with psychosocial disabilities to those without. Section 86(1) of the 2015 Act provides that a specific refusal of treatment set out in an advance healthcare directive should be treated as if made contemporaneously by the directive-maker, when they had the capacity to make that decision.[173] Therefore, as long as the making of the advance healthcare directive complies with the requirements of the 2015 Act, the refusal of mental health treatment in an advance healthcare directive should be treated in the same manner as the refusal of treatment for physical health.

The Commission recognises that there are circumstances where a valid advance healthcare directive may have to be overridden, as there is no safe alternative.[174] There may be a scenario where complying with an advance healthcare directive would pose a threat to public safety and the constitutional rights of others. However, the Supreme Court has recognised a right to refuse treatment, including lifesaving treatment.[175] Therefore, a decision to override an advance healthcare directive will require careful balancing of constitutional rights.

In England and Wales, the Code of Practice for the *Mental Health Act 1983* provides that:

> "Even where clinicians may lawfully treat a patient compulsorily under the Act, they should, where practicable, try to comply with the patient's wishes as expressed in an advance decision. They should, for example, consider whether it is possible to use a different form of treatment not refused by the advance decision. If it is not, they should explain why to the patient. Except where the Act means that they need not, clinicians must follow all other advance decisions made by their patients which they

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[172] Council of Europe Committee of Ministers, Recommendation CM/Rec(2009)11: Principles concerning continuing powers of attorney and advance directives for incapacity, adopted by the Committee of Ministers of the Council of Europe on 9 December 2009.
[173] Section 86(1) of the *Assisted Decision-Making (Capacity) Act 2015.*
[174] Dr Charles O'Mahony and Dr Fiona Morrissey, A Human Rights Analysis of the Draft Heads of a Bill to Amend the Mental Health Act 2001 (Mental Health Reform, October 2021) p. 76.
[175] Per Hamilton CJ, *In the matter of A Ward of Court* (withholding medical treatment) (No. 2) [1995] 2 IR 100, p. 126.

are satisfied are valid and applicable, even if the patients concerned are detained under the Act".[176]

Currently, advance healthcare directives do not apply to persons detained under Part 4 of the *Mental Health Act 2001*, as per Part 8 of the 2015 Act.[177] There is no legal right to have their advance wishes respected, even though they had capacity to make decisions about their mental health care and treatment at the time of making their directive. There are no other groups of individuals which are specifically excluded from this legal right. This exclusion is discriminatory and contrary to international human rights standards, including the right under the UNCRPD for persons with disabilities to be treated equally before the law. Advance healthcare directives should apply to both people who are voluntarily admitted, and people who are involuntarily detained in the mental health services.

The use of differential standards reinforces the notion that the preferences of individuals with mental health conditions are not respected equally. Advance healthcare directives should be provided for all persons on an equal basis with others in the General Scheme, the revised 2015 Act and those detained in the Central Mental Hospital under the *Criminal Law Insanity Act 2006*, following being found unfit to be tried, or following a finding of not guilty by reason of insanity, or having been transferred to the Central Mental Hospital for treatment unavailable in prison. Any measure to interfere with the rights of an individual to exercise capacity and consent to treatment must comply with human rights principles, in that the measure is reasonable, necessary and proportionate to the legitimate aim it designed to achieve.

The Commission recommends that the legislation should make it clear that the fact that a person has been admitted for treatment should not prevent them from making a valid advance healthcare directive, as long as they have the decision-making capacity to do so.

The Commission recommends that the General Scheme of the Mental Health (Amendment) Bill, the General Scheme of the Assisted Decision Making (Capacity) (Amendment) Bill and the *Criminal Law Insanity Act 2006* be revised to provide that an advance healthcare directive applies equally to those detained in the Central Mental

[176] Department of Health, Mental Health Act 1983: Code of Practice (2015) p. 75.
[177] Section 85(7)(a) of the Assisted Decision-Making (Capacity) Act 2015.

Hospital and persons who are voluntarily admitted and those who are involuntarily detained under these Acts.

Part 6 – Restrictive Practices

The continued use of seclusion, physical restraint, electroconvulsive therapy, involuntary administration of medication, and a recorded pattern of failure to comply with the rules governing these practices raises serious human rights concerns.[178] Seclusion and restraint are coercive practices associated with physical and psychological harm.[179] The Committee on the Rights of Persons with Disabilities has called for elimination of the use of seclusion and physical, mechanical and chemical restraints.[180] In 2020, the Commission called for the Human Rights Committee to ask the State what measures it is taking to reduce the incidence of and reliance on seclusion and restraint.[181]

The Commission recommends that the State reduce the use of restrictive practices, in line with its human rights obligations. The State should ensure that the use of these practices are only used in exceptional circumstances, where it is the only means available to prevent immediate or imminent harm to the persons or others, and its use should not be prolonged beyond what is necessary for this purpose.

Safeguards for the use of restrictive practices (Heads 85–88)

Heads 85–88 provide that the Mental Health Commission shall make rules set out in codes of practice in relation to seclusion, mechanical restraint, physical restraint and chemical restraint. In November 2021, the Commission made a submission to the Mental Health Commission's Public Consultation on the Rules and Code of Practice governing the use of seclusion and restraint.[182] The Commission therefore welcomes the opportunity to embed

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[178] Mental Health Commission, Annual Report 2020 (2021) pp. 28, 75–78.
[179] Tahani Hawsawi et al, 'Nurses' and Consumers; Shared Experiences of Seclusion and Restraint: A Qualitative Literature Review' (2020) 29(5) International Journal of Mental Health Nursing 831–845.
[180] Committee on the Rights of Persons with Disabilities, Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities, Adopted during the Committee's 14th session (September 2015) para. 12.
[181] IHREC, Submission to the United Nations Human Rights Committee on the List of Issues for the Fifth Periodic Examination of Ireland (August 2020) p. 36. See also IHREC, Submission to the Mental Health Commission's Public Consultation on the Rules and Code of Practice governing the use of seclusion and restraint (November 2021) p. 10.
[182] IHREC, Submission to the Mental Health Commission's Public Consultation on the Rules and Code of Practice governing the use of seclusion and restraint (November 2021).

human rights standards within the new rules and codes of practice covering the provisions on restrictive practices within the General Scheme. It is important to ensure that the General Scheme includes a commitment to the evaluation, monitoring and review of the operation and outcomes of the revised Rules and Code of Practice by the Mental Health Commission to ensure they are implemented in line with human rights standards.[183]

The Commission welcomes that Heads 85–88 contain safeguards that seclusion or restraint should only be used in exceptional circumstances, where there is no safe alternative and for as limited as time as possible. The drafting process provides an opportunity to strengthen the safeguards within the legislation and identify principles which should be included within the rules on the use of seclusion and restraint. Guidance can be taken from the CPT's revised standards for means of restraint in psychiatric establishments for adults.

In ensuring that the use of seclusion or restraint is a measure of last resort and is the least restrictive measure available, the CPT provide that:

> "Patients should only be restrained as a measure of last resort (ultimo ratio) to prevent imminent harm to themselves or others and restraints should always be used for the shortest possible time. When the emergency situation resulting in the application of restraint ceases to exist, the patient should be released immediately."[184]
>
> "In cases where the use of restraint is considered, preference should be given to the least restrictive and least dangerous restraint measure. When choosing among available restraint measures, factors such as the patient's opinion (including any preferences expressed in advance) and previous experience should as far as possible be taken into account."[185]

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[183] IHREC, Submission to the Mental Health Commission's Public Consultation on the Rules and Code of Practice governing the use of seclusion and restraint (November 2021) p. 10.
[184] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), Means of restraint in psychiatric establishments for adults (Revised CPT standards), CPT/Inf(2017)6 (21 March 2017) p. 2.
[185] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), Means of restraint in psychiatric establishments for adults (Revised CPT standards), CPT/Inf(2017)6 (21 March 2017) p. 4.

The Commission notes that the Heads are silent on whether the restrictive measures can take place concurrently. In this regard, the CPT provide that:

> "Sometimes seclusion, mechanical or physical restraint may be combined with chemical restraint. Such a practice may only be justified if it is likely to reduce the duration of the application of restraint or if it is deemed necessary to prevent serious harm to the patient or others."[186]

The Heads are also silent on whether a period of seclusion or restraint can be followed immediately by another period of seclusion or restraint. The World Health Organisation's Checklist on Mental Health Legislation provides that in assessing whether key components are included within mental health legislation, States should consider:

> "Does the law ensure that one period of seclusion and restraint is not followed immediately by another".[187]

The Heads do not address what should happen after a period of seclusion or restraint ends. The CPT have emphasised the importance of holding a debrief between the person and the multidisciplinary team caring from them:

> "[T]o explain the reasons for the restraint, reduce the psychological trauma of the experience and restore the doctor-patient relationship. This also provides an opportunity for the patient, together with staff, to find alternative means to maintain control over him/herself, thereby possibly preventing future eruptions of violence and subsequent restraint."[188]

The Heads set out that an approved inpatient facility must keep a register of the use of seclusion and restraint, and each use should be recorded in the register and on the person's clinical file; in addition to any other information required by the Mental Health Commission in its rules. The Commission is of the view that the reason for the use of restraint and seclusion, and its nature and extent should be included in the register and the person's

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[186] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), Means of restraint in psychiatric establishments for adults (Revised CPT standards), CPT/Inf(2017)6 (21 March 2017) p. 4.
[187] World Health Organisation, WHO Checklist on Mental Health Legislation (2005) p. 140.
[188] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), Means of restraint in psychiatric establishments for adults (Revised CPT standards), CPT/Inf(2017)6 (21 March 2017) p. 4.

clinical file.[189] The Heads provide that if an individual breaches any of the sections or the rules made under the sections they shall be guilty of an offence and shall be liable on summary conviction to a fine, not exceeding €5,000. It is welcome that the legislation sets out a requirement to comply with the human rights standards relating to restrictive practices, as the Mental Health Commission has highlighted concerning practice in relation to compliance with the rules.[190]

The provisions under the Heads only apply to involuntary persons, intermediate persons and persons detained in the Central Mental Hospital or in a designated centre (within the meaning of the *Criminal Law (Insanity) Act 2006*). The Heads explicitly set out that the provisions do not apply to voluntary persons. This is a welcome approach as the current Mental Health Commission codes of practices in relation to seclusion, mechanical restraint and physical restraint apply to voluntary patients.[191] The legislation or the new rules should address the circumstances where a restrictive practice is applied to a voluntary patient. The CPT's revised standards for means of restraint in psychiatric establishments for adults provides that in relation to the use of restraint on a voluntary patient:

[189] The CPT provide that: "The entries in the register should include the time at which the measure began and ended; the circumstances of the case; the reasons for resorting to the measure; the name of the doctor who ordered or approved it; and an account of any injuries sustained by patients or staff. Patients should be entitled to attach comments to the register, and should be informed of this entitlement; at their request, they should receive a copy of the full entry." See European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), Means of restraint in psychiatric establishments for adults (Revised CPT standards), CPT/Inf(2017)6 (21 March 2017) p. 5.

[190] In 2020, 28 approved centres used seclusion and, of these, 61% were compliant with the Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint. In 2020, after an inspection one centre was found to be non-compliant with the Rules Governing the Use of Mechanical Restraint as a young person was subjected to prolonged mechanical restraint, with the use of arm and leg restraints, over several months. In 2020, 55 approved centres used physical restraint and 76% of these were compliant with the Code of Practice on the Use of Physical Restraint. See Mental Health Commission, Annual Report 2020 (2021) pp. 76–78.

[191] The Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint provides that the definition of patient includes "a voluntary patient as defined by the 2001 Act"; see Mental Health Commission, Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint Issued Pursuant to Section 69(2) of the Mental Health Act, 2001 (October 2009) p. 11. The Code of Practice on the Use of Physical Restraint in Approved Centres provides that the Code "is applicable to all residents, that is, persons receiving care and treatment in an approved centre"; see Mental Health Commission, Code of Practice on the Use of Physical Restraint in Approved Centres Issued Pursuant to Section 33(3)(e) of the Mental Health Act 2001 (October 2009) p. 14.

> "In case the application of means of restraint to a voluntary patient is deemed necessary and the patient disagrees, the legal status of the patient should be reviewed."[192]

In England and Wales, the code of practice for the *Mental Health Act 1983* provides that:

> "If an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to prevent harm to others, then an assessment for an emergency application for detention under the Act should be undertaken immediately."[193]

As the use of restrictive practices raises significant human rights concerns, the Commission is of the view that it is important that persons are provided with assistance and support in discussions around the use of seclusion or restraint. Therefore, the Heads should provide for the assistance of an advocate, if required by the person concerned. The Heads or the rules to be developed by the Mental Health Commission should also include provision for informing persons who are subject to a restrictive practice about their rights, in particular the right:

> "to seek legal advice about complaints and to benefit from legal assistance when the interests of justice so require."[194]

The drafting of legislative provisions on restraint and seclusion provides an opportunity for Ireland to be proactive in reducing the use of restrictive practices and to develop strategies which promote less restrictive alternatives. The legislative process also provides an opportunity to align the standards under the legislation and the associated Mental Health Commission rules with human rights and equality standards, including the CPT's standards. In its 2019 visit to Ireland, the CPT made a number of recommendations to Ireland which should be reflected within the legislation and the rules, including:

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[192] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), Means of restraint in psychiatric establishments for adults (Revised CPT standards), CPT/Inf(2017)6 (21 March 2017) p. 5.
[193] Department of Health, Mental Health Act 1983: Code of Practice (2015) p. 300.
[194] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), Means of restraint in psychiatric establishments for adults (Revised CPT standards), CPT/Inf(2017)6 (21 March 2017) p. 5.

- The use of force to bring a person under control should be strictly necessary and proportional, and due regard should be had to gender-specific concerns;[195]

- A medical doctor should be informed immediately after a measure of seclusion or restrain is initiated, and a review should be carried out as soon as possible; and[196]

- Children should in principle never be subjected to means of restraint on account of their vulnerability.[197] In extreme cases where it is deemed necessary to intervene physically to avoid harm to self or others, the only acceptable intervention is the use of manual restraint, that is, staff holding the child until he/she calms down.[198]

The Commission recommends that the Heads under Part 6 be revised to ensure that the safeguards to be included under the legislation and within the rules and codes of practices comply with human rights standards, including the recommendations of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT).

The Commission recommends that the Heads under Part 6 be revised to include a commitment to an evaluation, monitoring and review of the operation and outcomes of the revised Rules and Code of Practice on seclusion and restraint by the Mental Health Commission to ensure they are implemented in line with human rights standards.

The Commission recommends that the Heads under Part 6 be revised to provide for the right of a person to access an advocate in discussions on the use of seclusion or restraint.

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[195] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), 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 23 September to 4 October 2019 (24 November 2020) p. 53.
[196] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), 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 23 September to 4 October 2019 (24 November 2020) p. 58.
[197] Head 127 – Section 67 provides for the restraint and seclusion of children.
[198] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), 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 23 September to 4 October 2019 (24 November 2020) p. 60.

Seclusion (Head 85)

Head 85 – Section 69(1) provides that a person should not be placed in seclusion, unless such seclusion is determined, in accordance with the rules of the Mental Health Commission, to prevent the person from injuring himself or herself or others and unless the seclusion complies with such rules.[199] The Commission notes that the current rules governing the use of seclusion set out that such interventions are only used in "rare and exceptional circumstances" and only where the person "poses an immediate threat of serious harm to self or others."[200] This is a higher threshold than what is included within Head 85 – section 69. The Commission is of the view that this higher threshold should be reflected within the Head to illustrate that seclusion should be an exceptional measure where it is the only means available to prevent immediate or imminent harm to the persons or others.

In its visit to Ireland, the CPT noted lengthy periods of seclusion, including periods of 86, 108 and almost 573 consecutive hours.[201] The CPT expressed serious doubts whether the seclusion of patients for such lengthy periods could be justified.[202] The CPT has said the use of seclusion and mechanical restraint should be for the shortest possible time, usually minutes rather than hours, and it should be ended when the underlying reasons for its use are no longer relevant.[203]

The CPT recommended that:

> "[E]very patient held in seclusion should be under continuous direct personal supervision from the very outset of the measure (so that the patient can fully see the

[199] Section 69(1) of the General Scheme.
[200] Mental Health Commission, Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint Issued Pursuant to Section 69(2) of the Mental Health Act, 2001 (October 2009) p. 15.
[201] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), 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 23 September to 4 October 2019 (24 November 2020) p. 59.
[202] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), 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 23 September to 4 October 2019 (24 November 2020) p. 59.
[203] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), Means of restraint in psychiatric establishments for adults (Revised CPT standards), CPT/Inf(2017)6 (21 March 2017) p. 4.

> staff member and the latter can continuously observe and communicate with the patient at all times). … In addition, patients should be secluded for the shortest possible time, have ready access to sanitary facilities without having to ask to use them and it should be ensured that the room itself is kept at a moderate temperature, with the provision of sufficient blankets."[204]

The CPT also recommended that less intrusive alternatives to seclusion should be available in mental health establishments such as de-escalation or relaxation rooms.[205] These recommendations can be addressed in the rules developed by the Mental Health Commission on the use of seclusion. The rules should also outline the need for a multidisciplinary review to determine whether the seclusion should continue or be ended.[206] The CPT have stated that if seclusion or mechanical restraint is used for more than a period of hours, it should be reviewed by a doctor at regular intervals.[207] Due to the concerning practice in lengthy periods of seclusion, there should be provision for an independent review of extended periods of seclusion or where there are multiple periods of seclusion in a short time frame.

The Commission recommends that Head 85 – section 69(1) be revised to provide that seclusion should only be used, in compliance with the rules, where it is the only means available to prevent immediate or imminent harm to the person or others.

The Commission recommends that the rules on seclusion developed by the Mental Health Commission should follow the recommendations of the European Committee for the

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[204] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), 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 23 September to 4 October 2019 (24 November 2020) p. 60.

[205] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), 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 23 September to 4 October 2019 (24 November 2020) p. 60.

[206] The Code of Practice in England and Wales provides that "A series of review processes should be instigated when a patient is secluded. These include the multi-disciplinary team (MDT), nursing, medical and independent MDT reviews. All reviews provide an opportunity to determine whether seclusion needs to continue or should be stopped, as well as to review the patient's mental and physical state." See Department of Health, Mental Health Act 1983: Code of Practice (2015) p. 304.

[207] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), Means of restraint in psychiatric establishments for adults (Revised CPT standards), CPT/Inf(2017)6 (21 March 2017) p. 4.

Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) and include provision for the review of seclusion, particularly for the independent review of extended or multiple periods of seclusion.

Mechanical Restraint (Head 86)

Head 86 – section 69A provides that a person should not apply mechanical means of restraint to a person, unless such restraint is determined, in accordance with the rules of the Mental Health Commission, for the purposes of treatment or to prevent the person from injuring themselves or others and unless the mechanical restraint complies with such rules.[208] Once again this is a lower threshold than the current rules governing the use of mechanical restraint which provides that such as interventions are only used in "rare and exceptional circumstances" and only where the person "poses and immediate threat of serious harm to self or others."[209] Including the requirement that the threat of serious harm be immediate would contribute to the reduction of the use of restrictive practices and ensure that they are only used as a last resort.

The Commission is of the view that mechanical restraint for the purpose of the administration of treatment should only be used in exceptional circumstances, where necessary and in accordance with the principle of the least restrictive treatment available. The Commission considers that the use of mechanical restraint should be subject to a multidisciplinary review and there should be an independent review of the use of mechanical restraint on a person where it has been applied for a prolonged duration or on multiple occasions over a short time frame. The CPT recommends that a person who is subjected to mechanical restraint should be under continuous supervision and a qualified member of staff should be permanently present in the room in order to maintain a therapeutic alliance with the patient and provide them with assistance.[210]

The Commission recommends that Head 86 – Section 69A(1) be revised to provide that mechanical restraint should only be used, in compliance with the rules, where it is the

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[208] Section 69(1) of the General Scheme.
[209] Mental Health Commission, Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint Issued Pursuant to Section 69(2) of the Mental Health Act, 2001 (October 2009) p. 15.
[210] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), Means of restraint in psychiatric establishments for adults (Revised CPT standards), CPT/Inf(2017)6 (21 March 2017) p. 4.

only means available for the purposes of the administration of treatment or to prevent immediate or imminent harm to the person or others.

The Commission recommends that the rules on mechanical restraint developed by the Mental Health Commission should include provision for the multidisciplinary review of mechanical restraint and the independent review of prolonged or frequent use of mechanical restraint on a person.

Physical Restraint (Head 87)

Head 87 – section 69B(1) provides that a person shall not apply physical means of bodily restraint to a person unless such restraint is determined, in accordance with the rules made by the Mental Health Commission, to be necessary for the purposes of treatment or to prevent the person from injuring himself or herself or others and unless the physical restraint complies with such rules. The Code of Practice on the Use of Physical Restraint provides that physical restraint "should be used in rare and exceptional circumstances" where the person "poses an immediate threat of serious harm to self or others."[211] As noted above, this represents a higher threshold for the use of physical restraint.

The ECtHR has held that:

> "In respect of the use of measures of physical restraint on patients in psychiatric hospitals, the developments in contemporary legal standards on seclusion and other forms of coercive and non-consensual measures against patients with psychological or intellectual disabilities in hospitals and all other places of deprivation of liberty require that such measures be employed as a matter of last resort, when their application is the only means available to prevent immediate or imminent harm to the patient or others".[212]

The ECtHR has stated that the potential danger is not sufficient to establish immediate or imminent harm, rather:

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[211] Mental Health Commission, Code of Practice on the Use of Physical Restraint in Approved Centres Issued Pursuant to Section 33(3)(e) of the Mental Health Act 2001 (October 2009) p. 13.
[212] *Aggerholm v. Denmark,* Application No. 45439/18, issued on 15 December 2020, para. 8.

> "[F]or a danger to be considered imminent, it must be specific, present and demonstrable. However, a latent danger that may manifest itself under certain conditions or circumstances that may occur later will not suffice."[213]

Therefore, the Commission is of the view that the higher threshold of immediate harm should be included in the General Scheme. Provision should be made in the rules for the multidisciplinary review of physical restraint and an independent review of prolonged physical restraint or repeated instances of physical restraint, in close proximity to each other.

The Commission recommends that Head 87 – Section 69B(1) be revised to provide that physical restraint should only be used, in compliance with the rules, where it is the only means available for the purposes of the administration of treatment or to prevent immediate or imminent harm to the person or others.

The Commission recommends that the rules on physical restraint developed by the Mental Health Commission should include provision for the multidisciplinary review of physical restraint and the independent review of long term or frequent use of physical restraint on a person.

Chemical Restraint (Head 88)

Head 88 – Section 69C provides for the use of chemical restraint. This practice is not covered in current rules or codes of practice. Section 69C(1) provides that:

> "'chemical restraint' means the use of medication to control or modify a person's behaviour when no medically identified condition is being treated, or where the treatment is not necessary for the condition or the *intended effect of the drug is to sedate the person for convenience or disciplinary purposes* [italics added]."

The Commission is concerned that the phrase 'for convenience or disciplinary purposes' appears to suggest that these are acceptable reasons for using chemical restraint. This is a very low threshold for justifying the use of chemical restraint and provides a wide margin of

[213] *Aggerholm v. Denmark,* Application No. 45439/18, issued on 15 December 2020, para. 111.

discretion to those who apply chemical restraint. The CPT's Revised Standards for Means of restraint in psychiatric establishments for adults provides that:

> "Means of restraint should never be used as punishment, for the mere convenience of staff, because of staff shortages or to replace proper care or treatment."[214]

The Commission is of the view that the threshold should be higher and that chemical restraint should only be used where it is the only means available to prevent immediate or imminent harm to the persons or others. To ensure this practice protects the rights of individuals the rules to be developed by the Mental Health Commission should provide for a multidisciplinary review of chemical restraint and an independent review where there is long term or frequent use of chemical restraint on a person.

The Commission recommends that Head 88 – Section 69C(1) be revised to provide that chemical restraint should only be used, in compliance with the rules, where it is the only means available to prevent immediate or imminent harm to the person or others.

The Commission recommends that the rules on chemical restraint developed by the Mental Health Commission should include provision for the multidisciplinary review of chemical restraint and the independent review of long term or frequent use of chemical restraint on a person.

Part 7 – Miscellaneous

Individual care plan (Head 100)

The Commission welcomes that individual care plans will be placed on a statutory footing and each person receiving treatment must have an individual care plan in place within seven days of admission (Head 100).[215] Head 100 – section 80 provides that the individual care plan will be developed, regularly reviewed and updated in consultation with the person concerned in a manner that is accessible to them. The Commission considers that further clarity could be given to the process of consulting with the person concerned. All persons in receipt of mental health services should have legal right to an individual care plan, which

[214] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), Means of restraint in psychiatric establishments for adults (Revised CPT standards), CPT/Inf(2017)6 (21 March 2017) p. 2.
[215] Similar provision is made for children under Head 112.

involves their full and active participation including the provision of appropriate support if needed. Support may include providing information in a format the person understands, giving them time to make the decision, providing access to an independent advocate, or talking to a trusted person who can support them to participate in the planning/decision-making process. The individual care plan should also form the basis for the development of an advance healthcare directive.

The Commission recommends that Head 100 – Section 80 be revised to provide that a person should be supported if necessary to participate in the development, regular review and updating of their individual care plan.

Part 8 – Admission of children to approved inpatient facilities

Guiding principles for children (Head 104)

The inclusion of a separate section of guiding principles for children under Head 104 – section 84 is welcomed by the Commission. Section 84 provides that the best interests principle is still the primary consideration[216] for those under 18 years of age.[217] The Commission notes that the draft heads under Part 8 differentiate between those over and under 16 years of age. For a child under 16 years of age, who is deemed to lack the necessary maturity and capacity, a number of factors such as the child's views and his or her will or preferences must be given due consideration at each stage of diagnosis and treatment. The guiding principles in respect of children also reinforce the importance of the provision of care and treatment in an age-appropriate environment and in close proximity to the child's home or family.

The Commission considers that the drafting of the guiding principles for children and Part 8 of the General Scheme offers the opportunity to enshrine the standards set out in Article 42A of the Constitution, and in the UNCRC and UNCRPD in mental health legislation and ensure Ireland is compliant with its international obligations related to the provision of mental healthcare to children.

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[216] The Ombudsman for Children's Office recommended that the best interests of the child should be the primary consideration in the guiding principles, in line with article 3 of the UNCRC and article 7(2) of the UNCRPD. See Ombudsman for Children's Office, Observations on the General Scheme of the Mental Health (Amendment) Bill 2021 (December 2021) p. 3.

[217] Section 84(1)(a).

The guiding principles should specifically recognised the following rights:

- The right of a child not to be separated from their family except as a last resort, where absolutely necessary;

- The right of the child to have their views heard in all matters concerning them, with due weight in accordance with the age and maturity;

- The right of the child to legal representation; and

- The right of the child to the assistance of an advocate.

The Commission recommends that Head 104 – section 84 be revised to ensure that the provisions align with the State's obligations under Article 42A of the Constitutions and the rights enshrined within the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities.

The Commission is concerned by the lack of alignment between the guiding principles in respect of children in terms of the presumption of capacity in the General Scheme and the *Mental Health (Amendment) Act 2018*. There is no presumption of capacity for children over 16 years of age in the *Mental Health (Amendment) Act 2018*,[218] whereas a presumption of capacity is provided for those over 16 years of age in the draft Heads. This is to be welcomed as it clarifies the rights of this age group regarding their admission and treatment. However, this inconsistency could potentially negatively affect the effectiveness of this principle and it should be taken into consideration during the drafting process. Consideration should be given to what supported decision making provisions will apply to 16 and 17 year olds who are subject to the revised mental health legislation.

To ensure consistency between the General Scheme and the *Mental Health (Amendment) Act 2018*, the Commission recommends that there should be an amendment to the 2018 Act to provide that for a child aged 16 years or older, it shall be assumed that the child has the necessary maturity and capacity to make decisions affecting themselves.

[218] Section 4(A) of the Mental Health (Amendment) Act 2018.

Hearings before the District Family Law Court (Head 104)

Head 104 – Section 84(3) provides that:

> "[s]o far as practicable, hearings before the District Court under this Part of the Act should be before a District Family Law Court."

The Commission notes a human rights analysis of the General Scheme includes the recommendation that while the District Family Law Court should make the initial decision on the admission of children as involuntary, a child friendly/age-appropriate version of the Mental Health Review Board should subsequently review the admission.[219] The Commission welcome this approach from a human rights and child-centred perspective.

The Committee on the Rights of the Child have stated that:

> "A child cannot be heard effectively where the environment is intimidating, hostile, insensitive or inappropriate for her or his age. Proceedings must be both accessible and child-appropriate. Particular attention needs to be paid to the provision and delivery of child-friendly information, adequate support for self-advocacy, appropriately trained staff, design of court rooms, clothing of judges and lawyers, sight screens, and separate waiting rooms."[220]

It would be a less formal environment than a family law court, and it would hopefully allow a child to express their views in line with human rights principles

The Commission recommends that Part 8 be amended to provide that the District Family Law Court should make the initial decision on admission of a child, but that reviews of the admission should be undertaken by a child friendly, age appropriate version of the Mental Health Review Board.

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[219] Dr Charles O'Mahony and Dr Fiona Morrissey, A Human Rights Analysis of the Draft Heads of a Bill to Amend the Mental Health Act 2001 (Mental Health Reform, October 2021) p. 25. Citing a recommendation of the Law Reform Commission at the District Court make the initial decision on admission of children and young people as involuntary for the purposes of the 2001 Act, but that a Mental Health Tribunal (with an age-appropriate focus) rather than the District Court should review admission; see aw Reform Commission, Report: Children and the Law: Medical Treatment (Dublin: LRC-103, 2011) pp. 136–137.

[220] United Nations Committee on the Rights of the Child, General Comment No. 12 (2009) The right of the child to be heard, CRC/C/GC/12 (20 July 2009) para. 34.

Admission for treatment of a child aged 16 years or older where consent is provided by the parent of child and the child is deemed to lack capacity (Head 107)

The Commission welcomes that Head 124 – section 104 will give children aged 16 years and older the right to refuse or consent to their own mental health treatment. However, the Commission is concerned that Head 107 – section 87 allows for the admission of a child aged 16 years or older as an intermediate person to an approved inpatient facility where consent is provided by the parents of a child who is deemed to lack capacity. This would appear to go against the international trend in children rights and the UK Supreme Court decision *In the matter of D (A Child)*.[221] In this case, it was found that if parental responsibility goes beyond what would be considered normal for a child of 16 and older, it will amount to a deprivation of liberty under Article 5 of the ECHR. Lady Hale, giving judgment for the Court, held that the consent of the parents does not substitute the subjective component under Article 5 of the ECHR of a lack of valid consent to the deprivation of liberty.[222] Lady Hale concluded that it was not within the scope of parental responsibility for the child's parents to consent to a placement which deprived them of their liberty.[223]

Lady Hale held that:

[221] [2019] UKSC 42. The issue in this case was whether it was within the scope of parental responsibility to consent to living arrangements for a 16 or 17 year-old child which would otherwise amount to a deprivation of liberty within the meaning of article 5 of the ECHR, in particular where the child lacked the capacity to make the decision for themselves.

[222] *In the matter of D (A Child)* [2019] UKSC 42, para. 42. Citing the test in *Storck v Germany* (2005) 43 EHRR 6, paras 74 and 89; the ECtHR held that there were three components in a deprivation of liberty for the purpose of article 5: (a) the objective component of confinement in a particular restricted place for a not negligible length of time; (b) the subjective component of lack of valid consent; and (c) the attribution of responsibility to the State.

[223] *In the matter of D (A Child)* [2019] UKSC 42, para. 49. Lady Hale held that: "This conclusion is consistent with the whole thrust of Convention jurisprudence on article 5 … it is also consistent with the principle of non-discrimination in article 2.1 of the United Nations Convention on the Rights of the Child, which requires that the rights set out in the Convention be accorded without discrimination on the ground of, inter alia, disability, read together with article 37(b), which requires that no child shall be deprived of his liberty unlawfully or arbitrarily, and article 37(d), which requires the right to challenge its legality. It is also consistent with article 7.1 of the United Nations Convention on the Rights of Persons with Disabilities, which requires all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children." See also *In the matter of D (A Child)* [2019] UKSC 42, para. 45.

> "Although there is no doubt that they, and indeed everyone else involved, had D's best interests at heart, we cannot ignore the possibility, nay even the probability, that this will not always be the case. That is why there are safeguards required by article 5. Without such safeguards, there is no way of ensuring that those with parental responsibility exercise it in the best interests of the child".[224]

This decision would indicate that in order to comply with Article 5 of the ECHR all the safeguards which are applicable in the case of a detention of an adult under this General Scheme would also have to be provided to a child aged 16 years or older.

The Commission recommends that Head 107 – section 87 be revised to strengthen the safeguards around the admission of child aged 16 years and older as an intermediate person to an approved inpatient facility.

Lady Hale considered that the principles which applied to children aged 16 years and older may apply to children younger than 16 years old:

> "Logically, this conclusion would also apply to a younger child whose liberty was restricted to an extent which was not normal for a child of his age, but that question does not arise in this case. The common law may draw a sharp distinction, in relation to the deprivation of liberty, between those who have reached the age of 16 and those who have not, but the extent to which that affects the analysis under the Human Rights Act is not clear to me and we have heard no argument upon it."[225]

Head 105 – section 85 provides that a parent may consent to the voluntary admission of a child under 16 years of age to an approved inpatient facility. As this admission could be regarded as amounting to a deprivation of liberty, there is a need to put in place effective safeguards to ensure that the detention is lawful.

The Commission recommends that Head 105 – section 85 be amended to include safeguards around the admission of a child under 16 years of age to an approved inpatient facility.

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[224] *In the matter of D (A Child)* [2019] UKSC 42, para. 49.
[225] *In the matter of D (A Child)* [2019] UKSC 42, para. 50.

Safeguards for the detention of a child (Head 107 and Head 109)

Head 107 – section 87(2) provides that a second mental healthcare professional, who is not a relative of the child, and will not be involved in the care and treatment of the child, shall carry out a capacity assessment on a child aged 16 years or older, for admission as an intermediate person to an approved inpatient facility. Similar to the recommendations outlined above, the Commission is of the view that this second assessment should be carried out by a suitably qualified independent mental healthcare professional who is on a panel maintained by the Mental Health Commission.

The Commission recommends that Head 107 – section 87(2) be amended to provide that the second assessment of capacity should be carried out by an independent mental healthcare professional who is on a panel maintained by the Mental Health Commission.

Head 109 – section 89 provides that in an application to a court for an involuntary admission or to extend an order, only one examination of a child by a consultant psychiatrist is required. The only requirement for the consultant psychiatrist is that they are not a relative of the child concerned. As the admission order may lead to a child being involuntarily detained, it is questionable whether having only one examination is a sufficient safeguard for the rights of the child. To further protect and vindicate the rights of the child, the Commission is of the view that a second examination is required and this examination should be carried out by a suitably qualified independent mental healthcare professional.

The Commission recommends that Head 109 – Section 89 be amended to provide that two reports of an examination of a child should be provided to the court, and the second examination should be carried out by an independent mental healthcare professional who is on a panel maintained by the Mental Health Commission.

Head 109 – section 89(6) provides that the court:

> "[H]aving considered the report of the consultant psychiatrist … together with any other evidence that may be adduced before it that the child fulfils the criteria for detention as set out in section 88, the court shall make an order that the child be admitted and detained for treatment in a specified approved inpatient facility for a period not exceeding 3 months."

There is no requirement for the court to provide reasons for why it made an order or whether it considered if alternative, less restrictive forms of treatment could be used instead. This potential lack of transparency in decision-making is concerning as the admission order can result in a child being detained for up to three months. Therefore, greater transparency and clarity is needed to explain why the detention is necessary for the child concerned.

The Commission recommends that Head 109 – section 89 be amended to provide that the court should provide reasons for its decision to make an order for detention and why alternative, less restrictive forms of treatment are not sufficient for the child concerned. The Commission further recommends that reviews should take place more frequently than every 3 months.

Head 109 – Section 89(6) provides that a court may make an order to admit and detain a child for treatment in an approved inpatient facility for a period not exceeding three months. Head 109 – section 89(12) provides that the:

> "court may on its own motion or on an application by any other person, vary or discharge an order or any condition or direction attaching to an order under this Part to include any order."

It is presumed that the child can challenge this order; however, this should be clear in the legislation. Article 5(4) of the ECHR provides that a child:

> "who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful."

The right to appeal to the Circuit Court should also be clearly outlined within the provisions.

The Commission recommends that Head 109 – Section 89 be amended to recognise the right of a child to initiate a review of their detention.

The Commission is of the view that the rights of the child under Head 109 – section 89 could be further safeguarded by providing that legal representation should be provided to a child from the beginning of the admission process. This could be done by extending the Mental Health Legal Aid scheme to children.

The Commission recommends that Head 109 – Section 89 be amended to provide that the child will be provided with legal representation from the beginning of the admission process.

Provision of information for a child admitted to an approved inpatient facility (Head 111)

Head 111 – section 91 provides for the provision of information to a child, their parents or persons acting in loco parentis where a child is admitted as a voluntary or involuntary person. If the 2015 Act is to apply to 16 and 17 year olds, the provision of information should also be provided to any support person appointed under that Act.

The Commission recommends that Head 111 – Section 91 is amended to provide that information should be given to any person appointed under the 2015 Act.

Admission of a child to an adult approved inpatient facility (Head 128)

Head 128 – section 108 provides for the admission of a child to an adult approved inpatient facility. The continued admission of children to adult mental health services is an ongoing source of concern for the Commission[226] There were 27 admissions of children to adult approved inpatient facility in 2020, compared to 54 admissions in 2019.[227] The Mental Health Commission have stated that children and young people should not be admitted to adult units, except in exceptional circumstances.[228] The Mental Health Commission have noted that the:

> ”reason for most admissions to adult units is due to an immediate risk to the young person or other, or the lack of a bed in a specialist Child and Adolescent Mental Health Services (CAMHS) unit.”[229]

The Mental Health Commission note that as CAMHS units are only in three counties nationally and do not generally take out-of-hours admissions:

[226] See IHREC, Submission to the UN Committee on the Rights of the Child on the List of Issues Prior to Reporting for the fourth periodic examination of Ireland (July 2020) pp. 26–27.
[227] See Mental Health Commission, Annual Report 2020 (2021) p. 4.
[228] Mental Health Commission, Annual Report 2020 (2021) p. 29.
[229] Mental Health Commission, Annual Report 2020 (2021) p. 29.

> "Children and young people in crisis are left with the unacceptable 'choice' between an emergency department, general hospital, children's hospital, or an adult inpatient unit."[230]

Section 108 provides that the admission of a child to an adult approved inpatient facility shall have due regard to the guiding principles under section 84, which includes that:

> "in so far as is practicable, to provide care and treatment in an age-appropriate environment".[231]

In its Annual Report 2020, the Mental Health Commission reported that there was 0% compliance with the code of practice on the admission of children to approved centres as the services did not provide age appropriate facilities and programmes of activities for children admitted to adult facilities.[232] This lack of compliance illustrates that the admission of children to adult approved inpatient facilities does not safeguard the rights of the child.

The UN Committee on the Rights of the Child has expressed concern to Ireland that children are being admitted to adult mental health services due to inadequate mental health services for children, long waiting lists for access to mental health support and insufficient out-of-hours services for children and adolescents with mental health needs.[233] Legislating for the admission of children to adult approved inpatient facilities infringes Article 37(c) of the UNCRC which provides that every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so. The admission of children to adult approved inpatient facilities is an inappropriate measure to the address the mental healthcare needs of children, and this practice should be ended.

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[230] Mental Health Commission, Annual Report 2020 (2021) p. 29.
[231] Head 104 – Section 84(1)(d).
[232] Mental Health Commission, Annual Report 2020 (2021) p. 20.
[233] United Nations Committee on the Rights of the Child, Concluding observations on the combined third and fourth periodic reports of Ireland, CRC/C/IRL/CO/3-4 (1 March 2016) para. 53(b). In the Commission's 2020 submission to the Committee on the Rights of the Child, it recommended the Committee asks the State what measures it is taking to reduce the number of children who are admitted to psychiatric wards and to ensure that, where such practice is necessary, facilities are age-appropriate; see IHREC, Submission to the UN Committee on the Rights of the Child on the List of Issues Prior to Reporting for the fourth periodic examination of Ireland (July 2020) p. 27.

The Commission recommends that Head 128 – Section 108 be removed from the General Scheme. The Commission further recommends that the legislation should explicitly set out that children should not be admitted to an adult approved inpatient facility.

Independent Complaints Mechanism

The Commission welcomes the call for the creation of an independent complaints mechanism to receive, investigate and determine all complaints about mental health services.[234] As the provisions of this legislation and their implementation will have significant implications for the fundamental rights of individuals including their right not to be deprived of their liberty, it is critical that adults and children are entitled to avail of an independent complaints mechanism in relation to their care. The independent complaints mechanism should be accessible and information on the independent complaints mechanism should be provided to adults and children in accessible formats after their admission to an approved inpatient facility, community residences and community mental health services.[235]

The Commission also calls for the ratification of the Optional Protocol to the UNCRPD, which gives the Committee on the Rights of Persons with Disabilities the authority to receive and consider communications from individuals or groups alleging violations of any of the convention's provisions.[236] The Optional Protocol also enables the Committee to undertake inquiries with States Parties where there is information or evidence indicating grave or systematic violations of the UNCRPD.

The Commission recommends the General Scheme be amended to provide for the creation of an independent complaints mechanism to consider complaints from adults and children. Information on the independent complaints mechanism should be provided to adults and children after their admission to an approved inpatient facility.

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[234] Mental Health Reform, Public Consultation on Draft Legislation to Update the Mental Health Act 2001 (09 April 2021) p. 13; Dr Charles O'Mahony and Dr Fiona Morrissey, A Human Rights Analysis of the Draft Heads of a Bill to Amend the Mental Health Act 2001 (Mental Health Reform, October 2021) p. 83.
[235] Dr Charles O'Mahony and Dr Fiona Morrissey, A Human Rights Analysis of the Draft Heads of a Bill to Amend the Mental Health Act 2001 (Mental Health Reform, October 2021) p. 83.
[236] See IHREC, Consultation on Terms of Reference and Work Programme for the Joint Oireachtas Committee on Disability Matters: Submission by the Irish Human Rights and Equality Commission (November 2020) pp. 13–14.

The Commission further recommends the ratification of the Optional Protocol to the United Nations Convention on the Rights of Persons with Disabilities

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Irish Human Rights and Equality Commission

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