MHC
Colmlsiun 'Meabhatr-Sh tnte | Mental Health Commtsslori

Senator Paul Coghlan
Chair
Seanad Public Consultation Committee
Seanad Eireann
Leinster House
Kildare Street
Dublin 2

21 June 2017

Re: Children's Mental Health in Ireland

Dear Senator Coghlan,

As agreed upon in the email of 25th April 2017, due to the tight deadline, The Mental Health Commission submitted a preliminary executive response to Seanad Public Consultation Committee on 12 May 2017.

The new Commission reviewed the preliminary response at its first business meeting on 30 May 2017 and are resubmitting, with amendments to the Seanad Public Consultation Committee.

Yours sincerely,

Patricia Gilheaney
Chief Executive

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Mental Health Commission Submission

Seanad Public Consultation Committee

Children's Mental Health in Ireland

Mental Health (Amendment) Bill 2016

1. Introduction

1.1 The Mental Health Commission (the "Commission") is an independent statutory body established pursuant to Section 32 of the Mental Health Act 2001 (the "2001 Act"). The principal functions of the Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interest of persons detained in approved centres[1] .

1.2 The Commission regulates the provision of inpatient mental health services through inspections carried out by the Inspector of Mental Health Services and the registration, ongoing monitoring and enforcement by the Commission. The Commission has published a range of codes of practice for the guidance of persons working in mental health services[2] including a Code of Practice relating to the Admission of Children under the 2001 Act[3]. The Code provides guidance in relation to admission of children (voluntary and Involuntary), treatment and leave (with and without permission).

1.3 The Commission, since its establishment, has been unwavering in its view that children should be admitted to age appropriate facilities.

1.4 Certain provisions of the 2001 Act apply to children and it is in this context that the Commission welcomes the invitation to comment on the Mental Health (Amendment) Bill 2016.

2 Children and the Mental Health Act 2001

2.1 The principles underpinning the 2001 Act are enshrined in Section 4. Section 4 refers to a "person" and as such is applicable to a child. Section 4 relates to making a decision under the Act concerning care and treatment. Section 4(1) states that the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made. Subsection (2) provides for the statutory duty in relation to any proposal to administer treatment to a person, to properly notify such person of that proposal and to take due account of their representations before making any decision in that regard. Subsection (3) further states that in making a

[1] An approved centre is an in-patient facility that provides care and treatment to a person suffering from a mental illness or mental disorder that is entered on the Register of Approved Centres established and maintained by the Mental Health Commission.

[2] In accordance with Section 33(3)(e) Mental Health Act 2001.

[3] Mental Health Commission (2006) Code of Practice Relating to Admission of Children and Addendum (2009) under the Mental Health Act 2001.

decision concerning care and treatment of a person due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy.

2.2 Section 23(2)(3)(4) makes provision for the detention of a child who is a voluntary patient in an approved centre but whose parents (or those acting in loco parentis) indicate a wish to remove the child but the child is still suffering from a mental order.

2.3 Section 25 of the 2001 Act makes provision for the involuntary admission in certain circumstances of children suffering from a "mental disorder".

2.4 Section 3 of the 2001 Act defines "mental disorder". This legal definition applies equally to children. Mental disorder means mental illness, severe dementia or significant intellectual disability where because of the aforementioned condition, there a serious likelihood of the child concerned causing immediate and serious harm to himself or herself or others. If the harm component is absent the definition of mental disorder can still be met if the severity of the condition has severely impaired the judgement of the child and failure to admit the child to an approved centre would be likely to lead to a serious deterioration in his or her condition, or would prevent the administration of appropriate treatment that can only be given if the child is admitted and, the reception, detention and treatment of the child would be likely to benefit or alleviate the child's condition to a material extent.

2.5 Involuntary admission of a child is only possible by way of a District Court Order pursuant to Section 25 of the 2001 Act. Section 25(14) of the 2001 Act refers to provisions of the Child Care Act 1991 that apply to proceedings under Section 25 of the Act. Such sections relate to procedural matters that are taken into consideration when an application under Section 25 of the Act is made to the District Court.

2.6 Section 26 of the 2001 Act relates to the procedure for granting permission to a person (patient or child) for absence with leave

2.7 Section 27 of the 2001 relates to measures which an approved centre can take if a person (patient or child) is absent without leave.

2.8 Section 29 of the 2001 Act provides for the voluntary admission of a person (including a child) to an approved centre.

2.9 In summary, the sections of the 2001 Act that relate to the admission of a child are - Sections 23 (2)(3)(4) (power to detain a child who is voluntary from leaving an approved centre), Section 25 (involuntary admission), Section 26 (absence with leave), Section 27 (absence without leave) and Section 29 (voluntary admission).

3. Report of the Expert Group on the Review of the Mental Health Act 2001[4]

3.1 The Commission actively engaged in the Review of the Mental Health Act 2001. It was presented on the Steering Group established in August 2012. In addition, members of the Commission's Legislation Committee met with the Chair of the Expert Group. Following publication of the Expert Group Report (the "Report") the Commission

[4] Department of Health (2015) Report of the Expert Group on the Review of the Mental Health Act 2001. Stationery Office: Dublin.

considered the recommendations therein and submitted further views to the Department of Health.

3.2 The Report contains 165 recommendations. Recommendations 111 to 123 inclusive relate specifically to children and are as follows:

111. Provisions relating to children should be included in a standalone Part of the Act and any provisions of the Child Care Act 1991 which apply should be expressly included rather than cross referenced.

112. Child should be defined as a person under 18 and thus brought into line with the Children Act 2001.

113. Dedicated Children's Part of the Act should stipulate the following guiding principles:
   a. Every child should have access to health services that aim to deliver the highest attainable standard of child mental health.
   b. The autonomy and self-determination of the child should be respected insofar as practicable in conjunction with parents or persons as required acting in loco parentis.
   c. There must be consultation with the child at each and every stage of diagnosis and treatment with due weight given to his/her views consistent with his/her age, evolving capacity and maturity and with due regard to his/her will and preferences.
   d. Services should be provided in an age-appropriate environment wherever possible.
   e. Services should be provided in close proximity to family and/or carers wherever possible.
   f. The child must receive the least intrusive treatment possible in the least restrictive environment possible.
   g. Where there is an intervention on behalf of the child, his /her best interests most be taken into account, and 'best interests' must be defined in a way that is informed by the views of the child, bearing in mind that those views should be given due weight in accordance with his/her age, evolving capacity and maturity and with due regard to his/her will and preferences.

114. Children aged 16 or 17 should be presumed to have capacity to consent/refuse admission and treatment.

115. For an admission of a 16 or 17 year old to proceed on a voluntary basis, the child therefore must also consent or at least must not object to his/her voluntary admission.

116. Where a 16 or 17 year old objects, the case should then be referred to a child friendly District Family law Court which can determine whether the child has the necessary maturity or capacity to make an informed decision. If the Court determines that the child has the necessary maturity and capacity, admission may only proceed on an involuntary basis by order of the Court. Where the Court determines that the child does not have the necessary maturity and capacity then voluntary

admission may proceed with the consent of the parents or person as required-acting in loco parentis.

117. The Group acknowledges that there should be no automatic presumption of capacity for children under the age of 16.

118. In the case of a child under the age of 16, voluntary admission should only take place where the parents or person as required acting in loco parentis consents, however the views of the child must be heard by parents and service providers and given due weight in accordance with the child's evolving capacity and maturity.

119. Admission and renewal orders for the involuntary detention of a child (under 18) should continue to require a Court Order and require justification that it is used as a last resort.

120. The requirement to notify the Mental Health Commission of information relating to admission and discharge of children should be elevated to primary legislation.

121. Advocacy services to children and to the families of children in the mental health service should be available.

122. Gardai (for clarity purposes) should be given the specific power to remove a child believed to be suffering from a mental illness satisfying the criteria for detention to a place where an age appropriate assessment can be performed and admissions should only be made to an age appropriate approved centre.

123. Places to which children are taken for such assessments should fulfil certain specific criteria (e.g. availability of child and adolescent psychiatry) and that relevant stakeholders are available, involved and informed (Gardai, parents, etc.). Also, certain locations may be inappropriate in this regard (e.g. a care home from which a child has absconded).

3.3 The Commission in particular wishes to note -

3.3.1 Recommendation 111 - the provisions of the Childs Care Act should not only be expressly set out in the legislation but the mechanics of how they are to operate should also be addressed.

3.3.2 Recommendations 114/115 - they need to be considered in relation to the Non-fatal Offences against the State Act and subsequent case law that has commented in it applicability.

3.3.3 Recommendation 122 - this is akin to Sections 13 and 27 of the 2001 Act.

3.4 The Commission, in its submission on the Report to the Department of Health,[5] indicated its support of the provisions in relation to children, many of which are innovative and highlight in particular, placing the child or young person in a more central position in the process of admission, care and treatment and in doing so adhering to their human rights standards. The Commission also stated that

[5] Submitted to Department of Health on 6 August 2016.

further attention needs to be paid in revised mental health legislation to the human rights of children.

3.4 The Commission, also made reference to the response of the Committee for the Convention on the Rights of the Child (the Committee). The Committee monitors implementation of the Convention on the Rights of the Child by its State parties. The Committee in its response to Ireland in February 2016 referred to the following:

(a) The lack of comprehensive legislation on children's consent to and refusal of medical treatment, particularly in mental health services;
(b) Children being admitted to adult psychiatric wards due to inadequate availability of mental health facilities for children;
(c) Long waiting lists for access to mental health support and insufficient out of hours services for children and adolescents with mental health needs, particularly eating disorders;
(d) The lack of child-focussed advocacy and information service for children with mental health difficulties.

The Committee recommended that Ireland must,

(i) Enact legislation that explicitly and comprehensively provides for children's consent to and refusal of medical treatment, and ensure that this legislation is in line with the objectives of the Convention and encompass clear recognition of children's evolving capacities.
(ii) Undertake measures to improve the capacity and quality of its mental health services for children and adolescents; in doing so, Ireland should prioritise strengthening the capacity of its mental health services for in-patient treatment, out -of-hours facilities, and facilities for treating eating disorders;
(iii) Consider establishing a mental health advocacy and information service that is specifically for children, and accordingly accessible and child-friendly.

3.5 The Commission is of the view that whilst improving the capacity and delivery of mental health services is appropriately placed in revised national mental health policy, it is clear that an opportunity is presented in the drafting of revised mental health legislation to incorporate the points raised by the Committee.

4. Comments on Mental Health (Amendment) Bill 2016.

4.1 The Commission notes that the title introducing the Bill states the following:

> "An Act to provide that all children must be admitted to child appropriate inpatient psychiatric units and providing that no child shall be admitted to an adult psychiatric inpatient unit (voluntarily or involuntarily) save in exceptional circumstances where such admission is in the child's best interests."

The Commission welcomes the policy intent of the Bill as it places in primary legislation the Commission's view as specified in the Code of Practice Relating to the Admission of Children (the Code) that was issued pursuant to Section 33(3) (e) of the 2001 Act in 2006, with a further Addendum in 2009. The Code states[6] that *the admission of a* child to *a unit* in *an approved centre providing care and treatment* to *adults is undesirable*

[6] Mental Health Commission (2009) Code of Practice Relating to Admission of Children under the Mental Health Health 2001: Addendum, p. 2. MHC: Dublin.

and may be detrimental to *the child.* In exceptional circumstances where there is no available alternative, such an admission may be necessary. In arriving at such a decision, due consideration of the risks to the child of not admitting him or her, and the potential adverse effects of such an admission, should be made.

4.2 It is worth noting that Section 2.5 of the aforementioned Code of Practice[7] specifies provisions that should be in place if approved centres for adults are used of necessity in exceptional circumstances. It is suggested that provisions akin to those specified in the Code should be considered for elevation to primary legislation.

4.3 It is noted that the Bill as currently drafted proposes to amend Section 14 of the 2001 Act to achieve the intent specified in the title. The Commission does not believe that the proposed amendment achieves the policy intent.

4.4 Section 14 relates to adults only. It applies in relation to *"a person (other than a child)"* who is the subject of an application (Section 9) and a recommendation (Section 10). It provides for the completion of an admission order for such a person by a consultant psychiatrist ifs/he is of opinion that the person concerned is suffering from a mental disorder. Therefore this does not appear to be the appropriate place to make such an amendment.

4.5 As stated in paragraph 2.4 above, Section 25 of the 2001 Act deals with the involuntary admission of a child, which is only possible by way of a District Court order. Therefore if an amendment was made it should be included in this section of the Act.

4.6 Furthermore, the draft amendment would appear to provide conflicting provisions in relation to detention of a child.

4.7 In relation to the actual wording of the draft amendment -

4.7.1-14A.(1) - the wording "...who is detained either voluntarily..." is a contradiction. It should say "...who is involuntarily detained either..." and the second "...involuntarily..." in the sentence can then be deleted.
4.7.2 -14A.(1) - uses of number 18 and 14A.(2) uses the word eighteen - you may wish to amend for consistency.
4.7.2-14A.(2)- refers to "exceptional circumstances". We agree with this and it appears to reflect what is in the MHC's Code. However, we believe that more detail is required.

4.8 Careful consideration of the various provisions relevant to children is required. The Commission suggests that the recommendations in the Expert Group report in relation to mental health legislation pertaining to children are implemented at the earliest opportunity.

4.9 The introduction to the Explanatory and Financial Memorandum makes reference to the number of children admitted to approved centres for adults as taken from Commission Annual Reports. It is worth noting that in the Annual Reports the Commission advises that the number of admissions does not equate to the number of children admitted. A child may be admitted on more than one occasion and to more than one approved centre over the course of a reporting year. In the absence of a unique patient identifier,

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it is not possible for the Commission to accurately report on the number of children admitted nationally in a reporting year.

5. Child Admission Data

5.1 Changes over time in child admission data is provided below:

(a) In 2016, 66% of child admissions[8] to adult units were 17 years of age; 22% were 16, and 12% were 15 and under. Therefore 88% of the children that were admitted to adult units were 16years or over and if they required care and treatment for physical illness it is unlikely that they would receive such treatment in a paediatric facility.

(b) The proportion of total child admissions to adult units:
2016: 1 in 7
2015: 1 in 4
2007: 2 in 3

(cl Number of adult units that admitted children:
2016: 19 adult units
2007: 32 adult units

(d) Number of child units and child beds:

Year	Number of child units	Number of registered beds
2016	6	102 (92 operational)
2011	6	70
2008	3	28

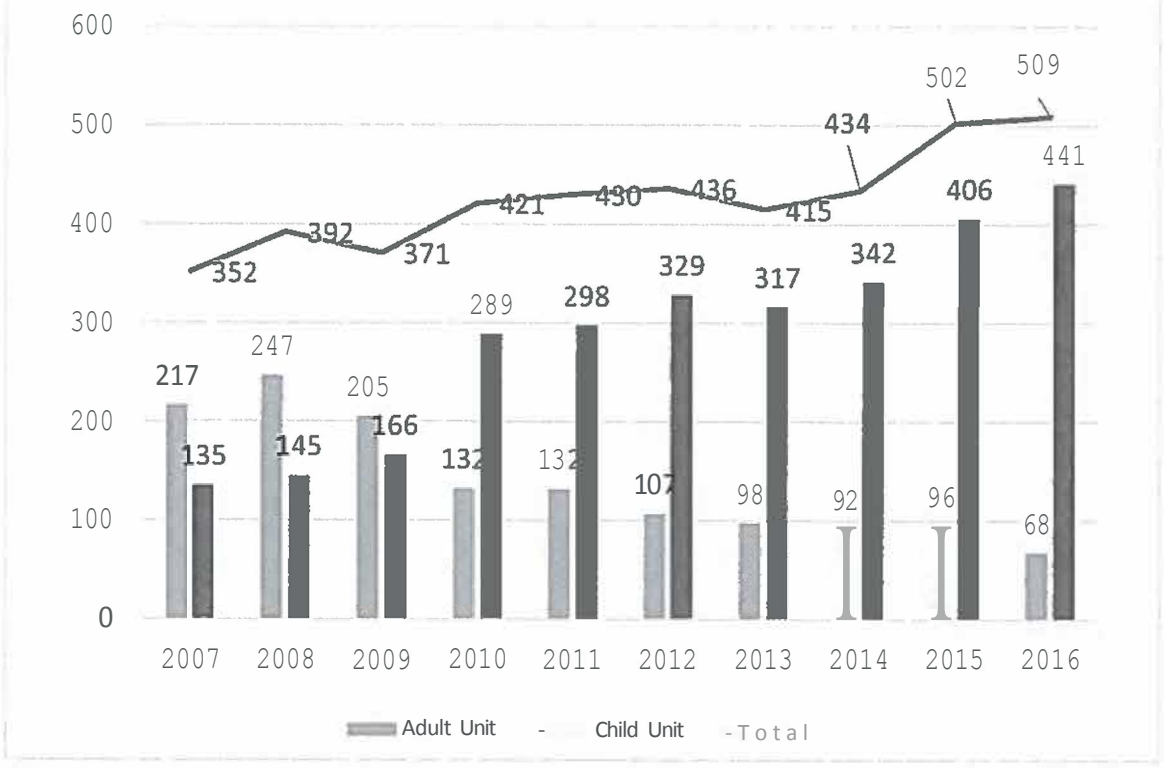
(e) Average duration of admission to adult units:

2016: 6 days
2011: 11 days

(f) Percentage of admissions to adult units that resulted in discharge and admission to child unit when bed became available:
a. 2016: 35%
b. 2014: 24%
c. 2011: 9%

(g) Child admissions by unit type (adult or child) from 2007 to 2016 is provided below:

[8]The number of admissions does not equate to the number of children admitted. A child may be admitted on more than one occasion and to more than one approved centre over the course of a reporting year.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Adult Unit
Child Unit
Total