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coimisiun meabhair - shláinte
mental health commission

Statement to the Joint Committee on Disability Matters

8 December 2022

Introduction

On behalf of the Mental Health Commission (the MHC), I would like to thank you for the opportunity to address the Committee today. I am joined by my colleagues Dr. Susan Finnerty, Inspector of Mental Health Services, Orla Keane, General Counsel for the Commission and lead for tribunals (DSS) and Gary Kiernan, Director of Regulation for the Commission.

The MHC is an independent statutory body established in April 2002 under the provisions of the Mental Health Act 2001 as amended. The principal functions of the MHC 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 interests of persons detained in approved centres.

The remit of the MHC was extended by the Assisted Decision-Making (Capacity) Act 2015 (the 2015 Act) which provides for the establishment of the Decision Support Service (the DSS). The DSS will support decision-making by and for adults with capacity difficulties and will regulate individuals who are providing support to people with capacity difficulties. The 2015 Act will establish a modern statutory framework to support decision-making by adults who have difficulty in making decisions without help. The Director of the DSS recently attended before this Committee on 10 November 2022 to outline the work done to ensure that the DSS is ready for commencement once the Act to amend the 2015 Act is passed and commenced.

The MHC would like to refer to a report entitled Mental Health and Human Rights by the UN High Commissioner for Human Rights dated 31 January 2017 dealing with issues of mental health and to refer the Committee to the following paragraph which the Commission fully endorses:

"Valuing mental health *21. In the context of health, the concept of parity of esteem refers to valuing mental health equally with physical health.[32] From a normative standpoint, the framework which establishes the right to health does not create a hierarchy where mental health is ranked lower than physical health. The strong relationship between physical and mental health calls for an approach which accords equal value to both and yet a lack of parity of esteem, where preferential consideration is given to physical health, remains the dominant perspective. Consequently, among other discrepancies, fewer financial and human resources are allocated for mental health and many mental health facilities tend to be dilapidated, with lower hygiene standards and fewer amenities. There are also significant data and research gaps in mental health, particularly in relation to the identification of the human rights situation of persons with mental health conditions and users of mental health services, and the impact of policy measures."*

The MHC has identified the following key areas which need to be addressed in order for mental health to receive parity with physical health and to ensure that a rights-based approach informs all aspects of mental health care.

1. Effective implementation of Sharing the Vision – A Mental Health Policy for Everyone.

Sharing the Vision (STV) is Ireland's national mental health policy to enhance the provision of mental health services and supports across a broad continuum from mental health promotion to specialist mental health service delivery during the period 2020-2030. This policy in tandem with reformed mental health and safeguarding legislation creates a significant opportunity for change and reform of Ireland's Mental Health Services in accordance with the principles set out in the UNCRPD.

The Department of Health, HSE and the National Implementation and Monitoring Committee (NIMC) are collectively responsible for driving and overseeing the implementation of the national mental health policy. The purpose of the NIMC is to drive reconfiguration, monitor progress against outcomes and deliver on the commitments set out in the Policy. The NIMC works with partners to evaluate performance, check overall progress and gather information on examples of good practice as informed by national and international research.

The MHC does not have oversight of the changes being brought about by the new strategy. Our current remit is to register and inspect inpatient approved centres and ensure a robust mental health tribunal process is in place.

While STV recognises that "people with disabilities, including mental health difficulties, often experience numerous barriers to employment and housing" it's recommendations, while relevant, may not go far enough in protecting the rights of people with enduring mental health difficulties who may be misplaced in inpatient or residential services. It is therefore necessary to ensure wider safeguarding and legislative mechanisms are in place for the protection of human rights.

2. Reform of the Mental Health Acts 2001 – 2018

The MHC continues to call for the urgent reform of the Mental Health Acts 2001 –2018. There is a need for much broader regulation of mental health services. Reform in this area along with reform of the regulations made under the Act will expand regulatory protections beyond inpatient facilities and will reinforce and improve existing protections for people who use mental health services.

The MHC received the draft Heads of Bill to amend the MHAs in July/ August 2019 and made comprehensive submissions to the Department of Health (DOH) in March and June 2020.

The MHC adopted a practical, person-centred and rights-based approach when making its Submissions. The Commission also emphasised parity of physical and mental health as an underpinning principle.

The MHC recommended:

- **Extension of the MHC regulatory remit to all community residential centres and services**. The aim is to have more people treated in the community rather than as inpatients but to do that community mental health teams need to be available, resourced and regulated to ensure that they are meeting the standards required to include those of the UNCRPD including Article 25 which requires that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.
- **Comprehensive amendments to Part 4 of the MHAs / Heads of Bill – Consent to Treatment.** The Commission provided direct advice on how the Act should deal clearly with issues of capacity and consent to address the changes in the law, societal norms and to comply with the relevant conventions (UNCRPD). Key amongst those amendments was that the assumption that sections 85(7) and 136 of the 2015 Act would be repealed / amended to allow all those involuntarily detained to have full access to the provisions of the 2015 Act; and
- **A new Part of the Act to deal with Restrictive Practices**, as the Commission considered it inappropriate that restrictive measures were included in Part of the 4 of the MHAs, which deal with issues related to treatment. Furthermore, the Commission recommended that each of the areas of restraint be separately addressed – Seclusion and Mechanical Restraint, which are addressed in the MHAs and Physical restraint and Chemical restraint / pharmacological restraint, which are not currently addressed in any legislation. The Commission has also recently reviewed its Rules and Codes on Restrictive Practices but unfortunately not all of the desired changes could be made due to the current legislation. However, when the MHAs are amended the current Rules and Codes, will be further revised updated to reflect all of the desired changes.

The recommendations above are reflected in the Scheme that was published in July 2021

In relation to the **involuntary detention of persons** under the MHAs, Ireland has one of the most robust systems in Europe to support those involuntarily detained and to ensure their rights are vindicated. However, more can be done and the Commission made a number of recommendations in its March 2020 Submissions and subsequently to include – agreeing to the reduction of the involuntary admission period from 21 to 14 days, consideration of only 3 month renewal orders, supporting the move that all applications for involuntary admission be made by authorised officers with no applications to be made by An Garda Síochána, that persons should not be brought to garda stations and if brought that there be strict time periods for action to be taken, that those bringing a person against their will to an approved centre be the subject of review by a mental health tribunal (which shall become a review board), involving the other members of a person's clinical team in the admission / renewal process (nurse, social worker, psychologist), supporting applications by the person to transfer to another facility, greater oversight in relation to applications to transfer to the Central Mental Hospital (given the waiting lists) and expanding the remit of the Circuit Court so people have easier access to justice.

However, for the above to be achieved, the DOH needs to commence work on the Bill and priority needs to be given to this by the Government. Minister Butler confirmed to this Committee that priority will be given to the drafting of the Bill in Q1/2 2023. We would urge

this Committee to support Minister Butler in ensuring that priority is in fact given to drafting this Bill and thereafter resources are allocated to ensure that the proposed provisions can be implemented.

3. **Congregated Settings**

The right to community-based mental health services, expressly recognised in Article 19 of the UNCRPD, has significant implications for the organisation of mental health services. It implies that:
(a) all persons with disabilities have the right to live in the community, choose their place of residence and have access to residential and domiciliary services as well as other community services
(b) States should facilitate the inclusion and full participation in the community of persons with disabilities
(c) community services and facilities for the general population should also be available for people with disabilities

Since 1984, the process of "deinstitutionalisation" in Ireland has led to developing supported accommodation services to enable people with mental health problems to live in the community instead of large psychiatric hospitals. A range of provisions were developed, including residential facilities that are staffed 24 hours a day. It was anticipated that once the housing needs of the cohort of former long stay hospital service users has been catered for, the requirement for the current level of 24-hour high support accommodation would decrease. This has not been the case.

In 2018 a national review of 24-hour supervised residences for people with mental illness was conducted by Dr Susan Finnerty. 8592_MHC_2018 Inspection_24hr.indd (mhcirl.ie)
She found that little progress had been made in addressing the rights of people with mental illness who live in 24-hour supervised community residences, a significant proportion of residences had 10 or more beds (43%).

The policy of housing people with mental illness in such facilities has continued, with the number of people residing in them remaining relatively stable over many years, currently around 1,200 people live in these settings. National policy stated that these residences should have a maximum of ten places to foster a non-institutional environment. In 2022, this is not considered in line with best practice. The HSE's own report – Time to Move on from Congregated Settings A Strategy for Community Inclusion Report of the Working Group on Congregated Settings (June 2011) – states that community houses for people with disabilities should have no more than four residents with their own rooms.

Many of these residences have multi-bed rooms, often with no privacy between beds. These residences accommodate people who have not received appropriate rehabilitation services at the appropriate time early in their treatment and who have now been "re-institutionalised" in these settings.

4. **Rehabilitation and Recovery**

Recovery is about people experiencing and living with mental health challenges in their lives and the personal goals they want to achieve regardless of the presence of those mental health issues. This recognises their right to create a good life, make a home, engage in meaningful work or learning and build good relationships with family, friends and people in their community. In 2019, the Inspector met many people who provide rehabilitation services on the ground for those marginalised and disabled by their enduring mental illness. In all instances, she was impressed by the dedication, creativity, inter-agency collaboration and the hard work that these staff members demonstrated in under-resourced and difficult circumstances. She also spoke with people with enduring mental illness who were frustrated and angry with their lack of progression to more independent living and who were stuck in a system that was not meeting their needs.

The MHC recognises the work of many community specialists in the HSE and community and voluntary sector. However, the MHC has no powers to regulate these services and so oversight and facts are sparse. The community rehabilitation team in Cavan/Monaghan is an example of good practice. It is a well-established team that is relatively well staffed in comparison with other areas nationally. Its staff are trained in therapies that are appropriate to the needs of the people with severe and enduring mental illness. There are many initiatives and linkages with other support services that are of assistance to the recovery of their client group. The team is not fully staffed; however, it has made use of the resources available to it, for example, in the use of multi-task attendants to provide practical support.

At that time of the Inspectors review, there were 23 rehabilitation teams across Ireland, 48% of that recommended by national policy. Of those teams, none were staffed to recommended levels. Many areas had no access to rehabilitation services, leaving people with enduring mental illness no prospect of reaching their full potential, attaining employment or education, a satisfying social and community life, or living in suitable housing with appropriate levels of support.

The Inspector also noted that, the provision of out of area specialist rehabilitation placements as a quick fix solution to delayed discharges contravenes best practice, has been proved to be detrimental for people in other jurisdictions and is unacceptable.

The new Model of Care for People with Severe and Enduring Mental Illness and Complex Needs is an opportunity to provide a service which is based on best practice, and to provide a care pathway for each person with severe and enduring mental illness. This would mitigate the prospects for these people remaining in continuing care or overly supported accommodation, with the consequent de-skilling and increased institutionalisation that this brings. Other people are left with families, often with ageing parents, who cannot provide the support and care needed. A small but significant number of people remain in inappropriate acute inpatient care, unable to move to community living due to the lack of provision of rehabilitation services. Because of the unmet need for rehabilitation, many

people with enduring mental illness have repeated admissions to inpatient psychiatric units, are then discharged, to be readmitted when things breakdown again – the so-called revolving door of admissions. In the long-term, this is counterproductive for both the person with enduring mental illness and the already severely under-resourced acute services.

5. **Statutory Safeguarding**

The MHC strongly supports a rights-based approach to safeguarding and recognises that people requiring care and treatment can be vulnerable to abuse and to not having choice and autonomy. MHC is calling for urgent reform of the safeguarding structures and mechanisms in place. At the policy level, it is unacceptable that people who use disability and older persons' services receive a service and protection from HSE adult safeguarding teams yet people in mental health services do not have access to this service.

At a legislative level, in contrast to the established statutory arrangements in place for children there is a stark lack of legal protection for adults who may be at risk of abuse, including institutional abuse. The MHC is calling for a legislative framework for safeguarding based on the principles of the UNCRPD in order to introduce appropriate legal mechanisms for adult safeguarding. The MHC will continue to work with the Department of Health to advance work which has begun in this area. As an immediate measure the MHC is calling for reform of the current HSE safeguarding mechanisms to ensure that mental health receives the same service as other sectors .

We have requested that our powers are extended to include regulation of community services. This is anticipated to occur once the revised mental health act comes through the Oireachtas and is commenced.

6. **Physical Environment**

The Convention on the Rights of Persons with Disabilities (Article 28 Adequate standard of living and social protection) recognises the right of persons with disabilities to an adequate standard of living for themselves and their families, including adequate food, clothing and housing, and to the continuous improvement of living conditions, and responsible persons shall take appropriate steps to safeguard and promote the realization of this right without discrimination on the basis of disability.

Many buildings are unsuitable as mental health facilities with multioccupancy rooms, lack of personal and private spaces and cramped bedrooms and living areas. These conditions compromise service user safety as well as the dignity and privacy for the service user. It also indicates a lack of good governance and lack of funding for maintenance, structural improvements, and new buildings.The MHC has repeatedly highlighted concerns in respect of the regulation on premises where average national compliance rates over the last 5 years are 35%. The HSE have responded, with some new builds in the last 3-4 years having single en suite bedrooms in modern spacious facilities which are located close to communities and other services. However, a targeted national capital plan is key to solving this issue. A clear national costed funded plan would provide significant improvements in the care outcomes for people who use services.

7. **Governance and Alignment with UNCRPD**

As the Committee has heard, every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others. This is expressly stated in the United Nations Convention on the Rights of Persons with Disabilities, UNCRPD. The Commission is passionate about seeking an end to the discrimination, stigmatisation and lack of parity for those with mental health difficulties.

In terms of the discussion before this Committee about the requirements to ensure compliance with UNCRPD, the Commission believes that following are three key pieces of legislation to be considered –

- Assisted Decision-Making (Capacity) Act 2015 (2015 Act) and the Amendment Bill
- Mental Health Acts 2001 – 2018 (MHAS) and the General Scheme to the MHAs
- Protection of Liberty Safeguards on which the Department of Health has recommenced work and on which the MHC is willing to assist where it can

<u>2015 Act</u>

The Amendment Bill to the 2015 Act passed the final stage on 29 November 2022. It is expected it be passed into law before the end of this year with commencement early next year. The Commission, via the DSS team, is ready for commencement and is anxious to get started with this important work.

To ensure parity for those with mental health issues under the 2015 Act, the Commission raised as far back as 2018 their concerns about sections 85(7) and 136 of the 2015 Act (see Appendix 1) which provide that the provisions of the 2015 Act will not apply to persons involuntarily detained under the MHAs insofar as their mental health is concerned. (It is important to note that this does not impact on decisions with regard to their physical health but this itself highlights the lack of parity.) This matter became critical late in 2021 / early 2022 when the 2015 Act as amended was due to be passed and commenced mid 2022 but this issue had not been addressed. The matter was escalated to the Board of the Commission, which resulted in a series of correspondence with the Department of Children, Equality, Disability, Integration and Youth (DCEDIY) and then with Minister O'Gorman. The Commission's position was and is still clear - the lack of parity for those involuntarily detained is unacceptable. The Commission acknowledges that there was movement on the issue in that now only those detained on what is referred to as the "risk ground" (section 3(1)(a) of the MHAs) will not be entitled to access to the 2015 Act with regard to mental health matters. The Commission has been informed that this is based on advice from the Attorney General's Office and the matter will need to be further addressed in the Amendment Bill to the MHAs. Therefore, while the MHC / DSS wants to commence the 2015 Act as soon as possible, it is also aware that until this matter and related matters are addressed there will not be full compliance with UNCRPD.

There is one further matter which the Commission would like to address. It relates to the report from the Sub-Committee on Mental Health Report on Pre-Legislative Scrutiny (PLS) of the Draft Heads of Bill to Amend the Mental Health Act 2001 - Report on Pre-Legislative Scrutiny of the Draft Heads of Bill to Amend the Mental Health Act 2001 (oireachtas.ie) Specifically we wish to refer to **Recommendation 2** which stated that the Sub-Committee 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 Commission would note the UNCRPD does not include the term psychosocial disabilities. On 1 July 2016, the Human Rights Council adopted resolution 32/18 on mental health and human rights. In the resolution, the Council requested the High Commissioner to prepare a report on the integration of a human rights perspective in mental health and the realization of the human rights and fundamental freedoms of persons with mental health conditions or psychosocial disabilities, including persons using mental health and community services, and to submit the report to the Human Rights Council at its thirty-fourth session. The Council specified that the report should identify existing challenges and emerging good practices, make recommendations in that regard and identify means of strengthening technical assistance and capacity-building. The Council were deeply concerned that persons with mental health conditions or psychosocial disabilities, in particular persons using mental health services, may be subject to, inter alia, widespread discrimination, stigma, prejudice, violence, social exclusion and segregation, unlawful or arbitrary institutionalization, overmedicalization and treatment practices that fail to respect their autonomy, will and preferences. The UN High Commissioner produced a report dated 31 January 2017 and in the report defines persons with psychosocial disabilities : *Three different categories should be clearly distinguished among those referred to in resolution 32/18: persons using mental health services (who are current or potential users of mental health and community services); persons with mental health conditions; and persons with psychosocial disabilities, namely, persons who, regardless of self-identification or diagnosis of a mental health condition, face restrictions in the exercise of their rights and barriers to participation on the basis of an actual or perceived impairment* (and the groups may overlap). Therefore, the Commission would not fully agree with the Recommendation of the PLS Report in that the terms mental illness and mental disorder will require to be retained in certain circumstances in the MHAs and that the term psychosocial disabilities may also be required in other circumstances.

Finally, as other attendees have informed the Committee, Ireland is one of few remaining EU member states that has not ratified the **optional protocol** to the UNCRPD. This is the mechanism that allows disabled people to take complaints to the UN. The State must also seek to ratify the optional protocol without delay and without any caveats in relation to those with mental health issues.