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# Opening Statement to the Oireachtas Sub-Committee on Mental Health –

# Pre-legislative Scrutiny on the General Scheme of the Mental Health (Amendment) Bill

**22nd March 2022**

Good morning and thank you for the invitation to discuss the current General Scheme of the Mental Health (Amendment) Bill 2021.

I am Dr Lorcan Martin, Vice President of the College of Psychiatrists of Ireland and a Consultant Specialist in General Adult Psychiatry. Accompanying me and representing the College today are Dr Imelda Whyte, Consultant Specialist in Child and Adolescent Psychiatry, Dr Atiqa Rafiq, Consultant Specialist in Later Life Psychiatry and Dr Norella Broderick, Senior Registrar in Learning Disability Psychiatry.

The College of Psychiatrists of Ireland is the sole accredited training, education and professional body for Psychiatry in Ireland, representing over 1,000 psychiatrists (both specialists and trainees) across the country. The mission of the College is to promote excellence in the practice of Psychiatry in all its components - training for doctors to become specialists in psychiatry, lifelong continuous professional education and advocacy for evidence-based standards of care in mental health services in order to achieve a fit for purpose contemporary service for Irish people.

The primary legislation, (though obviously there are other pieces of legislation), governing the delivery of mental health services in Ireland is the Mental Health Act 2001 which focuses primarily, though not exclusively, on the management of patients who are admitted for treatment involuntarily.

As you are aware, one of the necessary reasons to review and revise this act is to update the legislation to bring it in line with Human Rights, including the United Nations Convention on the Rights of Persons with Disabilities (or UNCRPD), and for it to be compatible with the, yet to be fully commenced, Assisted Decision Making (Capacity) Act and with other relevant Irish Legislation. The College actively supports such review and revision.

While the rights to autonomy and dignity are fundamental, so too is the right to person-centred, evidence-based care, and to the timely access to such care. This includes support for mental health challenges and distress *and* for treatment of mental illness and disorders. Similarly, families and carers have the right to expect timely and appropriate treatment for their loved ones and those in their care.

We believe the current draft Heads of Bill, while going further to incorporate human rights principles into mental health legislation, has gone so far as to now potentially prevent seriously ill people from getting the treatment they urgently need.

We note agreement with many issues and concerns highlighted by our colleagues in the IMO and IHCA who presented to you on the 8th February 2022.

## People treated involuntarily under the 2001 Act

I would like to draw your attention to some figures, if I may. In 2020, just over fifteen thousand people were admitted to psychiatric units or hospitals. Just under two and half thousand of these were involuntary admissions, of which just under nine hundred and fifty were first time admissions.

These people, by definition, represent the most seriously ill. By far the biggest number in this group had diagnoses of schizophrenia, schizoaffective and delusional disorders (1,098). Followed by this are other serious illnesses - mania and severe depression. All of these conditions, whether it is a first or recurrent episode, are best managed by early and comprehensive intervention, and by specialist treatment, ~~to~~ maximise the potential for recovery, restore function and optimise quality of life for the person. While specialist, community-based treatments are sufficient for most people attending mental health services, this group of people with severe illness and more complex needs require a much greater level of support and care to manage life changing mental illnesses, and this unfortunately may include involuntary admission.

Detailed reports with data are available. However, these figures represent very real people, with very real illnesses and very real suffering. Consequently, it behoves us all to alleviate that suffering and treat illness in whatever way is necessary.

**Concerns**

As you are aware, such are members' concerns that the current draft Bill will deny patients and people treatment and care, that the College held an EGM recently, which is unusual. We also surveyed our full membership and the results indicate the same concern (a summary of the results has been provided to the committee).

Eighty percent of survey respondents believe that the proposed revisions would impact on their ability to treat patients effectively. Seventy percent believe that the proposed revisions will have negative implications for families, because it will increase barriers to care for those who have concerns about mental illness in their relatives.

Over seventy percent of respondents believe that the proposed revisions will increase their workload, increase burnout, and impact further on the already major issue of staff recruitment and retention in psychiatry. Over sixty percent of those surveyed believe that the revisions will increase risk to staff on inpatient units which would very likely impact staff recruitment and retention in this environment.

Committee members already have our detailed submission provided to the Department of Health which outlines the specific parts of the draft Heads of Bill we believe are not tenable, require further examination, explanation and/or reasoning.

**Some of the specific issues and concerns around unintended consequences of proposed revisions are as follows:**

**1. Increased risks for patients, families and society**

The current Mental Health Act allows detention on the ground of presence of mental disorder and either presence of risk and/or need for treatment. The proposed revised criteria state that admission must be "immediately necessary for the protection of the life of the person, for protection from serious threat to the health of the person and the protection of others".

We argue that this will increase the risk to patients and families, as the proposed revised Mental Health Act cannot now be used until there is already a serious risk present.

Families and health professionals who are familiar with the person can detect early signs of relapse - which is unfortunately sometimes accompanied by lack of insight in the patient. This allows for families and health professionals to begin to seek treatment for them before the inevitable progression of the illness. However, serious mental illness (such as psychosis or bipolar disorder), under the proposed revisions, will need to be advanced to the point where there is a risk to life or health before treatment can commence. There is simply no other illness where doctors have to wait for a patient to deteriorate to a life-threatening state before treatment can be initiated. Furthermore, sometimes individuals can be severely mentally unwell with an inability to function. However, if they do not seek treatment themselves, they will go untreated indefinitely, unless they present with a serious immediate risk. The stipulation that someone with severe mental illness who lacks capacity cannot access treatment unless they pose a serious threat to themselves or others is also, we believe, stigmatising for mentally ill patients.

A core feature of all illness is the impact it has on functioning, no more so than severe mental illness. It is well recognised that untreated mental illness will cause the person to be increasingly less able to socially function, potentially leading to homelessness, substance misuse and imprisonment. This is one of, if not, the main driver behind Mental Health Legislation - to ensure that those who are unable to function and have impaired capacity due to severe mental illness have a safety net. Those with severe mental illness also disproportionately account for those who are homeless or in prison. The removal of this safety net will only increase this, and further

marginalise those with severe mental illness. This finding has been well recognised since the 1930s and is referred to as Penrose's Law where, as the number of psychiatric inpatients go down, the number of prisoners go up.

A clear example that strikes me is that although there are many remarkable sights in San Francisco, sadly one of these is the number of psychiatrically unwell homeless individuals, whose right to health and treatment is not being met.

## 2. Delays in patients accessing treatment

Currently, the application for detention in hospital under the Act can be initiated by a range of individuals including family members, emergency department staff, or members of An Garda Siochana. There was also provision for applications to made by individuals designated as "Authorised Officers" but this was only used in the minority of cases due to the difficulty accessing such authorised officers. The draft Heads of Bill now states that *only* authorised officers can initiate an application. We have a number of concerns about this which include:

a) Some services do not have access to any authorised officers. In the remainder of the country, there are insufficient numbers of authorised officers to provide 24/7, 365 days cover.
b) The cost implications of having sufficient authorised officers are significant. Additionally, it is likely that there will be marked difficulties recruiting such individuals.
c) Families will no longer be in a position to make an application, even though they may be the ones who know the person best, be best placed to identify early warning signs of relapse quickest, and may wish to be involved as much as possible in the care of their loved one.

## 3. Increased pressure on Irish Mental Health Services with negative consequences for patients

The revised proposals make considerable additional demands on consultant specialist time, which will have obvious knock-on effects on patient care. Based on the survey of our members, the impact on consultant time is estimated to be an additional 6 plus hours per week, which will lead to cancellation of clinics and increases in waiting times. This is, as you know, is in already stretched and overburdened services where we struggle to provide the support and care people deserve. Currently there are circa 485 approved specialist consultant posts, but more than 100 of those are unfilled or do not have a specialist in them. We need more than 835 consultant specialist psychiatrists by 2028, based on current and projected demand, and in the meantime between 276 and 350 will retire, or leave the services, over the next 10 years. Half of our current consultant psychiatrists are over the age of 50. The proposed new Act in its current form will be a significant disincentive to psychiatrists taking up posts in this jurisdiction. Quite simply, we are training doctors to leave.

The main aspects of the proposals that will impact on consultant time are as follows:

a) The current 2001 Act specifies that Mental Health Tribunals (which will be renamed Mental Health Review Boards) take place within 21 days of the commencement of the detention. However, under the proposed revisions, the Review Boards will take place within 14 days. This will inevitably result in more consultant time being taken up with the administrative work associated with more frequent and more numerous Review Boards. Time spent in Review Boards is time *not spent* in outpatient clinics, on ward rounds or supervising junior staff. And most importantly, it is unclear what benefit will be gained by the patient with this change.

b) Review Boards will take place at a time dictated by the Mental Health Commission to suit the panel - not, as in the present situation, where the time and day of the Review Board is agreed between the consultant and the Mental Health Commission. It will be extremely challenging to reschedule clinics if the Review Boards are scheduled at the same time as outpatient clinics. This will further affect the ability to prioritise working with our patients, which is after all why we become doctors.

## 4. Adverse impact on safety in inpatient units

College members have expressed concerns about safety on inpatient units resulting from significant restrictions (punishable by fines and convictions and potential criminal record) for the management of agitated patients (both voluntary and involuntary). No behavioural management of any type will be allowed on voluntary patients and, if it is necessary to detain such patients, then no treatments are allowed in the period during which the application process is taking place (which could take 12 hours). Should a voluntary patient become agitated on an inpatient ward, which is a common occurrence, there will now be very serious risks to other patients and staff, as staff will no longer be able to provide treatments which were previously possible while the application process is taking place.

A further concern among members is the current proposed provision criminalising breaches of the Mental Health Commission regulations relating to seclusion and restraint.

First, the threshold for the use of seclusion or restraint should be clearly set out in the parent legislation. As it stands under the draft Heads of Bill the Commission seems to have the power to make any changes it wishes to the use of seclusion and restraint. It is important to have this clearly defined as a matter of policy in the legislation. The regulations as developed by the Commission, then, deal with matters such as record-keeping and documentation, frequency of clinical review during an episode of seclusion etc. These are not matters properly within the purview of the criminal law.

A separate matter is the misuse of the power to initiate or continue seclusion or restraint. Any offence relating to the abuse of this power should be clearly set out in the primary legislation, and should include a requirement to show malicious intent or intention to misuse seclusion or restraint.

## 5. Admission of children to approved inpatient facilities

The Act currently provides important protections for children in care and subject to Court Orders. The new draft Bill is silent in relation to these vulnerable children, leaving them without the protections afforded to them currently.

The new draft Bill allows for children to be brought directly to approved inpatient facilities by An Garda Siochana. This is not in a child's best interest. Just because a child is presenting in crisis, this does not mean they have a mental illness. They require appropriate assessments, including medical, in an appropriate setting.

Thank you for your time today and for your consideration of our views of what is a complex piece of legislation but which, we believe, is seriously flawed. In its current iteration, it will make it harder for psychiatrists to do their jobs, exacerbate the current recruitment and retention crisis and – and this is most important of all – make it more difficult for seriously ill patients to be treated and return to their lives and their loved ones. My colleagues and I represent some of the varied specialties in Psychiatry and, between us, we treat people from early childhood through to late old age. We are all deeply passionate about providing the best possible outcomes for those in our care and it is for this reason that we have such concerns about the proposed amendments to the Mental Health Act.

We will be happy to answer your questions and provide any further explanation you require.