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Public Consultation on the Update of the Mental Health Act

Psychiatric Nurses' Association

PUBLIC CONSULTATION ON THE UPDATE OF THE MENTAL HEALTH ACT

Introduction:

The Psychiatric Nurses' Association (PNA) welcomes the opportunity to comment on the Review of the Mental Health Act 2001. As the professional representative body representing primarily psychiatric nurses, nurses working within intellectual disability services and general nurses working in specialist practice areas, we often submit and make representation on strategic developments which will have impact both for service users and our members. In this regard we are happy to offer our observations and general comments.

However, we wish to view the draft Heads of Bill and respectfully request same to add further comment and engagement.

We also wish to make comment on the resources that will be required to meet the provisions of the Mental Health Act, it is our view existing resources are insufficient to deal with the Act and the mental health budget will require a substantial increase. Currently the ability to provide comprehensive service to individuals, families, and those most vulnerable is somewhat challenged.

Although there is an undeniable need for adequate funding for the proper provision and implementation of the Act, there is equally an urgent need to match this level of funding in the delivery of mental health services. The right to treatment is as critical as the right to freedom.

4.1 Definitions

The Expert Group recommended that we change definitions in the Act:

• Replace 'mental disorder' in the Act with 'mental illness'. The Expert Group recommended this to separate the definition of mental illness from the reasons for detention.

'mental illness means a complex and changeable condition where the state of mind of a person affects the person's thinking, perceiving, emotion or judgment and seriously impairs the mental function of the person to the extent that he or she requires treatment.

• Remove 'significant intellectual disability' and 'severe dementia' from the Act. The Expert Group recommended this so that a person cannot be detained for only having dementia or an intellectual disability.

Agreed: This does not preclude the involuntary admission of persons with intellectual disabilities or severe dementia to approved centres because of mental illness and where they also meet the criteria for detention.

• Update how treatment is defined in the Act. The Expert Group recommended this so that. the definition of treatment includes tests, and that treatment applies to all people in approved centres.

:Recc 7 Treatment should include ancillary tests required for the purposes of safeguarding life, ameliorating the condition, restoring health or relieving suffering.

Recc 8. The definition of treatment should be expanded to include treatment to all patients admitted to or detained in an approved centre.

Recc 9. Treatment should be clearly defined in revised mental health legislation and clinical guidelines should be further developed for the administration of various forms of treatment.

Recc 10. Traditionally the focus of treatment was on the administration of medication, the Group would like to make it clear that treatment includes a range of psychological and other remedies and where treatment is specifically mentioned in this report, it should be interpreted in its wider sense and not viewed simply as the administration of medication.

Recc 11. The provision of safety and/or a safe environment alone does not constitute treatment.

Agreed Recc 7 – 11

• Add a new definition of 'voluntary patient'. The Expert Group recommended that a person.

who is voluntary should have the capacity to consent or refuse being admitted to an

approved centre.

Mental Health Amendment Act 2018 NOT COMMENCED: the substitution of the following definition for the definition of 'voluntary patient': "'voluntary patient' means a person who— (a) has capacity (within the meaning of section 3 of the Act of 2015), (b) has been admitted to an approved centre, and (c) has given consent to his or her admission.".

• Include a new category of patient. The Expert Group recommended that a third category be

included in the Act for people who need mental health treatment in an approved centre.

These people do not have the capacity to consent to treatment, but they do not need to be

involuntarily detained.

Agreed: Recc 26 – 33

26. The Group recommends a new category of patient known as 'intermediate' who will not be detained but will have the review mechanisms and protections of a detained person. Such patients would not have the capacity to consent to admission and equally do not fulfil the criteria for involuntary detention.

27. The Mental Health Commission must be informed of the initial and ongoing admission of this category of patient.

28. The same timeframe recommended for Mental Health Review Boards for involuntary patients should also apply for intermediate patients.

29. The role of the Review Board for this cohort of patient must focus on the question of capacity as, by definition intermediate patients will not fulfil the criteria for detention.

30. A detailed set of guidelines should be produced for this category of patient and the Mental Health Commission and the Office of Public Guardian should have a role in this regard.

31. The Group recommends that it would be appropriate for a Consultant Psychiatrist to have the authority to override a refusal of treatment by a decision-making representative in emergency circumstances where treatment is deemed necessary, and the person's actual behaviour is injurious to self or others and no other safe option is available.

32. A decision to override a refusal of treatment by a decision-making representative should be subject to review by a Mental Health Review Board which would convene within 3 days to decide if the situation presenting to the Consultant Psychiatrist fulfils the criteria for emergency circumstances. If the Review Board agrees that the circumstances were of an emergency nature, then the treatment authorised by the Consultant Psychiatrist may continue for as long as the emergency circumstances prevail subject to other provisions relating to second opinions etc.

33. Advance healthcare directives should apply for this category of patient on the same basis as that proposed for voluntary patients.

Question: what changes to definitions do you want to see in the new Mental Health Act?

Answer: We have some concerns that the removal of Severe Dementia and Intellectual Disability could inadvertently have converse consequences to the intention of such new definitions. In our experience it has been the case that where an individual with Severe Dementia / an Intellectual Disability has been admitted to an Acute Mental Health Unit for treatment of mental disorder there have been occasions whereby the service from which the individual originally came (nursing home / residential facility) have refused to take that individual back. Other concerns in this area surround the Assisted Decision-Making (Capacity) Act 2015. In this regard we are of the view that the Capacity Legislation must be commenced prior to changes to the Mental Health Act and therein will lie resource implications in order to safeguard those with Severe Dementia and Intellectual Disability. Noting that there a very small number of community intellectual disability teams in this jurisdiction with no day hospitals or specialist inpatient beds.

We wish also to make comment in respect of the category Intermediate patient in respect of admissions to Acute services whereby an individual presents with a dual diagnosis of mental health issues and substance abuse. Such individuals very often do not have capacity albeit temporarily at that time to consent to treatment. The issue arises whereby such individuals are presented to an acute unit by An Gardai (usually at night-time) without prior medical assessment. At present such individuals until assessed remain the responsibility of An Gardai – the question our members have posed is where does the responsibility lie in relation to this category of patient (Intermediate) until such an assessment can take place to ascertain admission. At present there are not sufficient resources within Acute services to safeguard such an individual should they be presented in a distressed state as set out above.

4.2 Guiding principles

The Expert Group recommended that we include a new set of guiding principles in the Act to replace the principle of 'best interests. These new principles will empower people to make decisions about their own mental health care and treatment. The Mental Health (Amendment) Act 2018 introduced guiding principles to the Act for adults and for children. We are looking at how to include guiding principles in the new Mental Health Act.

Mental Health Amendment Act 2018 NOT COMMENCED: Guiding principles to apply in respect of adults.

3. The Principal Act is amended by the substitution of the following section for section 4:

"4. (1) Where it is proposed to make a decision in respect of a person the subject of the decision under this Act, the person shall, so far as is reasonably practicable, be notified of the proposal and entitled to make representations in relation to it and before deciding the matter due consideration shall be given to any representations duly made under this section.

(2) The principles specified in subsections (3) to (11) (in this Act referred to as the 'guiding principles') shall apply in respect of the making of a decision.

(3) It shall be presumed that a person in respect of whom a decision is being made has capacity in respect of the matter concerned unless the contrary is shown in accordance with the provisions of the Act of 2015.

(4) A person shall not be considered as unable to make a decision in respect of the matter concerned unless all practicable steps have been taken, without success, to help him or her to do so.

(5) A person shall not be considered as unable to make a decision in respect of the matter concerned merely by reason of making, having made, or being likely to make, an unwise decision.

(6) There shall be no decision taken in respect of a person unless it is necessary to do so having regard to the individual circumstances of that person.

(7) A decision taken in respect of a person shall—

(a) be made in a manner that minimises—

(i) the restriction of the person's rights, and

(ii) the restriction of the person's freedom of action,

(b) have due regard to the need to respect the right of the person to dignity, bodily integrity, privacy, autonomy,

(c) be proportionate to the significance and urgency of the matter the subject of the decision, and

(d) have due regard to the need to have access to health services that have as the aim of those services the delivery of the highest attainable standard of mental health as well as the person's right to his or her own understanding of his or her mental health.

(8) Notwithstanding the generality of subsection (1), in making a decision—

(a) the person in respect of whom the decision concerned is being 4[2018.] Mental Health (Amendment) Act 2018. [NO. 10.] S.3 made shall be permitted, encouraged and facilitated, in so far as is practicable, to participate, or to improve his or her ability to participate, as fully as possible, in the decision,

(b) effect shall be given, in so far as is practicable, to the person's past and present will and preferences, in so far as that will and those preferences are reasonably ascertainable,

(c) account shall be taken of—

(i) the beliefs and values of the person (in particular those expressed in writing), in so far as those beliefs and values are reasonably ascertainable, and

(ii) any other factors which the person would be likely to consider if he or she were able to do so, in so far as those other factors are reasonably ascertainable,

(d) unless the person making the decision in respect of the person concerned reasonably considers that it is not appropriate or practicable to do so, he or she shall consider the views of any other person named by the person as a person to be consulted on the matter concerned or any similar matter,

(e) the person making the decision shall act at all times in good faith and for the benefit of the person in respect of whom the decision is being made, and

(f) the person making the decision shall consider all other circumstances of which he or she is aware and which it would be

reasonable to regard as relevant to the making of the decision concerned.

(9) In making a decision, the person making the decision in respect of the person concerned may consider the views of—

(a) any person engaged in caring for the person,

(b) any person who has a bona fide interest in the welfare of the person, or

(c) any other healthcare professionals.

(10) In the case of a decision in respect of a person who lacks capacity, regard shall be had to—

(a) the likelihood of the recovery of the person's capacity in respect of the matter concerned, and

(b) the urgency of making the decision prior to such recovery.

(11) In making a decision, the person making the decision—

(a) shall not seek to obtain information that is not reasonably required for making a decision,

(b) shall not use information for a purpose other than in relation to a decision, and

(c) shall take reasonable 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 believes it is no longer required.

(12) Section 4 shall not apply to a person who at the time of the decision is a child.

(13) In this section—

'capacity' has the same meaning as it has in section 3 of the Act of 2015;

'decision', means, in relation to a person, a decision under this Act concerning the care or treatment of the person (including a decision to make an admission order in relation to the person)."

Question: what guiding principles do you want to see in the new Mental Health Act?

Principle 1: Respect for the dignity of the person of The Code of Professional Conduct and Ethics 2014 Nursing and Midwifery Board of Ireland (NMBI)

Provides for:

"In exceptional circumstances - such as emergencies where a patient lacks capacity - consent to treatment or care is not necessary. A nurse or midwife may treat the person when it is immediately necessary to save their life or to prevent a serious deterioration in their condition and there is no advance refusal of treatment".

Whilst this principle is in keeping with that of the Expert Group it also highlights the necessity for nurses to treat an individual to save life in this regard mental health legislation has the difficult role of protecting the right of patients to autonomy and sometimes providing the mechanism to lifesaving treatment

4.3 Criteria for detention

The Expert Group recommended that we change reasons for involuntarily detaining a person to make sure that a person is not involuntarily detained just because they have a mental illness. The Expert Group recommended that a person should not be involuntarily detained just because the person is at risk of harm to themselves or others. Involuntary detention and treatment has to benefit the person and help them get better. A person should not be involuntarily detained just because they have different views or behaviour from other people.

Reccs 12-15

12. Detention of a person with a mental illness cannot be permitted simply by virtue of the fact that the person may have such an illness or because his or her views or behaviour deviate from the norms of the prevailing society.

13. The recommended new criteria for detention are:

a. the individual is suffering from mental illness of a nature or degree of severity which makes it necessary for him or her to receive treatment in an approved centre which cannot be given in the community; and

b. it is immediately necessary for the protection of life of the person, for protection from a serious and imminent threat to the health of the person, or for the protection of other persons that he or she should receive such treatment and it cannot be provided unless he or she is detained in an approved centre under the Act; and

c. the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit the condition of that person to a material extent.

14. Detention should only be for as long as absolutely necessary and the person continues to satisfy all the stated criteria.

15. Immediately a person no longer satisfies any one of these criteria, the admission or renewal order must be revoked. In those circumstances, the person may only remain in the approved centre on a voluntary basis or receive the required services which are provided in the community.

Question: should we change the reasons for involuntary detention?

The words immediately and imminent in section 13b are of concern to the PNA. We state this on the basis similar to previous point that involuntary admission must occur in the context that the patient can access appropriate care if required. By including such adjectives places an additional burden for both the individual and clinicians and are subjective in terms of timeframes and risk assessment. We also wish to highlight the term "material extent" on the basis of what definition of material extent is suggested in the context of detention to an approved centre.

4.4 Authorised Officers

The Expert Group recommended that Authorised Officers should be the only people allowed to make an application for involuntary detention. Authorised officers are HSE staff members who can make an application for involuntary detention. When a person is taken into Garda custody, an Authorised Officer should be the person to assess whether the person needs to go into hospital for mental health care. Increasing the numbers of Authorised Officers is included in the Programme for Government.

34 The Group recommends that there should be a more expanded and active role for Authorised Officers where involuntary admissions to an approved centre are being considered. This new role can lead to more appropriate and least restrictive treatment for individuals in community or other mental health settings and bring a greater focus on involuntary admission being a treatment of last resort.

36. The Group recommends that an Authorised Officer should be the person to sign all applications for involuntary admission to an approved centre (this also includes change of patient status in an approved centre from voluntary to involuntary – see section 2.17 on Change of Status for details). This will have the effect of reducing the burden on families/carers in these difficult circumstances and reducing the involvement of Gardaí in the admission process.

41. Where a person is taken into custody by the Gardaí under section 12 of the Act, the initial assessment, whether that is by the Authorised Officer or the Registered Medical Practitioner, should take place as soon as possible after the person is taken into custody. The maximum period which the person can be held prior to being assessed by the Authorised Officer or Registered Medical Practitioner should be 24 hours. A second 24-hour timeframe in which both the Authorised Officer and the Registered Medical Practitioner must carry out their assessments commences once the first such assessment is initiated.

Question: should Authorised Officers be the only group allowed to make an application for involuntary detention?

Psychiatric Nurses are and can become Authorised Officers and play a valuable role in in the admission process as experienced mental health professionals they provide a considered and holistic approach to patient care having regard to matters of risk assessment, family liaison and treatment modalities. However, this will require adequate resourcing to mitigate long waiting times and enable proactive response times, this will require detailed consideration as to whether the resources are best served in this way or indeed the provision of Crisis Response Teams as outlined in Vision For Change throughout the country fully staffed again serving a fundamental role in prevention and community treatment towards recovery. We do not believe Authorised Officers should be the only people allowed to make an application for involuntary detention.

In regard to recommendation 36 part 2 in brackets …..*The Group recommends that an Authorised Officer should be the person to sign all applications for involuntary admission to an approved centre (this also includes change of patient status in an approved centre from voluntary to involuntary – see section 2.17 on Change of Status for details).* We are not in agreement to this change.

We also believe as previously outlined there should be 24/ 7 crisis teams which would reduce the number of out of hour admissions with strong linkages made to An Gardai similar to the Serenity[1] Integrated Mentoring Model (SIM) UK , in that regard there is a role for Authorised Officers on such teams, which have the dual effect of (a) reducing the burden on families/carers in these difficult circumstances and reducing the involvement of Gardaí in the admission process and also provide a wrap around supportive model of care supplemented by crisis cafes outlined in Sharing the Vision 2020

4.5 Interdisciplinary approach to care and treatment

The Expert Group recommended that mental healthcare workers (other than doctors) should be more involved in the mental health care and treatment of people. For example, a doctor should ask another mental healthcare worker for their opinion before involuntarily detaining someone.

Question: should other mental healthcare workers play a bigger role in the mental health care and treatment of people?

Agreed It is our belief that the most appropriate mental health professional in this regard is the Clinical Nurse Manager in Charge of the acute unit.

4.6 Changing timeframes

The Expert Group recommended that we should reduce the length of time a person is involuntarily detained before being reviewed by a tribunal. It also recommended that we limit Section 26 leave to 14 days. Section 26 leave means when the doctor responsible for a person in an approved centre can grant permission to leave the approved centre for a set period of time. The Expert Group recommended that we shorten the period that medicine can be given to a person who does not have capacity when they are involuntarily detained from 3 months to 21 day.

[1] Serenity Integrated Mentoring (SIM) | AHSN Network

Recc 70. The provisions of Section 26 regarding permission to be absent from an approved centre for a specified period should be retained with greater clarification being provided in a Code of Practice (to be developed by the Mental Health Commission) which would outline the precise circumstances in which such provisions can be used. The time limit for such absences should be a maximum of 14 days and they should not be used as quasi-community treatment orders.

96. The recommendation to continue the administration of medicine every three months must be made by the treating Consultant who must also consult with another Mental Health Professional of a different discipline involved in the treatment of the patient and this must be officially recorded. The recommendation to extend the administration of medicine every three months must also be authorised by a second Consultant Psychiatrist from outside the centre.

Question: should we reduce the length of time in any of the cases above?

Whilst we are broadly in agreement with the shorter timeframes in the main, we feel it appropriate we highlight the significant resource implication this will require, and ultimately mental health budgets will have to increase to facilitate such changes in timescales.

Regarding the matter of Recc 70 section 26, we as an organisation are on the record that Government should examine the concept of Community Treatment Orders CTO's (mandatory outpatient treatment) in certain clearly defined situations , as a response for some persons with serious and persistent mental illnesses, who are treatment resistant , meet risk assessment standards and have not benefited from voluntary participation in mental health services if specific legal rights and safeguards are provided in mental health legislation.

Government policy on mental health, advocates the provision of treatment and care in the community and specifies that home-based treatments should be the main method of treatment delivery (Vision for Change 2006 Sharing the Vision 2020). In a survey on the location of treatment, 41% of patients who had been admitted involuntarily would have preferred to have been treated in their home (B. O 'Donoghue et al., 2010). This preference was more marked among those with an affective disorder and those who had experienced their first admission.

The inclusion of CTO's would allow clinicians to supervise patients to comply with their drug /medicines regime and return them to the approved centre if required for their therapeutic benefit. This would allow for a phased discharge for the individual with the proper safeguards in place for supervising the individual and a more appropriate mechanism for referral back to the centre in this regard than currently exists. Some of the literature describes better relations between families and patients or enhanced social contacts; reduced levels of violence and self – harm and earlier identification of patients' relapse (Dawson 2005).

Regarding Recc 96 we believe consultation with another Mental Health Professional must be with a professional who has completed Pharmacological training as part of the primary professional degree / qualification i.e., a Psychiatric Nurse/ Pharmacist.

4.7 Enhancing safeguards for individuals.

The Expert Group recommended that we improve safeguards for people receiving mental health

care and treatment, by:

• Updating the section on seclusion and restraint to limit when a person can be secluded or restrained

• Remove section 73, so that people can now bring civil cases to the High Court about their mental health care and treatment.

Question: how should we improve safeguards for people receiving mental health care and treatment?

In respect of answering this question having regard to the section on Consent to Treatment laid out in the report of the Expert Group and Concerns in this area surround the Assisted Decision-Making (Capacity) Act 2015. In this regard we are of the view that the Capacity Legislation must be commenced prior to changes to the Mental Health Act. In addition, we have not seen the draft Heads of Bill, we are also mindful that both the Mental Health Commission and the HSE as a main provider have also submitted, and without sight of such inputs / the dialogue surrounding same we are reserving comment but willing to engage with legislative changes at all stages.

4.9 Change of status from voluntary to involuntary

The Expert Group recommended that a person should not have to ask to leave an approved centre. before the process of changing their status from voluntary to involuntary begins. The Expert Group recommended that changing status from voluntary to involuntary should follow the same process as someone coming from the community who is involuntarily detained.

Recc 79: The Group also agrees that it should no longer be a requirement that a patient must first indicate a wish to leave the approved centre before the involuntary admission process is initiated. The Act should also be amended to specifically allow that process to be initiated in such cases in the approved centre in line with the recent High Court ruling on this matter (Judgement of KC v Clinical Director of St. Loman's Hospital).

Agreed We do have concerns regarding access to Authorised Officers and as previously discussed should not require an Authorised Officer.

4.10 Capacity

The Expert Group recommended that a person's capacity to make their own decisions should be included in the Mental Health Act. A capacity assessment should be carried out if a mental healthcare worker thinks a person might lack capacity to make decisions. The Mental Health Commission should make rules on capacity assessments. A person's capacity to consent is important for admission and for treatment. The 165 recommendations were published before the Assisted Decision-Making (Capacity) Act 2015 was introduced into law.

We are looking at how to introduce the issue of capacity in the Mental Health Act, in line with the principles of the Assisted Decision Making (Capacity) Act 2015. This includes providing supports to people so that they can make their own decisions.

Reccs 17 – 21

Recommendations:

17. If on admission of a patient, the admitting Mental Health Professional forms the view that the person may lack capacity to understand and give his/her informed consent to the proposed admission, they must refer the person for formal capacity assessment to be completed within 24 hours. The patient will be required to remain in the approved centre until such time as a capacity assessment is carried out.

18. The Mental Health Commission should develop and publish guidelines in relation to the assessment of capacity. Capacity assessment can be undertaken by Mental Health Professionals with the required competencies and such competencies should be accredited by the respective professional bodies who should provide support and training where required. The guidelines should also draw attention to the possibility that external factors such as 'institutional influence' can have a bearing on how people react to proposals or questions put to them.

19. Capacity should be monitored on an ongoing basis by the treating clinicians.

20. If following the capacity assessment, it is deemed that a person has capacity to admit themselves, a voluntary admission may proceed. If it is deemed that they need support to understand, to make, or to convey their decision, that support must be provided to assist in the voluntary admission process. If it is deemed that they do not have capacity in relation to this decision, and the person has a mental illness they may only be admitted on an involuntary basis provided they satisfy all the criteria for detention. A person who lacks capacity and has a mental illness but does not fulfil the criteria for detention, may in specified circumstances be admitted as an 'intermediate' patient.

21. Where relevant, information relating to how capacity is assessed and the right of appeal against a decision on their capacity to a Mental Health Review Board should be given to patients. In addition, they, and their family or carers if appropriate, should also be given information relating to the supports that may be available to the individual under the proposed capacity legislation.

Question: how should we introduce capacity to the Mental Health Act?

The discussion of Capacity in the recommendations of the Expert Group 2014 without commencement of the Assisted Decision-Making Capacity Act 2015 is limited, and any revised discussion surrounding the Mental Health Act will need to be compatible to the 2015 Act.

4.11 Consent to treatment

The Expert Group recommended that: All people receiving voluntary treatment should be allowed to refuse treatment at any time,

• All people receiving involuntary treatment who have capacity to make decisions should be

able to refuse treatment,

• Consent for treatment is required from all individuals who have capacity to make decisions,

If a person lacks capacity, they should be given supports to make decisions,

• Treatment refusal can only be overridden in cases where the treating doctor thinks treatment is necessary to protect the person's life or health, or for the protection of other people,

• People should be allowed to make advance healthcare directives,

• The length of time medicine can be given before getting consent from a person who does not have capacity should be reduced from 3 months to 21 days.

The Mental Health (Amendment) Act 2015 already introduced some of the recommendations of the Expert Group to update the Mental Health Act. The word 'unwilling' was removed in the Mental Health Act in the sections on Electro-Convulsive Therapy and administration of medicine.

Question: what changes to consent to treatment should we make?

In respect of answering this question having regard to the section on Consent to Treatment laid out in the report of the Expert Group and Concerns in this area surrounding the Assisted Decision-Making (Capacity) Act 2015. In this regard we are of the view that the Capacity Legislation must commence prior to changes to the Mental Health Act. In addition, we have not seen the draft Heads of Bill, we are also mindful that both the Mental Health Commission and the HSE as main provider have also submitted, and without sight of such inputs / the dialogue surrounding same we are reserving comment but willing to engage with legislative changes at all stages.

4.13 Inspection, regulation, and registration of mental health services

The Expert Group recommended that the Mental Health Commission should inspect and register residential and community mental health services. It recommended that registration and inspection of approved centres should happen every three years instead of every year. The Commission should be allowed to request a report from approved centres on how well they comply with mental health rules and regulations.

Recc 124. The Group recommends the registration and inspection at regular intervals of the following mental health services:

- Phase 1: Continue to register approved centres and inspect at least once in every three years and more often according to targeted risk. Disagree – Timeframe Too Long

- Phase 2: Register all community mental health teams and inspect against an increasing proportion of the services provided in the community.

- Phase 3 Register all High, Medium and Low Support Hostels; Crisis/Respite Houses; any other Residential Services; Day Hospitals, Day Centres and other facilities in which mental health services are provided and introduce inspections. on a phased basis.

Having regard to phases 2 & 3 we would like to have some understanding as to where such services will sit in terms of Registration with the Mental Health Commission and the Judgement Support Framework.

Members have articulated that services in this regard are underdeveloped and lacking in terms of policy Vision for Change 2006 and Sharing the Vision 2020. Colleagues articulated in response to this section that the "principle of therapeutic benefit "be included within the Act – as going some way to advocate for comprehensive services delivered in a way that minimises the requirement for Acute admission and advances choice and autonomy for individuals by providing alternative models of care, opportunities for early intervention with timely access within the community 24/7.

4.14 Provisions related to children.

The Expert Group made a number of recommendations in relation to children:

• A new standalone part of the Act for children,

• We should define a child as a person under 18 years of age,

• We should include a set of guiding principles for children,

• We should allow children aged 16 and 17 years of age to refuse or consent to their

admission and treatment,

• We should update the process of admission for children,

• Children and their families should have access to advocacy services.

Reccs 111- 123

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. Agreed

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

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 must 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. Gardaí (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 (Gardaí, parents, etc.). Also, certain locations may be inappropriate in this regard (e.g. a care home from which a child has absconded)

Question: what do we need to provide for in a new Part of the Act on Children?

Although the implementation of the Mental health Act 2001 has, in theory placed responsibility for 16- and 17-year-olds with child and adolescent services, in practice many general adult psychiatry

services have continued to cater for this group, pending the establishment of adequate child and adolescent services CAMHS .

Children who require mental health interventions, services and supports are seriously out of step with need. There is limited availability of the appropriate range of services – those in primary care, community care, in-patient centres, day centres, rehabilitation services and outreach services to provide support in the home and school. Children and Adolescents are still struggling with an outdated, fragmented system which causes children their carers and staff, moral distress and anguish.

The PNA have been campaigning for years for more resources for Child and Adolescent Mental Health Services (CAMHS) acknowledging if the child or adolescent is treated appropriately and in a timely fashion it may prevent a lifetime of reliance on Adult Mental Health Services, similar to our response at 4.13.

The rights of the child should mirror that of the adult as far as practicable. The Act does not support an independent review of children receiving enforced treatment or detention.

The Law Reform Commission [2] has recommended that a mental health tribunal (with an age-appropriate focus) rather than the District Court should review the admission and treatment of children and young people as involuntary patients for the purposes of the Act. Moreover, the Act should provide similar procedures for the involuntary admission of children and young people as apply in the case of adults, including, for example, obtaining a report by an independent psychiatrist. The role of parents/guardians in the process should also be clarified. The Act should also provide that both the treating consultant psychiatrist who makes the involuntary admission or detention order and the independent psychiatrist should have specialist training in Child and Adolescent psychiatry. It is imperative that the proceedings be appropriate for children and young people in accordance with Article 12 CRC.

Appropriate and mandatory procedural rules need to be put in place for tribunal hearings involving the involuntary admission and detention of children and young people under the Act similar to "conference proceedings" outlined in the Child Care Act 2001 in respect of care orders and also in accordance with the requirements of the CRC. The MHC recommended in its 2008 Report on the Act that increased emphasis be given to the rights of children by making it mandatory that children detained under the 2001 Act be appointed a legal representative and be offered the services of an advocate." There is also need for clarification as to how a child or young person can appeal a decision to have him or her detained. Adult patients have a right of appeal to the Circuit Court under section.

[2] [2] LRC CP59-2009 Recommendation 7.22