



An Roinn Sláinte  
Department of Health

# **The Deprivation of Liberty Safeguard Proposals: Report on the Public Consultation**

**July 2019**

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## PART I: INTRODUCTION

On 5<sup>th</sup> December 2017 the Government approved the publication for public consultation purposes of preliminary draft Heads of Bill to form Part 13 of the Assisted Decision-Making (Capacity) (ADMC) Act, 2015.<sup>1</sup> On 8<sup>th</sup> December 2017 the Department of Health launched a public consultation on this draft legislation, which was published along with a consultation paper, 'Deprivation of Liberty: Safeguard Proposals', on the Department's website. The views of the public were sought on all aspects of the draft Heads of Bill, as well as on specific questions detailed in the consultation paper, in order to inform the further development of the legislative provisions.

### Methodology

In addition to the publication on the Department of Health's website of the preliminary draft Heads of Bill and consultation paper on 8<sup>th</sup> December 2017, advertisements about the consultation were placed in *The Irish Times*, *The Irish Independent* and *The Irish Examiner*. Responses were also invited from 18 stakeholder-organisations and individuals via email. While the advertised closing date of the consultation process was 9<sup>th</sup> March 2018, submissions were accepted up until 8<sup>th</sup> May 2018.

The draft Heads of Bill are presented in Appendix I and the consultation paper is set out in Appendix II. Further to providing background information on the proposed legislative provisions, the consultation paper details 27 questions pertaining to the 13 draft Heads as well as 3 general questions.

A total of 51 submissions were received (electronically or in hard-copy), of which 37 were from organisations. These organisations include, *inter alia*, state agencies, representative bodies, healthcare providers, academic institutions, advocacy bodies and other voluntary-sector organisations. A list of the organisations from which submissions were received is provided in Appendix III. The responses received from individuals have been anonymised.

### Structure of the report

Comprised of 14 chapters, Part II of the report details the findings of the public consultation.

Chapters 1–13 are correlated with Heads 1–13 of the draft Heads of Bill. Each chapter commences with a brief summary of the provisions of the Head prior to setting out the responses to the questions detailed in the consultation paper. The responses to each question are grouped under sub-headings reflecting the emerging themes. Chapter 14 of the report details the responses to the 3 general questions posed at the end of the consultation paper.

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<sup>1</sup> See <http://www.irishstatutebook.ie/eli/2015/act/64/enacted/en/html>.

Every effort has been made to ensure that the report provides comprehensive coverage of the findings of the consultation. All views expressed by respondents have been noted by the Department of Health.

In this report, the Department of Health does not comment on or evaluate the responses received. Rather the report aims to provide an objective account of these responses.

Part III of the report presents the key findings of the consultation, detailing the views of respondents on which a degree of consensus emerged. It also provides an overview of recent developments which will inform the further development of the deprivation of liberty safeguards and of the next steps which the Department of Health will take to progress the legislation.

## **Policy context**

### **Liberty as a human right**

That liberty is a fundamental human right is well-established. Article 3 of the United Nations' Universal Declaration of Human Rights (1948) states that 'everyone has the right to life, liberty and security of person'<sup>2</sup> – rights that are also enshrined in the Charter of Fundamental Rights of the European Union (2000).<sup>3</sup> As the Office of the Public Advocate, Victoria observes:

International agreements, such as the International Covenant on Civil and Political Rights and the [United Nations] Convention on the Rights of Persons with Disabilities ('[UN]CRPD'), as well as modern human rights legislation, provide express recognition of, and protection for, this right.<sup>4</sup>

Nevertheless, as noted by the U.K.'s Ministry of Justice, liberty is a 'limited right', which means that it 'may be limited under explicit and finite circumstances'.<sup>5</sup>

### **United Nations Convention of the Rights of Persons with Disabilities**

As highlighted in the 'Roadmap to Ratification of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)', published by the Department of Justice and Equality in 2015, legislative clarity on the issue of the deprivation of liberty is required in order to ensure that Ireland meets its obligations under the United Nations

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<sup>2</sup> United Nations, Universal Declaration of Human Rights (1948), [http://www.un.org/en/udhrbook/pdf/udhr\\_booklet\\_en\\_web.pdf](http://www.un.org/en/udhrbook/pdf/udhr_booklet_en_web.pdf).

<sup>3</sup> See European Commission, Charter of Fundamental Rights of the European Union (2000), [http://www.europarl.europa.eu/charter/pdf/text\\_en.pdf](http://www.europarl.europa.eu/charter/pdf/text_en.pdf).

<sup>4</sup> Office of the Public Advocate, *Designing a Deprivation of Liberty Authorisation and Regulation Framework: Discussion Paper* (Carlton, Victoria, 2017), 15, <https://www.publicadvocate.vic.gov.au/our-services/publications-forms/439-discussion-paper-designing-a-deprivation-of-liberty-authorisation-and-regulation-framework-1?path>.

<sup>5</sup> Ministry of Justice, *Making Sense of Human Rights: A Short Introduction* (London, 2006), 3, <http://www.ncuh.nhs.uk/about-us/equality-and-diversity/documents/human-rights-making-sense-human-rights.pdf>.

Convention on the Rights of Persons with Disabilities (UNCRPD), (2006).<sup>6</sup> The UNCRPD was ratified in Ireland in March 2018 and came into effect on 19<sup>th</sup> April 2018. Signifying a shift in attitudes, article 12(2) of the UNCRPD provides that 'persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life'.<sup>7</sup> Article 14 of the UNCRPD ('Liberty and security of the person')

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:
  - (a) Enjoy the right to liberty and security of person;
  - (b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.
2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of the present Convention, including by provision of reasonable accommodation.<sup>8</sup>

## European Convention on Human Rights

In addition to meeting Ireland's obligations under article 14 of the UNCRPD, the deprivation of liberty safeguards must also accord with article 5(1)(e) of the European Convention on Human Rights (ECHR), (1950), which provides that:

Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

[...] (e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants.<sup>9</sup>

Article 5(4) of the ECHR is also pertinent to the legislative proposals, providing that:

Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.<sup>10</sup>

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<sup>6</sup> See

<http://www.justice.ie/en/JELR/Roadmap%20to%20Ratification%20of%20CRPD.pdf/Files/Roadmap%20to%20Ratification%20of%20CRPD.pdf>.

<sup>7</sup> See United Nations Convention on the Rights of Persons with Disabilities, article 12(2), (2006), <https://www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx#12>

<sup>8</sup> See UNCRPD, article 14, <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-14-liberty-and-security-of-person.html>.

<sup>9</sup> Council of Europe, European Convention on Human Rights (1950), 8, [https://www.echr.coe.int/Documents/Convention\\_ENG.pdf](https://www.echr.coe.int/Documents/Convention_ENG.pdf).

<sup>10</sup> *Ibid.*, 9.

However, the terminology of article 5 of the ECHR should be considered in the context within which it was written. The ECHR was decreed by the General Assembly of the United Nations on 10<sup>th</sup> December 1948 in the aftermath of the Second World War. The aim of article 5 is that no one shall be deprived of their liberty arbitrarily. As the Law Society of England and Wales has observed:

As interpreted by the European Court of Human Rights and by the courts in this country, article 5(1) [of the ECHR] has been identified as having three elements, all of which need to be satisfied before a particular set of circumstances will amount to a deprivation of liberty falling within the scope of the article:

- The objective element: i.e. that the person is confined to a particular restricted place for a non-negligible period of time;
- The subjective element, i.e. that the person does not consent (or cannot, because they do not have the capacity to do so) to that confinement;
- State imputability: i.e. that the deprivation of liberty can be said to be one for which the State is responsible.<sup>11</sup>

In the Irish context, effect was given to certain provisions of the ECHR by the enactment of the European Convention of Human Rights Act, 2003, which specifies that the Irish courts should interpret and apply statutory provisions or rules of law in a manner that is compatible with the ECHR's provisions 'in so far as is possible'.<sup>12</sup>

### Assisted Decision-Making (Capacity) Act

The legislative proposals on which the Department of Health consulted have been drafted to form a new part – Part 13 – of the ADMC Act. With the aim of supporting persons who lack decision-making capacity, the ADMC Act provides a statutory framework for individuals to make legally-binding agreements to be assisted and supported in making decisions about their welfare and their property and affairs.<sup>13</sup> As well as supporting assisted decision-making and co-decision-making, the ADMC Act 'sets out new arrangements for wards of court and for people who wish to make an Enduring Power of Attorney', as well as legislating for the establishment of the Decision Support Service (DSS) within the Mental Health Commission 'to provide a range of functions in relation to the new arrangements'.<sup>14</sup> To date, only a limited number of the provisions of the ADMC Act have commenced.

Neither the ADMC Act nor the Mental Health Act (MHA), 2001 provides procedural safeguards to ensure that people are not unlawfully deprived of their liberty in relevant facilities. In developing the legislative proposals, the Department of Health aims to address this gap in the existing legislation.

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<sup>11</sup> The Law Society, *Identifying a Deprivation of Liberty: A Practical Guide* (London, 2015), 13, <https://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/>.

<sup>12</sup> European Convention on Human Rights Act, 2003, section 2, <http://www.irishstatutebook.ie/eli/2003/act/20/enacted/en/print#sec2>.

<sup>13</sup> Citizens Information Board, 'Assisted Decision-Making (Capacity) Act 2015', *Relate* 43/4 (April 2016): 1–8 (1), [http://www.citizensinformationboard.ie/downloads/relate/relate\\_2016\\_04.pdf](http://www.citizensinformationboard.ie/downloads/relate/relate_2016_04.pdf).

<sup>14</sup> *Ibid.*, 1.

## PART II: FINDINGS OF THE CONSULTATION

### Chapter 1: Head 1 – Definitions

Head 1 presents the definitions of the key terms utilised in the proposed new Part of the ADMC Act, 2015 pertaining to the deprivation of liberty safeguards. This chapter details the views of consultation-respondents on the definitions provided.

**Question 1.1: Do you have any views / comments on the definitions currently included in this draft Head?**

#### Definition of ‘admission’ and ‘admission decision’

As indicated in the Explanatory Notes, while the draft Heads do not provide a definition of the ‘deprivation of liberty’, this ‘is captured in the definition of “admission” and “admission decision”, as set out in the box below. (Respondents’ comments on defining the deprivation of liberty are detailed at the end of this chapter under ‘Question 1.3’.)

‘Admission’ in relation to a ‘relevant facility’ means entry to, or residence in, a relevant facility where the relevant person will be under continuous supervision and control and will not be free to leave.

‘Admission decision’ means a relevant decision that a relevant person will live in a relevant facility where he or she will be under continuous supervision and control and will not be free to leave.

#### Respondents’ comments

##### *Language used in the definitions*

- 1.1 A number of respondents call for clarification of the meaning of the phrase ‘not be free to leave’ as well as for the definition of ‘continuous supervision and control’.
- 1.2 Commenting that ‘the inclusion of the [...] terminology “continuous supervision and control and will not be free to leave” is too broad in its application’, Nursing Homes Ireland (NHI) calls for ‘these terms [to] be specifically defined in their own right, particularly what is meant by the word control’. NHI notes that ‘control’ is defined in the *Oxford English Dictionary* as ‘the power to influence or direct people’s behaviour or the course of events’.
- 1.3 The National Advocacy Service for People with Disabilities (NAS) also calls for ‘free to leave’ and ‘continuous supervision and control’ to be defined.



- 1.4 Observing that the definition of ‘admission makes no mention of duration’, an individual respondent notes that:

Nursing homes as relevant facilities admit people for respite, for convalescence and for other reasons such as renovations: some such admissions are time-defined, others less so.

Accordingly, the respondent recommends that, ‘in the interests of clarity, “admission” throughout should become “detention”’.

- 1.5 Highlighting the role of ‘language as a tool of power’, the National University of Ireland, Galway’s Centre for Disability Law and Policy (CDLP) expresses concern that “admission decision” is a euphemism which masks the deprivation of the right to liberty of the person’.

- 1.6 The support and advocacy service, SAGE, observes that:

The terminology used in the Heads of Bill, for example ‘admission decision’ and ‘routine admission’, do not respect the inherent dignity of the relevant person, particularly in the context that the outcome of the decision may result in a deprivation of the person’s liberty.

- 1.7 Observing that the term ‘admission decision’ is commonly used in hospitals, the National Rehabilitation Hospital (NRH) suggests that the proposed usage in the legislation could cause confusion.

- 1.8 The Mental Health Commission (MHC) recommends that, in the definition of ‘admission decision’, ‘the word “relevant” before the word “decision” should be deleted as it is not necessary’ and that ‘the word “live” should be changed to “reside” as all people will reside in a relevant facility but not all of them will live there’.

#### *General comments on the definitions*

- 1.9 The Irish Nurses and Midwives Organisation (INMO) raises concerns about the stated definition of an ‘admission decision’, as that which pertains to individuals who are both under continuous supervision in, and not free to leave, a relevant facility. In respect of this two-fold definition, the INMO comments:

This seems in some senses contradictory, as it may arise that a person is not free to leave, but is not under continuous supervision and control, and the Act would not apply. Therefore, it is recommended that this definition be changed.

- 1.10 Similarly, an individual respondent observes that the definition of ‘admission’ and ‘admission decision’ entails the conflation of

two decisions or possibly three decisions together; the first, the actual admission to a facility; the second, whether the regime will amount to a deprivation of liberty, and thirdly whether the resident will be subjected to

specific restrictive practices such as physical, chemical or mechanical restraint.

Noting that there is a lack of clarity about ‘whether physical restraint or restrictive practices other than environmental restraint will be automatically part of the admission decision’, the respondent recommends that there should

be an additional definition of a restrictive practices decision which will draw attention to the admission being accompanied by planned restrictive practices.

Observing that ‘it would be concerning if persons in charge thought that imposing a deprivation of liberty impliedly authorised the use of restrictive practices’, the respondent suggests that the inclusion of a definition of restrictive practices ‘will encourage the decision-maker to consider whether it will be lawful and proportionate to include such practices’ as well as

assist[ing] HIQA [Health Information and Quality Authority] and persons with lawful authority to identify whether the relevant person [...] lacks capacity to consent to such restrictive practices, whether they were justified in compliance with the least restrictive principle and what review process is in place to review their use.

1.11 Noting that ‘individuals who are voluntarily admitted to approved centres are “free to leave” subject to the provisions of the Mental Health Act 2001’, St. Patrick’s Mental Health Services (SPMHS) opines that ‘the phrase “is not free to leave” is sufficient’ for the definition of ‘admission’.

1.12 NHI observes that:

The acid test referred to within the Supreme Court judgement in the U.K. (‘Cheshire West’) made reference to three elements which must be in place to deprive a person living in residential care of their liberty: 1. The capacity of the person must be in question; 2. They must be under continuous supervision and control; and 3. They will not be free to leave

Accordingly, NHI opines that ‘all three elements must be in place together rather than one or other of these elements at a time’.

1.13 Remarking that ‘a relevant person may lose capacity and be subject to deprivation of liberty after they have been admitted to a particular facility’ or that such a person may ‘require constant supervision within the home environment’ due to ‘advanced dementia or cognitive impairment’, the Citizens Information Board (CIB) contends that:

The term ‘admission decision’ does not adequately describe all decisions which result in continuous supervision and control of a relevant person.

The CIB therefore recommends that ‘consultation to establish a more appropriate and accurately descriptive term for this significant decision-making process should be undertaken’.

- 1.14 Noting that ‘the draft Heads are very much focussed on admission to a place and the controls while there’ rather than on ‘addressing the important issue of a person not wishing to be there and/or not agreeing with aspects of their care’, Safeguarding Ireland calls for

further consideration [to] be given (in light of the developments in case law of the European Court of Human Rights) to the use of the terms ‘admission decision’ and ‘under continuous supervision and control and is not free to leave’.

These views are also voiced by the Law Society of Ireland.

- 1.15 Noting that the definition of an ‘admission decision’ is ‘in preference to a definition of deprivation of liberty’, the INMO suggests that:

The definition should be explained such that in determining whether an admission decision is being made certain matters shall not be relevant. For example, it might be said that: ‘In deciding whether an admission decision is being made it shall not be relevant that the person is compliant or has not objected, the location of the placement shall not be relevant, the reason or purpose behind a particular placement is not relevant, and variations in the nature or degree of the continuous supervision and control shall not be relevant’.

- 1.16 Observing that “‘admission decision’ represents an over-medicalised definition of what should represent the provision of a spectrum of care’, Inclusion Ireland calls for ‘a definition of “deprivation of liberty”’ to be substituted for ‘the definition of “admission decision” to establish if a deprivation of liberty is taking place or not’.

- 1.17 While acknowledging that ‘currently, there is no legal requirement to ensure that the placement provided to a person is suitable for their needs’, the NAS emphasises the need to clarify that:

An admission decision should be to a relevant facility, which is suitable for the person, taking account of their care needs, social needs, disability, age and past and present will and preference.

- 1.18 SAGE recommends that:

- The terms ‘admission’ and ‘admission decision’ should be revised to reflect that the decisions in question will relate to a decision for a person to be in a ‘place of residence’ where they will receive care and potentially treatment.
- The definitions should reflect that the relevant person, if assessed to not have capacity to make the decision, is involved in the decision-making process in accordance with the Guiding Principles of the ADM[C] Act 2015.

- The definitions should reflect that the decision is 'whether or not' a person will be in a place of residence, as the outcome of the decision should not be predetermined.
- The definitions should also reflect that the decision may be subject to change and is not for an indefinite period of time or a permanent decision that the person be in a place of residence.

1.19 SPMHS advises that the 'definition [of admission decision] needs to include the person(s) legally entitled to make such a decision'.

1.20 Mental Health Reform (MHR) advises that:

The terms 'admission' and 'admission decision' should be extended to explicitly state that 'supervision and control' can include multiple individuals who engage in a supervisory role and not just one professional.

1.21 An individual respondent calls for the amendment of the definition of 'admission decision', suggesting the addition of 'and where the relevant person cannot consent to the care and treatment plan and also to restrictive practices'.

1.22 An individual respondent recommends that the definition of "admission decision" should specify that a court will decide'.

### **Definition of 'appropriate person'**

The Explanatory Notes to the draft Heads of Bill state that:

The introduction of 'appropriate person' is intended to ensure that a mechanism is available whereby the Minister may have persons appointed to make applications to court under Part 5 on behalf of a relevant person if no one else makes such an application, i.e. as a last resort.

The definition of 'appropriate person' included under Head 1 is detailed in the box below.

'Appropriate person' means a person identified in accordance with regulations made by the Minister under Head 12(2) to make an application to court under Part 5 on behalf of a relevant person.

### **Respondents' comments**

1.23 The MHC notes that:

The Heads of Bill do not address whether the Director of the DSS is to establish an additional Panel for such persons nor do the Heads address how or by whom the cost of appointment of such persons will be funded.

- 1.24 The National Disability Authority (NDA) recommends ‘the appointment of an independent advocate to the relevant person where necessary’. However, noting that ‘Section 99 (3) of the 2015 [ADMC] Act provides for Special Visitors who the Director [of the DSS] can direct to assess the capacity of a relevant person in relation to specific decisions’, the NDA further suggests that:

In some cases, the Director would subsequently direct a Special Visitor to assess the capacity of the relevant person in relation to the decision about admission. [...] Based on a Special Visitor’s report back to the Director about the relevant person’s capacity to make the decision, the Director may make an application to court for a determination. This process would replace the need for ‘an appropriate person’ to make an application to court.

- 1.25 The NDA proposes two options for legislative change to support ‘the appointment of an independent advocate to the relevant person’: (1) the amendment of the ADCMC Act, 2015 to support the establishment by the Director of the DSS of a panel of independent advocates and (2) the amendment of the Citizens Information Act, 2007 ‘that would give legislative powers to an independent advocacy service [...] so that a new function of personal advocates would be to support decision-making by relevant persons whose capacity may be in question’.

- 1.26 The Health Service Executive (HSE) Assisted Decision Making National Office recommends that ‘the role of the appropriate person should be expanded’ to ‘allow for the inclusion of an independent advocate in this definition’.

- 1.27 Both SAGE and Safeguarding Ireland call for a definition of an ‘independent advocate’ to be included in the Heads, with Safeguarding Ireland suggesting the following definition:

An independent advocate is a person who is on the panel established by the Director of the Decision Support Service and appointed for the purpose of supporting a relevant person to make a relevant decision or decisions.

- 1.28 Noting that ‘no provision is made within the definitions for the concept of an independent advocate’, the INMO suggests that, either ‘a new office should be created to assist such persons’ or

in turn it may be opportune to change the meaning of the Court Friend facility available to the Director under other provisions in the [ADMC] Act such that their range of activity would extend beyond assistance in the context of applications pursuant to part 5 of the Act.

- 1.29 MHR calls for ‘a particular emphasis on advocacy supports’ in the proposed legislation in order to enable ‘persons who are *de facto* detained’ to ‘1) make an informed decision about where they wish to reside and 2) to leave their current place of residence’, arguing that:

the provision of advocacy supports will be less costly and timely than the Courts system and may result in a reduction in Court time and expenses.

## Definition of 'chemical restraint'

The definition of 'chemical restraint' included in the draft Heads of Bill, and presented in the box below, is derived from the Department of Health's policy document, *Towards a Restraint Free Environment in Nursing Homes* (2011).<sup>15</sup>

'Chemical restraint' means the use of medication to control or modify a person's behaviour when no medically identified condition is being treated, or where the treatment is not necessary for the medically identified condition or the intended effect of the medication is to sedate a person for convenience or disciplinary purposes or to ensure that a person is compliant or is not capable of resistance.

## Respondents' comments

- 1.30 Several respondents welcome the definition of 'chemical restraint' provided, including NHI. However, NHI cautions that:

There are multiple examples in practice where there is a divergence of views between persons in charge, GPs [general practitioners] (and in some cases consultant psychiatrists / psychologists / geriatricians) and individual HIQA inspectors as to what constitutes chemical restraint. Many of these include circumstances where specific medical conditions are being treated but because the medicines are prescribed on a PRN [*pro re nata* (as needed)] basis they are often deemed by inspectors to be a chemical restraint.

Accordingly, NHI recommends that:

This definition should therefore be strengthened to include the medical evidence that needs to be available to justify where medical conditions are being treated and include reference to the clear and unambiguous clinical guidance on the appropriate use of PRN medications.

In particular, NHI calls for the legislation to make reference to the 'work [that] is currently underway via an Expert Advisory Group to develop Clinical Guidelines for the Appropriate Prescribing of Psychotropic Medication in People with Dementia' on its completion.

- 1.31 An individual respondent calls for clarification of the definition of chemical restraint, expressing the view that:

Once a person has a medical diagnosis that rationalises the use of a psychotropic drug, then the appropriate administration (and documentation) of same is not deemed a chemical restraint (regardless of whether the psychotropic drug is prescribed on the regular or PRN section of the person's prescription chart).

<sup>15</sup> See Department of Health, *Towards a Restraint Free Environment in Nursing Homes* (2011), [https://health.gov.ie/wp-content/uploads/2014/03/trfe\\_english.pdf](https://health.gov.ie/wp-content/uploads/2014/03/trfe_english.pdf).

However, the respondent reports that 'HIQA's interpretation [...] is that the administration of a PRN psychotropic drug is classed as a chemical restraint, irrespective of diagnosis' and that registered nurses' 'employer's definition [...] states "chemical restraint is always unacceptable"'. The respondent also notes that:

There is no reference to chemical restraint in [the] NMBI [Nursing and Midwifery Board of Ireland] draft "Standards for Medicines Management for Nurses and Midwives" (2015) or [in] the (2007) An Bord Altranais *Guidance to Nurses and Midwives on Medication Management*.<sup>16</sup>

1.32 SPMHS observes that, while the definition of 'chemical restraint' provided 'emphasises the centrality of the medical practitioner in the management of many aspects of deprivation of liberty safeguards', multi-disciplinary team-working is central to 'the codes of practice and regulations issued by the Mental Health Commission' under which approved centres are required to work.<sup>17</sup> Accordingly SPMHS suggests that 'the role and responsibilities of members of the multi-disciplinary team may need to be considered in this definition'.

1.33 An individual respondent describes the definition of 'chemical restraint' as

naïve and problematic when considering the reality of treating dementia, learning disability, and mental illness – saying 'no medically identified condition is being treated' or 'the intended effect of the medication is to sedate a person for convenience' is unworkable in practice as this distinction is not at all clear-cut (e.g. just look at the debates about the appropriate management of behavioural and psychological symptoms of dementia).

1.34 The College of Psychiatrists of Ireland advises that:

The term 'chemical restraint' is a politicised and non-clinical term and is never used by any clinician to describe clinical practice. The standard international classification systems, such as DSM-5 [Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> Edition], recognise that behavioural [...] symptoms exist in particular as part of all neurocognitive disorders, and that medications may sometimes attenuate these symptoms.

1.35 While opining that 'a good definition of chemical restraint is outlined', Acquired Brain Injury (ABI) Ireland comments that 'the wording could be clearer around section 39 residential services being definitively included under the legislation'.<sup>18</sup>

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<sup>16</sup> See An Bord Altranais *Guidance to Nurses and Midwives on Medication Management* (2007), [https://www.nmbi.ie/NMBI/media/NMBI/Guidance-Medicines-Management\\_1.pdf](https://www.nmbi.ie/NMBI/media/NMBI/Guidance-Medicines-Management_1.pdf).

<sup>17</sup> See [https://www.mhcirl.ie/for\\_H\\_Prof/codemha2001/](https://www.mhcirl.ie/for_H_Prof/codemha2001/).

<sup>18</sup> 'Section 39 residential services' are those funded by the HSE under section 39 of the Health Act, 2004.

- 1.36 The MHC queries the origin of the definition provided, recommending that:  
A comma should be inserted on the third line after the words ‘medically identified condition’. The word ‘where’ should be inserted between ‘or’ and the words ‘the intended effect’.

### Definition of ‘restraint practice’

As noted in the Explanatory Notes to the draft Heads of Bill, since ‘there is currently no statutory definition of restraint practices’, the definition cited under Head 1, and detailed in the box below, is derived from the Department of Health’s policy document, *Towards a Restraint Free Environment in Nursing Homes* (2011).

‘Restraint practice’ means the use of practices for non-therapeutic purposes that result in the intentional restriction of a person’s movement or behaviour and does not include chemical restraint.

In respect of this definition, the Explanatory Notes refer to HIQA’s *Guidance for Designated Centres: Restraint Procedures* (2014; rev. 2016), which states:

Restrictive procedures should only be used in limited circumstances after other options to keep people safe have been exhausted. Such procedures should only be used in strict adherence to international human rights instruments, national legislation, regulations, policy and evidence-based practice guidelines. An unwise decision by a resident is not always evidence of lack of capacity or the need for restrictive procedures, nor is the use of such procedures in one instance a reason to use them later without trying all other options first.<sup>19</sup>

### Respondents’ comments

- 1.37 The MHC expresses the view that ‘restrictive practice and/or procedure’ should be substituted for ‘restraint practice’ in order to ‘ensure that a “once-off event” is covered by the definition’, advising that ‘the use of the word “restrictive” is consistent with the terminology in other documents published by the MHC’.
- 1.38 Noting that ‘the word “restraint” seems to be used interchangeably with “restrictive practices”’, an individual respondent comments:

I have worked in Hong Kong, Australia and England and usually “restraint” was used in the context of physical restraint. The term “restrictive practices / interventions” connoted e.g. seclusion, use of belts, oppressive rules etc so it is much broader than physical restraint. It also captures the use of unlawful seclusion as a restrictive intervention particularly in homes for people with intellectual capacity with severe challenging behaviours.

<sup>19</sup> Health Information and Quality Authority, *Guidance for Designated Centres: Restraint Procedures* (2014; rev. 2016), 5, <https://www.hiqa.ie/sites/default/files/2017-01/Guidance-on-restraint-procedures.pdf>.



Accordingly, the respondent argues that the cited definition of restraint practices is 'too narrow' and calls into question the validity of confining it 'to non-therapeutic purposes', recommending that 'interventions used for allegedly therapeutic purposes ought to be scrutinised under the Bill'.

- 1.39 Saint John of God Community Services cites the following definition of a 'restrictive procedure' provided by HIQA in the *Guidance for Designated Centres: Restraint Procedures* (2016):

A restrictive procedure is a practice that:

- limits an individual's movement, activity or function;
- interferes with an individual's ability to acquire positive reinforcement;
- results in the loss of objects or activities that an individual values; or
- requires an individual to engage in a behaviour that the individual would not engage in given freedom of choice.<sup>20</sup>

Emphasising that 'restraint is always a restrictive practice; regardless of whether it is used for therapeutic or non-therapeutic purposes' and that 'if it meets the above criteria it is a restraint', Saint John of God Community Services opines that the definition used in the draft Heads 'is not in keeping with best practice', querying whether 'we need a statutory definition of restraint in the context of restrictive practices'.

- 1.40 Both HIQA and NHI highlight the fact that, contrary to the statement in the Explanatory Notes, a statutory definition of 'restraint' is provided in the 2013 regulations pertaining to the care and welfare / support of residents in designated centres for older people and in designated centres for persons with disabilities. In the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations, 2013 'restraint' is defined as 'the intentional restriction of a person's voluntary movement or behaviour' and in the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations, 2013 'restrictive procedure' is defined as 'the intentional restriction of a person's voluntary movement or behaviour'. In respect of these definitions, NHI comments:

The two critical words here are 'intentional' and 'voluntary'. A practice is only restrictive therefore by these legal definitions if there is a specific intent on behalf of the healthcare professional to restrict a person's voluntary movement and if that person is actually capable of voluntary movement.

While observing that 'many of the residents in nursing home care are not capable of voluntary movement by nature of their comorbidities', NHI criticises the continued use of a definition source from 'an outdated policy document [the Department of Health's 2011 policy-document] to guide practice in this area', remarking that this

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<sup>20</sup> *Ibid.*, 4.

is not helpful to healthcare professionals in their day-to-day practice and indeed creates difficulties with the regulation of these centres by HIQA.

Likewise noting that ‘the proposed heads are introducing a different definition and also a different term (‘restraint practice’), HIQA suggests that ‘the Department should consider standardising the definitions and terminology used in relation to restrictive practices’.

- 1.41 The Rehab Group calls for ‘a clearer definition of “restraint practice”’, querying whether it includes ‘all categories of restraint e.g. physical, mechanical, seclusion etc’ and, if so, what the definitions of each of these and the overarching definition would be. The Rehab Group recommends that the

reference to the intent of the intervention should be removed as it is the effect of an intervention that defines it as restrictive or not, not the intent.

In addition, the Rehab Group calls for the legislation to

make provision for all forms of rights restriction i.e. via restraint and seclusion so that people can avail of the same level of safeguards for such equally serious issues.

- 1.42 MHR maintains that:

The definition of ‘restraint’ should be broadened to explicitly state that restraint practices include all forms of manual or other forms of restraint (see Expert Group Report on Review of the Mental Health Act, 2001) and will be subject to appropriate guidelines developed by a relevant body. Consideration should be given to existing guidelines produced by the Mental Health Commission on seclusion and restraint practices.

- 1.43 SPMHS recommends that ‘the definition of “restraint practices” should be in accordance with the Mental Health Commission Code of Practice and Rules on Physical and Mechanical Means of Restraint’.<sup>21</sup>

- 1.44 SAGE calls for the definition of ‘restraint practice’ to ‘reflect that the application of restraint without consent is unlawful and is an interference with a person’s rights’; to ‘reflect an interpretation of ‘exceptional circumstances’ as referred to in the draft provision under Head 2(3)(g)’; and to reflect the concept of a restraint practice ‘being to prevent an imminent risk of serious harm’. SAGE also calls for the definition to reflect the fact that restraint practices are ‘a measure of last resort’, which should be ‘proportionate to the risk’, minimally restrictive, ‘in place for the shortest period of time’ possible, and respectful of ‘the views of the relevant person’.

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<sup>21</sup> See Mental Health Commission, *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* (2009), [https://www.mhcirl.ie/File/Revised\\_Rules\\_SecMR.pdf](https://www.mhcirl.ie/File/Revised_Rules_SecMR.pdf).

1.45 The INMO calls for ‘the concept of therapeutic restraint practices’ to be defined in order

to understand correctly the rights of a person, and to allow staff [to] effectively understand and implement the legislation in furtherance of those rights.

1.46 The CIB calls for the creation of ‘a statutory definition of restraint practices’, which should be ‘used across all statutory and regulatory documentation such as HIQA or HSE guidance’ in order to ‘promote understanding and standardised implementation across all health and social care settings’.

1.47 The National Dementia Office (NDO) and the Alzheimer Society of Ireland (ASI) call for ‘a definition of restraint’, reporting that:

An example for the HSE policy on restraint is: ‘Any physical, chemical or environmental intervention used specifically to restrict the freedom of movement—or behaviour perceived by others to be antisocial—of a resident designated as receiving care in an aged care facility’. It does not refer to equipment requested by the individual for their safety, mobility or comfort. Neither does it refer to drugs used—with informed consent—to treat specific, appropriately diagnosed conditions where drug use is clinically indicated to be the most appropriate treatment.

1.48 The NAS reports that:

The Mental Capacity Act 2005 (England and Wales) allows restrictions and restraint to be used in a person’s support, but only if they are in the best interests of a person who lacks capacity to make the decision themselves.

#### **Definition of ‘other medical expert’**

The Explanatory Notes accompanying the draft Heads of Bill state that:

‘Other medical expert’ is required to be defined so as to include experts who might not, strictly speaking, be considered ‘medical’ but whose expertise is the appropriate one for decisions on the admission of certain categories of persons, e.g. psychologists. The case law of the European Convention on Human Rights (ECHR) requires medical evidence to justify a decision to deprive a person of their liberty under Article 5(1)(e).

A definition of ‘other medical expert’ is not given under Head 1 in the draft Heads of Bill. Rather the note, detailed in the box below, is included indicating that the views of respondents to the consultation on this issue are sought.

‘Other medical expert’ includes a... [Note: The issue of ‘other medical experts’ is included as a question in the consultation paper.]

## Respondents' comments

- 1.49 Noting that ‘the ECJ [Court of Justice of the European Union] has ruled that detention on medical grounds must be certified by medical as opposed to non-medical healthcare professionals’, the College of Psychiatrists of Ireland observes that:

Medical experts are by definition medically trained professionals on the appropriate specialist register maintained by the Irish Medical Council and/or other medical regulatory authorities.

- 1.50 An individual respondent cautions that ‘allied health professionals would not fulfil the ECHR requirement for “medical” expertise, given the way the case law has evolved’ and that ‘the use of the word “medical” in the case law (rightly or wrongly) excludes those who are not doctors’.

- 1.51 Similarly, SPMHS observes:

There are no ‘other medical experts’ other than Registered Medical Practitioners. The case law of the European Convention on Human Rights (ECHR) requires *medical* evidence to justify a decision to deprive a person of their liberty under Article 5(1)(e). Other health professionals are not *medically* trained—they are however *clinically* trained.

- 1.52 An individual respondent calls into question the necessity for ‘medical evidence to justify a decision to deprive a person of their liberty’, as indicated in ECHR case law and referenced in the Explanatory Notes to the draft Heads of Bill, when ‘the Bill only requires a lack of capacity and not an accompanying mental disorder’.

- 1.53 SAGE also calls into question the emphasis placed on medical evidence to justify the deprivation of liberty, cautioning:

The decision [about] whether or not a person will become a resident in a ‘relevant facility’ should not be solely based on medical evidence, input or expertise which may result in a deprivation of liberty. The requirement for medical evidence may be relevant in the context of a person admitted in relation to a mental health disorder, however it is in contravention of Article 14 of the UNCRPD to deprive a person of their liberty based on their actual or perceived impairment.

- 1.54 Likewise, HIQA observes that:

The continued use of the terms ‘healthcare’ and ‘medical’ fails to reflect or recognise the guiding principles and concepts contained within the ADMC Act where it is recognised that whilst a medical condition may be one factor in determining an individual’s capacity – other professionals and advocates should be available to reflect the relevant person’s will and preferences. It should be noted that many centres that would fall under the definition of a ‘relevant facility’ are providing a social model of care.

1.55 MHR observes that:

The reference to ‘medical evidence’ as a basis for deprivation of liberty, in accordance with the European Convention on Human Rights appears to have been misinterpreted. This provision applies only in the context of mental health and does not allow for use in other areas of the disability sector.

1.56 NHI recommends that:

In order to maintain consistency with the [ADMC] Act 2015 [...] the definition of ‘other medical expert’ should have the meaning assigned to it by section 2 of the Medical Practitioners Act 2007.

However, opining that ‘a basic medical qualification’ would be insufficient to support complex ‘admissions decisions’ and ‘for the purposes of clarity and accessibility’, NHI further suggests that the definition of ‘other medical expert’ should ‘list the types of medical practitioners that would be responsible and accountable here’.

1.57 The Law Society of Ireland and Safeguarding Ireland opine that ‘the term “medical expert” is not appropriate in the context of the 2015 [ADMC] Act and should not be used’.

1.58 The HSE National Safeguarding Office and the HSE’s Older Persons’ Services call for the repeated references in the draft Heads to ‘medical expert’ and ‘medical evidence’ to be changed, commenting that their inclusion ‘reflects confusion between “mental disorder” and “decision-making capacity”’.

1.59 Likewise, the Disability Federation of Ireland (DFI) notes that the repeated references in the draft Heads to a ‘medical expert’, along with the requirement for ‘medical evidence [...] to justify a decision to deprive a person of their liberty’, conflict with the UNCRPD and with the ‘social model’ adopted in the ADMC Act, highlighting this as ‘a serious cause for concern’.

1.60 Recommending the substitution of ‘the term “other experts”’ for ‘other medical expert’ in order to encompass ‘non-medical healthcare professionals’, the NDA also expresses concern that ‘the use of the term “other medical expert” [...] is not in line with the 2015 [ADMC] Act’, with the emphasis which it places on the ‘functional assessment of a person’s capacity’ and that it

would seem to relate more to dealing with persons who have a ‘mental disorder’ for the purposes of the Mental Health Act 2001.

1.61 Noting that, in the ADMC Act, ‘applications to court under Part 5 require [...] input from a “registered medical practitioner and other healthcare professional”’, the HSE Assisted Decision Making National Office recommends that ‘this terminology should also be included in the Heads of Bill’.

1.62 Observing that ‘a “medical expert” is not required to decide whether or not a person lacks decision-making capacity’ and acknowledging ‘the developments in medical practice to move towards multi-disciplinary teams’, the Dublin Solicitors Bar Association (DSBA) suggests that ‘it may be more appropriate to refer to “healthcare professionals” rather than [to] “other medical expert[s]”’.

1.63 The INMO suggests that:

A functional description [of other medical expert] be adopted, such that other registered professionals who are in a position to provide relevant evidence to assist a court in making a decision would be included.

1.64 Noting that ‘the terms “medical expert”, “registered medical practitioner”, and “healthcare professional” are used interchangeably in the document’, the Division of Neuropsychology of the Psychological Society of Ireland (PSI) calls for clarification ‘with specific regard for who has authority, relevant expertise and experience and responsibility to contribute to this area’.

#### **Definition of ‘person in charge’**

The Explanatory Notes to the draft Heads of Bill state that:

The ‘person in charge’ is the acting manager with overall responsibility at any given time. There is no relevant statutory definition of person in charge. The concept mirrors that of the person in charge referred to in S.I. No 415 of 2013 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and in S.I. No 367 of 2013 (Care and Support Regulations for Designated Centres for Persons with Disabilities). In the majority of designated centres for older people, the person in charge would be a nurse. In designated centres for persons with disabilities the person in charge tends to be a nurse or social care professional. The person in charge also includes the clinical director of approved centres appointed by the relevant governing body.

The definition of ‘person in charge’ included under Head 1 is detailed in the box below.

‘Person in charge’ means the person in charge of the relevant facility.

#### **Respondents’ comments**

1.65 The DSBA calls for a clearer definition of the term, suggesting:

The definition of ‘person in charge’ requires to be explained more precisely. For example, is it proposed that the ‘person in charge’ be the CEO of an organisation with responsibility for a relevant facility or the person supervising a ward on a particular shift at a relevant facility?

1.66 Recognising ‘the important legislative functions resting with such persons, and the potential for criminal sanction’ as well as ‘the designation of such a person in other legislative measures’, the INMO calls for there to be ‘a descriptor of the

level of seniority envisaged by the legislation, bearing in mind the responsibilities imposed by the legislation on such persons'. The INMO notes that, at present, the role of the person in charge

is often understood on a location by location basis, bearing in mind that a location may be a community house accommodating for example four persons, up to a large residential facility accommodating many persons. In smaller locations the person in charge is often at the level of unit manager, and this is an error of principle at present considering the legislative responsibilities lying with such persons under other legislation. However, this will be even more problematic in terms of the current proposed legislation.

In the light of this, the INMO criticises the

failure to engage with the level of seniority associated with the persons currently working in those roles, their level of autonomy within the organisations where they work, the amount of time available to them to engage in administrative duties, their level of authority, and the limitations placed upon them.

- 1.67 NHI raises concerns about the amount of responsibility being given to persons in charge in the provisions, observing:

There is an over-reliance on the role of the Person in Charge (PIC) and statutory obligations being imposed on the PIC who in most cases is not a medical expert. This proposed legislation should place more obligations on the medical experts that are arranging admissions of relevant persons (based on their care needs) to nursing homes (relevant facilities) prior to the admission decision being made, rather than transferring this obligation to the PIC.

- 1.68 The CIB recommends that the person in charge should be a medical expert, commenting:

As the 'person in charge' is proposed to have significant responsibilities with regard to assessing the capacity of persons who may be admitted to the centre, and has to pay due regard to the needs and wishes of other residents in the centre, it is recommended that the 'person in charge' should be a 'medical expert' [...] or should have the ability to easily and regularly access such expertise.

- 1.69 The MHC describes the definition as 'totally inadequate', commenting:

The term 'person in charge' should include 'a healthcare professional on behalf of the person in charge'. This should be addressed in the definition which would eliminate the necessity for repeated references to same throughout the Heads.

1.70 MHR recommends that:

The 'person in charge' with responsibility for decisions relating to deprivation of liberty should include professionals from a range of different mental health disciplines and not solely medical professionals.

#### **Definition of 'relevant facility'**

The Explanatory Notes to the draft Heads of Bill state that:

A definition of 'relevant facility' is required to differentiate it from a 'designated centre' [as] defined in section 2 of [the ADMC] Act because it is not intended to cover child care centres or institutions in the deprivation of liberty provisions of the Act.

The Explanatory Notes further state:

Relevant facility is the place where the relevant person is to be admitted pursuant to an admission decision. The inclusion of a definition of relevant facility is necessary for clarity as to which facilities are considered in this Part (i.e. nursing homes and care/residential accommodation in addition to approved centres under the Mental Health Act 2001). As a number of mental health residential facilities do not have a statutory definition, it is necessary to have a definition encompassing a number of these facilities. The definition includes the sections of the Health Act 2007.

The text of the proposed definition of 'relevant facility' is set out in the box below.

'Relevant facility' means:

- (a) a designated centre as defined in section 2(1)(a)(ii), 2(1)(a)(iii) and (c) of the Health Act 2007, as amended; or,
- (b) an approved centre as defined in section 2(1) of the Mental Health Act 2001; or,
- (c) an institution at which residential services are provided by the Health Service Executive, a service provider or a person that is not a service provider but who receives assistance under Section 39 of the Health Act 2004 to persons in receipt of mental health services as defined by section 2(1) of the Mental Health Act 2001 but does not include any of the following:
  - i. an institution managed by or on behalf of a Minister of the Government; and,
  - ii. that part of an institution in which the majority of persons being cared for and maintained are being treated for acute illness or provided with palliative care; and,
  - iii. an institution primarily used for the provision of educational, cultural, recreational, leisure, social or physical activities; and,
  - iv. a special care unit provided and maintained in accordance with section 23K of the Child Care Act 1991.
- (d) such other facility as the Minister may prescribe by regulation.



## Respondents' comments

### *Scope of the definition*

- 1.71 The NDA calls for clarification of the 'settings included in a relevant facility for the purposes of the draft Heads' in order to 'address any confusion that may arise about what settings the draft legislation applies to'.
- 1.72 A number of respondents call for the provisions to be extended to other settings in which people may be deprived of their liberty, including acute hospitals, step-down facilities, hospices, respite care facilities, community-based housing, assisted living facilities, group homes and family homes.
- 1.73 The HSE National Safeguarding Office and the HSE's Older Persons' Services request clarification of 'the classification of a residential facility', noting that this 'currently appears confined to facilities as designated under the provisions of the Health Act'.
- 1.74 However, observing that 'it is unclear whether the area of respite care falls within the scope of the draft provisions', the HSE Assisted Decision Making National Office queries whether somebody who 'enters respite care for a short break [...] need[s] to go through the procedure as detailed in the draft Heads', suggesting that 'this would seem disproportionate'.
- 1.75 The NDO and the ASI recommend that 'the definition of nursing home as defined in section 2 of the Health (Nursing Homes) Act 1990 should be included' within the definition of 'relevant facility'. They also call for  
  
clarity [...] on whether the legislation applies to those in respite care [...] or those people who experience a delay in being discharged from an acute hospital and may remain in that setting for months and sometimes years.
- 1.76 Several respondents raised concerns that, although the definition of 'relevant facility' includes acute psychiatry inpatient units, it does not encompass acute medical wards in general hospitals and hospices. For example, the College of Psychiatrists of Ireland comments:  
  
The definition of a relevant facility needs further discussion. We do not understand the reasoning that excludes acute medical wards in general hospitals but includes acute psychiatric units in the same general hospitals. A legal framework already exists which regulates involuntary admissions under the Mental Health Act 2001 and acts to protect patients' interests.
- 1.77 Recommending the inclusion of day services within the scope of a 'relevant facility', Saint John of God Community Services remarks:  
  
The Bill speaks of person[s] in charge and appears to cover residential facilities only; the application of this legislation to govern the respective day service that a person is attending will allow for due process in all parts of the person's life.

- 1.78 The INMO and NAS highlight the exclusion of private providers of care from the definition of a ‘relevant facility’, with the INMO noting:

In defining a relevant facility, the breadth of the definition is welcome. However, entirely private providers of care are excluded (except for nursing homes) and this is insufficiently protective of the rights of persons. While it is recognised that entirely private facilities, for example in the provision of services for persons with a disability, are relatively rare, it is an area which should be addressed in the legislation.

- 1.79 The NRH notes that:

The term ‘relevant facility’ as currently described under the Heads of Bill will not include the NRH in terms of admitting patients for acute rehabilitation services.

- 1.80 The HIQA expresses concerns that the stated definition of a ‘relevant facility’ will not provide safeguards for vulnerable people residing in certain settings, remarking:

Consideration should be given to the use of this term [relevant facility] to reflect a more rights-orientated view of what is, or is to become, a person’s residence or home. It is noted that ‘designated centres’ as described in the Health Act (2007) are included in this definition along with ‘approved centres’ under the Mental Health Act (2001). There is a potential gap in this definition whereby vulnerable persons not living in designated centres or approved centres may not be afforded the protections of this legislation.

- 1.81 The NDO and the ASI suggest that:

In relation to the relevant facility in which the legislation applies, the definition of nursing home as defined in section 2 of the Health (Nursing Homes) Act, 1990 should be included.

- 1.82 Noting that ‘a designated centre is poorly defined in the Health Act 2007’, causing ‘confusion about what it includes and what it excludes’, the NDA calls for more detail to be provided on ‘the statutory definition of a designated centre’ in Head 1(a), drawing attention to HIQA’s guidance on this.<sup>22</sup>

- 1.83 The NDA also calls for clarity to be provided in relation to ‘the definition of “institution” in Head 1(c), observing that the term ‘has varying interpretations throughout the disability and mental health sectors’.

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<sup>22</sup> See Health Information and Quality Authority, *What Constitutes a Designated Centre for People with Disabilities? Guidance for Provider Organisations* (2013; rev. 2015), <https://www.hiqa.ie/sites/default/files/2017-01/What-constitutes-a-designated-centre.pdf>.

### *Approved centres*

- 1.84 Noting that the consultation paper states that the ‘safeguards will apply to mental health facilities in instances in which such persons have mental health issues but are not suffering from a mental health disorder and [who] therefore cannot be involuntarily detained under the Mental Health Act 2001’, the Law Society of Ireland and Safeguarding Ireland recommend that:

If this is what is intended, then it should be made clear in the legislation that persons in an approved centre for the purposes of Part 13 of the [...] ADMC Act 2015 do not include those who are subject to an admission order under section 14 of the Mental Health Act 2001.

- 1.85 Likewise, the NDA recommends that the clarity provided in the consultation paper on the application of the legislation to people with mental health issues should ‘be reflected in the definition of an approved centre in Head 1’.

### *Language used in the definition*

- 1.86 The HSE Assisted Decision Making National Office and a number of other respondents recommend replacing ‘relevant facility’ with ‘place of residence’.

- 1.87 MHR recommends that:

The term ‘relevant facility’ should be removed and replaced with ‘relevant place of residence/care’ to acknowledge that the services which are subject to the DOLS [deprivation of liberty safeguards] are places in which people live, often for long periods of time.

### *Other comments*

- 1.88 Noting that the deprivation of liberty ‘is not just an institutional issue’ and that situations can arise in which ‘the state knows or ought to know of a private confinement to which the person concerned cannot consent’ and which, in the absence of ‘an administrative mechanism [...] would require judicial authorisation’, an individual respondent queries:

What regime is intended to be in place where a person is to be deprived of their liberty other than in a relevant facility?

**Question 1.2: In particular, do you have any views as to the types of healthcare professionals that should be included within the definition of “other medical expert”?**

**Respondents’ comments**

- 1.89 While highlighting the distinction between medical experts and clinically trained health professionals, SPMHS nevertheless argues that:

Psychologists, nurses, occupational therapists, social workers and pharmacists are all registered health care practitioners and consideration should be given to their inclusion in the definition.

- 1.90 While maintaining that ‘ultimately the responsibility [for the determination of capacity] should lie with the clinicians with expertise in the assessment of capacity [...] i.e. clinical psychologist and clinical psychiatrist’ and that this assessment ‘should only be undertaken by persons appropriately experienced and qualified in the communication needs of people with disabilities’, the NAS calls for ‘the support of all the relevant professionals working in the person’s life [to] be sought in making a determination of capacity’ and suggests that the definition of ‘other medical expert’ should encompass the ‘GP, psychiatrist, nurse, public health nurse, [and] behaviour therapist’ as the ‘group of professionals [...] more likely to have knowledge of the relevant person’.

- 1.91 Recommending that the definition of ‘other medical expert’ should encompass ‘relevant health and social care professionals such as speech and language therapists, psychologists, occupational therapists and other relevant staff’, the NHR advises that:

In complex cases it is a team approach which is considered the best clinical approach in terms of assessing capacity in relation to particular decisions.

- 1.92 Observing that ‘capacity is not a medical concept; it is a legal and social concept’, an individual respondent calls for ‘psychiatrists, doctors, nurses, social workers, occupational therapists, and psychologists’ to ‘be able to undertake capacity assessments’, stating that:

They should have (1) a background that gives them a social-care perspective and (2) have the requisite training to carry out assessments.

- 1.93 While recommending that the definition of ‘other medical expert’ should ‘include all healthcare professionals, who are trained, qualified and licensed in their own fields to the highest standards’, St. Luke’s Nursing Home, Cork suggests that:

Where the aim is to accomplish / cover as many appropriate persons who are best placed to deal with the medical, physical or mental aspects of a relevant person it may be preferable to leave it more open ended.

- 1.94 While noting that ‘under ECHR law, medical evidence is required to justify a decision to deprive a person of their liberty’, the CIB recommends that ‘other healthcare professionals with specialist assessment expertise [should be] included within the definition of “other medical expert”’. Recommending that ‘it would be important to establish the role, function and mix of such professionals’ as well as ‘to develop and deliver appropriate education and training for the role’, the CIB notes that:

In England and Wales other professionals, for example Approved Mental Health Professionals (AMHPs), are often authorised by their agencies to carry out such assessments and, alongside other professionals, carry out subsequent Best Interest Assessments (BIA). Most AMHPs are social workers, with much smaller numbers of nurses, occupational therapists and psychologists. In Scotland, and in the proposed capacity legislation in Northern Ireland, a range of professionals are also defined in the legislation.

- 1.95 The Irish Association of Social Workers (IASW) suggests that consideration might usefully be given to the development of ‘a post based on the Authorised Officer under the Mental Health Act (2001)’ to support ‘admissions decisions’, recommending that the occupant of the post ‘would receive additional training and the support of their employing organisation to undertake this specialised role in making admission decisions’ and that they

would be a senior professional (social worker, nurse, therapist, psychologist, etc) working in the field of older persons services, disability services and / or mental health services.

- 1.96 Acquired Brain Injury Ireland (ABI Ireland) recommends that, as suggested in the Explanatory Notes, chartered psychologists should be included in the definition of ‘other medical experts’ since

their specialist training (usually at doctorate level) makes them well-qualified to assess questions around functional aspects of capacity as defined in the ADM Capacity Act 2015 i.e. verbal and non-verbal comprehension (understanding information relevant to a decision), verbal and non-verbal memory (retaining information long enough to make a decision), verbal and non-verbal reasoning (using or weighing information) and verbal and non-verbal communication (of a decision).

- 1.97 Noting that ‘in the English DOLs [deprivation of liberty safeguards] system, [...] the capacity assessment must be carried out by a mental health assessor or the best interests assessor’, which may include ‘a nurse, social worker, occupational therapist or chartered psychologist’, an individual respondent suggests that:

If the final Bill does not require a mental health assessment, those allowed to conduct a capacity assessment should to include social care professionals, clinical psychologists, neuro psychologists, and occupational therapists. There may be difficulties in implementing the legislation if the only medical experts allowed were consultant psychiatrists and not e.g.

geriatricians, rehabilitation specialists or neurologists dealing with acquired brain injury. General practitioners ought to be included as ‘experts’.

1.98 HIQA suggests that the Department of Health ‘should consider expanding any potential list to include relevant professionals in the social care field’ and that this should include ‘registered medical practitioner, registered social worker, behaviour support specialist, competent social care worker, registered nurse, [and] registered allied health professional’.

1.97 The Division of Neuropsychology of the PSI recommends that the definition of ‘other medical expert’ should encompass HCPs [health care professionals], particularly CP [clinical psychologists] and CNP [clinical neuropsychologists], who already are tasked on a routine basis to undertake specialist assessments and to provide opinions about decision-making capacity.

1.99 Noting that ‘capacity in a condition like multiple sclerosis can be very difficult to determine and can be variable and fluctuating’ the Multiple Sclerosis Society of Ireland (MS Ireland) emphasises that the definition of ‘other medical expert’ should encompass

healthcare professionals such as neuropsychologists who have expertise on the impact of specific neurological conditions such as MS on cognition and capacity.

1.100 The MHC recommends that ‘healthcare professionals’ should be substituted for ‘other medical expert’, advising that, once this substitution has been made,

section 121 (4) (f) of the 2015 Act which reads ‘...of a class as shall be prescribed by regulations made under section 31 that in their opinion...’, would be applicable.

1.101 MHR calls for ‘the term “medical expert” [to] be replaced with “health or social care professional”’, commenting:

This latter term means any expert from a recognised medical discipline, to include but not limited to psychologists, psychotherapists, social workers, social care workers, occupational therapists, and speech and language therapists on decisions relating to deprivation of liberty. This amendment is necessary to ensure multi-disciplinary involvement in decisions where a person’s liberty is at stake and to promote a further shift in legislation from a historically over-medicalised approach to care.

1.102 The CDLP recommends:

Eliminating the definition ‘other medical expert’ and adding instead an ‘interdisciplinary group’ with experts in all fields and with strong expertise, technical and practical knowledge of human rights and the [UN]CRPD, in order to support the person’s choice.

1.103 Recognising that admission decisions are life-changing for individuals, the National Clinical Programme for Older People (NCPOP) calls for ‘a broad representation of the needs, will and preference of the person’ when such a decision is being taken. Accordingly, the NCPOP recommends that there should be ‘a minimum of two independent medical assessors’, who should ‘be trained to a level that is consistent with the ECHR case law on required medical evidence’ and have

adequate training and expertise in the holistic assessment of the person in terms of identified medical, social and psychological needs and a firm understanding of the fluctuations that can arise as a result of mental health or medical issues.

1.104 Likewise, the Rehab Group and SAGE call for the view of more than one medical or healthcare professional to be sought in relation to a decision which may result in the deprivation of liberty.

1.105 Arguing that reliance on ‘the sole medical evidence’ of ‘one health professional’ to determine a person’s capacity ‘would be concerning’, the NAS calls for the ‘development of an independent medical expert panel’ in order to avoid ‘situations where “medical experts” are essentially rubber stamping a decision already made’ and ‘situations where over familiarity of a particular “medical expert” within a service [...] might call into question the independence of the medical expert’.

1.106 An individual respondent reports that:

Experience with the DOLS [deprivation of liberty safeguards] procedures in England and Wales where the Best Interests Assessor role is usually performed by social workers suggests that there can be significant disparity in decisions between medical practitioners and allied health professionals and that this tends to come to a head in the interface between the Mental Health Act and the Mental Capacity Act/DOLS.

### Question 1.3: Do you have any other views specific to Head 1?

#### Respondents' comments

#### Defining the 'deprivation of liberty'

A number of respondents call for the inclusion under Head 1 of a definition of the 'deprivation of liberty'.

1.107 The NDO and the ASI call for clarity on 'a clear definition of deprivation of liberty [...] which sets out its scope', querying whether it will encompass 'control over care, treatment, movement, medication management and/or activities of daily living' and whether it will

apply when the person has not consented; when the person assents but does not clearly give a statement of consent; when the person is deemed not to have mental capacity and/or when their will and preferences are unknown.

1.108 Noting that 'in the U.K., the lack of a clear definition of what constitutes a deprivation [of liberty] has led to difficulty', the Rehab Group also emphasises that 'there needs to be a very clear definition regarding what will be considered a deprivation of liberty', querying 'at what point does physical restraint, a keypad lock on a front door, seclusion become a deprivation'.

1.109 Recognising that 'the new regime will be implemented by frontline nurses and care staff', an individual respondent calls for 'an express definition of what constitutes a deprivation of liberty'. The respondent recommends that the definition should make reference to 'the Cheshire West judgement which decided the acid test for deprivation of liberty' as well as suggesting that the Law Society's *Identifying a Deprivation of Liberty: A Practical Guide* (2015) 'may be a useful resource for frontline workers'.<sup>23</sup>

1.110 While acknowledging that 'the meaning of "deprivation of liberty" is captured in the definitions of "admission" and "admission decision"', the CIB suggests that 'a specific, stand-alone definition including the circumstances in which it occurs would add clarity and would provide clear guidance for decision-makers'.

1.111 The CDLP expresses concern that, although 'the right to liberty in human rights law, including the [UN]CRPD, does not include a requirement of mental capacity for its exercise', the draft legislation 'links the perceived existence or absence of mental capacity to the right to liberty', thereby creating 'a second category besides involuntary patients under the Mental Health Act, with higher barriers to challenge the deprivation of liberty'. Noting that 'a deprivation of liberty only occurs where the person is detained without her valid consent', and that the ADMC Act 'recognises that even where a person is deemed to lack capacity, appointed supporters can interpret his or her will and preferences to form the basis of a decision', the CDLP reports that:

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<sup>23</sup> See <https://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/>.



The European Court of Human Rights has determined that objective and subjective criteria must be established to determine that a deprivation of liberty has occurred. The objective element seeks evidence that the person has been confined in a particular restricted space for a certain length of time. [...] Once this has been established, the additional subjective element, that the person has not validly consented to the confinement in question, must be proven.

In view of the foregoing, the CDLP recommends that, in line with ‘best international practice’, the proposed legislation should include a definition of deprivation of liberty which

must be broad and must include all situations in which a person has not provided free and informed consent to be in the relevant setting, or where the decision to place the person in such a setting is not made in accordance with the person’s will and preferences, or where the person’s will and preferences are unknown.

1.112 The DFI endorses the CDLP’s expressed views, as summarised in paragraph 1.111 above.

1.113 Noting that ‘the definition of deprivation of liberty under human rights instruments is broad and does not, in principle, exclude any particular form of detention or restraint’, the Irish Council for Civil Liberties (ICCL) advises that the ‘draft Heads of Bill only cover a fraction of the forms of deprivation of liberty that are occurring in care settings in Ireland’ since the legislation ‘applies only to “relevant facilities”’ and ‘excludes whole categories of people who are or may be arbitrarily deprived of their liberty from its remit’. The ICCL argues that:

A deprivation of liberty can occur where a person who is dependent on others for care is unable to avoid or escape a form of restricting or isolating care because they have been denied the opportunity to make their own decisions about the care that they receive.

1.114 Noting that ‘Head 1 does not define a “deprivation of liberty”’, an individual respondent calls for it to state that the ‘deprivation of liberty has the same meaning as in Article 5(1) of the European Convention on Human Rights’. Accordingly, the respondent suggests that:

Having regard to the case law of the European Court of Human Rights, the Head might define ‘deprivation of liberty’ as follows:

‘A deprivation of liberty means [i] that the person is under supervision and control in a particular facility, and is not free to leave that facility; [ii] the person has not validly consented to placement in that facility; and [iii] the placement is imputable to the State, as a result of its direct involvement in the person’s placement or its positive obligations under the law to protect the person against interference with their liberty carried out by private persons or entities.’

## Other comments

1.115 The MHC highlights the importance of the application of the guiding principles of the ADCM Act to the proposed legislation, remarking:

The 'Guiding Principles' contained in Section 8 of the 2015 Act should not be confined to a limited category of persons carrying out interventions as defined by the 2015 Act but should apply to all persons interacting with relevant persons. This needs to be addressed by both the DOH [Department of Health] and the DJE [Department of Justice and Equality].

1.116 The HSE Assisted Decision Making National Office and SAGE recommend the inclusion of a definition of 'specified person' and of 'healthcare professional' under Head 1.

1.117 Noting that 'there are [...] multiple references to the term "Director"' in the draft Heads of Bill, variously referring to clinical directors of relevant facilities and to the Director of the DSS, NHI recommends that 'Director [...] should also be included within the definitions'.

1.118 The MHC recommends that the phrase 'reasonable belief based on clinical and/or non-clinical evidence available at the time' should be substituted for 'reason to believe' in the Heads, arguing that the latter is 'too vague' and non-specific.

## Chapter 2: Head 2 – Application and Purpose of this Part

Comprising 3 subheads, Head 2 outlines the circumstances in which the proposed legislative provisions will apply and the purpose of the provisions. As indicated in the Explanatory Notes:

Subhead (1) provides that this Part of the Act is confined to circumstances which amount to a deprivation of liberty. Deprivation of liberty is not synonymous with living in a residential facility as it requires that the relevant person who lacks capacity be under continuous supervision and control in addition to not being free to leave the relevant facility. This subhead provides that the safeguards in this Part will apply when a person has been or is being admitted to a relevant facility and where they are, or will be under continuous supervision and control, and are not, or will not be, free to leave.

Noting that subhead (2) stipulates that the proposed legislative provisions will not apply to wards of court, the Explanatory Notes further elucidate that:

Subhead (3) sets out the purpose of this Part of the Act so as to clarify the point at which it applies, i.e. where a personal welfare decision is being taken under the Act that a relevant person should live in a relevant facility and where it is also necessary, for good and valid reasons, to take a further step to curtail their freedom or prevent them from leaving the relevant facility.

### Question 2.1: Do you have any views specific to Head 2?

#### Respondents' comments

#### Scope and application of the provisions

##### *Requests for clarification*

- 2.1 The NDO and the ASI state that 'clear instruction on when deprivation of liberty applies needs to be set out in the legislation'.
- 2.2 The CIB calls for 'the description of what constitutes deprivation of liberty [...] to be more directive about exclusion and inclusion factors' and to encompass:
  - whether the person agrees or disagrees with the detention;
  - the purpose for the detention or;
  - the extent to which it enables the person to live what might be considered a relatively normal life.
- 2.3 The Division of Neuropsychology of the PSI also raises questions about the scope of the provisions, asking for  
  
consideration [to] be given to the question of whether or not deprivation of liberty extend[s] to situations where a relevant person is free to leave a facility but is not made aware of this or where significant cultural (i.e. nursing

home care is portrayed as a permanent care arrangement with no alternative/option to leave) or logistical factors (unavailability of required care support within the home due to resource issues) preclude the person from doing same.

2.4 ABI Ireland comments:

In terms of the application and purpose it would be useful at a practical level to disambiguate whether the ‘under continuous supervision and control’ part is necessary over and above what would seem to be the paramount criteria of ‘not be free to leave’. In real-world settings it is entirely possible to have one or the other and not both. A person could be under continuous supervision and control (with 24/7 staffing) and free to leave, or the person may have very little supervision and control but not be free to leave (a locked setting with few staff). Is it one, or both or either?

2.5 MS Ireland calls for more clarity on what it means for someone to be ‘deprived of their liberty’, noting that:

People with MS and other similar conditions can be deprived of their liberty due to the fact that they cannot access supports such as home care and housing adaptations and therefore a nursing home is the only option available to them. MS Ireland is aware of situations where people have transferred to nursing homes on discharge from acute hospital and told this will be a temporary measure, only to still be there years later. People in these situations are being deprived of their liberty and it is not currently clear if the new Bill will cover such scenarios or not.

2.6 Likewise, the CDLP observes that:

The reality is that people are usually deprived of liberty not for medical reasons but due to a lack of available, accessible or affordable options to support the person to live well in the community.

2.7 Seconding the concerns expressed by the INMO, detailed in paragraph 1.6, the Rehab Group questions ‘why [...] all three criteria [detailed in Head 2(1)] need to be met in order for someone to be considered as being deprived of their liberty’, calling for ‘the definition of “control”, “continuous supervision”, [and] “being free to leave”’.

*Settings for the deprivation of liberty*

2.8 Calling for the proposed legislation to reflect the ‘onus on the intervener to give effect to the past and present will and preferences of the relevant person, insofar as [these] are reasonably ascertainable’, the NDO and the ASI call for clarity ‘on whether the legislation applies to those in respite care’ or to ‘those people who experience a delay in being discharged from an acute hospital’.

- 2.9 The Division of Neuropsychology of the PSI notes that the ‘deprivation of liberty can occur in settings other than residential settings, such as day services or access to transport’ and that:

There can also be situations where a person is deprived of their liberty by virtue of living with a housemate who requires restrictive practices.

- 2.10 Noting that ‘families may place a person in a hybrid setting’ in which ‘the person may actually live [...] for some time’ and that ‘people may be deprived of their liberty in their own home, or in respite care, or other temporary accommodation’, the NAS expresses the view that ‘the exclusion of certain settings / institutions from these provisions is problematic’.

### *Issues arising*

- 2.11 An individual respondent cautions that the approach adopted in Heads 1–2 will apply to a very large number of people, without differentiation between situations of coercion and situations in which the person seeks to manifest their assent to being in the relevant place. The respondent notes that, if a person who is not subject to apparent coercion and who is content with their living arrangements is considered to be deprived of their liberty, then the potential to utilise arguments based upon Article 5 of the ECHR to bring about a reduction in the level of restrictions imposed upon individuals with complex care-needs will have been lost. The respondent argues that enshrining the proposed definition of the deprivation of liberty in law would run the risk of negating any policy-goal of reducing coercive practices.

- 2.12 The NCPOP cautions that ‘specific issues arise for those persons who are receiving care within acute hospitals’. The NCPOP queries whether section 3 (a) of Head 2 is intended to cover those who ‘are already in a relevant facility on foot of [an] admission decision and require acute care in hospital’ and highlights the issues that could arise in the case of a patient in an acute hospital in respect of whom ‘an “admission decision” is pending’. The NCPOP cites the example of a

patient who was being monitored in [an] acute hospital while awaiting [an] ‘admission decision’, absconds from [the] ward to her home and is promptly brought back to [the] acute hospital by Gardaí (no acute medical needs).

Noting that currently the ‘hospital extends duty of care to these cases based on clinical judgement’ without a legislative basis, the NCPOP questions whether, if such a scenario were to occur after the enactment of the proposed legislation, the ‘decision to detain [would] be considered lawful or unlawful given that it happened outside of a “relevant facility”’.

- 2.13 The NCPOP also highlights the risk that ‘significant issues / implications in terms of court capacity’ could result in the

effective detention of vulnerable persons in acute hospitals with very prolonged lengths of stay [...] simply because this is the only place they can be detained without due recourse to law’.

- 2.14 Noting that ‘the provisions described rely exclusively on the person’s capacity and do not describe the circumstances that should prompt what / when an application relevant to the act should be made beyond this’, the NCPOP expresses concern that the legislation could

erode considerably existing protections under [the ADMC Act], Mental Health Act etc in that it merely requires an opinion to declare ‘non-capacity’ for the application to be pursued.

- 2.15 Noting that ‘the majority of existing residents (79%) in private and voluntary nursing homes are supported by the Nursing Homes Support Scheme [...] and therefore are subject to a “Care Needs Assessment”’, NHI argues:

To create a need to retrospectively review each and every one of these cases is overtly cumbersome and will place additional administrative demands on already over-stretched and under-resourced services.

- 2.16 Both the DSBA and the Irish Mental Health Lawyers Association (IMHLA) call for the broadening of the admissions procedure so that it applies to all admissions—voluntary and involuntary—to relevant facilities, thereby supporting their ‘proper regulation’. The IMHLA further comments that this ‘would also allow for clarification that involuntary entry could only take place as a last resort’.

- 2.17 Both the DSBA and the IMHLA call for the proposed legislation to stipulate that relevant persons ‘may only be admitted / continue to reside in relevant facilities which are independently monitored by a State body’, with the IMHLA citing HIQA as a suggestion for this role.

- 2.18 ABI Ireland observes that:

Head 2 [...] suggests that an option from the decision-making spectrum will need to be identified and formalised for many residents in section 39 organisations.

#### *Suggested textual amendments*

- 2.19 An individual respondent calls for the addition of ‘or to remain at’ after ‘to live in’ in Head 2(1)(c) in order to ensure that the legislation encompasses ‘the cohort of people who are already resident in the facility’.

2.20 The Irish Human Rights and Equality Commission (IHREC)

recommends that Head 2(1)(c) be deleted and replaced with a provision that requires an investigation of whether an individual has consented to confinement, which includes a consideration of whether an individual has capacity to consent as prescribed under the Assisted Decision-Making (Capacity) Act.

2.21 SPMHS calls for the insertion of a sub-section under Head 2(2) to state that 'this Part does not apply to people detained under the Mental Health Acts 2001/2008'.

2.22 Noting that 'parts 3 (a)–(g) do not deal really with the person currently elsewhere (acute hospital, at home or elsewhere)', the NCPOP recommends that two additional clauses should be added to Head 2(3), namely:

3(h) [...] 'establish a procedure to cover the period when a person, who is proposed to live in a relevant facility, is awaiting an admission decision, or is awaiting transfer to the relevant facility after an admission decision' and 3(i) 'establish a procedure for when a person, who is living in a relevant facility is reasonably believed to lack the capacity to make a decision to leave the relevant facility, but requires transfer from that facility, e.g. for acute medical care'.

2.23 An individual respondent calls for an additional clause to be included under Head 2(3), to stipulate that the purpose of Part 13 of the ADMC Act is to:

ensure that decisions about placing a person under continuous supervision and control give due weight to the person's past and present wishes and feelings, will and preference, beliefs and values and other factors that the person would be likely to consider if they had capacity.

2.24 The NDA recommends that Head 2(3) be amended to provide for:

- A procedure setting out how the healthcare professional assesses the relevant person's care needs, including consideration of possible admission to a relevant facility;
- A procedure for the appointment of an independent advocate to the relevant person.

2.25 The MHC calls for Head 2(3)(a) to 'be amended to read "...to lack capacity to make a decision to live in the relevant facility"'.

*Other comments*

2.26 The NRH observes that:

The terms regarding which persons would be included under the legislation [set] out in this Head seem comprehensive and inclusive.

## **‘Capacity’ and ‘reasonably believed’**

A number of respondents comment on the issue of the determination of the ‘capacity’ of a relevant person.

- 2.27 The NAS expresses concern that no reference is made to ‘how capacity is determined or [to] who is making the decision about whether or not the person has capacity’.
- 2.28 Noting that ‘there is a disparity nationally on obtaining capacity assessments’, which are variously performed by consultants and GPs, NHI calls for clarity ‘in terms of seeking the medical evidence required for court application’, recommending that ‘this should form part of the review of the GMS [General Medical Services] GP contract’.
- 2.29 Citing the British Law Commission’s view that ‘the [relevant] person must lack capacity to consent to the care or treatment arrangements which would give rise to a deprivation of that person’s liberty’,<sup>24</sup> an individual respondent observes that ‘a decision to live in a facility that will remove liberty [...] arguably requires a higher level of capacity’ than ‘an accommodation decision’ since

one is consenting not just to the accommodation but to the care, treatment, restrictive practices, medication and the removal of the right to live elsewhere or to leave the facility.

Accordingly, in respect of Head 2(3)(a), the respondent suggests that ‘the components of [the] capacity to make a decision to live in a facility’ should be detailed and that these

should embrace the accommodation decision and the separate decision to consent to the care and treatment provided there, and preferably a separate capacity decision for restrictive practices.

In addition, the respondent calls for the components of the ‘capacity to decide to leave the facility’ to be set out under Head 2(3)(c).

- 2.30 The NCPOP raises concerns about the lack of detail provided on the trigger for applications, suggesting that the safeguards provided are inferior to those provided under the Mental Health Act. The NCPOP observes:

The provisions described rely exclusively on the person’s capacity and do not describe the circumstances that should prompt what / when an application relevant to the act should be made beyond this. It could be argued that this would erode considerably existing protections under [the ADMC Act], Mental Health Act etc in that it merely requires an opinion to declare ‘non-capacity’ for the application to be pursued.

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<sup>24</sup> Law Commission, *Mental Capacity and Deprivation of Liberty* (London, 2017), 70, [http://www.lawcom.gov.uk/app/uploads/2017/03/lc372\\_mental\\_capacity.pdf](http://www.lawcom.gov.uk/app/uploads/2017/03/lc372_mental_capacity.pdf).



- 2.31 The IHREC recommends that 2(1)(c) be deleted and replaced with
- a provision that requires an investigation of whether an individual has consented to confinement, which includes a consideration of whether an individual has capacity to consent as prescribed under the Assisted Decision-Making (Capacity) Act 2015.
- 2.32 The NRH expresses concern that ‘the presumption of capacity as outlined in the ADMC Act and UNCRPD [...] is not specifically stated in the Heads of Bill’ and recommends that this issue should ‘be resolved to ensure a consistent approach which is in line with all relevant aspects of legislation’.
- 2.33 St. Luke’s Nursing Home, Cork emphasises the imperative to
- keep to the forefront the functional test for ‘capacity’ as outlined by Thorpe in “In Re C” [1994] All ER, where it was ruled that the prudent health professional will not merely rely on the diagnosis, but will rather question the patient on why the medical advice is being refused.
- 2.34 Noting that ‘the use of mental capacity as a precondition for valid consent for admission is problematic in a number of respects’, the CDLP comments:
- The right to liberty in human rights law, including the [UN]CRPD, does not include a requirement of mental capacity for its exercise. However, the trigger to activate the safeguards proposed in this bill is a presumed lack of capacity. [...] The bill’s starting point links the perceived existence or absence of mental capacity to the right to liberty, as that is the trigger for deprivation of liberty according to the bill. This creates a second category besides involuntary patients under the Mental Health Act, with higher barriers to challenge the deprivation of liberty, to seek a review of the detention, or release.
- In respect of this issue, the CDLP further states:
- As is well-established in the literature, assessments of mental capacity are inherently subjective and value-laden, and their results can be arbitrary and inconsistent. Therefore, to consider everyone who is suspected to lack capacity to be deprived of liberty would result in an overly-broad approach and fail to recognise the autonomy of people to make decisions about where and with whom to live.
- 2.35 A number of respondents call for a clear definition of the term ‘reasonably’ in Head 2 (3(a), 3(c) and 3(d)). For instance, an individual respondent seeks clarification of the grounds for determining that a person is ‘reasonably believed’ to lack capacity, noting the necessity for detailed knowledge of capacity assessments and their implementation.

2.36 SAGE comments that:

- Under Head 2(3)(a) the term ‘reasonably believed’ to lack capacity does not adequately reflect the requirement that a person’s capacity should be assessed functionally to determine if the person has the capacity to make the relevant decision.
- Head 2(3)(a) does not adequately reflect who will assess and determine the person’s capacity to make the decision whether or not to reside in a ‘relevant facility’.
- The current wording of Head 2(3)(a) places the decision to reside in a ‘relevant facility’ (to be admitted) ahead of the process to assess the person’s capacity to make the decision itself to reside in a ‘relevant facility’.

2.37 In an instance in which ‘a healthcare professional forms a view about the [relevant] person’s care and treatment needs and their capacity to make the [admission] decision’, the NDA calls for Head 2 to stipulate that the healthcare professional ‘should speak with the relevant person about possibly making a co-decision-making agreement and / or an enduring power of attorney’.

### **‘Chemical restraint’ and ‘restraint practices’**

A number of specific comments were made about the proposed prohibition of the use of chemical restraint in relevant facilities and of restraint practices ‘unless there are exceptional circumstances and in accordance with regulations prescribed by the Minister’, as detailed in section (3) subheads (f) and (g).

2.38 The NAS queries:

Who will determine when something is an ‘exceptional circumstance’ and how will this be decided and monitored? What safeguarding will be in place around the use (or potential misuse) of restraint practices—how is this to be monitored? What will constitute ‘restraint practices’?

2.39 HIQA makes the following observations in relation to chemical restraint:

It is HIQA’s experience that chemical restraint is used in both disability and older persons’ services. There are a number of perspectives on the current use of medication. While medication may be initially prescribed to treat a medical condition, providers and staff describe its use as a control on the behaviour of service-users and have identified it as a restraint in their communications with HIQA.

HIQA urges the Department to ‘engage with service-users, service-providers and health and social care professionals with a view to establishing the reality of chemical restraint use nationwide’.

2.40 Noting that ‘there are already regulations in existence which govern the use of restrictive practices in designated centres’, HIQA comments that:

The use of chemical restraint is one instance of where the current regulations may be at odds with the provisions of the proposed legislation.

Specifically, HIQA observes that Head 2(3)(f) is ‘in conflict’ with section 7(4) of Part 2 of the Health Act, 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations, 2013, which states:

The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence-based practice.<sup>25</sup>

Accordingly, in addition to calling for ‘the development of a statutory code of practice or guidance on the use of restrictive practices’, HIQA recommends that:

If the Minister proposes to make regulations under this Act, care should be taken to ensure that existing regulations are brought into line with any provisions under the new regulations.

- 2.41 An individual respondent calls for ‘restrictive’ to be substituted for ‘restraint’ in Head 2(3)(g).

## Wards of court

- 2.42 The Catholic Institute for Deaf People (CIDP) queries why the legislative provisions do not apply to wards of court.

- 2.43 The NDA also calls into question why wards of court are being excluded from the ambit of the legislation, commenting:

It is not clear from the Explanatory Notes why the Head—and proposed legislation—would not apply to wards. Not including wards would result in them not having access to the new procedures and safeguards available to others under this draft legislation, resulting in their unlawful admission and continued deprivation of liberty in relevant facilities which the proposed legislation is seeking to change.

- 2.44 Citing the National Safeguarding Committee’s *Review of Current Practice in the Use of Wardship for Adults in Ireland* (2017), both the CDLP and Inclusion Ireland highlight the limitations of Ireland’s wards of court system.<sup>26</sup> The CDLP

<sup>25</sup> See Health Act, 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations, 2013, 6, <https://health.gov.ie/wp-content/uploads/2014/03/si201303671.pdf/>

<sup>26</sup> See National Safeguarding Committee, *Review of Current Practice in the Use of Wardship for Adults in Ireland* (2017), <https://www.safeguardingireland.org/wp-content/uploads/2018/10/Wardship-Review-2017.pdf>. The National Safeguarding Committee was renamed Safeguarding Ireland in 2018.

observes that this relies “excessively on the integrity of families and professionals acting in the “best interests” of “vulnerable adults” and that “there are insufficient checks to ensure that the interests of the proposed ward are independently considered and possible conflicts identified”. Inclusion Ireland cites the National Safeguarding Committee’s stated concern that ‘the principles recognising the fundamental human rights of people with disabilities in the [UNCRPD] “are given no recognition in the current wardship system”’.<sup>27</sup>

- 2.45 Cognisant of the limitations of the current wards of court system, both the CDLP and Inclusion Ireland express concern about the exclusion of wards from the proposed legislation, as stipulated in Head 2(2). Inclusion Ireland comments that this is ‘unacceptable and not compliant with the UNCRPD’ while the CDLP observes that wards

can still be deprived of their liberty by the Court/Committee of the Ward without any remedy or way of appealing the decision.

While Inclusion Ireland comments that ‘safeguards on deprivation of liberty encompassing wards of court would go a long way to ensuring that such situations do not arise’, the CDLP recommends that:

The Bill must recognise that wards can be deprived of their liberty and provide an effective remedy to ensure that this detention can be challenged and the person’s liberty restored.

- 2.46 Observing that, ‘under [the] ADMC Act, wardship is being transitioned out’, the Division of Neuropsychology of the PSI comments that ‘this should be made explicit’ in the Heads of Bill.

- 2.47 While acknowledging ‘that the wards of court system will be abolished following commencement of the 2015 [ADMC] Act’, the HSE Assisted Decision Making National Office emphasises that:

Those who are currently in the wardship system should be offered the same protections as those who aren’t in the wardship system. Exclusion of wards of court is discriminatory and not in compliance with the UNCRPD. This Part of the 2015 Act should be amended to include anyone who lacks capacity and is admitted to a relevant facility.

- 2.48 Noting that ‘the wards of court are all due to be reviewed within three years as per the ADM Capacity Act 2015 and will be either discharged from wardship or reassigned somewhere on the decision-making spectrum’, ABI Ireland comments that, while the proposed legislation ‘may not apply to Wards now it will apply to some current wards in the future’.

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<sup>27</sup> *Ibid.*, 24.

*ECHR and UNCRPD compliance*

2.49 The Law Society of Ireland and Safeguarding Ireland note that the stipulation that the legislative provisions will not apply to wards of court 'is not in compliance with either the ECHR or the UNCRPD'.

2.50 SAGE likewise observes that:

Exclusion of wards from the Heads of Bill is discriminatory and not in compliance with the UNCRPD.

2.51 Similarly, the INMO observes that the exclusion of wards of court from the proposed legislation 'does not seem to follow the UNCRPD'.

### **Chapter 3: Head 3 – Person’s Capacity to Make a Decision to Live in a Relevant Facility in Advance of an Application to Enter the Relevant Facility**

Head 3 makes provisions for healthcare professionals to communicate with third parties in instances in which they have determined that a relevant person requires admission to a relevant facility but lacks the capacity to decide to live in such a facility. This is with a view to facilitating applications to court for admission decisions under Part 5 of the ADMC Act. Accordingly, as stated in the Explanatory Notes:

The purpose of this Head is to ensure that concerns about an individual’s capacity are identified as early in the process of planning for admission to a relevant facility as possible.

The Explanatory Notes further state that:

It is anticipated that a campaign encouraging the use of the decision support mechanisms of the Assisted Decision-Making (Capacity) Act and enduring powers of attorney will coincide with the commencement of the Act to avoid the need to attend court.

#### **Question 3.1: Do you have any views specific to Head 3?**

#### **Respondents’ comments**

#### **Definition of a ‘healthcare professional’**

- 3.1 An individual respondent expresses concern that Head 3 empowers ‘any “healthcare professional” [...] to determine that a person requires admission’. Noting the breadth of the definition of ‘healthcare professional’ in the ADMC Act, the respondent expresses concern that ‘a newly qualified podiatrist [...] gets the power to form a professional opinion regarding residence capacity’.<sup>28</sup>
- 3.2 NHI seeks clarity on the definition of ‘healthcare professional’ to which Head 3 refers, noting that the assumption ‘that either the GP or the PHN [public health nurse] are the primary source of referral for admission to a nursing home’ is undermined by statistics which indicate that ‘the majority of applications for [the] NHSS [Nursing Homes Support Scheme] “Fair Deal” are commenced in secondary care’. Accordingly, NHI recommends that:

The healthcare professional referred to under this Head should be limited to a medical expert or medical practitioner, as required by the European Convention on Human Rights and the Assisted Decision Making (Capacity) Act.

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<sup>28</sup> ‘Healthcare professional’ is defined in the ADMC Act as ‘a member of any health or social care profession whether or not the profession is a designated profession within the meaning of section 3 of the Health and Social Care Professionals Act 2005’. See <http://www.irishstatutebook.ie/eli/2015/act/64/section/2/enacted/en/html#sec2>.

- 3.3 Commenting that ‘it is assumed that the healthcare professional is the person’s GP, consultant or public health nurse’, an individual respondent emphasises that:

It is important to expressly clarify this to distinguish between them and the references in other Heads to a healthcare professional acting on behalf of the person in charge.

- 3.4 Reporting that ‘current practice [...] is that a multi-disciplinary team make a recommendation that the older person requires care in a residential setting’, and that ‘a local placement forum actually determines where the older person’s care needs are best met’, the IASW observes that ‘some consideration will have to be given as to which professional is being referred to under Head 3’. The IASW emphasises that ‘all healthcare professionals will require knowledge as to how one determines if there is a decision-making representative, co-decision-making agreement or EPA [enduring power of attorney] in place’.

### **Determining the capacity of a ‘relevant person’**

#### *The role of healthcare professionals*

- 3.5 A number of respondents emphasise that, in advance of making a decision about a relevant person’s admission to a relevant facility, healthcare professionals should ensure their adherence to the guiding principles of the ADMC Act, 2015.

- 3.6 SAGE comments that:

In making a determination in relation to a person to reside in a ‘relevant facility’, the healthcare professional should be required to outline the benefit of the intervention for the person as required in section 36(5) of the ADM[C] Act 2015 in relation to an application to Court.

- 3.7 The NDA calls for clarification to be provided within Head 3 on how the care-needs and decision-making capacity of relevant persons will be assessed by healthcare professionals, observing that:

It is currently unclear how this will be done and how the relevant person will be actively involved in the decision which may involve their admission to a relevant facility and them being deprived of their liberty.

Expressing the view that this omission ‘would result in the proposed legislation being at odds with Part 2 of the 2015 [ADMC] Act’, the NDA calls for the Heads to outline ‘the process to be followed by the healthcare professional, following the guiding principles set out in the 2015 Act’.

- 3.8 The HSE Assisted Decision Making National Office likewise expresses concern that the process by which the healthcare professional determines that a relevant person requires admission to a relevant facility ‘is not detailed’,

emphasising that this needs to be based on a functional assessment and to be cognisant of the guiding principles of the ADMC Act.

- 3.9 The HSE National Safeguarding Office and HSE's Older Persons' Services advise that there may be a need to designate within Head 3 the 'role of [a] registered health care profession[al] to undertake [a] social background assessment'.
- 3.10 Likewise, Safeguarding Ireland calls for Head 3 to 'specify that a social enquiry report and assessment of need [will be] carried out by a registered healthcare professional', stating that:

This report would look at home and social living circumstances/independent living capacity and consider issues such as frailty and social isolation. It would also contain evidence that any proposals on loss of liberty are the least restrictive option.

In line with this proposal, Safeguarding Ireland and the Law Society of Ireland call for Head 3(1) to state:

Before a healthcare professional determines that a relevant person requires admission to a 'place of residence' he or she must act in accordance with the guiding principles and must state the following:

- The benefit to the relevant person sought to be achieved by admission to a 'place of residence';
- The reason why the benefit to the relevant person sought to be achieved has failed to be achieved in any other appropriate, practicable and less intrusive manner;
- That every effort was made to permit, encourage and facilitate, in so far as practicable, the relevant person to participate, or to improve his or her ability to participate, as fully as possible in the decision as to where the relevant person should live;
- Effect was given, in so far as is practicable, to the past and present will and preferences of the relevant person as to where he or she should live.

Safeguarding Ireland and the Law Society of Ireland further recommend that Head 3(1)(a) should then commence:

Head 3(1)(a) Subject to the guiding principles being followed and a statement as set out above being complied with and where a healthcare professional determines that a relevant person requires admission.

- 3.11 Noting that 'busy health professionals prefer [...] to tick boxes on the capacity form rather than complete a detailed narrative justifying their reasons for stating that the person lacked capacity', an individual respondent calls for there to be a requirement for the completion of 'a capacity assessment form [...] by the healthcare professional setting out their reasons for stating that the person lacks the relevant capacity', and for 'the form [to] provide for narrative boxes which must be completed which will assist in ensuring that the functional test



has been used correctly'. Acknowledging that, while 'objections [to a relevant person living in a relevant facility] are not relevant to establishing a deprivation of liberty, they are relevant to the care plan and to the likely use of restrictive practices', the respondent also calls for there to

be a separate form dealing with the requirement under Head 3(1)(a) providing reasons why the person cannot continue to live in their own home or in a less restrictive environment and listing the persons consulted by the healthcare professional, their views and the person's views and the degree of objections to the person living in the facility.

The respondent further recommends that 'the healthcare professional should set out why a particular facility was chosen', disclosing 'any financial or other connection with the facility to avoid a conflict of interest and specify any financial interest by a member of his family in the facility'; and that:

The capacity assessor, potential resident, their advocate or/and person with lawful authority should be provided with the restrictive interventions policy of the facility before admission.

- 3.12 Expressing concern that, under Head 3(1) it falls to a single healthcare professional to determine a relevant person's capacity to live in a relevant facility, MHR calls for 'multi-disciplinary input [to] be required in identifying a concern about a person's capacity (or lack thereof)'. Accordingly, MHR recommends that Head 3(1b) should make

reference to 'presumption of capacity' of the person, in addition to the provision of decision-making supports, where necessary, prior to a decision being made about a person's deprivation of liberty.

- 3.13 Similarly, the INMO opines that 'insufficient attention is paid to the role of the multidisciplinary team in relation to the assessment of a relevant person's capacity, commenting:

While the ultimate responsibility for a[n admission] decision may rest with an individual, we believe that where such decisions are to be made, the proposed language should be enhanced by referring to a decision being made; '...where appropriate following consultation with the multidisciplinary team'.

- 3.14 The Division of Neuropsychology of the PSI also suggests that 'a team-based assessment' may assist with the evaluation of a relevant person's capacity, and that this might encompass 'for example psychology, social work and [a] manager who has access to [the] budget and can action specific needs'.

- 3.15 Cautioning that 'the decision to move to a residential facility should not be made on the sole advice from one medical expert', the Irish Hospice Foundation (IHF) calls for the involvement of

a broad range of people to include the person, their family and healthcare professionals who use a holistic, person centred approach that moves away from the medical model of care.

- 3.16 The NRH calls for ‘health and social care professionals other than a registered medical practitioner [to] be able to provide medical evidence’, observing:

Often the expertise of psychologists, speech and language therapists and occupational therapists are [*sic*] required to assess and/or to demonstrate that all reasonable efforts have been made to facilitate the relevant person’s capacity in so far as possible. Social workers often assess the family situation and/or the family’s understanding of previous known wishes and preferences of the person and manage the aspect of adult safeguarding where relevant.

- 3.17 The IASW suggests that consideration might usefully be given to the development ‘of a post based on the Authorised Officer under the Mental Health Act (2001)’, who ‘would be a senior professional (social worker, nurse, therapist, psychologist, etc) working in the field of older persons services, disability services and / or mental health services’ who would be trained to make admissions decisions. The IASW envisages that such an officer could assist in instances in which ‘there is no decision-making representative, co-decision-making agreement or EPA is in place’.

#### *Other comments*

- 3.18 An individual respondent expresses concern that Head 3 ‘does not give fair notice of what conditions must be met’ to underpin the healthcare professional’s determination that a relevant person requires admission to a relevant facility, querying ‘what must exist in relation to the cared-for person before the health professional can trigger the protective-placement process’. The respondent recommends that ‘the Head should make [it] clear’ that:

It provides for both paternalistic intervention (protecting the cared-for person’s safety and welfare) and police-power (protecting against dangerous behaviour by the cared-for person).

Noting that article 5 of the ECHR ‘requires the objective existence of an “unsound mind” as a condition for confinement’, the respondent suggests that ‘it is strongly arguable that the healthcare professional should be required to have reason to believe that the cared-for person is of unsound mind’.

- 3.19 SAGE observes that:

Head 3(1) and the accompanying Explanatory Note 1 are not in line with the principles of the ADM[C] Act, which creates a statutory presumption of capacity [and] states that a person’s capacity should be assessed functionally.

SAGE further notes that ‘the process as outlined in Head 3 does not enable a process of capacity building with the person and supported decision-making’ as required under the Act.

- 3.20 Noting that ‘the role of the appointed advocate or decision-maker, should one exist, is unclear’, MS Ireland observes that:

[Head 3] appears not to be fully in accordance with the Assisted Decision Making (Capacity) Act as there is no mention of capacity building to support decision-making or co-decision-making.

- 3.21 In respect of the determination of a relevant person’s capacity, MS Ireland observes:

There is [...] no mention of the stipulation in the Assisted Decision Making (Capacity) Act that capacity or lack of capacity can no longer be determined by single one-off tests but will be context and situation-specific. For example, the relevant person may have capacity to make decisions regarding where they live, but not to have full control over their financial affairs. No mention is made in this section of the Bill as to how capacity will be determined in the specific context of deciding whether the relevant person should be admitted to a facility whereby they will be deprived of their liberty.

- 3.22 The Division of Neuropsychology of the PSI calls for ‘greater clarity [...] on what an assessment of DMC [decision-making capacity] is assessing’, querying:

(1) Is the person being assessed as to their ability to decide on moving home with full awareness and acceptance of identified risks? (2) Or is the ability to decide upon moving to LTC [long-term care] with the option of leaving, should this arrangement be deemed unsuitable/unsatisfactory at a future point [being assessed]? Or (3) [Is] the ability [to] decide upon moving to LTC without an option of leaving [being assessed]?

Noting that ‘decisions on capacity will be intrinsically linked to the availability of [...] resources’, the Division of Neuropsychology further questions whether

there [is] an assumption [...] that a healthcare professional’s determination that a person requires increased support and supervision equates to a determination that LTC / residential care is the only environment that can provide same.

- 3.23 Noting that ‘a reasonable belief’ is the ‘proposed standard to be applied by a healthcare professional in relation to a decision as to a lack of capacity’, the IHREC observes:

The draft heads propose that this standard be applied in both routine and urgent circumstances. This approach differs from that applied under the Mental Health Act 2001, where the views of healthcare professionals are subject to a lower threshold in emergency circumstances. The UN

Committee on the Rights of Persons with Disabilities has stated that States 'must respect and support the legal capacity of persons with disabilities to make decisions at all times, including in emergency and crisis situations'.

- 3.24 The NDA suggests that, further to the appointment of an independent advocate to the relevant person and further to the receipt from the advocate of a report on the relevant person's decision-making capacity,

the Director [of the DSS] may decide to make an application to court or send out a Special Visitor to assess the relevant person's capacity to make the decision and report back to her. Based on the Special Visitor's report, she may make an application to court for a determination if required.

- 3.25 NHI calls for the revision of article 7 of the Nursing Homes Support Scheme Act, 2009 to make reference to 'the exact information that is required to be documented in the care needs assessment for compliance with this proposed legislation' and for the 'Common Summary Assessment Record / Single Assessment Tool [...] to be revised [...] for this purpose'. Specifically, NHI recommends that, where appropriate, the care needs assessment report on which admission to a nursing home is based should

explicitly document where it is unlikely that a person will ever cease to require care services or whether the person is a relevant person and is likely to be deprived of their liberty, by reason of their admission to the relevant facility (i.e. nursing home).

NHI further suggests that in order 'to ensure that full and complete assessments are carried out by the relevant medical expert', the report should 'be subject to regulatory oversight by the Director' of the DSS.

- 3.26 In order to ensure 'that a person's capacity is not being assessed too far in advance of the application being made', the HSE Assisted Decision Making National Office recommends that the title of Head 3 should be changed to 'person's capacity to make a decision to live in a relevant facility at the time of an application to enter the relevant facility.

- 3.27 SAGE expresses concern that, although 'the decision to live in a "relevant facility" is not yet made', the 'phrasing of Head 3(1)(b) implies the outcome of the decision is already determined'.

- 3.28 The MHC opines that Head 3(1)(b) 'is a repetition of sub-head (1)(c) of Head 2' and that, accordingly, 'it is superfluous and should be deleted'.

## Supporting 'relevant persons'

### 3.29 The NDA emphasises that:

An assessment of the relevant person's capacity to make the decision about their care, and possible admission to a relevant facility, should only be undertaken, if they have been given all appropriate assistance and support, in line with the guiding principles of the 2015 Act, and the assessment of their capacity to make the decision is in compliance with Section 3 of the Act of 2015.

Accordingly, noting 'the need for the healthcare professional to support the relevant person as far as possible to make the decision about their admission', the NDA calls for healthcare professionals to

provide a statement of how he or she applied the guiding principles in supporting the relevant person to make a decision about their care and treatment. [...] If the relevant person could not make the decision, even after all supports practicable were provided, but he or she expressed a wish or a preference about admission, it should also be noted by the healthcare professional.

### 3.30 Likewise, the NAS argues that:

There should be a positive duty on the 'professionals' to justify how they reached the conclusion of a person lacking capacity thus depriving them of their liberty. They should be required to show that all efforts were taken to support the person's capacity and that communication around the decision was made in a communication style that was suitable for the relevant person.

### 3.31 Opining that 'Head 3 is unclear regarding the support that a relevant person should receive while making the decision to live in a relevant facility', the HSE Assisted Decision Making National Office emphasises that, as per the ADMC Act, 'the relevant person should be involved as far as practicable in making the decision to move into a relevant facility'. Accordingly, the HSE Assisted Decision Making National Office recommends that:

The current 3(1) should become 3(2) and a new 3(1) should be developed, highlighting the process that needs to be undertaken to maximise the relevant person's capacity to make the decision to live in a relevant facility. This should be based on the guiding principles of the 2015 Act, promoting participation of the relevant person in the decision as far as possible.

### 3.32 The Central Remedial Clinic (CRC) recommends that:

The Heads of Bill should be more in line with the provisions of the Assisted Decision-Making (Capacity) Act in terms of the supports that people could have through assisted decision-making, co-decision-making and representative decision-making and through advance healthcare directives.

- 3.33 Noting that Head 3(2) empowers the healthcare professional to notify decision-making representatives, relevant persons and other specified persons of their 'determination that the relevant person requires to be admitted' to a relevant facility 'in writing in the prescribed manner', an individual respondent raises concerns about 'the supports' that will be made available to relevant persons with 'literacy or visual problems' to help them to understand the decision, observing that:

The [ADMC] Act 3(3) notes: A person is not to be regarded as unable to understand [the] information relevant to a decision if he or she is able to understand an explanation of it given to him or her in a way that is appropriate to his or her circumstances (whether using clear language, visual aids or any other means).

- 3.34 The NAS calls for the stipulation in Head 3(3) that healthcare professionals will notify relevant persons 'in the prescribed manner' of their decision to admit the person to a relevant facility

to be expanded upon in terms of how this communication is delivered to the person ensuring they have optimum opportunity to understand it and feedback if possible.

Stressing that, in accordance with the guiding principles of the ADMC Act, 'any communication to the relevant person' should be 'done in a way which the person can understand', the NAS calls for the relevant person to 'be given the option of having support when this information is being provided'.

- 3.35 The HSE National Safeguarding Office and HSE's Older Persons' Services call for the proposed legislation to make

greater provision for support and intervention to be given to a person to maximise his or her capacity to make an admission decision before a healthcare professional forms a view that the relevant person lacks capacity and if there is no person with authority to consent to the admission to trigger an application to court.

- 3.36 Observing that 'the focus is on the [relevant] person's "capacity" and effective detention in an "all-or-nothing" situation', the NCPOP calls for there 'to be an emphasis on the protections that can be effected for the person at any point beyond the admission decision'.

- 3.37 Emphasising that 'WRAP [Wellness Recovery Action Plan] is a good model of forward planning', Rehab Group service-users recommend that:

Opportunities should be sought while an individual is well to seek their preferences and allow them to [...] plan for times when they cannot speak for themselves.

- 3.38 An individual respondent expresses concerns about whether due regard will be shown for the privacy of relevant persons, opining:

A healthcare professional will write to people, no doubt including personal and private information about a relevant person, without the permission of that person. The functional nature of capacity assessment (and the presumption of capacity) means that potentially lacking capacity to make one decision (where to live) does not imply lacking capacity to decide who should receive information.

- 3.39 An individual respondent observes that, while the Explanatory Notes to Head 3 state that ‘by making an application to court on behalf of the relevant person, legal aid can be availed of’, there is no reference to the ‘provision of legal aid for the person themselves if they wish to challenge the application’.
- 3.40 Likewise, noting that legal aid will be made available to those making a court application on behalf of a relevant person, the IASW queries whether it will also be available to relevant persons themselves.
- 3.41 The CRC emphasises that ‘everyone should have the right to access support to help with legal decisions about their liberty’ in line with the UNCRPD.

#### **Healthcare professionals’ notification of appointed or specified persons**

- 3.42 Noting that Head 3(2) ‘gives discretion to the healthcare professional to notify persons with lawful authority and the potential resident’ of their ‘determination that the relevant person requires to be admitted’, and that the Explanatory Notes state that healthcare professionals ‘should seek to ascertain whether any third party has legal authority to admit the person to a relevant facility’, an individual respondent calls for it to ‘be mandatory’ for the healthcare professional ‘to notify persons with lawful authority and the resident’.
- 3.43 Observing that ‘the healthcare professional appears to have an obligation to notify people’, Saint John of God Community Services comments:

This differs from the procedure under the Mental Health Act where it is the obligation of the person making an application under Part II of MHA 2001 to submit or produce this application to the healthcare professional (medical practitioner in the case of MHA 2001) so specific procedures will need to be considered in this regard.

- 3.44 In respect of the provision in Head 3(3) for a healthcare professional to notify a ‘person or persons specified by the relevant person [...] of his or her determination that the relevant person requires to be admitted and [...] lacks the capacity to decide to live in the relevant facility’, ABI Ireland commends the requirement for

the healthcare professional (HCP) to establish whether there is already someone on the decision-making spectrum as per the ADM[C] Capacity Act 2015, and [...] to formally notify the person who may be admitted and anyone else they nominate.

- 3.45 Opining that the ‘notification of the individuals specified by the relevant persons in all circumstances pertinent to the relevant person’s liberty is of the greatest importance’, St. Luke’s Nursing Home, Cork recommends that:

A proper procedure to be followed should be set out in a ‘Code of Practice’ and the simplicity of this code should be paramount.

- 3.46 The NRH welcomes ‘the obligation for the health and social care professional to make enquiries as to arrangements which may already be in place, such as co-decision-maker, under the [ADMC] Act’, but cautions that ‘the challenge [...] will be in terms of speed of response from other parties particularly at a time of crisis for many families’.
- 3.47 The NRH cautions that the proposal, detailed in Head 3(2), to empower healthcare professionals to notify decision-making representatives ‘specified by the relevant person’ of their ‘determination that the relevant person requires to be admitted and [...] lacks the capacity to decide to live in the relevant facility’ will ‘require tight time frames in terms of access to legal proceedings to prevent reduced access to national beds’.
- 3.48 Noting that the NDA is ‘devising the statutory codes relating to the ADCMC Act’, which ‘go some way to outlining the types of people who may be consulted’ in an instance in which ‘the relevant person is not in a position to state who should be contacted’, HIQA asks:

What would happen in circumstances where the relevant person does not or cannot specify anyone to be contacted? Is there scope for the inclusion of text which would allow other persons to be contacted with a view to making the appropriate application to the court under Part 5? Perhaps contact could be permitted with persons who may be reasonably expected to know the will and preference of the relevant person?

- 3.49 In respect of Head 3(3), an individual respondent cautions:

Persons with severe ill health may be unable to furnish the professional with the contact details of relevant family members. The professional should be obliged to notify family members whose contact details have been furnished by professionals or neighbours where it would be in the interests of the relevant person that those members be notified. This is more relevant to a single person with no children who may have infrequent contact with extended family.

- 3.50 Saint John of God Community Services expresses concern that ‘relevant persons who may not have the capacity or ability to specify people’ to be contacted ‘could possibly be disenfranchised if this circumstance is not taken into consideration’.



- 3.51 The HSE National Safeguarding Office and HSE's Older Persons' Services note that 'difficulties might arise if the relevant person names people about whom there are safeguarding concerns'.

### **The role of decision-making supporters**

- 3.52 Safeguarding Ireland maintains that 'the distinction between 3(2) and 3(3) is not tenable except perhaps in the case of a decision-making representative who has been appointed by the court and can revert to the court at any time'. Safeguarding Ireland further states that '3(2) as drafted is at variance with the provisions of the guiding principles of the ADMC Act' and 'not appropriate for a number of reasons', namely:

If there is no person (either appointed by the relevant person or by the court) with authority to make an admission decision, then in compliance with the guiding principles, it must be established if the relevant person can either make the relevant decision (admission decision) or has the capacity to appoint a co-decision-maker to jointly make the decision with him or her or has the capacity to appoint an attorney under an enduring power of attorney and give such attorney authority to make an admission decision. [...]

Apart from the decision-making representative who can revert to the court at any time, neither the co-decision-maker nor the attorney has any [...] authority to [make an application to court under Part 5]. While there is such provision under Section 36(4) [...], the Head as drafted does not provide that account must be taken of the will and preference of the person in the particular circumstance. A live example might best illustrate the point, where a person has given an attorney authority to deal with his or her property and affairs but has stated 'over my dead body will I give him authority to put me into a nursing home.' The right of a person not to give authority for specific decisions must be fully respected and not simply be overridden when the person lacks capacity.

- 3.53 The HSE Assisted Decision Making National Office also notes that Head 3(2) 'is inconsistent with the guiding principles of the 2015 Act' and calls for it to be revised to reflect the fact that

while the decision-making representative can revert to the court at any time, the co-decision-maker and the attorney do not have the authority to do this under a co-decision-making agreement or an enduring power of attorney.

Accordingly, the HSE Assisted Decision Making National Office advises that the 'Head needs to be amended to ensure that only people with authority can make an application to court in respect of the relevant person'.

- 3.54 The NDA questions the appropriateness of giving co-decision-makers or attorneys 'the opportunity to make an application to court under Part 5 [of the ADMC Act] where necessary' on behalf of a relevant person, as indicated in Head 3(2). Noting that these decision-making supporters would 'not have

authority in relation to whether the relevant person should be admitted', the NDA argues that:

Contacting these decision-making supporters in relation to whether the relevant person should be deprived of their liberty and expecting them to make a Part 5 application is questionable.

The NDA further observes:

The relevant person may have had good reason not to give them that authority in the first place and may not wish them to have any authority in this area of their lives so contacting them and expecting them to make a Part 5 application may not be appropriate.

- 3.55 Noting that 'by definition, the decision(s) where [co-decision-makers, decision-making representatives and attorneys] have authority do not include deciding where someone should live', an individual respondent expresses concern that such decision-makers 'are all given a privileged position in these proposals'. Emphasising that, for example, 'lacking capacity to make one decision (where to live) does not imply lacking capacity to decide who should receive information', the respondent questions:

Why should a co-decision maker appointed, for example, by a relevant person to assist them in making a specific once-off financial decision be notified of anything unrelated to that specific decision?

- 3.56 The CIB calls for 'the differentiation between assisted decision-making and co-decision-making [to be] defined more specifically'.

- 3.57 Noting that "'personal care" as defined in Section 4 of the 1996 [Powers of Attorney] Act does not extend to healthcare', the MHC calls into question the validity of the decision-making role assigned to registered EPAs in Head 3. The MHC argues that assigning this role to an EPA is inappropriate given that 'healthcare matters will almost invariably arise in the context of admission to a facility'.

- 3.58 The NDA notes that, in respect of applications to court on behalf of a relevant person, section 36 (5) (c) of Part 5 of the ADMC Act places

an onus on the applicant for the purposes of Part 13 of the Act, to explain to the court what other less intrusive ways have been attempted to support the person to make the decision about their admission to a relevant facility and why they have failed.

- 3.59 Emphasising that, in accordance with 'the guiding principles of the ADM[C Act], particularly section 8(7)(b)', the decision-making process must 'respect the will and preferences of the relevant person', the CDLP argues that:

Decision-making representatives and holders of a power of attorney should not be authorized to deprive a person of liberty as proposed by the heads of Bill.

The CDLP further emphasises that, in an instance in which an appointee under the ADMC Act is authorised to

make a decision which results in a deprivation of liberty [...] where the decision does not respect the will and preferences of the relevant person [...] there must be an opportunity to challenge the decision-maker and a process to discover the person's will and preferences.

Recognising that 'in some cases, it will not be possible to determine with absolute certainty the true will and preferences of the relevant person', and recognising the imperative 'to protect the individual's right to autonomy and equal recognition before the law as set out in the [UN]CRPD', the CDLP recommends that:

In these circumstances, a court must make the best interpretation possible at that time, based on all available information, of what the relevant person's will and preferences would be concerning the decision to enter or remain in a relevant facility.

- 3.60 Noting that a significant number of people 'self-refer for admission to a nursing home on a purely private basis' and that 'in these instances, there may not be a healthcare professional making a determination for admission and [that] the obligation could therefore be transferred to the person in charge of the nursing home', NHI reports that:

There is a real and genuine concern from PICs [persons in charge] [about] the obligations to make enquiries as to whether a co-decision-making agreement or a relevant order under 3 (1) (ii) to 3 (1) (v) is in place.

Noting that this is 'simply unachievable in practice' since it is unclear how such enquiries should be made and to whom they should be addressed, NHI

asserts that the obligations in this Head should be solely for general practitioners in the community or the lead medical expert or medical practitioner involved in conducting the statutory care needs assessment in acute services.

## **Independent advocacy**

- 3.61 The IHF emphasises that:

Safeguards must provide for an independent advocate to ensure that the rights, will and preferences of the person are taken into account when reaching a decision to move to a residential facility.

3.62 Likewise, SAGE recommends that:

The right of access to an independent advocate and the process of engaging an advocate for a person by the healthcare professional should be included in Head 3, with access to an advocate as early as possible in the decision-making process.

3.63 Observing that 'independent advocates play a key role in supporting people to have a stronger voice and to have as much control as possible over their lives' and that 'an independent advocate may support the relevant person to access [...] decision-making supporters', the HSE Assisted Decision Making National Office comments:

It is essential Head 3 is redrafted to provide that the relevant person is able to access an independent advocate in situations where they do not have any decision-making supporters to help them make the decision about their care.

3.64 The INMO emphasises that, in order 'to ensure that the best interests and rights of the relevant person are fully considered and their perspective adequately advanced', there is an imperative for the relevant person to have 'access to an independent advocacy service or an independent advocate'.

3.65 The NDA calls for the proposed legislation to make provision for the appointment of 'an independent advocate' to a 'relevant person', stating:

If the relevant person does not have an advocate to support them or a decision-making representative, designated healthcare representative or attorney with the authority to decide whether they should be deprived of their liberty, an independent advocate should be made available to the relevant person.

Noting that 'the 2015 [ADMC] Act provides for a statutory code for advocates' which interprets them as being independent, 'linked to an organisation and free from conflict of interest with the relevant person', the NDA recommends that, in instances in which a relevant person does not have an advocate, the healthcare professional who has determined that they

may need admission to a relevant facility and may lack capacity to make that decision, [...] should contact the Director of the Decision Support Service and request that she appoint an independent advocate within a defined time-period, from a panel of trained independent advocates, to the relevant person.

Envisaging that the independent advocate would 'would work with the relevant person to help them voice their will and preferences about their proposed care and where possible, to support them to make the decision', the NDA opines that this 'would act as an important safeguard to protect and promote [the relevant person's] human rights and their right to autonomy' as well as serving

to reduce the number of cases brought before the courts in respect of the deprivation of liberty.

- 3.66 Arguing that ‘the role of independent advocates in supporting persons with disabilities is of fundamental importance’ and ‘that independent advocacy can play a key role in facilitating persons to understand and to exercise choice over their decision-making rights’, Inclusion Ireland describes the absence of independent advocacy from the ADMC Act as ‘a fundamental flaw’. Accordingly, Inclusion Ireland recommends the amendment of the ADMC Act through the proposed legislation

to provide for the right to an independent advocate, not only where there is a deprivation of liberty but where there is a decision-making representative appointed.

Noting that ‘in Ireland, the provision of advocacy is fragmented’ and that ‘the current National Advocacy Service [...] is limited in reach and not resourced to adequately support all persons with disabilities’, Inclusion Ireland calls for the establishment of ‘a National Advocacy Authority [...] that has responsibility for coordination and oversight of all forms of advocacy services’.

- 3.67 Safeguarding Ireland argues that, in instances in which ‘the relevant person does not have the capacity to enter into a co-decision-making agreement nor to appoint an attorney for the purposes of giving authority to consent to admission’, an ‘independent advocate [...] would be best placed to indicate who may be the person suited to make the application to the court’, which ‘may include the independent advocate him/herself’. Accordingly, Safeguarding Ireland calls for Head 3(2) to state:

Where a healthcare professional, following enquiries, believes that there is no admission decision in place then he or she should request the Director to nominate an independent advocate from the panel established under section 101.

- 3.68 Emphasising that ‘the right of the person to access independent advocacy support is essential to ensure that decisions made are taken with the will and preference of the person being independently represented’, the NAS reports that:

In England and Wales [...] the assessment process for a standard authorisation [of the deprivation of liberty] involves at least two independent assessors who must have received training for their role. There will always be one mental health assessor and one best interests assessor who will stop deprivation of liberty being authorised if they do not think all the conditions are met.

Accordingly, the NAS stresses that, in the implementation of the ADMC Act, ‘the role of independent advocacy should be emphasised’ in order to ensure that a decision to deprive a ‘relevant person’ of their liberty is ‘based on the will and preference of the person’.

- 3.69 Noting that ‘independent statutory advocacy worked extremely well in the English mental capacity and DOLs [deprivation of liberty safeguards] system’, in which ‘the supervisory body must appoint a “relevant person’s representative” (“RPR”) when a person is made subject to a DOLs authorisation’ and in which ‘there is a limited role for an independent mental capacity advocate (IMCA)’, an individual respondent calls for ‘relevant persons’ to ‘be provided with an independent advocate who will advocate for them with the staff in the facility and relevant professionals’. In respect of this recommendation the respondent comments:

This would assert the resident’s voice, will and preferences about the care plan, medication and restrictive interventions. Where there is no person with lawful authority, whether the potential resident objects or not, then there should be an independent advocate appointed. A decision is required as to whether like England, an independent advocate is only provided when there is no family member willing to be appointed as a person with lawful authority, and there is no attorney.

- 3.70 Reporting that ‘in the UK access to an Independent Mental Capacity Advocate is mandatory for deprivation of liberty cases’, the NDO and the ASI express concern ‘that there is not a single mention of an advocate in the draft Heads’, commenting that:

An independent advocacy or advocate service is needed to ensure that individuals’ rights are protected and all practicable steps and possible alternatives have been exhausted before progressing to deprivation of liberty. [...] This type of service will need to be properly resourced and regulated.

- 3.71 The NDO and the ASI express concern that it is unclear ‘how the individual’s voice is being heard in relation to admission/detention’ and that it is not ‘clearly set out how their rights are being protected and [by] who[m] and in what way these are being advocated for’.

- 3.72 The NCPOP likewise emphasises that Head 3 ‘needs to establish where the voice of the person themselves is being heard in relation to the admission decision / detention’, querying how ‘this [is] being advocated for’.

### **Information campaign**

- 3.73 The DSBA indicates its support for ‘the provision of a campaign to provide information and education to the public regarding deprivation of liberty safeguards’.
- 3.74 The NRH also welcomes the proposed campaign to encourage ‘the use of the decision support mechanisms of the Assisted Decision Making (Capacity) Act and enduring powers of attorney’ which, it suggests, will ‘introduce a cultural shift into Irish society in terms of advance planning for loss of capacity’.

However, the NRH notes that this will take a substantial period of time to produce effects', reporting that:

A recent survey among NRH staff showed that although 90% did not wish to have aggressive treatment if they had PDOC [Prolonged Disorder of Consciousness], only 4% have actually taken out power of attorney.

- 3.75 Similarly, welcoming the proposed 'public awareness campaign', the CIB cautions that

it is likely that very many people will not have planned ahead with regard to these issues, therefore necessitating a large number of admissions in urgent circumstances.

- 3.76 Noting that, as indicated in the Explanatory Notes, 'a campaign encouraging the use of the decision support mechanisms of the Assisted Decision Making (Capacity) Act and enduring powers of attorney will coincide with the commencement of the Act', St. Luke's Nursing Home, Cork questions whether 'it is envisaged that section 10 of the [...] Act, 2015 would be implemented before Part 13 (as approved)'.

- 3.77 Emphasising that 'family carers need to be supported in understanding the meaning and implication of the new legislation relating to deprivation of liberty', the NDO and the ASI call for 'clear and accessible information' on the proposed legislation to be made available and opines that 'the proposed campaign around decision-making arrangements [...] will be vital'. They also call for 'guidance [...] for professionals who will be involved in driving the decisions that need to be made'.

- 3.78 An individual respondent recommends that:

A public campaign explaining Part 13 [of the ADMC Act] should target family members to take responsibility for their loved one who now needs to live in a facility and deter family members [from] moving that responsibility to the State.

- 3.79 The MHC refutes the suggestion made in the Explanatory Notes that the proposed campaign 'will "avoid" the need to attend court'.

#### **Other comments**

- 3.80 Noting that 'reference is made to the healthcare professional' and that an 'outline of [a] possible procedure for proposed admission' is provided in Head 3, Saint John of God Community Services calls for 'a statutory framework with a well-defined and accessible application process (including [a] body for administration and regulation)' to be instigated.

3.81 The IHF emphasises that:

Support, education and resources to include adequate time must be provided to medical, social and health professionals to support the decision-making process and to ensure that no deprivation of liberty occurs.

The IHF also calls for 'support, education and resources for family members [to be] incorporated into the safeguarding provisions' in order to 'reduce [the] coercion and collusion that could occur between healthcare professionals and families' in respect of admissions decisions.

3.82 NHI expresses concern that the requirement to make the enquiries outlined in Head 3 and / or the process of making an application to court in respect of a relevant person 'could result in additional delayed discharges in the acute sector', which could in turn result in reversion

to the default position of emergency / urgent admissions being made as provided for under Head 5 rather than a planned admission as is the intention here.

3.83 SPMHS opines that 'the provisions provided for in the Assisted Decision Making (Capacity) Act, 2015 are sufficient for the purposes of this Head'.

3.84 The MHC calls for the deletion of 'them' from line 4 of Head 3(3).



## Chapter 4: Head 4 – Procedure for Routine Admission of a Relevant Person to a Relevant Facility

Outlining the requirements for the admission of a relevant person to a relevant facility in routine circumstances, Head 4 stipulates that, excepting the ‘urgent circumstances’ addressed in Head 5, nobody shall be admitted without ‘an admission decision’ or the provision of documentary evidence to the person in charge to show that:

- (a) another person has the legal authority to admit the person and that person consents to admission or
- (b) an appropriate court order has been made.

As further stated in the Explanatory Notes, Head 4 also provides that, in instances in which

a decision-making representative under [the ADMC] Act has been appointed but no admission decision has been made, then the person in charge or healthcare professional on behalf of the person in charge will inform the decision-making representative or the attorney, as well as the relevant person and other specified persons that it has been determined that the relevant person requires to be admitted and the person in charge believes the relevant person lacks capacity. The purpose of the notification is to alert such persons to the position and give them an opportunity to make the relevant application to court. By making the application to court on behalf of the relevant person, legal aid can be availed of.

**Question 4.1: Do you think the term ‘under continuous supervision and control’ should be defined? If so, what should this definition include?**

### Respondents’ comments

### Arguments for, and recommendations in respect of, the scope of the definition of ‘under continuous supervision and control’

#### *Calls for a definition*

- 4.1 A number of respondents call for the term ‘under continuous supervision and control’ to be defined, including ABI Ireland, the CIB, the DSBA, the IASW, the IMHLA, the MHC, MS Ireland, the NAS and NHI as well as individual respondents.
- 4.2 ABI Ireland calls for ‘more clarity on this clause and whether it is dependent or independent of “not free to leave”’.
- 4.3 Observing that ‘the term “under continuous supervision and control” could cause difficulty’, Saint John of God Community Services recommends:

Major refinement or qualification of the term [...] or an alternative term referring to a person’s limitations in terms of egress/exit and/or limitations in terms of free movement, or lack of supports to facilitate egress or have liberty, within a particular relevant facility.

### *The European policy context*

- 4.4 The HSE Assisted Decision Making National Office, the Law Society of Ireland and Safeguarding Ireland call for the definition of ‘under continuous supervision and control’ to ‘be determined with reference to recent decisions of the European Court of Human Rights’.
- 4.5 The HSE Assisted Decision Making National Office calls for the definition to be cognisant of ‘emerging policy developments in England and Wales and Scotland’.
- 4.6 Emphasising that ‘persons being dealt with under Parts 1–12 of the 2015 [ADMC] Act and those under Part 13 should be treated equally and the legislative provisions be applied consistently’, the DSBA along with the IMHLA cite the following definition included in the English and Welsh Law Commission Consultation Paper:

Restrictive care and treatment should include, but should not be limited to, any one of the following:

- (1) continuous or complete supervision and control;
- (2) the person is not free to leave;
- (3) the person either is not allowed, unaccompanied, to leave the premises in which placed (including only being allowed to leave with permission), or is unable, by reason of physical impairment, to leave those premises unassisted;
- (4) barriers are used to limit the person to particular areas of the premises;
- (5) the person’s actions are controlled, whether or not within the premises, by the application of physical force, the use of restraints or (for the purpose of such control) the administering of medication – other than in emergency situations;
- (6) any care and treatment that the person objects to (verbally or physically);
- (7) significant restrictions over the person’s diet, clothing, or contact with and access to the community and individual relatives, carers or friends (including having to ask permission from staff to visit – other than generally applied rules on matters such as visiting hours).<sup>29</sup>

The IMHLA recommends that ‘under continuous supervision and control’ should be defined accordingly in the proposed legislation.

- 4.7 NHI endorses the view expressed in the U.K.’s Supreme Court Judgement on the ‘Cheshire West’ case that ‘continuous supervision and control’ is one of the ‘three elements which must be in place to deprive a person living in residential care of their liberty’.

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<sup>29</sup> See Law Commission, *Mental Capacity and Deprivation of Liberty: A Consultation Paper* (London, 2015), 68, [http://www.lawcom.gov.uk/app/uploads/2015/07/cp222\\_mental\\_capacity.pdf](http://www.lawcom.gov.uk/app/uploads/2015/07/cp222_mental_capacity.pdf).

- 4.8 Acknowledging that ‘the term “under continuous supervision and control” derives from the Cheshire West case’, the CIB emphasises that ‘the term should have a clear definition in the Irish context, given the different configurations of health and social care’.
- 4.9 Opining that ‘the Stanev v. Bulgaria case in the European Court of Human Rights [(2012) 55 EHRR [European Human Rights Reports] 22] provided a very worrying broad-brush approach to determining continuous supervision of [*sic*] control’, NHI expresses concern that, if insufficient safeguards are in place, ‘private and voluntary nursing homes [...] could simply refuse to admit [relevant] persons’, which ‘would have wider implications for the entire health service and may essentially close down the whole health service in Ireland’.

*Examples of ‘continuous supervision and control’*

- 4.10 In respect of the definition of ‘continuous supervision and control’, an individual respondent calls for ‘examples of what is and is not under this definition [...] to be provided in advance in order to define the scope of the legislation’.
- 4.11 The CIB calls for the definition of the term to

be accompanied by illustrative examples of what does and does not constitute continuous supervision and control in different settings. For example, the definition may vary considerably in hospitals, intensive care units, palliative care settings, nursing homes for elderly people, centres for people with varying degrees of intellectual disability and capacity.

*Scope of the definition*

- 4.12 Noting that ““continuous” does not have to mean literally every minute of the day’ but rather that ‘it is more about the overall effect on a person’s life’, and that ‘the higher the likelihood of any form of control [...], the more likely it is that the supervision and control element of [the person’s] care would be considered “continuous”’, the NAS argues that the definition of the term

should include but should not be limited to where:

- a person would not be left on their own for more than a short period, even if they asked to be;
- a person is so disabled that carers are effectively deciding all or many aspects of their daily life (e.g. when to get up and go to bed, where to sit, when to watch TV, when to eat, when and where to go out); or
- they need support with all or many everyday tasks (e.g. cooking, shopping, bathing) and would be stopped from trying to do them if no carer was available to help or supervise them at the time; or
- psycho-social restraint—the use of ‘power-control’ strategies;
- where a person could make decisions about their daily living and exercise choices around what they would chose to engage in but they are limited in doing so due to either due to limited resources or

options to facilitate same which leads to requirements on them to work to timelines that suit the facility and [to] row in with group living.

4.13 The NRH advises that:

‘Under continuous supervision’ should include monitoring via security bracelets or CCTV, locked or code-access doors or gates, or specialising, which has the purpose of preventing the relevant person from leaving the facility.

4.14 While acknowledging that ‘definitions [...] run the risk of not accommodating the exceptional cases [of] which this area is likely to have a high prevalence’, the Division of Neuropsychology of the PSI questions whether “continuous” includes 24 hours per day 7 days per week’ and, if so, ‘over what time frame, e.g. at least 4, 8 weeks’ and calls for clarification of the ‘level (rating?) of control and specific type of control, e.g. physical, chemical and or environmental’ to which the definition refers.

The Division of Neuropsychology of the PSI also calls for clarification of the rationale for the imposition of ‘continuous supervision and control’, suggesting that making reference to “risk” and “significant harm” and ways to assess same’ may assist. Querying whether a ‘risk of falls/risk of financial exploitation/fire hazard management’ is ‘a justifiable rationale for “supervision and control”’ and ‘at what threshold’, the Division also calls for clarification of the ‘level of supervision required [...] e.g. a staffed house or a setting where the person is in visual contact at all times’.

*Challenges arising*

4.15 NHI emphasises that the nursing home has to balance the rights and freedoms of residents with their statutory obligations [...] to provide high-quality safe services, protect residents from abuse and maintain residents’ wellbeing and safety’. Accordingly, NHI calls for ‘greater clarity [...] on the definition of continuous supervision and control in the context of the health and safety of the resident’, noting that this is ‘necessary to safeguard against unintended allegations of abuse’. NHI cautions that:

If being ‘under continuous supervision and control’ is not defined then this could lead to assertions that the nursing home are [*sic*] subjecting a person to psychological abuse, defined in the HSE’s *Safeguarding Vulnerable Persons at Risk of Abuse: National Policy & Procedures* as such:

‘Psychological Abuse’ includes emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse,

isolation, or withdrawal from services or supportive networks (HSE, 2014).<sup>30</sup>

However, noting ‘that PICs [persons in charge] would have to statutorily report notifications of abuse to HIQA under regulation 31(1) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended)’ and that this would be ‘impractical and an unnecessary administrative burden’, NHI calls for the proposed legislation to be cognisant of the current review of the HSE’s *National Policy & Procedures* and of HIQA’s on-going development of national standards on safeguarding, and to ‘reflect the most up to date available evidence and consensus opinion garnered from both agencies’.

- 4.16 Noting that, while ‘many residential settings have 24-hour staffing which could be defined as providing continuous supervision’, others ‘provide residents with one to one supervision, called a “special”’, the IASW emphasises that ‘the definition [of ‘under continuous supervision’] needs to be explicit in terms of what continuous supervision means’. In respect of the definition of ‘control’, the IASW comments:

While most residential settings endeavour to promote choice and autonomy, residents do not live in [...] the manner they would have if they lived at home. The choices provided to residents, while well-meaning, are defined by the residential setting and often determined by factors that suit the running of the setting. Control of residents with[in] a setting can include control over personal care, diet and meal, routine, activities, socialisation, finances, accommodation, medication management, visiting / visitors, etc.

- 4.17 In respect of the ‘need to clearly define “under continuous supervision and control”’, MS Ireland observes that:

A person may not be physically controlled or restrained from leaving a relevant facility but they are prevented from doing so because they lack the physical ability to leave.

#### *Other comments*

- 4.18 The IASW comments that ‘it may also be necessary to define “not free to leave”’.

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<sup>30</sup> Health Service Executive, *Safeguarding Vulnerable Persons at Risk of Abuse: National Policy and Procedures* (2014), 9, <https://www.hse.ie/eng/services/publications/corporate/personsatriskofabuse.pdf>.

## Views of those opposed to the definition of ‘under continuous supervision and control’

- 4.19 St. Luke’s Nursing Home, Cork argues against the inclusion of a definition of the term ‘under continuous supervision and control’, stating that this ‘is clear and speaks for itself and should be interpreted on a case by case basis’.
- 4.20 Similarly, an individual respondent opines that the term ‘is already as clear as it can be’ and that ‘a definition [...] would be difficult or impossible to formulate or operate, given the diversity of circumstances in which these measures are intended to be applied’.
- 4.21 The College of Psychiatrists of Ireland ‘take[s] the view that the current description is adequate’.
- 4.22 SPMHS opines that ‘the phrase “is not free to leave” is sufficient’.
- 4.23 Stating that ‘the Commission does not agree that the term “under continuous supervision and control” should be defined in this legislation’, the IHREC comments:
- In light of jurisprudence and given that the term ‘under continuous supervision and control’ only comprises one part of the objective element of deprivation of liberty, [...] it would not be advisable to attempt to enshrine particular circumstances in statute. Therefore, the Commission is of the view that an assessment of the objective element of the test, i.e. the question as to whether an individual was under continuous supervision and control and was not free to leave, would depend on the factual matrix before the court.
- 4.24 Likewise, noting that ‘it would be very difficult to provide for an exhaustive definition of “under continuous supervision and control” in legislation’, the NDA recommends that ‘guidance could be provided in a statutory code of practice provided for in the draft Heads of Bill’.
- 4.25 SAGE also advises that the ‘concepts and how these will be applied in practice will need greater exploration in guidelines or codes of practice’.

**Question 4.2: When the person in charge has reason to believe that a relevant person may lack capacity to decide to live in a relevant facility, who should be notified with a view to affording them the opportunity to make an application to Court under Part 5 of the Act? This issue also arises in Heads 3(3), 7(4) and 8(1).<sup>31</sup>**

## **Respondents' comments**

### **Persons to be notified**

4.26 The Division of Neuropsychology of the PSI suggests that 'the responsible clinician, the treating team, [the] patient's committee, family' could legitimately be notified of a relevant person's lack of capacity to decide to live in a relevant facility.

4.27 Emphasising that 'the DOH [Department of Health] and the Department of Justice and Equality should ensure to adopt a consistent approach', the MHC recommends that:

A list of the categories of persons to be notified should be included in Part 13 or, as the same issue arises in relation to notifications within Parts 1–12 in the 2015 Act, within Regulations applicable to Parts 1–13.

4.28 The NDA notes that:

The person in charge/relevant staff may, as per Section 8(8) of the 2015 Act for the purposes of consulting in relation to making an intervention, consult with any person engaged in the caring of the relevant person and any person who has a *bona fide* interest in the relevant person.

4.29 Noting that 'it may be problematic for the relevant person to identify who they want notified at a time when they lack capacity to decide on an admission for themselves', ABI Ireland comments:

It would be good if the legislation could list some obvious people [to be contacted by the person in charge] like the general practitioner and the person's solicitor if they have one. If they don't have one, perhaps the person needs referral to a local FLAC [Free Legal Advice Centre].

4.30 An individual respondent recommends that:

In the event that the person in charge cannot obtain details of persons with lawful authority, if the relevant person has been unable to furnish contact information, besides contacting the Director, the person in charge should contact the person's GP or/and local HSE office and if they have contact

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<sup>31</sup> In respect of question 4.2, the consultation paper notes that 'in every place "person in charge" appears in this consultation paper, please read as "person in charge or healthcare professional on behalf of the person in charge"'.

details of family members, they should be provided despite data protection concerns.

4.31 NHI suggests that the 'primary persons' who should be notified of a relevant person's lack of capacity to decide to live in a relevant facility

may include (but are not limited to):

- The person themselves (where they are able to retain and use the information);
- Family members / next of kin / significant others;
- Person's solicitor (where known);
- General practitioners;
- Social workers;
- Independent advocates.

Noting that 'often residents with moderate to severe cognitive impairment [...] often do not have any family members available to assist [with] the process for application to the courts', or that such relatives 'may not wish to participate in the process', NHI suggests that:

In these circumstances, it would be preferable if there was an appointed social worker (specialised in care of the older person) that could take a case-holding approach should there be a need for further review at a later stage. As the majority of persons are supported under the NHSS Act 2009 then it is recommended that the HSE, through an appointed social worker, would remain responsible for the continuing supervision of relevant persons as is the case in many health authorities across the UK for relevant persons there.

4.32 Questioning whether it should fall to the person in charge to notify a third party of their belief that a relevant person lacks the capacity to decide to live in a relevant facility, the IASW recommends that:

If [...] no decision-making representative, co-decision-making agreement or EPA is in place, then the new role akin to the authorised officer [referred to in paragraph 3.10 above] could be of assistance in this circumstance by making the application to court for an admission decision.

4.33 The College of Psychiatrists of Ireland recommends that:

If the relevant person has nominated a next of kin or if they already have a co-decision-maker or decision-making representative appointed under the Act, an easily assessable register of agreements and decisions under the Act needs to be held by the Decision Support Structure [*sic*] and available to those working in this area.



4.34 SPMHS advises that:

If no admission decision is in place and no co-decision-maker, decision-making representative or attorney has been appointed, the person-in-charge should be legally obliged to inform the Director of the Decision Support Service.

4.35 Expressing concern that ‘the [relevant] person’s voice is being heard’ and that sufficient provision is made for safeguarding and advocacy, the NCPOP calls for the DSS ‘to have a more robust role / mandate’ in the implementation of the proposed legislation, recommending that:

The DSS is advised of all ‘admission decisions’ to be progressed under this legislation—they should be the office of record in terms of any recorded legal agreements brought about regarding EPOA [enduring power of attorney] / decision-making representatives etc and they should be involved from outset.

<b>Concerns raised</b>
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4.36 Opining that the third party to be notified of a relevant person’s lack of capacity to decide to live in a relevant facility ‘will surely vary from case to case’, an individual respondent suggests that ‘more specific regulation might not be useful’.

4.37 The MHC cautions that the identification of the individual to be notified of a relevant person’s lack of capacity to decide to live in a relevant facility ‘could present problems’, observing:

If it is to be a family member, a relevant person may be separated or may not have contact with his or her children and healthcare professionals should exercise caution when considering whom it is appropriate to contact.

4.38 Likewise noting that ‘there may be no family to advise or assist’, the NRH emphasises that:

There would also need to be clarity in situations where there are safeguarding concerns in relation to the care or treatment of the patient by family members. In these situations, the speed of response from the Decision Support Service (DSS) will be a major concern for healthcare providers.

4.39 Safeguarding Ireland emphasises that ‘it is not appropriate to notify persons who may have been given authority for some decisions but not given specific authority to consent to make an admission decision’.

4.40 The HSE Assisted Decision Making National Office emphasises that ‘it is not appropriate for the person in charge to notify anyone who has not been given authority to make decisions on behalf of a relevant person’ of their view that such a person lacks decision-making capacity.

### *Role of the ‘person in charge’*

- 4.41 An individual respondent expresses concern that, given ‘that there is no statutory definition’ of a ‘person in charge’, that ‘HIQA regulations stipulate managerial / administrative qualifications and skills’, and that the person in charge ‘is not necessarily a healthcare professional’, he or she may lack ‘what are essentially professional skills [...] in assessing residence capacity’.
- 4.42 Noting the ‘burden of responsibility’ placed on persons in charge in respect of the requirement for them to notify a third party of their belief that a relevant person lacks the capacity to decide to live in a relevant facility, the CIB observes:

In many cases, assessments of capacity may form part of the ongoing care plan for existing residents. Identification and appointment of co-decision makers, decision-making representatives or attorneys may be part of the care-planning process.

- 4.43 Noting that persons in charge are ‘required to make a judgement call on a referral’s capacity to make a decision about a placement’, the Rehab Group ask:

How do they do this? What needs to form the basis for this judgement call?  
Who do they contact in this instance? Family/Decision Making office?

### *Role of attorneys*

- 4.44 Expressing concern about ‘the extensive powers afforded to “attorneys” (in addition to the “person in charge”, “decision-making representative” and the Courts) on decisions relating to a person’s deprivation of liberty’, MHR calls for a clear definition of

the powers of ‘attorneys’ (under the enduring power of attorney system) as they relate to this legislation so that ‘attorneys’ are not automatically afforded decision-making authority on matters that the person did not agree to.

## **The role of independent advocates**

- 4.45 Emphasising ‘the requirements of [the] 2015 Act that a relevant person should be supported as far as possible to make a decision before anyone—including the court—assesses their capacity’ to do so, the NDA recommends that:

The emphasis here should be on supporting the person to make the decision in the first instance, rather than contacting others with a view to them making a Part 5 application.

The NDA highlights the relevance of the role of an independent advocate or ‘special visitor’ in the provision of this support.

4.46 Likewise, the NAS states:

The relevant person in all circumstances should be [the] first person notified of this and should be supported to access an independent advocate to support them in this regard. There is an absence within the draft of recognition that until proven otherwise the relevant person has equal recognition as having capacity before the law and so should be supported to the greatest extent possible in having their voice heard.

4.47 Emphasising the relevant person's 'right of access to an independent advocate', SAGE comments:

The engagement of an independent advocate as early as possible in the process would benefit the person by maximising their capacity to make the decision for themselves, or to enter a co-decision-making agreement for the purpose of making a decision whether or not to reside in a 'relevant facility' or to create an EPA and thereby reducing the need for a lengthy and costly application to court.

4.48 Safeguarding Ireland states that:

Access to an independent advocate by the relevant person will enable an advocate [to] ascertain, first if the relevant person can be supported to make the relevant decision and then to suggest who might be an appropriate person to notify from the relevant person's perspective. If there is no such person, then the independent advocate may [be] the appropriate person to make the application to court and will be in a position to assist and attend with the relevant person in court or, if the relevant person is not attending the hearing concerned, promote the interests and will and preferences of the relevant person in court.

4.49 The INMO also recommends that 'an independent advocate facility [should] be established to ensure an effective form of assistance which ensures that the rights and interests of a relevant person are defended'.

4.50 The HSE Assisted Decision Making National Office emphasises that 'the relevant person should be supported, in as far as practicable, to make the decision themselves' with the support of an independent advocate if required.

4.51 The CIB recommends that:

The current situation where general social workers, adult safeguarding social workers and independent advocates do not have authority to enter private nursing homes or to offer support and assistance to individuals living in private residential care facilities should be reviewed in consideration of their potential advocacy role for individuals in residential/nursing home care.

4.52 HIQA recommends that:

consideration should be given to including certain persons who may be reasonably expected to know the will and preference of the relevant person.

However, noting that ‘there may be circumstances where a person is incapable of saying who should be contacted on their behalf and [that] it may be useful to have an option for other people to be contacted’, HIQA also emphasises ‘the need to place on a formal footing an independent advocacy service’.

4.53 The HSE’s Older Persons’ Services opines that ‘there are issues [...] and gaps in this Head with regards to the necessary access to an independent advocate’, commenting that:

Routine admission should only proceed when parties acting in the best interests of the vulnerable person are involved with the decision-making process, such as the decision-making support service, EPOA [enduring power of attorney] or independent advocacy services.

**Question 4.3: Do you have any other views specific to Head 4?**

**Respondents’ comments**

**Title of Head 4**

4.54 Observing that ‘each time of admission can have a different context and rationale’, the HSE National Safeguarding Office and the HSE’s Older Persons’ Services question the appropriateness of the use of the adjective ‘routine’ in the title of Head 4 and whether it would ‘be better to talk about “evidenced recurring context”’.

4.55 Emphasising that ‘a person who is deprived of their liberty needs to be informed of their rights’ and that ‘there needs to be a remedy in place for an individual to have their liberty restored’, the DFI emphasises that ‘a decision to deprive an individual of his or her liberty should never be described as “routine”’.

4.56 The Law Society of Ireland and Safeguarding Ireland recommend that ‘the word “routine” should be deleted from this heading’, commenting that:

No admission which consists of an intention to deprive a person of his or her liberty can be termed ‘routine’.

4.57 Likewise, arguing that ‘a procedure which can result in a person being deprived of their liberty should be an exception rather than “routine”’, SAGE comments that ‘the term “routine” is inappropriate to describe a procedure which may result in a vulnerable person being deprived of their liberty’.

### *Routine vs. emergency admissions*

4.58 Noting that ‘the deprivation of liberty should not be a routine action’, the INMO suggests that Head 4 should ‘be retitled to refer to the “Procedure for Non-Emergency”, thereby distinguishing it from Head 5.

4.59 Both the NDA and the NRH call for clarification of what is meant by a ‘routine’ admission, with the NRH querying whether

someone arriving at a residential facility from an acute hospital setting who has been delayed in discharge for a period of time due to appropriate supports not being available for them to return home [would] be classified as a ‘routine’ or ‘urgent’ admission.

### **Capacity assessment**

4.60 Recognising that ‘capacity is decision-specific’, an individual respondent voices concern that ‘the provision for capacity assessment is inadequate’ since ‘the Head does not spell out the specific and focal requirements in relation to [the] capacity to make a decision to live in a relevant facility’. Noting that ‘the purpose of the capacity assessment should be to determine whether the person lacks the capacity to consent to the care and treatment arrangements involving the deprivation of liberty’, the respondent calls for the capacity assessor to be required to indicate in their report whether the [relevant] person appreciates that:

- they would be placed in the facility to receive care and treatment for particular reasons;
- the care and treatment would include varying levels of monitoring, supervision, confinement, medical treatment;
- staff at the hospital would be entitled to carry out property and personal searches;
- the person must seek permission of the relevant staff to leave the facility and, until the staff at the facility decide otherwise, would only be allowed to leave under supervision; and
- if they left the facility without permission and without supervision, the staff would take steps to find and return them, including contacting the Garda.

In addition, the respondent suggests that:

The capacity assessment should [...] indicate whether the capacity of the person to consent to arrangements that are proposed or in place is likely to fluctuate, and, if so, the likely duration of any periods during which the person is likely to have capacity to consent to those care and treatment arrangements.

4.61 An individual respondent indicates that ‘helpful extracts about the relevant test for capacity are set out in *CC v KK* and *STCC [2012] EWCOP 2136*’.

4.62 An individual respondent expresses concern that:

It is a conflict of interest for a healthcare professional employed by or contracted by the facility to determine that a potential person lacks capacity to be admitted to that facility. The healthcare professional assessing capacity must be independent of the facility except potentially in an emergency under Head 5.

Accordingly, the respondent suggests that Head 4(2)

could be amended to provide that the person in charge should only admit the potential resident if a capacity assessment completed by an independent healthcare professional is provided together with the formal admission decision or recommendation made by that professional.

### **Role of decision-making representatives**

4.63 Noting that 'to comply with article 5(1)(e) ECHR, any order would have to be based upon medical evidence of unsoundness of mind (or equivalent), and evidence that the deprivation of liberty is necessary and proportionate', an individual respondent queries whether it is the intention in Head 4 'that a decision-making representative/EPA is giving consent on behalf of the individual so that there is (in Article 5 terms) no deprivation of liberty'. In respect of this hypothesis, the respondent comments:

If so and given that this has significant implications as to the procedural safeguards to be afforded the individual, because they are being opted out of Article 5 (and hence Article 5(4)) I would strongly suggest that the circumstances under which such consent can be given be circumscribed – for instance in the way that Scottish Government are proposing in relation to lasting powers of attorney in their AWI [Adults with Incapacity (Scotland) Act] consultation.

4.64 Observing that 'this Head, and the other Heads [...] make the assumption that if a co-decision-maker or decision-making representative or attorney is already in place, then any one such individual is the appropriate person to make an application to Court under Part 5', the MHC comments:

If any such individual is already authorised by an instrument to make an admission decision, then obviously no application to Court is required. If no such individual is so authorised, then there may be a reason why that is the case. In the case of an attorney appointed when the relevant person had full capacity, the relevant person might not have wanted the attorney to be in a position to make an application for the deprivation of his or her liberty.

Accordingly, the MHC reiterates the imperative for the provision of advocacy services to relevant persons 'at the earliest stage possible'.

4.65 ABI Ireland calls for Head 4 to clarify that:

A DMA [decision-making assistant], CDM [co-decision-maker], DMR [decision-making representative], or EPA cannot admit someone unless it was pre-agreed that the decision to admit was one they could make down the line when the person lost capacity.

To this end, ABI Ireland suggests that ‘it would be well worth reiterating here clauses from earlier in the [ADMC] act’ which emphasise this.

4.66 Expressing disagreement with the inclusion of a provision ‘which would permit an attorney [...] or a decision-making representative to deprive a person of their liberty, while recognising that medical evidence would be required before this could be done’, the IMHLA ‘recommends that the court itself should approve any deprivation of liberty’.

4.67 Referencing ‘the review procedures afforded to persons who are the subject of admission / renewal orders under the Mental Health Act, 2001’, the DSBA states:

The DSBA does not support the draft provision which would permit an attorney under a registered power of attorney or a decision-making representative to authorise the deprivation of a person’s liberty.

#### **Supports for relevant persons**

4.68 Noting that Head 4 ‘detail[s] the role of the person in charge’, the NRH calls for the ‘procedure for the person’ to be outlined, detailing ‘how the process will be communicated, by whom it will be communicated, the person’s right to access independent advocacy’ and the ‘supports [that] will be available [...] in making an appeal’.

4.69 While acknowledging that ‘there may be concerns that in practice the Circuit Court would not have the capacity to deal with the potential number of applications’ and that ‘the relevant person may not be in a position to attend the court hearing’, the IMHLA ‘recommends that a legal advisor should be automatically assigned to the relevant person’.

4.70 The IHF emphasises that:

Once a decision has been made for a person to move to a residential care facility, safeguards must be in place to ensure that, following a comprehensive assessment of needs, the residential facility selected is appropriate and can meet the person’s needs and [that] this is revisited as needs change.

## Facilitating timely admissions and discharges

- 4.71 Seeking clarity on ‘the prescribed or proposed timeframe from application to the court to the granting of an order under section 37 (3); 38 (2) (a); 48 or 38 (2) (b)’, NHI comments:

The timeframe needs to be short and concise so as not to delay admissions and contribute further to delayed discharges in acute services. It is recommended that there are defined timelines identified for the court to ensure applications are processed and completed within an expedient manner.

- 4.72 Noting that ‘a back log of decision-making [...] could impact quite significantly on the person by way of depriving them of their liberty for [an] extended time-period’, the NRH queries:

What measures [that] are in place to ensure decisions to allow a person to leave will be made in a timely fashion to avoid unnecessary delays to their discharge?

## Other comments

- 4.73 An individual respondent expresses concern about the statement in Head 4(2) that ‘the person in charge or the healthcare professional on behalf of the person in charge may admit the relevant person’, commenting:

So, they have been given a discretion to disobey a court order which may have expressly provided that the potential resident be admitted to that named facility. [...] Surely if proceedings were issued by relatives or those with legal authority requesting that the court make an admission decision, the person in charge would be served with the proceedings and would tell the court why they disagree to the admission before the order was made.

- 4.74 While commending ‘the concept of a court-based application system as outlined in the Heads of Bill’, the IMHLA calls for

consideration [to] be given to a tribunal-based system as in some cases it may be easier for the relevant person to attend a tribunal hearing in the facility and tribunals may be better to able to deal with potential numbers of cases.

- 4.75 The NRH enquires about the role of the HSE, HIQA, the MHC and the DSS under Head 4.



### *Recommended textual amendments*

- 4.76 Highlighting ‘the equal right of all persons with disabilities to live in the community’, enshrined in article 19 of the UNCRPD, and calling for the deprivation of liberty safeguards to ‘include a responsibility to ensure alternatives to institutional forms of living where possible’, Inclusion Ireland expresses concern that:

The central thrust of the proposed amendments does not recognise that there are alternatives to living arrangements which deprive persons of their liberty.

Accordingly, the organisation recommends that section 1 of Head 4 should be amended to read:

Subject to Head 5, no relevant person shall be admitted to a relevant facility where he or she will be under continuous supervision and control and will not be free to leave unless all alternative living arrangements have been exhausted. An admission decision is required in order to admit a person to a facility where his or her liberty may be deprived.

- 4.77 The MHC makes recommendations for the following minor amendments to the wording of Head 4(2) and (3):

(2)(i)(a) and (b)—On the basis that evidence of only one such order is required to be produced, the word ‘or’ should be inserted at the end of (a) and (b) (and before (c)).

(2) The last two paragraphs of this section should be amended (as there appears to be an incorrect reference to ‘intervener’ which appears in the 2015 Act but does not appear anywhere in Part 13 save for in this section) as follows:

‘...is produced to the person in charge or the healthcare professional on behalf of the person and the person in charge or the healthcare professional on behalf of the person may admit the relevant person’.

The MHC further suggests that ‘a specific time-period should be specified for the production of the documentation in this section’, and that, in addition to replicating ‘the steps set out in Head 3(3)’, Head 4(3) should be amended

first, by inserting the words ‘and shall’ between the words ‘where necessary’ and the words ‘notify such of them’ on the seventh line of this sub-head; and secondly to provide for the situation where no decision-making representative has been appointed.

- 4.78 The NDA calls for it to be stated ‘that Head 4(2) has to be read subject to a revised Head 3’.

4.79 An individual respondent states that ‘at the end of page 12, the words “or court order” should be added after “admission decision”’.

## **Chapter 5: Head 5 – Procedure for Admission of a Relevant Person to a Relevant Facility in Urgent Circumstances**

Comprising 8 subheads, Head 5 sets out the procedure for the admission of a ‘relevant person’ to a ‘relevant facility’ in urgent circumstances—namely, as outlined in subhead 1, ‘to prevent an imminent risk of significant harm to the person’s health or welfare or [...] to another person’ in an instance in which the person in charge (or a healthcare professional on behalf of the person in charge)

has reason to believe, upon an application of the guiding principles in section 8, that the relevant person lacks capacity to decide to live in the relevant facility; and [...] evidence of an admission decision is not produced.

Accordingly, as stated in the Explanatory Notes, Head 5 provides that, in such circumstances, an exception may be made to the stipulation under Head 4(1) that ‘no relevant person shall be admitted to a relevant facility [...] unless an admission decision has been made in their regard’, enabling the person in charge (or a healthcare professional acting on their behalf) to temporarily admit such a person under their own authority taking into account the medical evidence (as indicated in subhead 2).

As indicated in the Explanatory Notes, subhead 3 provides that the person in charge (or a healthcare professional acting on their behalf) ‘will give written notification within 5 days of the urgent admission of the relevant person to the relevant person and other specified people’ detailing their belief ‘that the relevant person lacks the capacity and requires to be admitted’. Subhead 4 stipulates that this notification will be also be given to any appointed decision-making representative or attorney within 5 days of the urgent admission and, with a view to ensuring ‘that decisions are made, where possible, by the person closest to the relevant person’, subhead 5 states that:

The temporary admission decision shall be replaced by a formal admission decision given by the decision-making representative under section 44(6) or by an attorney under section 62 where the authorisation authorises restraint to the like extent as the temporary admission decision.

Subhead 6 stipulates that ‘where a temporary admission decision is in place, any person making an application to court under Part 5 of the [ADMC] Act shall notify the person in charge’, while subhead 7 provides that, in an instance in which the person in charge does not receive notification of such an application within 10 days, they

shall contact the Director [of the DSS] and request that an appropriate person be assigned to make an application to court under Part 5 on behalf of the relevant person as soon as practicable but no later than a further 10 days.

As indicated in the Explanatory Notes, subhead 8 provides that ‘a temporary admission decision shall be valid for 25 days and shall then lapse unless the court makes an order continuing the decision’.

**Question 5.1: In subhead (1), what are your views on the proposed circumstances in which an urgent admission can be made?**

**Respondents' comments**

**Scope of proposed circumstances**

5.1 A number of respondents endorsed the criteria for urgent admissions set out in Head 5(1), including the College of Psychiatrists of Ireland and SPMHS.

5.2 The MS Society of Ireland queries:

Would 'instances in which there is an imminent risk of significant harm to the person's health or welfare' cover situations where a person wishes to return to their own home from a hospital setting but is unable to do so due to lack of supports? Would this also cover situations in which a caregiver is suddenly taken ill or is otherwise no longer able to provide caring duties?

5.3 Similarly, while acknowledging that 'where there are no alternatives, the proposed circumstances outlined in subhead [1] warrant urgent admission of a relevant person', the CIB note that:

It is possible that such circumstances will arise frequently in cases of a sudden deterioration of a person's capacity, a sudden increase in their care needs or a sudden breakdown of their formal or informal care arrangements and where no advance care provisions are in place.

5.4 The Division of Neuropsychology of the PSI comments:

An urgent admission can be made where the person's safety is a concern, e.g. level of personal neglect has deteriorated below most basic standards, risk of demise, not taking essential medications, physical assault [of] family/carers and or self.

5.5 Noting that a person may be deprived of their liberty 'due to a lack of suitable alternative accommodation', SAGE suggests that:

Consideration should also be given to the circumstances in which a vulnerable adult or older person is admitted to a 'relevant facility' due to immediate care needs, or ongoing care needs on the basis that there is no other appropriate accommodation or facility to care for their needs.

5.6 Saint John of God Community Services calls for the criteria for urgent admissions outlined in Head 5(1) to make reference to the relevant person's 'broader circumstances', noting that these 'may be the main factor necessitating consideration for residential admission'.

- 5.7 Likewise, noting that ‘many older people in particular are living in designated centres as there is no suitable alternative residence for them’, the Law Society of Ireland and Safeguarding Ireland comment that ‘if existing residents of such centres are to come within the provision of Part 13 then this Head needs to be recast’.
- 5.8 The NCPOP suggests that ‘there [is] a distinction to be drawn between those cases where a person is already known to services and may have risks already flagged within the system’ and instances in which ‘persons not already known to the services [are] found wandering, confused, etc’, which ‘would need to be seen as part of an emergency medical process’.
- 5.9 The NRH observes that:
- For persons in the care of the NRH, [an urgent admission] is likely to only occur if the person is acutely ill and would therefore fall under current procedures.
- 5.10 Noting that ‘having a disability is either lifelong or acquired’ and that ‘it rarely develops suddenly compared with physical illness’, the NAS emphasises that:
- For people with disabilities or older people who have cognitive issues, such emergency detentions should be of the absolute last resort.
- 5.11 Noting that Head 1(5)(a) is confined ‘to preventing an imminent risk of significant harm’, an individual respondent suggests that reference should be made to ‘the cessation of significant harm to the person’s health and welfare that is already occurring’ since ‘the person may have been living for a long time in a situation of significant risk, which is now perceived as escalating’. The respondent further suggests that ‘imminent’ should be replaced with ‘urgent’ in order to ‘cover a broader range of circumstances justifying a temporary admission decision’.
- 5.12 While acknowledging that ‘the circumstances provided for at subhead 1 appear appropriate in terms of authorising a temporary decision to be made’, the INMO emphasises that, in respect of the definition of ‘an imminent risk of significant harm’,

it is important that the criteria are narrow enough to ensure sufficient protection of the rights of the person, yet broad enough to encompass the range of necessary circumstances which would necessitate such a temporary decision.

Accordingly, the INMO recommends that:

it would be useful if the Minister were empowered to issue regulations which would specify the matters to be considered in determining the threshold in such cases.

- 5.13 The Law Society of Ireland and Safeguarding Ireland question the basis upon which ‘a healthcare professional has reason to believe that an immediate admission is necessary’, cautioning:

The legislation should set out the criteria for ‘urgent circumstances’. If this [*sic*] is not included, then in practice where a person has not given authority to another to make an admission decision or there is no court order in place, this section will be used for such admissions without the necessary safeguards.

## Definitions and terminology

- 5.14 An individual respondent suggests that ‘harm’ might usefully be defined, citing the definition given in section 53 of the Adult Support and Protection (Scotland) Act, 2007.<sup>32</sup>

- 5.15 Citing ‘the decision of Mr. Justice O’Neill in the case of MR v. Byrne (High Court, 2<sup>nd</sup> March 2007)’, the MHC calls for the definition of ‘imminent risk’ and ‘significant harm’.

- 5.16 Likewise, noting that ‘the term “significant harm” can be subjective’, the HSE Assisted Decision Making National Office calls for ‘further guidance [...] providing examples of what is meant by this term’.

- 5.17 NHI recommends that:

The proposed legislation should provide, by way of definition or associated guidance documents, what set of circumstances would present an ‘imminent risk of significant harm’ which would then permit a person in charge to make a temporary admission decision.

- 5.18 The NRH calls for ‘imminent risk’ and ‘extreme urgency’ to ‘be better defined’ as well as seeking clarification in respect of the meaning of ‘significant harm’, noting that ‘severity of harm to self or others is [...] open to variation in interpretation’.

- 5.19 MHR calls for

the term ‘urgent admission’ [...] to be more clearly defined so as to ascertain what circumstances are considered urgent in the context of deprivation of liberty and for who those circumstances apply.

- 5.20 Likewise, the Rehab Group calls for clarification of ‘urgent’, noting that ‘changes in family or current circumstances may necessitate an urgent move also’.

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<sup>32</sup> See <https://www.legislation.gov.uk/asp/2007/10/section/53>.

- 5.21 The MS Society of Ireland seeks clarity on ‘what is meant by “routine” and “urgent” admissions’ and ‘by “an imminent risk of significant harm to the person’s health or welfare”’, as well as on ‘who would determine this’.
- 5.22 The CIDP, the HSE’s Older Persons’ Services, the HSE National Safeguarding Office, the Law Society of Ireland and Safeguarding Ireland call for the term ‘emergency admission’ to be utilised and recommend that consideration be given to the definition of this provided by HIQA in *National Quality Standards for Residential Care Settings for Older People in Ireland* (2008).<sup>33</sup>
- 5.23 The HSE Assisted Decision Making National Office recommends that Head 5 should be renamed ‘Procedure for Admission of a Relevant Person to a Relevant Facility in Emergency Circumstances’ and that it should include the definition of ‘emergency admission’ cited in the *National Quality Standards for Residential Care Settings for Older People in Ireland*.
- 5.24 The NDA and HIQA query the utilisation of ‘urgent circumstances’ in the title of Head 5, calling for the term ‘emergency admission’, as defined in HIQA’s *National Standards for Residential Services for [Children and Adults] with Disabilities* (2013), to be used instead.<sup>34</sup>
- 5.25 Noting that “urgent circumstances” are not defined in the Heads of Bill’, SAGE calls for the utilisation of ‘the term “emergency” or “emergency admission” [...] in line with HIQA *National Standards* for designated centres’ in order to ensure that the legislation is ‘consistent with established terminology’.
- 5.26 The INMO likewise recommends that ‘the term urgent should be changed to emergency [...] for the purposes of internal consistency within the proposed amended Act’, noting that the term is utilised in ‘the other provisions of the Act where imminent risk of serious harm is invoked, e.g. sections 44(5) and 62(1)’ and that

this amendment is justified considering the description of the type of circumstances which allow an admission to be made in the absence of judicial or other adequate authority.

- 5.27 The CDLP observes that, while

used in clinical settings, [...] the wording imminent or imminent violence is not founded in standard medical and psychiatric dictionaries.

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<sup>33</sup> See HIQA, *National Quality Standards for Residential Care Settings for Older People in Ireland* (2008), 67, [https://www.hiqa.ie/system/files/HIQA\\_Residential\\_Care\\_Standards\\_2008.pdf](https://www.hiqa.ie/system/files/HIQA_Residential_Care_Standards_2008.pdf).

<sup>34</sup> See HIQA, *National Standards for Residential Services for Children and Adults with Disabilities* (2013), 109, <https://www.hiqa.ie/sites/default/files/2017-02/Standards-Disabilities-Children-Adults.pdf>.

## Interaction with the Mental Health Act, 2001

5.28 Noting that the criteria for admission detailed in Head 5 ‘appear to be based on [a] mental health emergency’ and ‘tied to imminent risk of serious harm to the relevant person or another under the Mental Health Act’, the HSE’s Older Persons’ Services and the HSE National Safeguarding Office call for the inclusion of criteria relating to meeting the immediate care-needs of ‘a very ill or extremely frail older person’ in instances in which ‘no other suitable resource’ is available.

5.29 Similarly, the NDA calls for ‘the criteria set out in Head 5 on urgent admissions’ to be re-examined, noting that they ‘seem to apply only to those persons detained under the Mental Health Act 2001’. The NDA suggests that ‘there may be a need for an urgent admission where the relevant person is not at risk of significant harm to their own health and welfare or that of others’, citing by way of example

a case [...] where an elderly parent of an adult with an intellectual disability suddenly dies and the adult is admitted because there is nobody else to care for them.

5.30 The Law Society of Ireland and Safeguarding Ireland question whether the admissions criteria outlined in Head 5(1)(a) are intended to encompass ‘a person who has a “mental disorder” as defined in the Mental Health Act 2001’.

5.31 While describing the proposed procedure as ‘sensible in terms of the circumstances of the individual’, ABI Ireland calls for ‘clarity as to how this [...] legislation will interact with the Mental Health Act 2001 (MHA 2001)’, commenting:

It is critical that Section 39 organisations do not become default admitters for MHA 2001 exclusions (i.e. people with personality disorders, social deviance, or addictions).

5.32 Noting that ‘the language used in this subhead in relation to risk and harm echoes the provisions of the Mental Health Act 2001’, the IASW calls for clarification that

the circumstances in which [the] proposed urgent admissions take place are separate from circumstances necessitating an involuntary admission to Approved Centres of persons suffering from mental disorders.

5.33 Noting that the criteria for urgent admissions set out in Head 5(1) reference the Mental Health Act, 2001, as legislation which ‘addresses the issue of the deprivation of liberty in a clinical and hospital setting’, the DFI expresses concern that:

This can lead to discrimination against persons with disabilities which is justified through paternalistic justifications and a ‘best interest’ approach.



This does not comply with the ADM(C) A[ct] 2015 or the principles of the UNCRPD in terms of respect for the ‘will and preference’ of a person.

### **Urgent admission as the least restrictive option**

5.34 The NRH argues that:

There should be an onus to prove that the severity of harm could not be removed or reduced by a less restrictive action—i.e. environmental surroundings including living arrangements can impact on a person’s potential to harm.

5.35 Likewise, the NDA emphasises that urgent admissions ‘should only occur when all other least restrictive options have been considered and none are [*sic*] available’ and that ‘appropriate safeguards’ should be ‘put in place so that the relevant person does not remain at a relevant facility for longer than is necessary’.

5.36 While acknowledging ‘that in certain circumstances, someone may need to be admitted to a relevant facility urgently’, the HSE Assisted Decision Making National Office states:

This should only occur when all other least restrictive interventions have been exhausted, and there is no other option. Safeguards need to be built in to Head 5 to ensure that the relevant person is not deprived of their liberty for longer than necessary.

5.37 SAGE recommends that Head 5(1)(a) should stipulate that:

the admission/intervention is proportionate to the significance and urgency of the matter, and that it is the least restrictive of the person’s rights and freedoms.

### **Application of the guiding principles of the ADMC Act**

5.38 Emphasising that ‘the person in charge should [...] apply the guiding principles’ of the ADMC Act when making temporary admissions decisions as well as when ‘deciding whether the person lacks capacity’, an individual respondent recommends that Head 5(1)

should state that the person in charge must ascertain the person’s will and preferences and their objections and [...] document the objections and the measures to be taken to address those objections.

5.39 Likewise, the IHREC

recommends that Head 5(1)(b) should be amended to ensure that the guiding principles set out in section 8 of the [ADMC] Act 2015 are [...]

applied to an intervention in its entirety rather than [solely to] an assessment of capacity.

- 5.40 The CDLP observes that ‘the criterion of danger to self’ enshrined in Head 5(1)(a)(i) ‘contravenes the principle of respect for the person’s will and preferences’ which is enshrined in the ADMC Act and in the UNCRPD, noting that:

The CRPD Committee has stated that the paradigm of will and preferences must replace the best interest determinations, respecting the rights, will and preferences of the person, in accordance with article 12, paragraph 4

Accordingly, the CDLP emphasises that relevant persons ‘must have the opportunity to challenge their detention’, commenting:

Legislative provisions are required which recognise those in this situation as being deprived of liberty and provide effective remedies to restore the individual’s right to liberty, rather than the introduction of paternalistic safeguards which merely justify or ‘rubber-stamp’ the deprivation of liberty.

- 5.41 Noting that ‘there is a requirement for the principles of the ADMC Act to be knitted in throughout the legislation’, MHR expresses ‘concern that the “least restrictive” principle does not feature in the draft legislation until Head 6’.

- 5.42 Likewise, the IHREC recommends that:

Head 5(2)(b) should be amended to require a medical expert to apply the last resort test set out in Head 6(1)(a)(ii) when reviewing the validity of a temporary admission decision.

## Textual amendments

- 5.43 Opining that “‘imminent risk of significant harm to the person’s health or welfare” on its own is inadequate’, an individual respondent recommends that the following text should be incorporated into Head 5(1)(a):

**And** temporary admission would be a proportionate response to the seriousness of the imminent risk **And** that there is no other appropriate, practicable and less intrusive manner to protect the relevant person from that significant harm. **And** admission will not itself cause significant distress or significant harm to the person’s health or welfare, including quality of life.

- 5.44 The MHC recommends that ‘the word “and” should be inserted on a new line at the end of sub-head [1](a) and before the beginning of subhead [1](b)’ and that ‘the word “and” at the end of sub-head [1](b) should be placed on a new line to ensure consistency’.

- 5.45 Arguing that ‘if the person in charge is of the belief that the relevant person should be prevented from leaving the facility, then the admission decision

should specify what techniques will be used to prevent this', an individual respondent recommends that:

Under Head 5(1), it should be inserted that the person in charge has reason to believe that it will be necessary to implement restrictive interventions despite the least restrictive principle because the relevant person objects to the admission, or because of the nature of their illness or/and behaviour, and that the likely interventions would be specified in the temporary admission decision.

5.46 In order 'to prevent [Head 5] being applied overbroadly based on vague criteria', an individual respondent calls for subhead 1 to be amended to include the following italicised text

(a) has reason to believe, *based on documented information and other relevant information, if any*, that the immediate admission of the relevant person is necessary—

(i) to prevent an imminent risk of significant harm or *gravely disabling deterioration* to the person's health or welfare *as a result of not having access to an arrangement of care and treatment that provides for the essential health or welfare needs of the person*, or

(ii) is necessary to prevent an imminent, *substantial* risk of *serious physical harm* to another person, *as evidenced by recent behaviour causing, attempting, or threatening harm to another person, or placing another in reasonable fear of sustaining physical harm*; [...]

(d) *is satisfied that appropriate care and treatment is available in the relevant facility.*

5.47 The Law Society of Ireland and Safeguarding Ireland recommend the addition of the following sub-clause to Head 5(1)(a):

(iii) Admission is a proportionate response to the likelihood of harm and the seriousness of the harm.

#### Other comments

5.48 NHI comments that:

It is highly likely that the majority of nursing homes would refuse to admit a relevant person in these circumstances because the conditions placed upon them are too onerous, the circumstances surrounding the admission may potentially leave the nursing home exposed under the law, and because they are largely unachievable in practice.

- 5.49 The IASW expresses concern about the inclusion of Head 5(1)(a)(ii), commenting:

If the relevant person poses a risk of violence / harm to others, an admission to a designated centre populated by many other vulnerable adults may not be the appropriate decision or setting for the relevant person.

**Question 5.2: In subhead 2(b), should a health professional other than a registered medical practitioner be able to provide medical evidence? If so, what type of healthcare professional? This issue also arises in Head 6(2).**

### **Respondents' comments**

#### **Views in support of the provision of evidence by other health professionals**

- 5.50 Emphasising that 'unless a "person in charge" is a healthcare professional, he or she is not otherwise governed by the guiding principles in section 8' of the ADMC Act, the MHC comments that:

The person in charge should not just take into account 'medical evidence', he or she should also take into account the views of two healthcare professionals one of whom is a registered medical practitioner and the other who will be from a category specified in the list to be set out in Part 13 or in the regulations.

- 5.51 The NDA recommends that:

Other experts should include other non-medical healthcare professionals as many will have the knowledge and competence to carry out an assessment of a relevant person's capacity to make a decision about their admission to a relevant facility. They could include a social worker or a public health nurse.

- 5.52 Likewise, arguing that 'social workers are better placed than doctors to assess whether there is an imminent risk of significant harm to a person's welfare' and noting that in other jurisdictions 'a best interests assessor (usually a social worker) will assess the person's social needs', an individual respondent recommends that:

The 1st paragraph of (2)(a) be amended to: "in deciding...shall take into account evidence from health and social care professionals and any other evidence which may be available.

- 5.53 Similarly, MHR recommends that:

An 'urgent admission' should require the input of a multi-disciplinary team, as opposed to the opinion of just one professional.

5.54 Saint John of God Community Services calls for the involvement in the admission procedure of psychologists and a 'designated officer/social worker'.

5.55 Opining that 'clinical psychologists and clinical neuropsychologists have [...] expertise that places them in a central position to assist in these circumstances', the Division of Neuropsychology of the PSI suggests that:

Healthcare professionals who meet the following i.e. (1) have experience of working with the patient, (2) have a good rapport with the patient, [and] (3) have [...] expertise in the area of concern can contribute 'medical' evidence or rather evidence pertinent to the welfare of the patient.

5.56 Noting that 'capacity is not a medical condition but variance in cognitive ability and function', the NAS suggests that:

If the matters are not related to a medical condition, perhaps there are other healthcare professionals who have regular experience in these matters who should provide evidence.

The NAS also emphasises the imperative for the legislation to define the role of 'the relevant statutory agencies – ordinarily the HSE, but also local government, primary care and acute care' with whom in all likelihood 'there will have been engagement' by the relevant person.

5.57 The MS Society of Ireland recommends that 'healthcare professionals such as neuropsychologists who have expertise on the impact of specific neurological conditions such as MS on cognition and capacity' should be able to provide medical evidence.

5.58 The CIB calls for 'other healthcare professionals with specialist assessment expertise' to be 'included within the definition of "other medical expert"'.

5.59 SAGE comments that:

A decision that a person will reside in a 'relevant facility' should consider all aspects of the person's circumstances, [...] should not be solely based on a medical model of care, and should include input from appropriate health and social care professionals.

5.60 ABI Ireland calls for chartered psychologists to be able to provide medical evidence.

5.61 While arguing that 'only those listed as medical experts in the definition section should assess capacity rather than the person in charge', an individual respondent recommends that:

Evidence of risk of harm to self or others should be able to be provided by social care professionals or Gardaí or nursing staff independent of the facility.

- 5.62 Noting that ‘the requirement to have medical evidence is suggesting the ongoing conflation with mental illness’, the Law Society of Ireland and Safeguarding Ireland argue that ‘provision should be made in subhead 2(b) for a registered medical practitioner and another healthcare professional’, suggesting that ‘a social worker or a public health nurse would be the more appropriate person to ascertain the accommodation needs of a relevant person’.
- 5.63 The INMO recommends that ‘the views of a medical practitioner and other relevant registered health and social care professionals’ should be taken into account.
- 5.64 Noting that ‘the term “medical evidence” is contrary to the principles in the 2015 [ADMC] Act’, the HSE Assisted Decision Making National Office observes:

The functional approach to capacity is not a medical test, and therefore any evidence that is presented should reflect the totality of the relevant person’s contact with healthcare professionals.

Accordingly, the HSE Assisted Decision Making National Office recommends that:

subhead 2(b) should be amended to state that advice should be sought from ‘a registered medical practitioner and other healthcare professionals’.

- 5.65 Noting that a ‘functional assessment rather than medical’ is required and suggesting that two people rather than one should ‘sign off’ on the admission decision, the Rehab Group recommends that ‘multidisciplinary team members with expertise relevant to the person’s support-needs should be identified’, citing a ‘psychologist, occupational therapist and behaviour therapist’ as examples.
- 5.66 Arguing that the professional should be required to consult experts in the relevant specialist area where appropriate’, the IMHLA suggests that:

A list of relevant experts for relevant settings should be provided, including for example:

- Hospital: health professional at consultant level;
- Nursing home: health professional at consultant level;
- Residential setting for people with intellectual disability: registered medical practitioner with expertise in intellectual disability.

## Views opposed to the provision of evidence by other health professionals

- 5.67 Expressing concern about the stipulation in Head 5(2)(a) that the person in charge shall take into account the medical evidence which ‘may’ be available, an individual respondent opines that only registered medical practitioners should be able to provide medical evidence.
- 5.68 Likewise, the IMHLA comments that ‘only a registered medical practitioner should be able to provide medical evidence’ and ‘that the practitioner should have a high level of expertise and experience’. However, the IMHLA expresses the view that ‘the professional should be required to consult [with] experts in the relevant specialist area where appropriate’, including, *inter alia*, with a ‘health professional at consultant level’ in hospitals and nursing homes and with a ‘registered medical practitioner with expertise in intellectual disability’ in a ‘residential setting for people with [an] intellectual disability’.
- 5.69 St. Luke’s Nursing Home, Cork opines that the deprivation of liberty of a relevant person ‘should be based on the highest standard of medical advice’, citing the ‘patient’s registered medical practitioner’, ‘consultant psychiatrist’ or an ‘independent medical opinion’ as appropriate sources.
- 5.70 Noting that ‘a temporary admission decision is a highly complex situation and should not be based on the opinion of the PIC [person in charge] only’, the NCPOP observes that:
- It is usual in similar scenarios (e.g. a person wants to leave an acute hospital but there is a risk of significant harm if they do so) for two independent medical doctors to make a decision on the capacity of the person and on the risk posed to the person.
- 5.71 The DSBA recommends that:
- Only a registered medical practitioner should be able to provide medical evidence upon which decisions are made and be required to consult relevant specialists where appropriate.
- 5.72 Asserting that ‘only a registered medical practitioner can provide medical evidence’, SPMHS states that ‘if other evidence is required this should be specified’, noting that ‘clinically formulated, socially formulated [...] and psychologically formulated evidence [...] may be crucial to the decisions being made’. However the SPMHS cautions that ‘such evidence may not be congruent with the case law interpretation of the European Convention on Human Rights’.

## Other comments

- 5.73 The NDA ‘recommends that “medical evidence” be changed to “evidence” in Head 5(2) in order to ensure that ‘all relevant evidence’ (medical and non-medical) is taken into account in the decision-making process, including evidence ‘about the relevant person’s accommodation needs’.
- 5.74 Noting that ‘the wellbeing and best interest of the relevant person is paramount at all times and particularly in circumstances where there is an immediate risk’, St. Luke’s Nursing Home, Cork emphasises that:
- In such circumstances, a temporary admission decision by the person in charge should be grounded on the best medical evidence.
- 5.75 The HSE Assisted Decision Making National Office opines that Head 5(2)(a) is incongruent with the 2015 [ADMC] Act, and therefore should be amended to say ‘any and all evidence which may be available’.
- 5.76 The DSBA emphasises that ‘the relevant person must have been personally examined by a medical professional’.
- 5.77 The IMHLA recommends that the legislation ‘should state that the professional must have personally examined the relevant person’ and ‘require that the professional has submitted a report in writing to the court’.
- 5.78 An individual respondent cautions that:
- As long as medical practitioners retain a centrality in the Mental Health Act legislation there is a real risk of patients falling between two stools as different professionals take very different approaches to the legislation.
- 5.79 The NDA suggests that an alternative to the procedure outlined in Head 5(2)(b) is
- to make provision for the person in charge or the healthcare professional to notify the Director of the Decision Support Service of any urgent interventions, [...] stat[ing] the exceptional emergency circumstances that gave rise to such an intervention. The Director would have the power to appoint an independent advocate to visit the relevant person to seek to support them to make the decision about remaining in or leaving the relevant facility. As proposed under Head 3, a Special Visitor could be sent out subsequently in some situations to assess the relevant person’s capacity [...] and report back to the Director.
- 5.80 The NAS emphasises the necessity for the healthcare professional providing evidence to adhere to ‘clear guidance that protects the [relevant] person from the deprivation of liberty by virtue of poorly informed or biased opinion’, calling



for ‘a guidance document [to] be provided outlining a process to follow when providing reliable evidence’.

- 5.81 An individual respondent calls for ‘independent’ to be inserted before ‘registered medical practitioner’ in Head 5(2)(b) in order to allay any ‘concern that health practitioners who have a financial connection with the facility may be involved in the admission process’.
- 5.82 The IHREC notes that ‘the reference to a second healthcare professional in the 2015 Act has not yet been defined’ and

that registered medical practitioners are prohibited from making a recommendation for involuntary admission under the Mental Health Act 2001 in the following circumstances:

- (a) if he or she has an interest in the payments (if any) to be made in respect of the care of the person in the approved centre concerned,
- (b) if he or she is a member of the staff of the approved centre to which the person is to be admitted,
- (c) if he or she is a spouse, a civil partner or a relative of the person, or
- (d) if he or she is the applicant.

Accordingly, the IHREC recommends that:

careful consideration must be given to the definition of medical expert in order to ensure that there is no imbalance of power between the categories of persons prescribed.

Suggesting that chapters 6–8 of the Law Reform Commission’s *Report: Consolidation and Reform of Aspects of the Law of Evidence* (2016) ‘may be of wider relevance to the issues under consideration’,<sup>35</sup> the IHREC further recommends that:

Consideration be given to the exclusion of medical experts from providing medical evidence in certain circumstances, such as those set out in section 10(3) of the Mental Health Act 2001.

- 5.83 HIQA calls for ‘consideration [to] be given to requiring evidence from two practitioners/experts, similar to requirements under the Mental Health Act (2001)’.
- 5.84 The NRH emphasises that ‘all possible sources of relevant information should be sought and considered prior to making decisions’ and that ‘validation of facts is essential’. Accordingly, the NRH recommends that, in the procedure for urgent admissions, ‘there should be a role [...] for at least two independent assessors’, one of whom could serve as an independent advocate. Nevertheless, the NRH emphasises that there remains ‘a positive duty [...] on

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<sup>35</sup> See Law Reform Commission, *Report: Consolidation and Reform of Aspects of the Law of Evidence* (2016), 194–340, <https://www.lawreform.ie/fileupload/Evidence%20Report%20Completed%20Revised%2018%20Jan.pdf>.

the person in charge to prove the rationale for determining that the person lacks capacity’.

- 5.85 NHI comments that the stipulation in Head 5(2)(b) that the advice of a registered medical practitioner or medical expert should be sought no later than 3 days after the temporary admission decision is made

is unachievable in practice given the earlier reference to under-resourced GP services and the IMO [Irish Medical Organisation] Communique. This would be particularly difficult in rural locations where the relevant facility that makes the temporary admission may be outside of the relevant person’s GP catchment area.

- 5.86 Noting that ‘subhead 2 requires the PIC [person in charge] to revoke the admission decision if the medical practitioner believes that the conditions in subhead 1(a) or (b) have not been met’, NHI comments:

The use of the word ‘or’ rather than ‘and’ here implies that admission may have been necessary to prevent imminent risk but that the person did not lack capacity according to the medical practitioner when assessed up to 3 days later. This does not account for capacity which may be fluctuating.

Questioning to where the relevant person would be discharged ‘if the imminent risk of harm provided for under subhead 1(a) is still present and the PIC is required to revoke the temporary admission decision’, NHI further notes that subhead 2 contravenes ‘the requirements under regulation 25 (Temporary absence or discharge of residents) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended)’.

**Question 5.3: In subhead (7), who should make the application to Court if no one else does so? Do you have a view on the proposed role of the Director of the Decision Support Service? This issue also arises in Heads 7(6), 7(11) and 8(3).**

#### **Respondents’ comments**

#### **Views on who should make an application to court**

- 5.87 The NCPOP recommends that:

The ‘appropriate person’ [to make an application to court] needs to have competency in clinical risk-assessment and knowledge of the legislation around assisted decision-making. Such persons could include health and social care professionals with appropriate training in disabilities, older person’s care including medical social workers, clinical nurse specialists and advance nurse practitioners in a relevant discipline, ADONs [assistant directors of nursing]/directors of public health nursing, medical physicians and occupational therapists.

- 5.88 SPMHS and ABI Ireland opine that ‘the Director of the Decision Support Service should make the application’.
- 5.89 The INMO opines that, ‘as the primary provider of health and social care services in the State’, the HSE should make the application to court if no one else does so, noting that ‘the professionals involved in such decisions will be closely aligned to the services and structures of the HSE’.
- 5.90 SAGE suggests that ‘an independent advocate could have the role of contacting the Director of the Decision Support Service’ and that:
- An independent advocate could be assigned by the Director to make an application to court on behalf of the relevant person, by inclusion of ‘Independent Advocate’ in Section 35 Part 5 of the ADM[C] Act 2015.
- 5.91 The HSE Assisted Decision Making National Office also calls for ‘the role of the independent advocate [...] to be included in Head 5’.
- 5.92 Likewise, the INMO calls ‘for the office of an independent advocate to be established to assist a relevant person’ or for ‘an amendment to the [ADMC] Act which increases the range of functions associated with the Court Friend office’.
- 5.93 An individual respondent notes that ‘there is no information as to who can be an “appropriate person”, which the proposed legislation indicates will be determined through regulations to be made by the Minister under Head 12.
- 5.94 Noting that, prior to making an application, ‘the Director may [...] consult with any person who has any function in relation to the care and treatment of a relevant person under section 95(5) or direct a Special Visitor to visit the relevant person under section 99(5)’, Safeguarding Ireland suggests that:
- The appropriate person [...] may be the independent advocate who will be responsible for notifying the Director of the need for [an] application to court.
- 5.95 NHI emphasises that making an application to court if no one else does so ‘is not a role for the person in charge’, recommending that ‘a social worker (specialised in care of the older person) should be assigned to the relevant person for this purpose’.
- 5.96 The Rehab Group calls for clarity about ‘the people who can/should make the application to court [...] in order of preference’, suggesting that ‘they should include the PIC, but only if there is no other family member etc to do so’.
- 5.97 The DSBA suggests that, ‘having regard to [...] provisions 35–37 of the 2015 [ADMC] Act’, applications to court should ‘be made by the relevant person’s family, next of kin or relevant facility and not by the Director of the Decision Support Services’.

5.98 The HSE Assisted Decision Making National Office opines that:

No one should make an application to court unless they have the authority to do so for the relevant person, and [that] this should include an independent advocate.

5.99 Saint John of God Community Services comments:

In relation to the making of an application to the Court if 'no one else does' there would need to be a specific framework/setup such as in MHA 2001 for availability of an officer (analogous to the position of "Authorised Officer" under the MHA 2001) who can make an application in such circumstances.

### **Views on the proposed role of the Director of the Decision Support Service**

5.100 An individual respondent expresses the view that 'the role of the Decision Support Service seems appropriate', recommending that:

They should formulate a panel of people to make such applications (similar to *guardian ad litem*s, or the various panels under the Mental Health Act 2001).

5.101 Likewise endorsing the proposed role of the DSS, the College of Psychiatrists of Ireland comments that:

It would appear reasonable that the Service develop a panel of persons qualified to make applications in these instances.

5.102 The NAS states that 'the Director of the Decision Support Service should be notified of all such cases within 24 hours'.

5.103 Questioning 'why the Director would be asked to make applications to court for the possible admission of relevant persons to relevant facilities', the NDA recommends that:

The Director should be involved much earlier in the process in appointing independent advocates to relevant persons urgently placed, and where necessary, sending out Special Visitors to assess their capacity to decide to remain in or leave the relevant facility.

Accordingly, the NDA suggests that, instead of 'an appropriate person be[ing] assigned to make an application to court under Part 5 on behalf of the relevant person', as indicated in Head 5(7), 'the process outlined in Head 3 could be applied'.

5.104 Calling for clarity about ‘whether the Director will conduct litigation inhouse or delegate her power to private solicitors’, an individual respondent recommends that:

The Director should be given power to allocate an independent advocate (non-lawyer) to advocate on behalf of the relevant person.

5.105 St. Luke’s Nursing Home, Cork emphasises the importance of the role of the Director ‘in maintaining the highest standards for any decision on a relevant person’s liberty’.

5.106 In respect of the role of the Director, NHI comments:

The Director of the Decision Support Service needs to be proactive in providing guidance and information and be easily accessible and available at times other than normal office hours for these emergency cases. In addition, they should provide a role in directing and supervising appropriate persons assigned to make applications to the court to ensure that they process the application within the required timeframes set out herein.

5.107 The DSBA comments that ‘it would be contrary to [the] ethos of the role of the Director [of the] Decision Support Service for the Director to make or direct applications for Admission Orders’.

5.108 Noting that the proposed role of the Director ‘runs contrary to the role of the [DSS] as outlined in the [ADMC] Act’, the HSE Assisted Decision Making National Office advises that:

The role of the Director should be limited in this regard to appointing someone from the panel, if required (which may include Special Visitors to determine capacity) or appointing an independent advocate to support the relevant person in the process.

5.109 Noting that Head 5(7) ‘provides that the Director is notified when the person with lawful authority has not taken court action’, an individual respondent recommends:

This should be amended to also provide that where there appears to be no person with lawful authority, the person in charge must notify the Director within 2 days of that information being available.

### **Resourcing of the Decision Support Service**

5.110 Commenting that the proposed role of the Director ‘falls within the remit of [the DSS]’ the CIB cautions that:

The ability to make the application to court within the defined time-frame will depend on the resources available to the Director and also on the

number of available and suitably qualified people that have been appointed to the panel of decision-making representatives.

5.111 ABI Ireland cautions that:

[The DSS] is likely to have to make a significant number of applications in the short term as it is very likely that people will not have co-decision-makers, decision-maker representatives, enduring powers of attorney, or court decision-making orders in the early years after the ADM Capacity Act 2015 is enacted. This will certainly have implications for the resources available to the Decision Support Service.

5.112 Noting that ‘since it is difficult to predict how many Part 13 proceedings will be issued, the Director will find it hard to predict how many legal staff she will require’, an individual respondent queries

whether the Director can seek her legal costs from a person with lawful authority who has declined to apply rather than have such costs come from the legal aid budget.

#### **5.4 Do you have any other views specific to Head 5?**

##### **Respondents’ comments**

##### **Timelines**

5.113 An individual respondent observes that ‘the timelines are extremely generous for an “urgent situation”’, questioning how ‘waiting 5 days to tell the relevant person’ about a temporary admission decision can be justified.

5.114 MHR opines that ‘the timelines set out under this Head [...] are too lengthy and should be reconsidered’.

5.115 Recommending that Head 5 should be ‘reworked to take account of access to an independent advocate by a relevant person where an emergency admission is required’, Safeguarding Ireland expresses the view that ‘the timelines set out in this section will then have to be reconsidered in the light of more appropriate safeguards being available’.

5.116 In respect of the timeframes indicated in Head 5, an individual respondent comments:

Since the person in charge must seek medical evidence within 3 days, why does the relevant person have to wait a further 2 days before being furnished with this evidence? The person in charge should serve any documents that assisted the making of the temporary admission within 48 hours of the admission. When further evidence is supplied as per (2)(b),

then that evidence should be supplied to the resident within 24 hours of receipt of that evidence.

The respondent also expresses concern that, as stipulated in Head 5(4), ‘the person in charge is given an additional 5 days after receipt of an order or co-decision-making agreement to notify the person with legal authority’, observing

the resident has not had the opportunity to challenge their detention and it is arguable that A5(4) of the ECHR has not been complied with because of this proposed timescale.

5.117 Noting that ‘there is an inconsistency between the time periods in sub-heads (2)(b) and (3)’ and that ‘persons must be treated equally regardless of the legislative provision under which they are detained’, the MHC recommends that ‘the time periods in the 2001 [Mental Health] Act, i.e. 24 hours, should be applied [...] in relation to the detention of a person subject to the person being assessed’. While suggesting that this time-period ‘could [...] be increased to 48 hours’, the MHC opines that, ‘on the assumption that the 5 days in [...] sub-head [4] is [*sic*] in addition to the five days referred to in sub-head (3)’ and that accordingly ‘the relevant person could be detained on the basis of a temporary admission decision for a period of 10 days’, the specified time-periods (inclusive of those given in sub-head 7) ‘are too long’.

Calling for ‘the periods prescribed in Part 13 [to] be as short as possible notwithstanding that [they] will pose a challenge for the services and the local circuit court’, the MHC notes that:

It is envisaged the whole process from the making of the temporary admission decision to the time it gets to court will be 25 days. This is akin to the 21 days under the 2001 Act. However, there are key differences in that the first thing done under the 2001 Act is to appoint a legal representative to the patient and the second is that the decision by the tribunal is completed within the 21 days. Such safeguards are not provided for here.

5.118 Opining that ‘there is no reason why the [relevant] person should not be informed within 24 hours of the admission decision and the rationale’, the NAS likewise observes that ‘the timeframes in Head 5 are too long’.

5.119 In respect of the timeframes outlined in Head 5, the NCPOP opines that:

Although it seems reasonable for the PIC to be able to detain the person to allow further assessment, 3 days to get medical advice seems excessive— all relevant facilities should have access to emergency on-call medical support within a few hours. A second independent opinion within 24 hours should be mandatory, of both the capacity and the risk, and then expert assessment within 3 days.

5.120 Noting that ‘the timeframes outlined in this draft Head mean that a relevant person could be deprived of their liberty for 5 days before [they are] informed

of the reasons for them being detained', the HSE Assisted Decision Making National Office calls for these to be amended.

- 5.121 SAGE observes that 'the timeframes outlined in this section could result in a person being arbitrarily deprived of their liberty for 5 days' as well as 'indicat[ing] that a person could be arbitrarily deprived of their liberty for up to 25 days'. SAGE notes that:

There is no maximum time-period applied in the circumstance where the court orders that the temporary admission decision shall continue until the court has disposed of the application, which creates a risk of a prolonged period of arbitrary deprivation of liberty based on an initial temporary admission.

- 5.122 Noting that 'the current draft Heads of Bill propose detention for up to 25 days without review', both the DSBA and the IMHLA call for 'the time limits in the section to be shortened'.

### **Supports for relevant persons**

- 5.123 Noting the resource-implications, the HSE's Older Persons' Services recommends that consideration should be given to the provision of support for urgent admissions decisions

by independent parties requiring 24-hour access to bodies such as the Decision-Making Support Service, independent advocacy groups, medical assessors e.g. consultant geriatrician / GP known to the vulnerable person and social work services.

- 5.124 Similarly, MHR calls for 'a provision on immediate access to an independent advocate [...] to be included under this Head'.

- 5.125 SAGE comments that:

The [relevant] person should be facilitated to participate in the decision-making process with the support of an independent advocate and the supported decision-making structures available under the ADM ACT 2015.

- 5.126 Stating that 'the procedure for admission of a relevant person to a relevant facility in "urgent circumstances" is not clear', the DFI calls for

consideration [...] to be given to the effectiveness of non-coercive methods that could help people who are experiencing a situation of emotional distress, self-harm, 'challenging behaviour' or mental health crisis. For example, this may include family groups or support circles.

- 5.127 The MHC calls for the specification of 'the supports that are to be provided to the relevant person during the period of the "temporary admission decision"',



recommending that these should be rendered 'by way of an advocate and / or a solicitor as in the case of a person detained under the 2001 Act'.

5.128 The CIDP notes that the role of the Special Visitor is not mentioned in Head 5.

5.129 Similarly noting that 'the role of Special Visitor is not utilised in this section', SAGE suggests that 'the Special Visitor could be requested by the Director [of the DSS] to meet with the person who is admitted in emergency circumstances'.

5.130 Likewise, the HSE Assisted Decision Making National Office calls for 'the role of Special Visitor to be included in this section', commenting:

The Special Visitor could be requested to meet with the relevant person who is admitted in the emergency circumstances to make a determination of decision-making capacity as requested by the Director of the Decision Support Service.

### **Human rights issues**

5.131 An individual respondent expresses the view that 'there is an insufficient balance of risks and rights from a human rights perspective' in the current legislation and calls for regulation to 'set out the forms that will contain the temporary admission decision, the capacity assessment and evidence of risks of harm'.

5.132 An individual respondent questions whether, in terms of the 'right to liberty and security' enshrined in article 5 of the ECHR, the 'urgent circumstances' outlined in Head 5 constitute 'a deprivation of liberty' or whether they should be 'considered to be an emergency, in which there is limited ability to dispense with evidential requirements'.

5.133 In respect of sub-head 8, the NAS recommends that 'there should be a specific right of appeal', opining that 'it should not be left open that the [temporary admission] decision shall simply lapse'.

### **Written notification of the relevant person**

5.134 Noting that the stipulation in Head 5(3) for 'the PIC to notify the relevant person [...] in writing of specific circumstances around the making of a temporary admission [...] is a contradiction in terms', NHI questions 'how it is proposed that the relevant person would receive or process' the written notification referred to in Head 5(3) and how this would 'be evidenced or regulated'.

5.135 In respect of Head 5(3) and (4) the Law Society of Ireland and Safeguarding Ireland comment:

Any notification being given to the relevant person and any other person or persons that may have been specified by the relevant person in writing

under the provision of this subhead should also be notified to the Director of the Decision Support Service.

- 5.136 Calling for clarification of the form of the written notification to be provided to the relevant person and others specified by them under subhead 3, the MHC emphasises that:

In keeping with the ethos of the 2015 [ADMC] Act, [...] steps must be taken to explain the written communication to the relevant person, to provide supports and to keep a record of all supports provided.

### Head 5(5)

- 5.137 SAGE questions ‘what safeguards are in place for a person who is the subject of an emergency admission’ under Head 5(5), noting that:

The current draft implies that a formal decision that the person will reside in a ‘relevant facility’ is made by a person without the specific authority to make an ‘admission decision’.

- 5.138 Noting that a ‘lack of clarity could lead to mis-interpretation of [...] Head [5(5)] and confusion for appointed decision-makers under the [ADMC] Act’, SPMHS queries:

What does the legislature intend in the circumstance where the decision-making representative etc. does not wish to have the temporary admission decision replaced by a formal admission decision?

- 5.139 An individual respondent expresses concern that Head 5(5)

removes any discretion from the person with lawful authority to request a variation of the restrictive interventions or their removal or to ask for the revocation of the temporary admission decision.

The respondent emphasises that ‘it is important that all objections by the resident to staying at the facility are documented by the staff’ so that the person with lawful authority ‘can analyse the objections and contribute to an urgent review of the temporary admission’. The respondent further states that:

Also, the type of restrictive interventions and frequency and duration must be reviewed by the person with lawful authority, the treating medical practitioner, the person in charge and any other relevant professionals.

- 5.140 An individual respondent notes that in Head 5(5) there is ‘the first mention that the temporary admission would include restraint’ and ‘the first mention of an “authorisation” which is not defined under the definitions’, recommending that “authorisation” should be deleted and substituted by a “formal admission decision”.

## Other comments

5.141 An individual respondent raises concerns about the risk that the manner in which the proposed legislative provisions ‘atomise responsibility for decision-making’ could result in those managing relevant facilities assuming responsibility for relevant persons over whom ‘they are not allowed to exercise “continuous supervision and control”’ but for whom ‘no one else is accepting responsibility to organise more appropriate accommodation’.

5.142 An individual respondent expresses concern that, while applications ‘to court for admission seem highly cumbersome for something intended to apply to a large number of people’, allowing greater discretion in terms of the procedure to be followed in urgent circumstances could result in ‘an ever developing sphere of legislation where the uncertainties can paralyse those trying to apply the legislation’ or to ‘the undesirable situation where people avoid the legally prescribed system and what could be considered “informal” detention’.

5.143 The IASW notes that:

This proposed legislation will have implications for many respite settings, where older persons, adults with a disability and adults with mental health needs often received temporary respite breaks in designated centres, sometimes without the capacity to consent to this temporary admission.

5.144 Arguing that the person in charge ‘has to accept that the threshold of evidence has been met and [...] to accept the person’ but that ‘they should not be allowed to make the actual admission decision because of financial interest in admission’, an individual respondent observes:

Head 5 is out of alignment with Head 4 in that if there is sufficient independent evidence that the potential resident lacks capacity and meets the risk and harm threshold, then why cannot the professional(s) that are supplying the evidence not certify that an emergency admission is required, rather than have the person in charge, who has a financial interest in making the temporary admission decision?

5.145 The NAS calls for the inclusion in subhead 3 of ‘more detail [...] to bolster the functional approach to capacity assessment in line with the ADM[C] Act’, commenting:

The person in charge should be obliged to provide evidence of how they have supported the person’s decision-making [...] to demonstrate [that] they are utilising the functional approach rather than assuming they lack capacity without being obliged to substantiate this further.

When capacity assessments are undertaken, the persons performing the assessments must be suitably qualified or knowledgeable and suitably matched to the disability of the person assessed. Information upon which the capacity assessment is based must also be presented to the assessor in a clear, consistent and appropriate way.

5.146 Noting that ‘Head 5(4) does not refer specifically to the making of an “admission decision” when referring to the role of a co-decision maker, decision-making representative or attorney’, SAGE advises that:

Suggested amendments to Section 44 and Section 62 of the ADM Act 2015 also need to be included for the role of co-decision-maker.

5.147 The IMHLA suggests that ‘the nature of the health condition needed as part of an admission decision should be stated’, noting that ‘it may be appropriate to refer to a “disorder or disability of mind”, for example’.

5.148 Noting that the U.K.’s Law Commission recommends that deprivation of liberty safeguards should authorise ‘the means by, and manner in which, a person can be transported to a particular place or places’,<sup>36</sup> an individual respondent suggests that ‘a conveyance provision would be useful for Head 5’ and that:

The Gardaí and ambulance service should be given power to convey, using reasonable force in defined circumstances, if professionals and family have been unable to convey the person.

5.149 The MHC calls for the insertion of ‘the words “Save in the case of a temporary admission order referred to in sub-head (2)(b) above”’ at the beginning of sub-head 8.

5.150 The MHC highlights ‘the decision of the Court of Appeal on 14 February 2018 in the case of the PL-v-the Clinical Director of St. Patrick’s Hospital and Others [Record No: 2014/881] which, it suggests, ‘may be relevant in relation to the basis on which a temporary admission may be made’.

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<sup>36</sup> Law Commission, *Mental Capacity and Deprivation of Liberty* (2017), 49.

## Chapter 6: Head 6 – Procedure for Making an Admission Decision

As stated in the Explanatory Notes, the purpose of Head 6 is ‘to ensure that an admission decision is based on medical evidence, as required by the ECHR’. Accordingly, subhead 1 stipulates that the authorisation of a decision-making representative or attorney to make an admission decision is contingent upon the provision of expert medical opinion that the decision is necessary and proportionate. Subhead 2 permits a decision-making representative or attorney to rely on the evidence provided by a medical expert to the court ‘where that evidence is still relevant’.

Subhead 3 prohibits the court from mandating an admission decision unless the evidence of a medical expert, and the necessity and proportionality of the decision, have been considered. Subhead 4 stipulates that, when authorising an admission decision, the court will ‘make an order appointing a decision-making representative or [...] amend an existing decision-making representation order’. As stated in the Explanatory Notes, ‘this is intended to assist operationally by having the relevant person represented for any consequential decisions’.

### Question 6.1: Is the evidence of one medical expert sufficient?

#### Respondents’ comments

#### Endorsements of the sufficiency of the evidence of one medical expert

- 6.1 The College of Psychiatrists of Ireland and SPMHS concur that the evidence of one medical expert is sufficient.
- 6.2 The IMHLA also opines that ‘the evidence of one medical expert would be sufficient’, with the caveat that ‘the term “medical expert” would need to be defined in a specific manner’, as detailed in paragraph 5.68 above. However, calling for ‘the medical expert’s view [...] to be part of a more robust system of admission, the IMHLA recommends that ‘the Bill should state that the expert must have personally examined the relevant person’; ‘that the expert must submit a report in writing to the court’; and that ‘the nature of the health condition needed as part of an admission decision should be stated’.
- 6.3 The IASW is of the view that:

The evidence of one medical expert may be sufficient provided that the relevant person has had their care needs assessed by a multi-disciplinary team, led by another consultant-grade doctor.
- 6.4 Noting that ‘in English court applications [...] there will only be one doctor’ and that ‘in DOLs [deprivation of liberty safeguards] authorisations, there is only one mental health assessor’, an individual respondent suggests that there is

no benefit from having two registered medical practitioners acting as experts as a standard practice when capacity-evidence is unlikely to be challenged provided that the standard of the assessments is good.

However, the respondent also notes that, in English ‘DOLs authorisations [...] there will always be evidence from a social care professional about the social and family background of the relevant person’, opining that this ‘best interests assessment [...] is the most useful of all of the 6 assessments required for the issuing of a DOLs authorisation’.

### **Calls for the provision of additional evidence**

- 6.5 The MHC recommends that ‘the evidence of two healthcare professionals, one of whom is a registered medical practitioner, should be provided’.
- 6.6 Likewise, ABI Ireland opines that ‘at a minimum it is reasonable that it should be two experts (as it used to be to start the process of making a person a ward of court)’.
- 6.7 The DSBA calls for evidence to be provided by ‘at least one medical expert and a healthcare professional’ as well as by ‘a relevant medical specialist’ where appropriate.
- 6.8 Calling for the utilisation of ‘validated assessments and a standardised format’ in order to ‘ensure that the medical evidence in each case is based on factual evidence (objective) and not opinion-based (subjective)’, NHI opines ‘that two medical experts would be preferable to ensure the decision is fair, transparent and legally sound’.
- 6.9 The NAS comments:
- There should be at least two independent medical experts and in addition information on what the assessment is based should come from multiple sources—workers who know the person well, family, friends, advocates [...] to reflect the social model of disability.
- 6.10 Reporting that ‘in a condition as complex and variable as MS [...] it is unlikely that the view of one medical expert as to whether or not [relevant persons] have capacity would be sufficient’, MS Ireland also calls for ‘consideration [to] be given to broadening this out beyond medical experts to other healthcare professionals’.
- 6.11 The HSE’s Older Persons’ Services and HSE National Safeguarding Office emphasise that there ‘should be more than one medical expert determining admission including at least one party who knows the vulnerable person’s capacity, medical/psychological/cognitive history and general baseline status’. Highlighting the need for ‘a social background assessment and evidence in that report that admission is the least restrictive option’, they further emphasise that admission decisions ‘should be made with a second registered healthcare

professional such as a social worker or a public health nurse or other healthcare professionals’.

- 6.12 While recognising ‘the necessity for medical evidence’, the INMO suggests that ‘evidence as to welfare [...] may well be better articulated by other health and social care professionals involved in providing services to a person’.
- 6.13 Questioning the centrality of the evidence provided by a medical expert to the proposed procedure for making an admission decision, the Division of Neuropsychology of the PSI calls for consideration to be given to ‘evidence from relevant health professionals’, such as nurses and clinical psychologists, and to the opinion of ‘the professional who has the most experience of working with the patient’.
- 6.14 Emphasising that the procedure for making an admission decision ‘should consider all of the person’s circumstances and [...] overall care needs and risks’, SAGE recommends that ‘inputs from a broad range of healthcare professionals should be sought’.
- 6.15 Recommending that ““medical expert” should be amended to “medical and health and social care professional””, MHR suggests that:

Health and social care professional should be considered in the widest sense and should include but not [be] limited to psychologists, psychotherapists, occupational therapists and social workers, social care workers and speech and language therapists.

- 6.16 Saint John of God Community Services calls for ‘the evidence of more than one healthcare profession[al]’, inclusive of psychologists and social workers as well as of a medical expert, to be taken into consideration, with the caveat that this requirement could be waived ‘in the initial process of an application/admission being pursued under urgent or emergent circumstances’.
- 6.17 While emphasising the importance of ‘independence and objectivity’ in the decision-making process, and describing ‘the availability of independent medical experts’ unknown to the relevant person as ‘a crucial safeguard’, the CIB nevertheless acknowledges that:

In situations where the person objects to the proposed care arrangements, evidence from another medical expert could help to resolve the dispute.

- 6.18 Noting that ‘a second opinion might be useful to assist the family with expectations of recovery’, the NRH recommends that:

Relevant health and social care professionals [should be] involved depending on the needs of the relevant person, the expertise required and any differences of opinion with key family members.

- 6.19 Calling for ‘the term “medical expert” [to] be amended to “registered medical practitioner” so that it correlates with the rest of the 2015 [ADMC] Act’, the HSE Assisted Decision Making National Office notes that:

In the 2015 Act, in order for a relevant person to create an enduring power of attorney or enter into a co-decision-making agreement, there is a requirement for a statement from two professionals—a registered medical practitioner and another healthcare professional.

Accordingly, the amendment of the proposed legislation to align with the Act is recommended.

- 6.20 The IHREC notes that ‘in Irish jurisprudence on mental health, medical evidence has been provided by a number of healthcare professionals’, and that the ADC Act ‘requires a statement by a registered medical practitioner and another healthcare professional in relation to co-decision agreements and enduring powers of attorney’. Accordingly, the IHREC ‘recommends that the evidence of at least two medical experts should be provided in deprivation of liberty cases’ while calling for ‘consideration [to] be given to exclusion of medical experts from providing medical evidence in certain circumstances, such as those set out in section 10(3) of the Mental Health Act 2001’.
- 6.21 Drawing attention to ‘the requirements for detention under mental health legislation’, an individual respondent comments that ‘one “medical expert” is entirely insufficient’.
- 6.22 Noting that ‘under existing safeguarding legislation the absence of any legally mandated independent advocate to represent the voice of the person places them in a particularly vulnerable position’, the NCPOP opines that ‘this important decision should require at least two independent medical assessors’.
- 6.23 While conceding that ‘the “one expert” view could be necessitated from a practical point of view’, St. Luke’s Nursing Home, Cork comments that ‘there is scope to go further than just [to] rely on one medical expert’.
- 6.24 Noting that ‘the court may wish to seek other expert opinion, and not necessarily medical, in situations where it is not satisfied with the first expert advice provided’, the NDA recommends that ‘it should be left open to the court to decide how many experts it wishes to receive expert evidence from’.



## Other comments

6.25 Observing that ‘paragraph 1 of the Explanatory Note to Head 6 is incorrect in stating that the ECHR requires an admission decision to be based on medical evidence’, the Law Society of Ireland and Safeguarding Ireland argue that ‘a report of a “medical expert” is not required’. They further note that this requirement

is not consistent with the provisions of Parts 1 and 2 of the ADMC Act 2015 nor in compliance with the UNCRPD.

6.26 An individual respondent expresses concern about the provision of evidence ‘by less well-defined “medical experts” (e.g. social workers, psychologists, non-consultant medical practitioners)’ if ‘the evidence is not tested in court’.

6.27 An individual respondent seeks clarity on the procedure for the appointment of the medical expert, querying whether they will be ‘appointed by the court or chosen by the person with lawful authority’. Arguing that ‘the court must have power to control the experts’, the respondent suggests that the establishment of

a panel of medical experts that the Court can use who have received specific training on how to assess capacity, the ADM[C Act] as well as on Part 13 [...] will reduce the prospect of the applicant, the person in charge and any other interested party hiring various medical experts.

6.28 NHI observes that:

The availability of GPs to assist in the provision of medical evidence will be constrained by the current GMS GP contract-provisions and the general under-resourcing of the sector, particularly in rural locations.

## Question 6.2: Do you have any other views specific to Head 6?

### Respondents’ comments

### Criteria for admission decisions

#### *‘Harm’ and ‘significant harm’*

6.29 Observing that there are references to both ‘harm’ and ‘significant harm’ in Head 6, an individual respondent seeks clarification on ‘which is the correct reference’, recommending that ‘specific terms should be defined’.

- 6.30 Suggesting that Head 6(1)(b)(i) could ‘be widened to “protect from harm and/or in the best interests of [the relevant person’s] health, welfare or quality of life”’, HIQA observes that:

There may be occasions where an admission decision is sought to improve a person’s quality of life as opposed to simply preventing them from harm.

In addition to suggesting that ‘there may be a merit in providing a definition for what is meant by “harm”’, HIQA further recommends the deletion of ‘significant’ from Head 6(1)(b)(i), commenting that ‘this may be an excessively high threshold to meet’ and that ‘harm over a prolonged period of time can have a detrimental impact on the rights, health, and welfare of an individual’.

- 6.31 Arguing that the inclusion of ‘significant harm’ as the primary criterion for making an admission decision as ‘insufficiently protective’ and noting that ‘welfare has been identified as a relevant consideration by the ECtHR [European Court of Human Rights] and is recognised within [...] Head 5 in the context of “urgent” decisions’, the INMO recommends that ‘harm should be extended to refer to harm to health or welfare’ both in subhead 1 and subhead 3.

- 6.32 Noting that ‘the word “harm” is not defined’ and that the ‘wording appears to be borrowed from the Mental Health Act 2001’, the Law Society of Ireland and Safeguarding Ireland seek clarity on whether the intention of Head 6 is for ‘the relevant person [to] be provided with care elsewhere if there is no “harm”’. They call for the proposed legislation to provide for ‘situations in which there is no alternative accommodation for a relevant person and they lack capacity to make any decision’.

- 6.33 Likewise calling for a definition of ‘harm’, the HSE Assisted Decision Making National Office comments:

It is unclear what the process is if someone is not at serious risk of harm but has no other alternative but to be admitted to a relevant facility—for example, a young adult who has an acquired brain injury but, due to lack of accessible accommodation at home, has been admitted to a nursing home.

- 6.34 Likewise calling into question why ‘significant’ does not precede ‘harm’ in subhead 3 and the lack of emphasis on ‘the rights for the person to be present, to be heard and to be represented (with legal aid)’, an individual respondent opines that “‘significant harm’ is inadequate’ and that it should be replaced with

‘overall interests’ including consideration of the person’s will and preferences, harm from non-detention, harm from detention, and quality of life

- 6.35 Noting that ‘harm’ is not preceded by ‘significant’ in subhead 3(a) and (b), an individual respondent opines that, in subhead 3, ‘the threshold is too low for a court to order deprivation of liberty’.

- 6.36 The IMHLA recommends that ‘in Head 6(3)(a) and (b), the references to “harm” should be replaced with references to “significant harm”’.
- 6.37 Recommending that ‘the Department should take account of legal precedent on the definition of harm to self and harm to others, as defined by the courts’, MHR calls for ‘the criteria “significant harm” for deprivation of liberty [...] to be clarified and [to] be of a significantly high bar’.

#### *Capacity assessment*

- 6.38 Observing that Head 6 ‘is framed in the negative, i.e. to protect the person from harm, and to some extent aligns itself to concepts within mental health legislation’, HIQA calls for ‘broader consideration [to] be given to the assessment of capacity to take into account the functional model outlined within the ADMC Act’.
- 6.39 An individual respondent suggests that, ‘given the way in which capacity is defined under the 2015 [ADMC] Act’, Head 6 is problematic because it seems to equate ‘lack of capacity [...] with being of unsound mind’, thereby running ‘the serious risk of incompatibility with Article 5(1)(e) ECHR’.
- 6.40 An individual respondent notes that in Head 6(1) ‘there is no express provision that the person with lawful authority has to be satisfied that the relevant person lacks capacity to make the relevant decision’.

#### *Necessity and proportionality*

- 6.41 Calling for it ‘to be reiterated that every effort should be undertaken to support the person’s capacity’, the NAS also stresses that ‘the emphasis on the necessity and proportionality of the decision is an important inclusion’.
- 6.42 The NDA calls for the statement in the Explanatory Note requiring the decision-making representative or attorney to ensure the necessity and proportionality of the admission decision ‘to be translated into a provision in the draft Heads for the purposes of applying to the healthcare professional in Head 3’.
- 6.43 Observing that ‘there is a poor attempt’ in Head 6 to set out the imperative for the necessity and proportionality of the admission decision, the Law Society of Ireland and Safeguarding Ireland call for
- these important principles [...] to be more fully developed, to include an initial assessment of needs and risks, giving effect to the presumption of capacity and evidence of support given to the relevant person to make an admission decision before any action is taken or intervention made.
- 6.44 An individual respondent questions the necessity for the inclusion of the statement (in Head 6(1)(b)(ii)) ‘that the expert should have an opinion on the least restrictive alternative’ given that ‘sections 8(6)(a) and (c) of the ADM[C Act] already encompass’ this.

In respect of this matter, the respondent suggests that:

The *pro forma* to be completed by the medical expert should include an express reference to the least restrictive principle to remind the expert to consider this when making a recommendation on placement.

- 6.45 The IHREC notes that ‘the proportionality test established by Article 5 ECHR may require a consideration of whether detention on the basis of disability amounts to arbitrary detention in the [...] context of developments in international human rights law’.

*The relevant person’s will and preference*

- 6.46 While commending the fact that ‘Head 6(1)(b)(ii) addresses the area of least intrusive manner’ and calling for this to ‘be emphasised with reference to Part 8(6) of the 2015 [ADMC] Act’, the HSE Assisted Decision Making National Office observes that ‘Head 6 does not specifically address and reference the will and preference of the relevant person’.

- 6.47 Noting that the ADCM Act ‘strongly favours the approach of decisions being made based on the will and preference of the person affected over best interests’; that the U.K.’s Law Commission has identified issues arising in relation to the utilisation of ‘best interests assessments’; and that ‘the lack of choice and availability of placement and support options, especially home support options, in Ireland are a concern’, the CIB suggests that ‘it may be advisable [...] that a strong well-being principle is followed rather than the principle of best interests’.<sup>37</sup>

- 6.48 Noting that Head 6 ‘reflects more of a “best interest” approach than [an] approach required to reflect [the] person’s will and preference’, and that there is ‘no sense of what a proportional response to “risk” is beyond the person being deprived of their liberty’, the NCPOP emphasises that:

It is important that this bill is supported by clear guidance on risk assessment, capacity assessment, and is consistent with advocacy and human rights legislation.

- 6.49 Advising that Head 6 ‘should allow for consideration that a person may make their own decision to live in a “relevant facility” at any stage while the procedure is on-going to seek an order from the court’, SAGE calls for subhead 1(a) to ‘include a clearer reference to the Guiding Principles which should be followed in accordance with the ADM[C] Act 2015’.

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<sup>37</sup> See Law Commission, *Mental Capacity and Deprivation of Liberty*, 75.

## Other comments

- 6.50 Emphasising that ‘it is imperative that a proportionate response is made in relation to any deprivation of liberty decision’ that is cognisant of ‘the benefits and risks [...] to the person, in addition to their will and preferences’, MHR recommends that the criteria for admissions decisions ‘should be narrowed’. Referring to the *Report of the Expert Group on the Review of the Mental Health Act 2001* (2015), MHR suggests that ‘this may involve for example introducing an additional criteria [sic] such as “benefit of treatment” for the person’ in Heads 5 and 6.<sup>38</sup>
- 6.51 The IHREC notes the disparity between the criteria for urgent admissions set out in Head 5 and those set out in Head 6. (Head 5 identifies the prevention of ‘imminent risk of significant harm to another person’ as a reason for admission whereas Head 6 does not.)

## Textual amendments

- 6.52 Opining that ‘the problem with [Head 6] is that it does not spell out the decisional criteria or conditions for making an order placing a person in a facility’, and that ‘the danger is that this approach will vest excessive discretion in healthcare professionals and the judges’, an individual respondent comments that, as required under article 5(1) of the ECHR,

the purpose of Head 6 should be to provide fixed criteria and rules and a formalised admission procedure for authorising care or treatment arrangements that give rise to a deprivation of liberty.

Accordingly, the respondent recommends that Head 6 should stipulate that:

The court may authorise arrangements for care and treatment in the relevant facility, if

- a capacity assessment has been carried out in respect of the person that confirms that the person lacks the capacity to consent to the arrangements for care or treatment that are proposed or in place in the relevant facility;
- the relevant person has a condition that is severe enough to necessitate care or treatment for the person’s own welfare and safety in the relevant facility;
- an assessment has been carried out by an appropriate medical expert in respect of the person that confirms that the person is likely to benefit from the arrangement for care or treatment that are available in the relevant facility;

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<sup>38</sup> See Department of Health, *Report of the Expert Group on the Review of the Mental Health Act 2001* (2015), <https://health.gov.ie/blog/publications/report-of-the-expert-group-review-of-the-mental-health-act-2001/>.

- the arrangements for care and treatment in the facility are necessary in the sense that less restrictive or intrusive arrangements would not suffice to prevent serious physical harm or grave disablement to the relevant person or the substantial risk of serious physical harm to another and the arrangements are proportionate to the aims pursued.

6.53 The IMHLA recommends that:

The Bill should state that an admission decision shall only take place as a last resort if **all** of these conditions are fulfilled:

- A. There has been a capacity assessment.
- B. The capacity assessor has found that the person lacks capacity to decide on whether to enter the relevant facility.
- C. The court has considered guiding principles including the following:
  - a. The enjoyment of the highest attainable standard of health, with the relevant person's own understanding of his or her health being given due respect.
  - b. Autonomy and self-determination.
  - c. The policy against new entrants to congregated settings.
  - d. Dignity (there should be a presumption that the relevant person is the person best placed to determine what promotes/compromises his or her own dignity).
  - e. Bodily integrity.
  - f. Least restrictive care.
- D. Either of the following applies:
  - a. the court is satisfied that it would have been the person's will and preference to enter the setting, taking account of the principles in section 8 of the Assisted Decision-Making (Capacity) Act 2015 or
  - b. the court is satisfied, having regard to the right to liberty, that entry to the setting is necessary for the protection of life of the person, for protection from a serious threat to the health of the person, or for the protection of other persons.
- E. The court is satisfied that the setting is the most appropriate available for the person in light of their needs and that the admission decision is proportionate to the risk of harm involved.

6.54 Recommending that 'the nature of the health / mental conditions grounding an application for an admission decision should be stated', the DSBA recommends that:

The Bill should provide that an admission decision shall only take place as a last resort and only if the following conditions are fulfilled:

- A. There has/have been a capacity assessment/s;
- B. The relevant person has been afforded the opportunity to provide his/her own independent capacity assessment;
- C. The capacity assessor has found that the relevant person lacks capacity to decide on whether to enter the relevant facility;

- D. The relevant facility is the most appropriate available for the relevant person in light of their needs;
- E. The admission decision is proportionate to the risk of harm involved.
- F. Either of the following applies:
  - a. it would have been the relevant person's will and preference to enter the relevant facility taking account of the principles in section 8 of the Assisted Decision-Making (Capacity) Act 2015; or
  - b. having regard to the right to liberty, that entry to the relevant facility is necessary for the protection of life of the relevant person, for protection from a serious health threat or for the protection of other persons.
- G. Consideration be given to the guiding principles including the following:
  - a. The enjoyment of the highest attainable standard of health, with the relevant person's own understanding of his or her health being given due respect;
  - b. Autonomy and self-determination;
  - c. Dignity (there should be a presumption that the relevant person is the person best placed to determine what promotes/compromises his or her own dignity);
  - d. Bodily integrity;
  - e. Least restrictive care.

6.55 In addition to recommending that the references throughout Head 6 to 'medical expert' should be changed to 'two healthcare professionals, one of whom is a registered medical practitioner', the MHC calls for the end of subhead 2 to 'be amended to read [...] "to make an admission decision **and** where that evidence is still **applicable**"' and for the deletion of the word 'of' in subhead 3(b).

6.56 Calling for Head 6 to 'specify in more specific terms what the court can do', an individual respondent recommends the inclusion of the following text:

The court may authorise specific arrangements for care and treatment, including: authorised are:

- arrangements that a person is to reside in one or more particular places;
- arrangements that a person is to receive care or treatment at one or more particular places; and
- arrangements about the means by which, and the manner in which, a person can be transported to a particular place or between particular places.

6.57 Observing that Head 6(2) 'allows a non-professional person with lawful authority to ignore medical expert evidence given to a court', an individual respondent recommends that:

This subsection should be reframed to state that the person with lawful authority shall take the medical expert's opinion into account unless there

is evidence available that the relevant person's health and capacity has changed since the medical expert's opinion was furnished to the Court.

- 6.58 The Law Society of Ireland and Safeguarding Ireland recommend the re-positioning of Head 6 directly after Head 2 in the proposed legislation.

#### **Other comments**

- 6.59 An individual respondent expresses concern that 'there is no requirement for the medical expert to supply a risk analysis or risk assessment or a pros and cons document setting out the alternatives to institutional care', arguing that 'this gives far too much power to the medical expert'.

- 6.60 Emphasising that 'in circumstances where there may be a deprivation of liberty, the highest standards must be exercised', St. Luke's Nursing Home suggests that 'an independent report could be sought as seen with the Mental Health Act 2001 under section 17(1)(c).

- 6.61 A number of respondents, including the HIQA, INMO and SAGE, emphasise the importance of the provision of an independent advocate to support the 'relevant person'.

- 6.62 Noting that responsibility and liability for the implementation of restrictive practices in a relevant facility rests with the staff, an individual respondent advises that the amendments proposed in the 'Explanatory Notes' to sections 44 and 62 of the ADMC Act

should indicate that the lawful representative is giving authority to the person in charge to use restrictive practices including restraint and to deprive the person of their liberty.

- 6.63 Both the DSBA and the IMHLA call for the proposed legislation to make provision 'for the publication of redacted court decisions made under this part of the Bill'.



## Chapter 7: Head 7 – Persons Living in a Relevant Facility

Comprising 12 subheads, Head 7 sets out the procedure to be followed in three scenarios, namely:

1. When a person living in a relevant facility wishes to leave but there is reason to believe that they lack the capacity to make this decision;
2. When a person who elected voluntarily to reside in a relevant facility after the commencement of this legislation subsequently loses the capacity to decide to continue to live there;
3. When a person whom the court has determined lacks capacity is living in a relevant facility and regains capacity.

Subheads 1–3 stipulate that, in the first of these three scenarios, the person in charge (or the healthcare professional acting on their behalf) ‘may temporarily prevent the relevant person from leaving [...] provided that the conditions in Head 5(1) are met’ and that, in such a scenario, ‘the provision of Head 5(2) to (8) shall apply’. However, subhead 2 states that the provision of subhead 1 will not apply if ‘the change in capacity is likely to fluctuate and [...] the loss of capacity will only last for a short period’, while subhead 3 indicates that the person in charge (or the healthcare professional acting on their behalf)

shall not incur any liability where, during the time in which the relevant person is temporarily prevented from leaving is in place, the capacity of the relevant person fluctuates.

Subheads 4–8 set out the procedure to be followed in the second of the scenarios detailed above. Subhead 4 states that, in this scenario, the person in charge (or the healthcare professional acting on their behalf) will notify the relevant person (and others specified by them) of their view that the relevant person no longer has decision-making capacity ‘for the purpose of affording them the opportunity to make an application to court under Part 5’. Subhead 5 stipulates that the person making such an application will notify the person in charge (or the healthcare professional acting on their behalf) of this, while subhead 6 states that (subject to subhead 8), if such notification is not received within 3 months ‘the person in charge shall contact the Director [of the DSS] and request that an appropriate person be assigned to make an application to court’ within 21 days. As outlined in the Explanatory Notes, subhead 7 provides that an application to court under subheads 4 and 6 will not be required

if there is an enduring power of attorney or decision-making representative authorised to make an admission decision or an admission decision is ordered by the court or declared to be lawful by the court.

Subhead 8 specifies that subhead 6 will not apply in instances in which the person in charge (or the healthcare professional acting on their behalf) believes that the relevant person’s

change in capacity is likely to fluctuate and that the loss of capacity will only last for a short period, or there is a high probability of the person’s demise within a short period.

Subheads 9–12 pertain to the third of the aforementioned scenarios, with subhead 9 stipulating that, in an instance in which the person in charge (or the healthcare professional acting on their behalf) believes that the relevant person has regained decision-making capacity, they will notify the relevant person and any appointed decision-making representative of their belief ‘for the purpose of affording them the opportunity’ to apply for a review of the court order. As noted in the Explanatory Notes, subhead 10 ‘provides that the person in charge shall be notified of the application to the court to have the declaration of the court reviewed’, while subhead 11 stipulates that, in an instance in which such notification is not received within 21 days, the person in charge (or the healthcare professional acting on their behalf) will contact the Director of the DSS to ‘request that an appropriate person be assigned to make an application to court under Part 5 [of the ADMC Act] on behalf of the relevant person’ within the next 21 days. Subhead 12 specifies that subhead 11 will not apply if the person in charge (or the healthcare professional acting on their behalf) believes that

the change in capacity [of the relevant person] is likely to fluctuate and that the regaining of capacity will only last for a short period.

**Question 7.1: In subhead (2), do you have views on how the issue of fluctuating capacity should be addressed?**

#### **Respondents’ comments**

#### **Definition of ‘fluctuating capacity’**

- 7.1 St. Luke’s Nursing Home, Cork notes that ‘there is no definition given to the term “fluctuating capacity”’.
- 7.2 The MHC and the NAS call for the definition of ‘fluctuating capacity’.
- 7.3 NHI likewise opines that ‘the proposed legislation should include a definition of “fluctuating capacity” or “capacity that is likely to fluctuate”’, calling for this to ‘include reference to delirium’.

#### **Assessment of fluctuating capacity**

- 7.4 The MHC call for fluctuating capacity to be determined with ‘an overall healthcare assessment, not just a medical assessment’, recommending that this ‘should be specific to each person’.
- 7.5 Observing that ‘the procedures set out suggest an over-interference with a person’s autonomous decision’, the HSE National Safeguarding Office and the HSE’s Older Persons’ Services recommend that the assessment of fluctuating capacity should ‘be based on a multi-disciplinary best practice assessment’.

- 7.6 The Law Society of Ireland calls for it 'to be emphasised in subhead (2)' that 'the 2015 [ADMC] Act allows for a functional approach to capacity that is issue specific, time specific and context specific'.
- 7.7 Advising that it 'is extremely difficult to assess [fluctuating capacity] in terms of offering a prognosis of whether and when capacity may return, even for a clinical psychologist or psychiatrist', ABI Ireland recommends that 'a PIC [person in charge] or their HCP [health care practitioner] team-leader [...] should contact a medical practitioner'.
- 7.8 SPMHS recommends that 'medical evidence should be obtained to ascertain the likelihood and length of fluctuating capacity'.
- 7.9 Noting that 'there is always an assumption of capacity', the NCPOP emphasises that 'the trigger for believing' that a relevant person has lost their decision-making capacity 'would need to be defined'. Observing that 'it cannot be assumed that staff in a relevant facility have the skills to formally assess capacity', the NCPOP queries whether staff training will be provided or whether assessments will be conducted by medical practitioners.
- 7.10 An individual respondent comments:
- Taking account of the seriousness of a deprivation of liberty and the person in charge's financial conflict of interest, there must be a requirement that the resident's capacity is independently assessed.
- 7.11 Expressing concern that the person in charge (or a healthcare professional acting on their behalf) is responsible for determining a relevant person's capacity, and noting that 'this is a significant decision to make', the HSE Assisted Decision Making National Office recommends that this 'significant decision [...] should be made by the person in charge and another healthcare professional' in order to 'provide safeguards not only for the relevant person, but also for the staff members involved'.
- 7.12 ABI Ireland observes that Head 7 places 'a very heavy burden [...] on the person in charge in terms of temporarily preventing the relevant person from leaving the relevant facility'.
- 7.13 Noting 'the risk of arbitrary deprivation of liberty due to a temporary admission', SAGE calls into question whether the proposal for temporary admissions decisions to be 'made by one person only [...] is the most appropriate approach'.
- 7.14 Noting that the 'ADM[C] Act 2015 provides for a statutory presumption of capacity' SAGE calls for the relevant person's capacity to
- be assessed functionally and in accordance with the principles of the ADM[C] Act 2015 including a process of building the person's capacity to make the decision, through supported decision-making, or engaging in a co-decision-making agreement.

- 7.15 Emphasising the importance of not ‘repeat[ing] standard tests within certain timeframes in order to preserve the validity of the assessment’, the NRH comments that:

Emerging and fluctuating capacity would be factors to consider in terms of when to review capacity to make a decision to leave a relevant facility.

- 7.16 St. Luke’s Nursing Home, Cork queries:

In an interim situation where a patient’s liberty is being put on hold until a decision is reached—would continual assessment of the relevant person pre-empt the rush / delay ensuing from such fluctuation arising? Is this practical?

### Supporting relevant persons

- 7.17 The INMO calls for ‘all appropriate supports’ to be offered to relevant persons to maximise their decision-making capacity in accordance with the provisions of the ADMC Act.

- 7.18 MHR calls for

provisions [...] to be included to ensure that persons who are *de facto* detained [...] are enabled through decision-making and advocacy supports to (1) make an informed decision about where they wish to reside and (2) to leave their current place of residence.

- 7.19 Noting the difficulties inherent in legislating ‘for people whose capacity to make a decision may change throughout the day’, the NDA calls for the instigation of ‘a system that is practical and operationally manageable but [which] also contains adequate safeguards for the relevant person’.<sup>39</sup> Drawing attention to the ‘draft Code of Practice for Advocates being developed by the NDA’, the organisation recommends that these safeguards should include the appointment of an independent advocate to the relevant person and suggests that the provision within the Heads of a code of practice ‘could give guidance on the issue of fluctuating capacity’.

- 7.20 Emphasising that ‘regard must be had to section 3 of the 2015 [ADMC] Act which provides for a functional construction of capacity’, the Law Society of Ireland and Safeguarding Ireland remark that ‘the need for [the] assistance and support of an independent advocate is particularly necessary when a person’s capacity may fluctuate’ and call for this role to be ‘dealt with by [a] detailed code of practice’.

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<sup>39</sup> The NDA refers to ‘the challenges involved in making provision for fluctuating capacity in law’ highlighted in the U.K. Law Commission’s report, *Mental Capacity and Deprivation of Liberty* (2017), 81.

They further suggest that:

When a review of the implementation of the Act takes place, this matter can be revisited as to whether there should be legislative provision based on best practice experience.

- 7.21 The HSE Assisted Decision Making National Office also recommends that, in an instance in which a relevant person wishes to leave a relevant facility but is deemed to lack the capacity to make the decision to do so, 'it is necessary that the relevant person has access to an independent advocate'.
- 7.22 SAGE likewise calls for the 'process of engaging an advocate [to] be included as early as possible, and prior to an application to court under Part 5 of the ADM Act 2015 being made on behalf of the person'.
- 7.23 Highlighting the imperative for 'access to/oversight from an independent advocacy service' and recognising that 'fluctuating capacity is very difficult to address because of limited resources and appropriate personnel', the Division of Neuropsychology of the PSI emphasises the importance of 'facilitation of liberty even if it ends up only on a temporary basis'.
- 7.24 The INMO highlights the importance of the provision of an independent advocate to support relevant persons who have lost or regained decision-making capacity.
- 7.25 Expressing concern that 'the Heads of Bill [...] imply that the decision to live in a "relevant facility" will be a permanent decision' and noting the imperative for the on-going assessment of a relevant person's capacity 'in keeping with the definition of functional capacity as put forward by the Assisted Decision Making (Capacity) Act', the IHF calls for 'all practical steps [to] be taken to build the capacity of the person and support the person to make their own decision'.
- 7.26 Likewise calling for fluctuating capacity 'to be looked at in tandem with how the ADM addresses this matter', the NAS recommends that:

There should be a requirement for the person in charge to evidence how they have attempted to engage with the person at various times to support their decision-making. [...] There should be multiple documented attempts and the involvement of key others in this also.

- 7.27 The Law Society of Ireland highlights the emphasis in section 8(7) of the ADMC Act on

the importance of the intervener working with the relevant person to encourage and facilitate their participation as fully as possible in the intervention.

- 7.28 The Rehab Group calls for the empowerment of 'people at times when they are deemed to have capacity to make decisions [...], with a robust process of documentation to support [this]'; for people to 'document their will and

preferences [...] when they are deemed to have capacity'; for 'the decision/admission' to be delayed 'if possible, if the person does not have capacity for a period of time'; and for 'the situation/decision process' to be reviewed 'as soon as the person once again holds capacity'.

#### Other comments

7.29 An individual respondent expresses the view that the issue of fluctuating capacity 'is addressed as well as it can be in the draft Heads of Bill'.

7.30 Similarly, the College of Psychiatrists of Ireland comments that 'we are in broad agreement with the treatment of this issue in the Heads of Bill'.

7.31 Observing that 'the Head is unclear as to how relevant facilities should handle the issue of fluctuating capacity' and that 'it needs to address the needs of adults whose right to liberty is at risk in a relevant facility', the DFI calls for Head 7 to be

redrafted and a different process developed, to make it clear that individuals with fluctuating capacity should have their right to liberty protected and should have their will and preferences taken into account.

7.32 Noting that 'capacity (and cognition) may fluctuate due to delirium [...] or due to "sundowning"—the tendency in dementia in particular for people to be worse at night'—an individual respondent argues that:

If someone has residence capacity at 9am, it is unacceptable to tell them they can't leave on the basis that they might not have such capacity at 9pm.

7.33 Noting that 'Head 7 is problematic in that a number of provisions do not apply to people with fluctuating capacity', MHR expresses 'the view that despite the recognised limitations of the "functional approach" [...] the deprivation of liberty safeguards should comply with the principles of the ADMC Act in this regard'. Accordingly, MHR advises that:

there should be no provision in the legislation that does not recognise that because a person does not have capacity at a certain point in time, [it] does not mean that they will not have capacity in the future (whether later that day, week, month, or year).

7.34 The HSE Assisted Decision Making National Office highlights the stipulation in section 8(9) of the ADMC Act that

regard shall be had to (a) the likelihood of the recovery of the relevant person's capacity [...] and (b) the urgency of making the intervention prior to such recovery.

Arguing that ‘this is especially important where the relevant person has fluctuating capacity’, the HSE Assisted Decision Making National Office calls for it ‘to be taken into consideration prior to any intervention’ and ‘to be emphasised in Head 7’.

- 7.35 Endorsing the view of the U.K.’s Law Commission that ‘it is legitimate to authorise arrangements that remain in place even during limited periods of capacity to consent or object to the arrangements’,<sup>40</sup> the CIB calls for ‘the issue of fluctuating capacity [to] be specifically addressed in the legislation in line with the general principles of the [ADMC] Act’. They caution that:

To not do so would result in in a continuous cycle of assessment, court applications and re-admission and could expose health and social care professionals to legal risks.

- 7.36 Opining that ‘the regulations or code should specify how the issue of fluctuating capacity should be dealt with’, an individual respondent argues that:

If the capacity assessment indicates that the person’s capacity [...] will fluctuate, the arrangements should not cease automatically if [...] the regaining of capacity will last for a short period only.

- 7.37 The MS Society of Ireland calls for

Further guidance [...] to be developed around [fluctuating capacity], giving consideration to the difficulty of making such assessments in the case of complex and variable neurological conditions such as MS.

- 7.38 NHI observes:

Capacity to make decisions can be impacted on by a range of factors such as mood, time of day, who is asking the questions and how they communicate, for example. Often fluctuating capacity can also be impacted negatively where there is a sudden change of circumstances, thereby a relevant person who has capacity to leave at a particular point in time and is permitted to do so could very likely lose that capacity when placed in unfamiliar surroundings and present a danger to themselves or others.

Accordingly, NHI queries how relevant persons with fluctuating capacity are to be managed and ‘what happens in out-of-hours scenarios’, in which transferring responsibility to junior nursing staff ‘would severely impact on recruitment and retention within the sector’.

- 7.39 NHI notes that ‘subhead 2 is contradictory in that it states that subhead 1 shall not apply if capacity is fluctuating’ while ‘subhead 1 provides that the PIC [person in charge] may temporarily prevent a person from leaving the relevant facility if the conditions in Head 5(1) are met (i.e. risk of imminent harm)’.

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<sup>40</sup> Law Commission, *Mental Capacity and Deprivation of Liberty Summary* (2017), 13, [https://s3-eu-west-2.amazonaws.com/lawcom-prod-storage-11jsxou24uy7q/uploads/2017/03/Mental\\_Capacity\\_Report\\_Summary.pdf](https://s3-eu-west-2.amazonaws.com/lawcom-prod-storage-11jsxou24uy7q/uploads/2017/03/Mental_Capacity_Report_Summary.pdf).

Accordingly, NHI questions whether, under subhead 2, 'PICs [are] supposed to "stand back" and knowingly allow their residents to come to harm', noting that:

This would be fundamentally against both the individual nurses' code of professional conduct and the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended).

7.40 Opining that 'one could see a challenge being brought under Head 7(2)', St. Luke's Nursing Home, Cork calls into question the justification for the subhead presented in the Explanatory Notes—namely that the exemption of relevant persons from subhead 1 in instances of fluctuating capacity 'is required in order to avoid a situation where fresh applications are [...] made more frequently than the court can hear such applications'. St. Luke's Nursing Home, Cork queries whether 'this [could] be considered pre-judgement'.

7.41 Seeking clarification on the intended meaning of subhead 2, the INMO queries:

Is it meant that a person may be temporarily detained without reference to subhead 1, and the related Head 5, where it is believed their absence of capacity will be for a short time?

The INMO opines that such an 'approach may be practical' provided that a definition of 'short period' is provided.

7.42 Saint John of God Community Services advises that it 'is likely to be extremely difficult to regulate [fluctuant capacity] as a separate entity' and that accordingly this will 'need to be based on practical considerations in relation to other procedures, monitoring and review, governance etc. in relation to capacity'.

7.43 An individual respondent opines that the issue of fluctuating capacity would best be addressed 'by avoiding the inherently cumbersome use of the courts to determine capacity-applications'.

7.44 NHI observes that:

There are multiple references to relevant persons that may have 'fluctuating capacity' included within the document and in particular, there are specific parts where it expressly states that particular sub-heads will not apply where the person in charge reasonably believes that the change in capacity is likely to fluctuate i.e. 7(2); 7(8); 7(11); 8(5); 11(2)(d).



**Question 7.2: In subhead (2), do you have a view on the length of time that would be considered a ‘short period’? This issue also arises in Heads 7(8), 7(12) and 8(5).**

### **Respondents’ comments**

#### **Endorsements of the definition of a ‘short period’**

- 7.45 The Division of Neuropsychology of the PSI and the NAS call for a ‘short period’ to be defined.
- 7.46 SPMHS likewise opines that ‘the legislation should stipulate what the maximum time is in relation to the “short period”’.
- 7.47 The INMO also maintains that ‘a definition of a short period is required’, commenting that ‘a failure to define a short period is insufficiently protective’ of the relevant person.
- 7.48 Noting that ‘the issue of short periods of loss of capacity tends to apply in cases of delirium’, an individual respondent comments that the definition of a ‘short period’ is ‘a rather important issue when considering the application of deprivation of liberty procedures to acute medical settings’.
- 7.49 While querying ‘what [...] a “reasonable time-span” for exercising the required steps’ would be, St. Luke’s Nursing Home, Cork observes that:

Lacking definition regarding the concept of time-span / gravity can complicate issues for the relevant person and therefore negate any possibility of [them] availing of same.

#### **Suggestions for the definition of a ‘short period’**

- 7.50 Calling for there ‘to be a robust assessment by relevant healthcare professionals’ of the relevant person’s capacity, the NRH advises
- that enhances in ability to make decisions would need to be noted over a period of at least 4 to 6 weeks in order to ensure correct timing of a review.
- 7.51 Similarly, an individual respondent suggests that ‘a month or longer [would] not be an unreasonable period for the treatment of an underlying physical health problem and resolution of delirium’, while nevertheless anticipating that ‘many cases [would] go beyond this timeframe’.
- 7.52 Emphasising that decisions about relevant persons’ capacity should be made by ‘a medical practitioner [...] not the PIC / HCP’, ABI Ireland suggests that ‘one month would be a reasonable short timeframe from loss of capacity to expected demise’. The organisation explains that:

This is based on the existing practice timeframe within which a GP doesn’t have to notify the coroner following a patient’s death, if they had a condition

from which they were expected to die, and the GP had seen them in the last month.

7.53 Noting that ‘Head 6 stipulates that the Director of the Decision Support Service has 21 days to appoint an appropriate person to make an application under Part 5 on behalf of the relevant person’, SPMHS recommends that ‘the “short period” should be at a maximum 21 days, subject to medical advice’.

7.54 The NCPOP observes that ‘a short period in relation to life expectancy would seem reasonably to be death anticipated within weeks’.

7.55 While expressing concern that ‘the person in charge (or random healthcare professional) will judge life-expectancy’, an individual respondent suggests that ‘two weeks would seem to be respectful of the individual’.

7.56 The INMO suggests that, in defining a ‘short period’

recourse may be had to the Head dealing with ‘urgent’ circumstances, and the lesser period of 3 days, after which the matter should be dealt with in similar terms to subhead 1.

7.57 The DSBA recommends that ‘the “short period” specified in Head 7(2) and other subheads should be a period of 24 hours’, further commenting that:

In the event that Head 7(11) is retained, [...] the two 21-day periods in Head 7(11) should be shortened to two periods of 14 days.

7.58 The IMHLA recommends ‘that the “short period” specified in Head 7(2) and other subheads should be a period of three hours’.

7.59 While opining that ‘it is difficult to quantify what would be deemed a short period’, NHI remarks:

If it restricted a PIC [person in charge] from preventing a person in imminent danger from leaving, then the period of time would likely require [*sic*] to be a matter of minutes rather than hours or days.

### **Challenges of defining a ‘short period’**

7.60 Along with an individual respondent, the College of Psychiatrists of Ireland highlights the difficulties attendant upon defining a ‘short period’ given ‘the diversity of circumstances in which these provisions may apply’.

7.61 Noting that ‘in MS, not only can it be very hard to identify the extent to which the disease has affected a person’s cognitive functioning, but symptoms of the condition can also vary from day to day’, the MS Society of Ireland comments that it ‘would be extremely difficult to determine’ the length of the time that should be considered a short period ‘in conditions like MS’.

- 7.62 Citing the view of the U.K.'s Law Commission, that 'there is no statutory definition of "short period", nor can there be',<sup>41</sup> the NDA observes that:

What constitutes a short period will necessarily be a subjective decision but providing an objective definition for it in primary legislation is also problematic.

Accordingly, seconding the view of the Law Commission, the NDA recommends that the matter should be 'dealt with in a Code of Practice to be provided for in the draft Heads of Bill'.

- 7.63 Observing that 'the term "short period" is very subjective and providing a specific length of time could be challenging', the HSE Assisted Decision Making National Office recommends that the 'issue should be dealt with in a code of practice' that should be published once the proposed legislation is enacted.
- 7.64 Noting that 'the reference to "short period" in each of the sub-heads (2), (8) and (12) refers to different matters', the MHC opines that 'one specific time-period may not be applicable' and suggests that 'specific time-periods should be inserted in each sub-head' in order to ensure that provisions are not 'open to legal challenge'.

#### Other comments

- 7.65 Observing that 'each case is different', St. Luke's Nursing Home, Cork cautions that 'any timelines need to be reasonable'.
- 7.66 Likewise noting that 'the period of time [...] will depend on the reason for fluctuating capacity', the Rehab Group recommends that 'review periods should be built in from the outset'.
- 7.67 Noting that 'fluctuation in capacity for one individual may last minutes, but for others it might last for hours or days', the CIB recommends that:

The issue of fluctuating capacity should be addressed as part of an individualised care plan for the person and in this context a 'short period' should be defined specifically with regard to the individual's care needs and history of care needs.

Acknowledging that 'occasions where individuals regain their capacity to consent or their capacity to object to care provisions [...] may cause distress or upset for the individual concerned and indeed for staff or family members', the CIB also calls for 'constructive management of such instances [to] be addressed as part of the individual's care plan [...] in a manner that minimises distress or upset for the individual'.

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<sup>41</sup> Law Commission, *Mental Capacity and Deprivation of Liberty*, 82.

- 7.68 The MHC recommends that ‘the reference to a “short period” should be replaced with a specific period’.

### **Question 7.3: Do you have any other views specific to Head 7?**

#### **Respondents’ comments**

#### **Applications to court in respect of a loss of decision-making capacity**

- 7.69 Questioning the basis on which the relevant person is deemed to have lost capacity and observing that the submission of an application to court in respect of a relevant person’s voluntary decision to live in a relevant facility ‘is not respecting the right of the autonomy of the relevant person’, the Law Society of Ireland and Safeguarding Ireland argue that the procedure outlined in subhead 4 ‘is an intervention that is totally unnecessary’. Instead they call for effect to be given to the provisions of the ADMC Act, including ‘the presumption of capacity unless the contrary is shown’, the application of the Guiding Principles, and the respect for the will and preference of the relevant person enshrined therein.
- 7.70 NHI notes that, in an instance in which a relevant person voluntarily entered a relevant facility after the commencement of the proposed legislation, the Guiding Principles of the ADMC Act would apply and that the person ‘would have also entered into a contract of care as per regulation 24 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended)’. Accordingly, NHI argues that ‘these residents should [...] not have to be subjected to further applications to the court just to obtain the necessary court order to reaffirm their “will and preference”’, describing the process outlined in subhead 4 as ‘cumbersome and an unnecessary use of limited resources’. Instead NHI recommends ‘strengthening the processes within the “Care Needs Assessment Report” to clearly document a person’s future wishes should they subsequently lose capacity’, suggesting that these reports ‘could then be subject to regulatory oversight by the Director [of the DSS], to ensure compliance with the [ADMC] Act, if that was deemed appropriate’.
- 7.71 The HSE Assisted Decision-Making National Office likewise opines that the provision in subhead 4 of ‘an opportunity to apply to court where someone has previously decided to live in a relevant facility and may now lack capacity’ is ‘unnecessary’, arguing that, if

it was the relevant person’s choice to decide to live there, and [...] this decision was based on their known will and preference, they would have chosen to live there at a time when they lacked capacity’.

Noting that ‘the 2015 [ADMC] Act allows for the least interventionist approach’, the HSE Assisted Decision Making National Office opines that ‘an application to court in this instance would go against this principle’.

- 7.72 In relation to the procedure set out in Heads 4–8 to be followed in an instance in which a relevant person who voluntarily elected to live in a relevant facility loses the capacity to decide to continue to do so, SAGE calls for

consideration [to] be given to the potential interference in a person's rights and if it is necessary and the least restrictive of the person's rights to initiate an application to court under Part 5 of the ADM[C] Act 2015 when a person initially consented to live in the 'relevant facility'.

- 7.73 MHR expresses 'concern that where a person once chose (with capacity) to live in a particular "facility" and now lacks capacity, they must go through the courts system to seek approval to continue to live in their place of residence', noting that 'many key stakeholders are of the view that this [...] overrides the will and preferences of the person'.

- 7.74 The NDA queries why, in an instance in which a relevant person 'voluntarily consented to admission and now expresses a desire to leave and their capacity is in question', it 'would be necessary to contact the Director [of the DSS] [to] ask for an appropriate person to make an application to court'.

#### **Definition of 'demise'**

- 7.75 NHI calls for clarification of the meaning of 'demise', referred to in subhead 8, querying:

Is this death, a significant decline in the [relevant person's] cognitive functioning or is it meant in the context of discharge from the nursing home? [...] When is a person deemed at the end of their life in the context of their cognitive functioning?

- 7.76 The HSE Assisted Decision Making National Office and the NDA describe 'demise' as an 'inappropriate' term to use in primary legislation.

#### **Provisions for relevant persons who regain decision-making capacity**

- 7.77 In respect of the timeframe indicated in subhead 11 for an appropriate person, assigned by the Director of the DSS, to make an application to court on behalf of a relevant person living in a relevant facility who has regained decision-making capacity, an individual respondent comments:

21 days seems an inordinate length of time to keep someone who has, *prima facie*, regained capacity against their will pending an application to reconsider their deprivation of liberty.

Noting that 21 days 'is of a similar period [...] to an admission order under the MHA to an approved centre', the respondent observes that 'patients there would expect to have a tribunal at a much earlier time'.

7.78 The IMHLA calls for the ‘two 21-day periods’ referred to in subhead 11 to ‘be shortened to two periods of four days’.

7.79 The NRH notes that ‘section 3 [subheads 9–12] is particularly relevant for NRH patients as they may regain capacity after a period of time in a relevant facility’.

7.80 In respect of the procedure outlined in subheads 9–12 to be followed when a relevant person regains capacity, SAGE comments:

If the person has capacity to make the decision whether or not to be in the place of residence, this decision should be respected and consideration should be given to the potential interference in a person’s rights and if it is necessary and the least restrictive of the person’s rights to initiate an application to court.

7.81 The IMHLA calls for Head 7 to

include a clear statement of principle that if the circumstances change so that the relevant person has regained capacity and no longer wishes to live in the relevant facility, the person should be discharged immediately.

7.82 The HSE Assisted Decision Making National Office, the Law Society of Ireland and Safeguarding Ireland opine that the provisions detailed in subhead 9, pertaining to a relevant person who has regained capacity, are ‘excessive’, commenting that a notification to the Director of the DSS and the court of the change in circumstances by the relevant person and the person in charge should suffice.

#### **Other comments**

7.83 Emphasising that ‘situations may arise where a person who previously lacked capacity may regain it permanently or for longer than a “short period”’, the CIB recommends ‘that court applications for review should be treated expeditiously’.

7.84 Likewise emphasising that ‘an application to court in such circumstances must be made expeditiously’, the MHC expresses the view that ‘the periods referred to are too long’.

7.85 Noting that subhead 6 effectively sanctions the deprivation of liberty of a relevant person for 3 months, an individual respondent observes that ‘this period is not in keeping with article 5(4) of the ECHR and should be reduced to a maximum of 25 days’.

7.86 SAGE calls for the reference in subhead 1 to the relevant person’s expressed ‘desire to leave the relevant facility’ to

be expanded to reflect that a person may express that they do not wish to be in or to live in a ‘relevant facility’ without specifically requesting to leave.

7.87 The IHREC expresses concern that the stipulation in subhead 3 ‘that the healthcare professional “shall not incur any liability” for temporarily preventing a person from leaving where the capacity of the person fluctuates’ will ‘provide blanket immunity to healthcare professionals and [...] act as a barrier to an effective remedy for the individual concerned’. Accordingly, the IHREC ‘recommends that Head 7 should be revised to ensure access to effective remedies’.

7.88 While opining that Head 7 ‘would seem to go some way to meeting a definition of deprivation of liberty based upon the imposition of measures against a person’s will’, an individual respondent emphasises that:

It is important to make clear any desire to leave can be expressed in a wide range of ways (including through the agency of family/friends).

The respondent expresses concern that the definition implied in Head 7 ‘will not pick up individuals who are merely compliant with [...] arrangements to which in truth they do not assent’.

7.89 Noting that a relevant person may have been admitted to a relevant facility because a family-member signed ‘a contract of care’ with such a facility on their behalf; because they were ‘coerced into making a decision to reside in a “relevant facility”’; or because ‘they were not aware of other options available to them’, SAGE emphasises the imperative to raise awareness of the legislative provisions with all relevant persons in relevant facilities to ensure that they ‘are equally beneficial to all vulnerable adults and older people’.

7.90 Noting that ‘the person in charge is permitted to temporarily prevent the relevant person from leaving the relevant facility’, the NAS seeks clarification on the ‘measures [that] are allowed to actually prevent the person from leaving’.

7.91 Opining that ‘in the event that the relevant person regained capacity the Admission Order requires to be revised’, the DSBA recommends that:

Heads 7(9) to (11) should be replaced with a provision requiring that, if the circumstances change so that the relevant person no longer satisfies the conditions for admission, the Admission Order should be discharged and arrangements be made to facilitate the new status of the relevant person.

7.92 The INMO and the MHC advise that their comments in respect of Head 5 apply to Head 7(1) and, more broadly, the MHC emphasises that:

Persons under this Head should not be treated differently to persons under the other Heads; the same time periods should apply throughout Part 13.

7.93 The IHREC recommends that:

Heads 7(1)(a)(ii), 7(2), 7(4), 7(9) should be amended to ensure that the guiding principles set out in section 8 of the Assisted Decision-Making

(Capacity) Act 2015 are to be applied to an intervention, in its entirety rather than an assessment of capacity.

7.94 The MHC recommends that in subhead 4 ‘the reference to “at” in the fourth line should be amended to read “a” and that ‘the reference to a “as soon as practicable” should be replaced with a specific period’ both in subhead 4 and subhead 9.

7.95 Noting that it is unclear whether the provision of legal aid referred to in the Explanatory Notes ‘is for the representation of the relevant person [...] or whether it is for a family member seeking to be appointed as a decision-making representative’, an individual respondent calls for

the extent of the proposed legal aid scheme for Part 13 [of the ADMC] [...] to be made clear well before implementation.

7.96 Saint John of God Community Services observes that ‘much of [Head 7] appears to mirror/reference or extrapolate from procedures under Part II of the MHA 2001 for Approved Centres’ and that accordingly it

will likely need to be refined to cater for centres and / or models of support in intellectual disability services; other than Approved Centres under MHA 2001.



## **Chapter 8: Head 8 – Transitional Arrangements for Existing Residents on Commencement of this Part**

Along with Head 7(1)–7(3), Head 8 pertains to relevant persons who are residing in relevant facilities prior to the enactment of the proposed legislation.

Subhead 1 stipulates that, in an instance in which a person in charge (or a healthcare professional acting on their behalf) believes that a relevant person living in a relevant facility at the date of the commencement of the legislation lacks the capacity to decide to live there, the person in charge (or the healthcare professional acting on their behalf) will notify the relevant person, ‘and any other person or persons that may be specified by the relevant person’, of this belief within 10 days in order to provide them with an opportunity to make an application to court under Part 5 of the ADMC.

Subhead 2 specifies that the person making an application to court will notify the person in charge (or the healthcare professional acting on their behalf) that they have done so. Subhead 3 states that (subject to subheads 4 and 5), if such notification is not received within 12 months and 1 day, then the person in charge will ask the Director of the DSS to assign an appropriate person to make a court application on behalf of the relevant person within the next 21 days.

Subhead 4 outlines the circumstances in which subheads 1 and 2 do not apply, namely

where evidence of

- (a) An interim order under section 48 authorising the admission of the relevant person;
- (b) an order under section 37(3) declaring a proposed admission of the relevant person lawful;
- (c) a decision-making order made under subsection 38(2)(a) authorising the making of an admission decision in respect of the relevant person; or
- (d) a registered enduring power of attorney authorising an attorney(s) to make an admission decision in respect of the relevant person; or
- (e) an order under section 38(2)(b) appointing a decision-making representative for the purposes of making a decision in respect of personal welfare matters, including an admission decision

is produced to the person in charge or the healthcare professional on behalf of the person in charge.

Subhead 5 stipulates that subhead 1 shall not apply in instances in which the person in charge (or healthcare professional acting on their behalf) believes that the relevant person’s ‘change in capacity is likely to fluctuate and that the loss of capacity will only last for a short period’ or that ‘there is a high probability of the person’s demise within a short period’.

## Question 8.1: Do you have any views specific to Head 8?

### Respondents' comments

#### Time-frames

*Time-frame (of 12 months and 1 day) for the receipt by the person in charge of notification of a court application*

8.1 While the DSBA expresses the view that 'the 12-month period proposed in Head 8.1 [*sic*] is appropriate', the majority of respondents call for the time-frame of 12 months and 1 day indicated in subhead 3 for receipt by the person in charge of notification that a court application has been made on behalf of a relevant person to be shortened.

8.2 The HSE Assisted Decision Making National Office comments:

It is [...] unclear why existing residents are required to wait for 12 months and 1 day before the person in charge is required to contact the Director to request that an appropriate person is assigned to make an application to Court. This is a long period of time for someone to be deprived of their liberty. This timeframe should be reduced.

8.3 Similarly, while acknowledging that 'there are, presumably, resource considerations, especially on the commencement of any new legislation' and that 'this rather protracted time-frame might permit phasing of court hearings', an individual respondent queries 'why existing residents should wait for over a year before there is a default notification to trigger a capacity review under the 2015 Act (subhead 8(3))', noting that 'for people who are deprived of liberty and do not have someone to make an application sooner, a year is a very a long wait'.

8.4 Noting that the time-frame of 12 months and 1 day indicated in subhead 3 'seem[s] overly long' and that it 'could lead to the deprivation of someone's liberty for a significant period of time', the NAS expresses concern that, even after this period has elapsed,

there is no time-frame outlined for the procedure and ultimately therefore it [could] lead to a significant period of detention without any checks and balances in place.

8.5 An individual respondent opines that 'it is unacceptable if people can be detained for over a year before their detention is dealt with by a court'.

8.6 While acknowledging 'the investment in resources to the Decision Support Service and the Court Service that are [*sic*] required', the College of Psychiatrists of Ireland expresses the view that 'the time-frame for transitioning from current practice to adherence to the Assisted Decision Making (Capacity) Act 2015 needs to be more timely', and that:

All patients concerned should see this process commence for them within six months of the commencement of the Act and their status regularised within 12–18 months.

8.7 HIQA recommends that:

Consideration should be given to making it a requirement to contact the Director of the Decision Support Service sooner than 12 months in cases where the person in charge believes that no application will be made on behalf of th[e] [relevant] person.

8.8 While acknowledging ‘the resource pressures’ that will impinge on the implementation of the proposed legislation, an individual respondent observes that the proposed time-frame of 12 months and 1 day for the receipt of notification of a court application in respect of a relevant person ‘is in breach of 5(4) of the ECHR’, and that ‘there is no justification for the length of this delay especially when independent advocacy is not being provided for by the Bill’. While noting that ‘this delay is presumably being justified on the basis that these residents have not expressed a desire to leave the facility which would place them under Head 8’, the respondent nevertheless argues that:

Pending a court application, the person in charge should have to notify the Director [of the DSS] within a month so that the Director could allocate an advocate or/and appropriate person.

8.9 The IMHLA ‘submits that the 12-month period in Head 8(3) should be shortened to six months’.

8.10 The MHC opines that ‘a period of “12 months and 1 day” is unacceptable where a person is potentially being deprived of their liberty unlawfully’.

8.11 SAGE observes that ‘there is no indication of why a lengthy time-period of 12 months and 1 day is applied in Head 8(3).’

*Other comments*

8.12 MHR comments that ‘the timelines included under this Head [...] are too lengthy and should be reconsidered’.

8.13 St. Luke’s Nursing Home, Cork notes that ‘if the PIC [person in charge] is living abroad/away, the timeframe of 10 days [indicated in subhead 1] might not be sufficient’.

8.14 Noting that ‘there are very clear timelines for PICs’, NHI calls for ‘corresponding timeframes for the Director’, describing the absence of these from the proposed legislation as ‘a fundamental flaw’.

NHI comments:

Timeframes for the Director are essential to ensure that persons wishing to make an application are processed within a timely manner and in line with the constraints of the average length of stay.

### **Resource implications of proposed transitional arrangements**

8.15 The CIB expresses concern that:

The transitional arrangements for existing residents on commencement of this legislation are a matter of concern in terms of the resources required to ensure compliance with the law.

Noting that the implementation of the proposed legislation 'will require significant resources, both in terms of assessment and in terms of court applications' given the number of people in Ireland who are in residential care, the CIB emphasises that 'it will be important to ensure that care for this vulnerable grouping is not compromised through the process'.

8.16 While endorsing 'the proposal that [relevant persons] must be informed and have the right to make an application to court', the NRH notes that 'this will raise resource issues in terms of who would review capacity in complex cases'.

8.17 Opining that, due to the increasing prevalence of dementia, 'there is likely to be a surge in applications to the court to be in compliance with this Part', NHI observes that:

The courts would struggle to cope with the numbers of applications in a timely manner (as has been the case in the UK), particularly if the applications rely on medical evidence from medical practitioners that will also be over-stretched.

NHI further notes that the pressure on the courts 'will be compounded by the fact that the average length of stay [in a nursing home] is now recorded as 1.9 years', which, the organisation suggests, may result in failure to process court orders prior to residents' deaths.

8.18 An individual respondent likewise expresses concern that

even with a 12-m[onth] transitional period, the overwhelming numbers involved (nursing homes in particular) will completely overwhelm the system and lead to the problems seen in England and Wales where the [...] people are then left outside of the legally mandated system, either because the procedures are ignored for patients lacking capacity, or the courts and other decision-makers are unable to act within the specified time-frames.

- 8.19 With a view to 'reduc[ing] some of the resource pressures on the Director [of the DSS] and the Courts', an individual respondent recommends that:

Once the commencement date for Part 13 is set, then in advance of a phased implementation period, facilities and healthcare professionals should arrange for capacity assessments to be conducted to establish which residents appear to lack relevant capacity, including incapacity to consent to deprivation of liberty and restrictive practices.

### Supporting decision-making

- 8.20 Opining that 'the reliance on the "specified person" to initiate the process for transitional arrangements is problematic', MHR calls for the legislation to 'be developed to be more proactive in enabling people to make decisions about where they wish to live'.

- 8.21 Emphasising that 'Part 13 and particularly Head 8 must apply to a ward of court', Safeguarding Ireland calls for clarification

that what is intended [in Head 8] is that, before a view is formed that a person lacks capacity to make an admission decision, [...] every effort must be made to maximise the person's capacity to make this particular decision.

- 8.22 Advising that 'Head 8(5)(ii) should be removed', SAGE recommends that:

Head 8(5)(i) should be revised to reflect the statutory presumption of capacity, the process of maximising a person's capacity to make relevant decisions, to engage in a decision-making assistant agreement, or a co-decision-making agreement, or potentially to create an EPA and an AHCD [Advance Health Care Directive].

### *Independent advocacy*

- 8.23 Emphasising the imperative for people with dementia to be 'assigned an independent advocate who can support their rights', the NDO and the ASI advise that:

There is a crucial need for an independent advocate to support the review process and transitional arrangements and ensure that all practicable steps and possible alternatives are exhausted when deprivation of liberty is being considered.

- 8.24 Likewise, the CDLP recommends that 'independent advocacy must be made available to all persons admitted or who continue to reside in relevant facilities', calling for the proposed legislation to 'establish a specific role for independent advocates to safeguard against deprivation of liberty'.

- 8.25 The HSE Assisted Decision Making National Office emphasises that:
- If it is thought that someone lacks capacity to make a decision on where they are residing, it is important that they are given the opportunity to access an independent advocate.
- 8.26 The INMO also highlights ‘the necessity for the assistance of an independent advocate’.
- 8.27 The NDA calls for the appointment of an independent advocate in an instance in which
- the relevant person in a relevant facility did not consent to being admitted, where they do not have a decision-making representative or an attorney with authority to make a decision to deprive them of their liberty, and where they lack capacity to make an enduring power of attorney.
- 8.28 The HSE’s Older Persons’ Services and the HSE National Safeguarding Office observe that:
- The procedures provided for in this Head [...] indicate the need by the relevant person of access to an independent advocate’.
- 8.29 Similarly Safeguarding Ireland opines that Head 8 illustrates the need for the assignment of independent advocates to relevant persons who ‘do not have persons close to them’, envisioning that ‘if there is a reasonable belief that a person lacks capacity then the independent advocate will notify the Director of the Decision Support Service’.
- 8.30 The NAS argues that ‘it should be obligatory that individuals are offered the option of independent advocacy’ in instances in which there are concerns about the person’s decision-making capacity.

### **Role of the person in charge**

- 8.31 The DFI observes that, in addition to placing ‘a significant administrative burden on service providers’, the proposed legislation ‘has the potential to place a major burden on the “person in charge”’. Calling for ‘the lack of safeguards [...] to be addressed’, the DFI expresses concern that the responsibility assigned to the person in charge could ‘lead to people being arbitrarily detained’.
- 8.32 The NDO and the ASI note that, in terms of assessing relevant persons’ capacity, notifying relevant persons of a loss of capacity, and liaising with the Director of the DSS in relation to the assignment of appropriate persons to make court applications, ‘the proposed legislation places a high level of responsibility on the “person in charge”’, which ‘will have significant implications for care facilities’.

8.33 Noting that ‘there are large numbers of people currently living in designated centres for older people and people with disabilities who will likely not have the capacity to make a decision to continue to live in that centre’, HIQA observes that:

The onus appears to be on the persons in charge to identify these people and then make the appropriate persons aware of the circumstances.

8.34 The NAS observes:

The emphasis on the person in charge only having reason to believe that a person lacks capacity to make a decision to continue to live in the facility places too much power in the hands of one individual. A second person should have to agree in all circumstances with the decision to deprive someone of their liberty.

8.35 The HSE Assisted Decision Making National Office suggests that ‘Head 8 needs to emphasise what the trigger is for someone to question the relevant person’s capacity to decide to live in a relevant facility’.

### **Court applications**

8.36 As detailed in paragraph 7.70 above, NHI argues that a relevant person who voluntarily entered a relevant facility and entered into a contract of care should not be subjected to a further court application to reaffirm their will and preferences. However, NHI notes that the proposed legislation

would apply to existing residents who lacked the capacity to decide at the time the ‘Care Needs Assessment’ was completed and the admission was arranged.

8.37 Similarly, MHR calls for a distinction to be drawn in Head 8 ‘between those individuals who enter residences with capacity and those who do not’.

8.38 Noting that, under the proposed legislation, ‘access to court is only available for those who do not already have decision-making representatives or powers of attorney in place’, the CDLP emphasises that, as per article 5(4) of the ECHR, ‘direct access to a court to challenge the deprivation of liberty and secure effective assistance is necessary’ for all relevant persons.

8.39 Likewise, the DFI expresses concern that ‘the bill only provides for access to court for those who do not already have a decision-making representative or enduring powers of attorney in place’, observing that ‘this clearly conflicts with the requirements of the ECHR that a person [should] have direct access to a court and effective redress for the deprivation of liberty’.

8.40 The NCPOP comments that ‘applications via the Decision Support Service should be the norm, unless the person has a nominated legal entity to act on their behalf’.

## Other comments

- 8.41 SPMHS opines that the provisions outlined in Head 8 'are reasonable'.
- 8.42 Noting that Head 8 'will be of particular relevance to 'those persons availing of residential services under the auspices of voluntary bodies', Saint John of God Community Services emphasises that:

A robust, well-defined, statutory and likely national procedure and framework with appropriate levels of governance and resourcing support (including significant administration resourcing support) will need to be put in place to facilitate proposals to safeguard the relevant persons in question.

The organisation also calls for the appointment of 'a regulatory body for governance [...], whether this be the proposed Decision Support Service or an alternative body'.

- 8.43 The IHREC recommends that:

Head 8(1) should be amended to ensure that the Guiding Principles set out in section 8 of the Assisted Decision Making (Capacity) Act 2015 are [...] applied to an intervention in its entirety rather than [only to] an assessment of capacity.

- 8.44 The MHC calls for clarity in respect of 'a relevant person's status during the periods' referred to in subheads 1 and 2, commenting that 'if this is not addressed, the matter will be open to legal challenge'.

- 8.45 The NDO and the ASI emphasise that 'there needs to be clarity about the process and timeline' for decision-making in respect of relevant persons with dementia who wish to leave relevant facilities. Calling for the provision of 'clear and accessible information', the organisations also stress that 'it will be important that the family carer is informed of the transitional process and how such arrangements will be made'.

- 8.46 Acknowledging that 'unlawful deprivation of liberty is a serious offence and violation of human rights' and that the right to 'compensation in the event of unlawful deprivation of liberty' is enshrined in article 5(5) of the ECHR, the CDLP calls for 'the right to compensation and accessible remedies [...] to be included in the text of the bill'.

- 8.47 NHI welcomes the inclusion of subhead 5 'to remove the obligation to make an application for persons with fluctuating capacity', while calling for clarification of the definition of a 'short period' and 'demise'. NHI suggests that:

A short period [...] could be defined by persons who are in receipt of specialist palliative care or for those who the medical practitioner has decided are for 'comfort care' only.



## Chapter 9: Head 9 – Review of Admission Decisions

Head 9 makes provision for the review of admission decisions pertaining to relevant persons, as required under the ECHR. Recognising that the deprivation of liberty arises because of a lack of capacity, and with a view to minimising the number of court applications, subhead 1 incorporates such reviews into the capacity reviews provided for under section 49 of the ADMC Act.

On the basis of medical evidence, subhead 2 makes provision for the court to discharge or vary the decision-making order while subhead 3 enables the court to ‘make an order confirming the admission decision’ and to ‘give such directions as it thinks appropriate for the order [...] to have full effect’.

Subhead 4 requires the person in charge (or the healthcare professional acting on their behalf) to ‘keep under review the degree and extent of supervision and control and lack of freedom to leave the relevant facility to which the relevant person is subject’, and to inform relevant decision-making representatives of any need for the adjustment of this which arises.

### Question 9.1: Do you have any views specific to Head 9?

#### Respondents’ comments

#### Medical evidence

- 9.1 The MHC calls for the amendment of the references to ‘medical evidence’ in subheads 2 and 3 ‘to read “the evidence of two healthcare professionals, one of whom is a registered medical practitioner”’, and for there to be a requirement for the second healthcare professional to be drawn ‘from a list of the categories established under Part 13 or regulations’.
- 9.2 Noting that the proposed review process ‘is based on medical evidence, and [that it] does not refer to a functional approach to capacity assessment as required under the ADM[C] Act 2015’, SAGE advises that it ‘would not be in compliance with the UNCRPD’. Cognisant of ‘the nature of the decision that a person will reside in a “relevant facility” which may result in a deprivation of liberty’, SAGE calls for ‘a broader representation of appropriate healthcare professionals’ to be consulted in the review process.
- 9.3 The CIDP also suggests that the review of admissions decisions should ‘be based on the functional test’.
- 9.4 Opining that ‘medical evidence may not be appropriate in all cases’, the NDA recommends that ‘in reviewing admission decisions, the court should hear “appropriate evidence” instead of medical evidence’.
- 9.5 The HSE Assisted Decision Making National Office similarly comments that ‘medical evidence may not be the most appropriate information needed regarding the admission decision’.

- 9.6 Noting that ‘the ECHR does not require medical evidence unless the person being deprived of his or her liberty has “mental disorder” and is being involuntarily detained’, the Law Society of Ireland and Safeguarding Ireland suggest that ‘medical evidence may not be the most appropriate evidence with regard to an admission decision’.
- 9.7 NHI recommends that the review of an admission decision and of the medical evidence ‘should be a role for appointed persons or persons assigned by the Director [of the DSS] or HSE social workers’, rather than devolving to the person in charge; and that ‘a standardised validated assessment’ should be used ‘to reduce the risk of litigation and to ensure that all reviews are conducted in a fair and transparent manner’.
- 9.8 Noting that ‘the ECHR requires that there would be medical evidence required’ for a review of an admission decision and that ‘some persons may need to be reviewed by a specialist centre’, the NRH expresses concerns about the resources required to implement the process outlined in Head 9.
- 9.9 Observing that ‘subsection 2 refers to medical evidence but Head 6 referred to medical expert’, an individual respondent highlights the ‘need for consistency between the making of the [decision-making] order and the review of the order’.

#### **Time-frames for review**

- 9.10 An individual respondent comments:

Leaving it to the court to specify the intervals for review of the decision places patients at risk of losing access to timely justice if their capacity should change, does not allow procedures for appeal to be initiated by the patient/other interested parties, and has specific issues when considered alongside the MHA.

- 9.11 The IHREC observes that:

As Head 9(1) relates to reviews of declarations of capacity under sections 37(1) and 49(1) of the 2015 [ADMC] Act, the draft proposals do not seem to provide an adequate opportunity for a court to specify intervals at which it may review an admission decision.

Suggesting that this may have been ‘a drafting error’, the IHREC continues:

The Department may have intended to refer to section 37(3) where reference has been made to section 37(1) in order to ensure that admission decisions would be subject to regular review by a court, similar to what is already provided for in the 2015 [ADMC] Act.

- 9.12 Noting that Head 9 ‘requires a court to review an admission decision at intervals determined by the court’, HIQA suggests that:

The Department might consider setting minimum review periods for admission decisions and the rationale for continuing to implement arrangements to deprive a person of their liberty.

- 9.13 MHR also recommends that the ‘timeframes for review of a deprivation of liberty decision should be set out under the safeguards’, arguing that ‘it is not sufficient that the courts can determine such timeframes at their own discretion’.

- 9.14 The IMHLA calls for Head 9 to stipulate that ‘when the court specifies an interval for review, the interval may be any period up to six months’ and that:

The relevant person has the right to apply for a court review during the relevant interval, without having to wait until the review date arrives.

- 9.15 Opining that “hooking” the deprivation of liberty review to the review of capacity is reasonable’ given that ‘the deprivation of liberty and the admission decision are inextricably linked’, the CIB recommends that:

All restrictions or deprivations imposed on a person should be subject to frequent review and, where appropriate or necessary, subject to appeal or challenge.

However, the CIB nevertheless acknowledges that there may be ‘a case for extending the period of judicial review in situations where there is a long-term and stable diagnosis which results in a lack of capacity’.

- 9.16 SPMHS opines that:

The review periods and review process should offer the same protections as those provided for in the case of the involuntary detention of an individual under the Mental Health Act 2001.

- 9.17 The DSBA calls for ‘the provision of a robust review process’ which encompasses ‘six monthly internal reviews’ and ‘audited reviews by an appropriate public body’, and within which ‘court applications may be made at any stage of the process’.

### **The role of the court**

- 9.18 Calling into question the procedure to be adopted ‘in cases where the court has not specified an interval to review an admission decision’ under subhead 1, NHI also seeks clarity on the role of the court in instances in which ‘a relevant person or an appointed person refuses to cooperate with the review’ or in which ‘a relevant person or an appointed person does not agree with the decision to revoke an order’.

- 9.19 An individual respondent calls for subsection 4 to be amended ‘to confine itself to review by the court only’ and for the ‘review and monitoring by persons in charge and persons with lawful authority [...] to be moved to heads 5–7’.
- 9.20 Observing that ‘the right to review by the court is problematic in that it is the same court that made the decision about deprivation of liberty that will be responsible for its review’, MHR calls for ‘a right of appeal to a higher court’ to be enshrined in the proposed legislation.
- 9.21 ABI Ireland describes ‘the clauses that require the court to review its findings on a person’s capacity’ as ‘a good safeguard’ and as ‘absolutely vital to the entire deprivation of liberty process’.
- 9.22 MHR emphasises that ‘the review and repeal system provided through the courts must be accessible’, calling for ‘courts to sit in nursing homes and other residences’.

#### **Provision for relevant persons to make an application to court**

- 9.23 SAGE observes that Head 9

does not refer to the option for a relevant person, or a person who has a *bona fide* interest in the welfare of the relevant person, to make an application to court under Part 5 of ADM[C] Act 2015.

- 9.24 The HSE National Safeguarding Office and the HSE’s Older Persons’ Services recommend that Head 9 should make ‘provision for a relevant person to have the right to make [an] application to the court if he or she has the capacity to do so’.
- 9.25 The Law Society of Ireland and Safeguarding Ireland call for the provision in the ADMC Act for ‘a relevant person [to] apply to the court him or herself’ to be reflected in Head 9, commenting that:

It should not be necessary in such circumstances for a court to hear ‘medical evidence’ or evidence from a third party where the person is able to attend in court and give whatever direct evidence the court may require.

#### **Supporting relevant persons**

- 9.26 Observing that the ‘reliance on [the] courts system for appeal creates significant potential for bottlenecks’ and expressing concern that ‘in a very busy courts system’, the rights of relevant persons will not be protected, the NCPOP suggests the introduction of a ‘requirement for [the] appointment of a person similar to [a] “*guardian ad litem*” in other areas to ensure fairness’. Noting ‘that the ECHR does not stipulate [a] requirement for a judicial review’, the NCPOP further suggests that there may be ‘a rationale for having [a] review process that builds in independent advisory panel[s] to operate potentially in each area’.

- 9.27 The INMO recommends that ‘explicit reference should be made to the role of the Court Friend in the absence of other legal representation’ and that:

An explicit cross reference should be made to Head 7(1) and related provisions in respect of the facility for a person to make an application, or to be assisted in doing so.

### **Scope of the provisions for the review of admission decisions**

- 9.28 While welcoming ‘the provision for review of decisions’ under Head 9, HIQA reiterates its suggestions (detailed in paragraph 6.30 above) that the scope of the proposed legislation should be broadened ‘to include cases where a person’s health, welfare or quality of life can be improved’; that a definition of ‘harm’ should be provided; and that the inclusion of the adjective ‘significant’ before ‘harm’ should be reconsidered.

- 9.29 The NAS calls for the review of admission decisions to ‘include a review of all medication’, for the supports that ‘will be provided to the relevant person to assist them through the review process [...] to be clearly defined’, and for there to ‘be an onus for the evidence submitted to detail what less intrusive options have been considered [...] and the reason they cannot be supported’, querying:

What scope exists for other independent parties, such as independent advocates, to put forward less intrusive options that may exist?

- 9.30 Noting that ‘the preliminary draft heads give rise to situations in which an individual may be deprived of his / her liberty apart from in situations where an admission decision has been made’ and that ‘the draft heads do not provide for a right to apply for a review of a temporary admission decision’, the IHREC expresses concern that ‘the system of review proposed in the preliminary draft heads may be limited in scope’. Accordingly the IHREC recommends that the proposed legislation ‘should be revised to provide for a regular review of a temporary admission decision’ and ‘to provide for a comprehensive right to review a deprivation of liberty, which may be instigated by the relevant person’, as well as calling for the Department of Health to ‘consider how such a right to review may be extended to individuals who fall outside the scope of the current proposals’.

- 9.31 MS Ireland comments:

Reviews of admission decisions should also account for those who are deprived of their liberty by virtue of the fact that they cannot access appropriate supports and/or housing adaptations in order to return to their own homes.

MS Ireland calls for such individuals to ‘have the right to regular reviews of their circumstances’ as well as ‘regular updates from service-providers as to when the supports they require are likely to be made available’.

## Role of person with lawful authority and person in charge

- 9.32 An individual respondent notes that subhead 4 transfers responsibility for the deprivation of liberty of a relevant person from the person in charge 'to the person with lawful authority to make a decision to adjust the degree of supervision and control'. However, noting that 'with staffing resources it is unlikely that a person in charge will initiate a request to reduce control', and that a 'person with lawful authority may wish to seek guidance from a specialist in behaviour management or mental health', the respondent suggests that:

The person with lawful authority should also be given power to review whether the facility is still the right facility to meet the relevant person's needs rather than to just review the regime within the facility.

- 9.33 Noting that 'the person in charge has a financial interest in retaining the relevant person', an individual respondent recommends that 'the person with lawful authority ought to be regularly seeking review meetings with the person in charge and with relevant professionals'.

- 9.34 Noting that 'nursing homes are statutorily obliged under Regulation 25(3) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) to ensure that all residents are discharged in a planned and safe manner', NHI opines that 'it is reasonable therefore to permit PICs to temporarily delay a person's wish to leave a nursing home so that risk minimisation can take place'.

- 9.35 NHI expresses concern about 'the administrative burden that a review of existing residents would place on medical professionals and persons in charge. Noting that persons in charge would be most likely to consult GPs 'to verify that the correct procedures and documentation are in place to comply with the legislation', NHI comments that:

The over-reliance of [the] statutory obligations on the person in charge, who does not have any governance or management role in the execution of HSE GMS contracts is impractical and unfair.

## Monitoring

- 9.36 SAGE recommends that:

Consideration should be given to seeking the input of a General or Special Visitor to monitor and review the degree and extent of supervision and control and lack of freedom to which the relevant person is subject in the 'relevant facility'.

- 9.37 Calling for greater focus in the proposed legislation on 'respecting the rights and fundamental freedoms of the person inside the relevant facility', the CDLP recommends the establishment of 'an independent national body to monitor that human rights are being respected' as well as for 'independent monitoring in

accordance with the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) [...] and article 16 [UN]CRPD’.

- 9.38 Noting that the difference between the provisions for the review of admission decisions outlined in the proposed legislation and in the remainder of the ADMC Act arises because ‘two separate issues are being addressed by the courts under Part 13, namely capacity and liberty’, the MHC opines that ‘the review provisions are in order’ with the proviso that the references to ‘medical evidence’ in subheads 2 and 3 should ‘be amended (as detailed in paragraph 9.1 above) and that:

Specific requirements as to the monitoring and / or regulation of the persons in charge in relation to their obligations under this sub-head should be inserted.

### **Legal aid**

- 9.39 NHI queries whether legal aid will be provided for the review of admission decisions.
- 9.40 Noting that article 13(1) of the UNCRPD calls for ‘effective access to justice for persons with disabilities on an equal basis with others’, the IHREC recommends that:

Legal aid provisions under section 52 of the Assisted Decision-Making (Capacity) Act 2015 should be extended to deprivation of liberty reviews and individuals should be supported to have their voice heard during court proceedings.

- 9.41 Observing that ‘there is no mechanism for dispute resolution where the person with lawful authority and the person in charge disagree on the restrictive interventions or care and treatment plans’ pertaining to a relevant person, an individual respondent calls for the provision of legal aid to support mediation in such an instance, highlighting the fact that ‘this may necessitate an amendment to the Mediation Act to include disputes under the ADM[C Act] and in particular Part 13’.

### **Other comments**

- 9.42 The College of Psychiatrists of Ireland indicates its broad ‘agreement with Head 9, as written’.
- 9.43 An individual respondent calls for the inconsistency between Head 6(3)(a), which ‘allowed the initial court admission order to be made on grounds of harm without the harm having to meet the significant threshold’, and Head 8(3), which enables the court to make an order confirming the admission decision ‘in order to protect the relevant person from significant harm’, to be resolved.

- 9.44 Noting that, as indicated in the Department of Health’s consultation paper, people involuntarily detained under the Mental Health Act, 2001 will not fall under the remit of the proposed legislation, the NDA ‘queries whether maintaining an admission order “in order to protect the relevant person from significant harm” is an appropriate criterion’.
- 9.45 Noting that ‘the last line [of Head 9(4)] states that the degree of supervision should be adjusted to accord with the needs and preferences of the relevant person’, an individual respondent observes that ‘there is no mention of their will or preferences or taking account of their objections’.
- 9.46 An individual respondent recommends that, in addition to the provisions detailed in subhead 4, ‘the review process should include [...] the degree of objection by the relevant person and their level of distress at not being allowed to leave’.
- 9.47 An individual respondent notes that, in subhead 4, “adjustment to” should be changed to “adjust the...”.



## Chapter 10: Head 10 – Chemical Restraint and Restraint Practices

Head 10(1) prohibits the court, decision-making representative or attorney from authorising the administration of medication to a relevant person ‘with the intention of controlling or modifying [their] behaviour or ensuring that [they are] compliant or not capable of resistance’, while subhead 2 prohibits the person in charge (or healthcare professional acting on their behalf) from administering such medication. Subhead 3 prohibits a person in charge (or healthcare professional acting on their behalf) from subjecting a relevant person

to a restraint practice unless there are exceptional circumstances and such practice is in accordance with regulations prescribed by the Minister under Head 12.

As noted in the Explanatory Notes, since ‘the use of chemical restraint is in breach of Article 3 of the European Convention on Human Rights’, sections 44 and 62 of the ADMC Act will be amended ‘to ban outright the use of chemical restraint’.

### Question 10.1: Do you have any views specific to Head 10?

#### Respondents’ comments

#### Chemical restraint

10.1 The CIB, DSBA, the HSE Assisted Decision Making National Office, the IHREC, the IMHLA, the INMO, the Law Society of Ireland, the NDA, and Safeguarding Ireland express their support for the prohibition of chemical restraint as detailed in Head 10.

#### *Challenges associated with prohibition of chemical restraint*

10.2 Noting that ‘chemical restraint is used in “relevant facilities” currently’, Saint John of God Community Services queries how it will be prohibited.

10.3 Observing that, ‘from an evidential perspective, it is hard to prove that a psychotropic medication has been prescribed for an improper purpose’, an individual respondent opines that ‘it would be very hard to enforce this Head’.

10.4 Similarly, the Division of Neuropsychology of the PSI queries whether ‘dementia [is] to be identified as a “medical condition” that requires treatment’ and, if so, if ‘the use of chemical restraint to manage symptoms [...] appl[ies] here’.

10.5 The NAS calls for ‘greater definition/clarity on what constitutes a medication which is not necessary for a medically identified condition’.

10.6 Questioning whether ‘specifying the use of [...] chemical restraint in particular is helpful’, the NCPOP expresses concern that this may imply ‘that other forms

of restraint including physical / certain environmental restraints are permissible without the appropriate safeguards’.

- 10.7 Both the NHI and an individual respondent highlight the fact that doctors (rather than persons in charge) have responsibility for the prescription of medication, problematising the provisions set out in Head 10. The individual respondent suggests that, instead, the provisions could be restricted to ‘prescriptions with PRN directions’ or

could allow the person in charge and the person with lawful authority to query the doctor about the purpose of the prescribed medication and to seek an independent review of the medication, its dosage, efficacy for the purpose for which it was prescribed and scope of PRN.

### *Regulations and policies*

- 10.8 SAGE comments that:

There is a need to introduce regulations on the administration of medication to ensure that the purpose for which medication is given does not come within the provisions set out in Head 10(1).

- 10.9 Noting ‘the therapeutic context in which medication is permitted’, the INMO suggests that ‘ministerial regulations in relation to medication matters’ would ‘be useful’ and that they

would assist in ensuring that the margins of therapeutic usage are appropriately implemented in as protective a manner as possible for persons who may be in receipt of medication for a legitimate purpose.

- 10.10 Calling for ‘illustrative guidelines which clarify circumstances where administration of medication could be construed as chemical restraint’, the CIB recommends that:

In order to avoid duplication and to ensure clarity and consistency, policies with regard to the use of chemical restraint in exceptional circumstances should replicate those of other regulatory bodies such as HIQA and the HSE.<sup>42</sup>

- 10.11 NHI calls for

clinical guidance for healthcare professionals on the appropriate use of medication (which has the potential to be misused as a chemical restraint) and the circumstances when it is deemed to be necessary to treat a medically identified condition.

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<sup>42</sup> By way of an example of such policies, the CIB cites the Health Service Executive’s *National Consent Policy* (2017), <https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/consent/national-consent-policy-august-2017.pdf>.

### *Monitoring and oversight*

- 10.12 Observing that the ‘use of chemical restraint for non-therapeutic reasons is a challenge to define, manage and police’, the Division of Neuropsychology of the PSI calls for consideration to be given to ‘how this is monitored, reviewed and regulated’.
- 10.13 Noting that ‘medication should only be administered for a medically identifiable condition’, the CIB calls for ‘clear and comprehensive records [to] be maintained’.
- 10.14 The Law Society of Ireland and Safeguarding Ireland call for ‘oversight of the administration of medication [to] be undertaken in accordance with regulations prescribed by the Minister under Head 12’.

### *Definition and terminology*

- 10.15 Inclusion Ireland recommends that ‘chemical restraint’ should be defined as:
- the use of medication to control or modify a person’s behaviour when no medically identified condition is being treated, or where the treatment (or the dosage) is not necessary for the medically identified condition or the intended effect of the medication is to sedate a person for convenience or disciplinary purposes or to ensure that a person is compliant or is not capable of resistance.
- 10.16 Noting that ‘there is a requirement for a statutory definition of restraint procedures’, Saint John of God Community Services calls for
- reference to ensure restraint procedures for behaviours of concern are not used in the absence of positive behaviour support (as outlined in the Health Act 2007) with specific reference to functional assessment.
- 10.17 Noting that ‘behavioural and other symptoms exist in particular as part of all neurocognitive disorders and that medications may sometimes attenuate these symptoms’, the College of Psychiatrists of Ireland observes that ‘chemical restraint is a politicised and non-clinical term, which is never used by any clinician to describe clinical practice’. Accordingly, the College of Psychiatrists of Ireland recommends that Head 10 ‘needs to be rewritten’ in order to ‘reflect the realities of working in the early 21<sup>st</sup> century’ and that it should be entitled ‘Medication and Restraint’.

### *Other comments*

- 10.18 Questioning ‘what a “medically identified condition” is in this context’, an individual respondent
- welcome[s] the provision that someone who is unhappy, agitated or aggressive because they are being detained should not receive any medication to facilitate that detention.

10.19 Noting that ‘the appropriate use of drugs to reduce symptoms of medical conditions such as anxiety, depression or psychosis does not constitute restraint’, the CIB emphasises that:

A fundamental principle is that informed consent should be sought before any intervention is commenced and before medication is prescribed.

10.20 The HSE Assisted Decision Making National Office calls for ‘future amendments’ to address the chemical restraint of patients in acute hospitals ‘who will not be protected by the safeguards provided for in this legislation’.

10.21 In order to ensure compliance with the ECHR, the CIB calls for legislation to be ‘enacted in Ireland to enforce an outright ban’ on chemical restraint.

### **Restraint practices**

10.22 The NDA welcomes the prohibition of restrictive practices except in exceptional circumstances, highlighting the establishment by HIQA of an Expert Group on Restrictive Practices, of which the NDA is a member.

10.23 HIQA ‘strongly welcomes any legislative measures which govern the use of restrictive practices’.

#### *Definition and terminology*

10.24 The CIDP, the MHC and the Rehab Group call for the definition of ‘exceptional circumstances’ in the proposed legislation.

10.25 The NAS also calls for ‘exceptional circumstances [...] to be very clearly defined’, noting that subhead 3 ‘currently does not account for the person’s surroundings including people impacting negatively on their behaviour’.

10.26 The HSE National Safeguarding Office and HSE’s Older Persons’ Services call for Head 10 to ‘include a clear definition of the range and type of interventions that come within [the] term of restraint practices’, such as ‘physical or mechanical restraint’, environmental restraint, chemical restraint, [and] single separation’.

10.27 MHR recommends that ‘the circumstances in which restraint is allowed [...] should be narrowed from “exceptional circumstances” to “in an emergency to save the life of the person”’.

10.28 While expressing support for the stipulation in subhead 3 that relevant persons shall not be subjected to restraint practices ‘unless there are exceptional circumstances’, the HSE Assisted Decision Making National Office calls for ‘further detail [...] as to what is an exceptional circumstance in this context’.

## *Regulations and guidelines*

- 10.29 The IHREC expresses concern ‘that Head 10(3) provides for the use of restraint practices in “exceptional circumstances” which ‘have not been defined’. The IHREC calls for these circumstances to be prescribed in regulations which ‘should be developed in accordance with article 17 [UN]CRPD and the guiding principles set out in section 8 of the 2015 [ADMC] Act’.
- 10.30 Likewise, the Rehab Group calls for ‘further regulations [...] to be prescribed in relation to the use of restrictive practices’.
- 10.31 The HSE Assisted Decision Making National Office notes that ‘a regulation will be required to support’ the implementation of the prohibition of restraint practices in all but exceptional circumstances.
- 10.32 The HSE National Safeguarding Office and HSE’s Older Persons’ Services also call for regulations in relation to the use of restraint practices, emphasising that restraint
- should be considered only as a last resort, for a short time-limited period and if the person is at imminent risk of self-harm or harm to others.
- 10.33 Welcoming the proposal to ‘introduce regulations prescribed by the Minister for the use of restraint practices’, SAGE recommends that:
- A consultation process should be undertaken to get input and expertise on how regulations are operationalised in practice.
- 10.34 Emphasising that ‘there is a need to ensure that existing regulations are consistent with any new regulations arising out of this legislation’ and noting that ‘there is no national policy governing the use of restrictive practices’, HIQA expresses the view ‘that it would be an opportune moment to review the whole area’. Reporting that ‘HIQA is currently in the preparatory stages of developing a programme of thematic inspections focused on the area of restrictive practices’, the organisation comments that ‘there is a case to be made for the development of a statutory code of practice or statutory guidance on the use of restrictive practices’.
- 10.35 NHI observes that there are ‘no current clinical guidelines about the use of restrictive practices and what constitutes exceptional circumstances’.
- 10.36 The NRH likewise emphasises the imperative for the legislation ‘to be underpinned by good practice guidelines for healthcare staff on the ground’.
- 10.37 The DSBA and the IMHLA recommend that ‘guiding principles regarding the Ministerial regulations on restraint practices should be specified’ in subhead 3.

### *Implementation of legislative provisions*

- 10.38 Noting that ‘restraint practices, and other rights restrictive strategies, are used currently in relevant facilities’, Saint John of God Community Services queries ‘how [...] these [will] be supported in the context of DSS’.
- 10.39 MHR calls for it to ‘be explicitly stated in the proposals that there is a requirement for implementation of a national programme to phase out seclusion and restraint practices’.
- 10.40 Observing that ‘Head 10 could be interpreted in a very subjective manner in terms of “exceptional circumstances” where restraint practices would be permitted’, the DFI advises that ‘this issue needs to be addressed and safeguards need to be put in place’. Noting that such practices are ‘prohibited under the UNCRPD, the DFI expresses concern about the absence of a ‘commitment to phase out seclusion and restraint practices’.
- 10.41 Commenting that ‘there is a lack of clarity about the permissible uses of restraint and seclusion’, and individual respondent recommends that:

The Bill should provide that where an act is intended to restrain a person who lacks capacity, the person carrying out the act must reasonably believe it is necessary to do so [...] and that the act is a proportionate response to the likelihood of the suffering of harm [...], and that it is not reasonably practicable before taking those steps to apply to a court for an order to authorise the deprivation of liberty.

### **Other comments**

- 10.42 The Division of Neuropsychology of the PSI suggests that the use of chemical restraint and restraint practices is inextricably linked to the availability of staffing resources, observing that ‘the need for more restrictive measures reduces’ in facilities with clinical psychologists and that ‘there is a reduced need for medication in adults with an intellectual disability’ in ‘optimum environments with access to resources and trained staff’.
- 10.43 Querying ‘who will regulate this area’, NHI comments:
- Retaining a prohibition for the use of chemical restraint or restrictive practices which is targeted at PICs [persons in charge] and nursing staff only without clear and unambiguous clinical guidelines will essentially compound recruitment and retention difficulties and will negatively impact this area.
- 10.44 Querying how the prohibition of chemical restraint and of restraint practices in all but ‘exceptional circumstances’ will be ‘supervised’ and to whom it will be reported, the NCPOP emphasises that ‘all decisions relating to the use of restraint need to be made as part of a care plan that reflects the medical indication, use and form of restraint’.

- 10.45 Likewise, the CIB recommends ‘that requirements for medication and all healthcare interventions [should be] reviewed regularly as part of the person’s individual care plan’.
- 10.46 Emphasising that the use of restraint practices should always be the last resort, Rehab Group service-users call for the legislation to set out definitively the circumstances in which someone can be restrained; to provide guidelines on the qualifications required of the professional who makes the decision to restrain a relevant person; and to provide a mechanism for ‘a named individual [...] of the person’s choosing’ to be ‘notified in the event of restraints of any kind being used’.
- 10.47 Emphasising that ‘people need to understand that they have the right not to take medication’, the NAS calls for ‘safeguards [...] and access to appeals and reviews by independent parties’ to be provided for in the legislation.
- 10.48 An individual respondent recommends that:
- Detailed information should be given by providers in user-friendly language to potential residents and current residents explaining the extent to which restrictive interventions are used and in what circumstances so that a fully informed consent can be furnished where they have capacity to consent.
- 10.49 The DFI opines that ‘the definition of “restraint” is too broad and could potentially cause problems when interpreting the regulations that are yet to be drafted’.
- 10.50 Noting that ‘a slightly different / shorter definition’ of the terms chemical restraint and restraint practices is utilised in Head 10 by comparison with that which is referred to in Head 2 (as defined in Head 1), ABI Ireland suggests that ‘the longer Head 2 [*sic*] definition should be duplicated in the text in Head 10’.
- 10.51 Inclusion Ireland calls for the inclusion in the proposed legislation of ‘an explicit prohibition of restraint of all kinds’.
- 10.52 Observing that the use of physical and/or chemical restraint is a violation of human rights, as enshrined in articles 15 and 19 of the United Nations’ Convention on the Rights of Persons with Disabilities (UNCPRD), the CDLP calls for restraints to be proscribed, commenting:

We strongly urge that the Bill set out a clear prohibition on the use of restraints. To make this prohibition feasible in practice we also suggest implementing alternatives to coercion measures and community support, including peer-support and also awareness-raising and training of service-providers and personnel of all relevant facilities, both public and private.

## Chapter 11: Head 11 – Records to be Kept

As stated in the ‘Explanatory Notes’, Head 11 ‘sets out the records that must be kept for inspection by HIQA and the Inspector of Mental Health’ in respect of the proposed legislative provisions. Subhead 1 makes provision for the Minister to

prescribe by regulations the categories of records to be kept by relevant facilities and other persons under this Part to facilitate verification of compliance with this Part.

Subhead 2 enumerates the ‘categories of records which may be required to be kept’ under such regulations, which, as stated in the Explanatory Notes, ‘are those evidencing the various decisions and notifications which a person in charge may [...] make’. Subhead 3 stipulates that ‘the regulations shall specify to whom the person in charge [...] shall make any of the records prescribed [...] available for inspection’.

**Question 11.1: Do you have a view on the types of records that must be kept under this Head?**

### Respondents’ comments

### Decision-making supports

- 11.1 The HSE National Safeguarding Office and HSE’s Older Persons’ Services suggest that records should be kept of the ‘assistance and supports given to a relevant person to enable them to make an admission decision, including access to an independent advocate’.
- 11.2 Similarly, the Law Society of Ireland and Safeguarding Ireland call for records to be kept of the ‘assistance and supports given to a relevant person to enable them to make an admission decision’, which they note ‘may be required by the court’. In addition, Safeguarding Ireland recommends that records ‘of when, and in what circumstances, access to an independent advocate was sought’, observing that these ‘will be required under regulations’.
- 11.3 Likewise, the NDA recommends that healthcare professionals should maintain ‘a record of how the [relevant] person was supported to maximise their capacity to make the decision’ as well as ‘of when an independent advocate was sought for the relevant person and the reasons for same’.
- 11.4 The NAS calls for records to be kept ‘of how decision-making was supported over time’.



11.5 SAGE recommends that:

Records should be kept to document the [...] steps taken to build the [relevant] person's capacity and support the person to make a decision whether or not to reside in a 'relevant facility' in accordance with the ADM[C] Act 2015, including access to an independent advocate for the person.

11.6 The HSE Assisted Decision Making National Office calls for records to be kept of 'how the person was supported to maximise their capacity to make the decision' as well as of 'when an independent advocate was sought, and the circumstances pertaining to this'.

### **The relevant person's will and preference**

11.7 The NDA recommends that healthcare professionals should keep records of the relevant person's 'will and preference / [the] decision they may have communicated'.

11.8 The NAS calls for records to be maintained of 'the views / will and preference of the relevant person and / or known preferences identified by their independent advocate'.

11.9 The NAS further advises that:

There should be some records kept that show that the placement is the most appropriate placement for the person and that due consideration was given to the placement—i.e. taking relevant persons' will and preference into account.

11.10 Emphasising that 'it is imperative that such individuals are enabled and provided with the necessary supports to leave their place of residence', MHR recommends that:

Head 11 should include a provision that where a person has capacity and expresses a wish to leave, a record of same will be kept.

11.11 Opining that the 'proposed legislation should act as a tool to progress human rights for people with dementia', the NDO and the ASI emphasise that:

There will need to be clear and thorough documentation maintained in relation to values, wishes and preferences of people with dementia.

### **Capacity assessment**

11.12 NHI suggests that the records kept should include 'a copy of the Care Needs Assessment report' as well as 'records relating to the process for determining "fluctuating capacity"'.

11.13 SAGE recommends that 'records should be kept to document the process of assessing the person's capacity using a functional approach'.

### **Medication administration**

11.14 The HSE National Safeguarding Office and HSE's Older Persons' Services recommend that records should be kept on the 'reasons for the administration of chemical restraint medication'.

11.15 SAGE calls for records to 'be kept regarding the administration of medication'.

11.16 The Law Society of Ireland and Safeguarding Ireland call for 'records relating to the reasons for the administration of medication' to be kept in order 'to ensure compliance with the requirements of Head 10 (1) and (2)'.

11.17 The IHREC recommends that:

Head 11 should be amended to require mandatory record keeping in relation to the administration of medications in order to ensure that such medications are not being used for the purposes of chemical restraint.

11.18 NHI suggests that 'records relating to the rationalisation for prescribing medications for medically identified conditions' should be kept.

### **Restraint practices**

11.19 The IHREC recommends that:

Head 11 should be amended to require mandatory record-keeping in relation to the use of restraint practices.

11.20 The HSE Assisted Decision Making National Office calls for records to be kept on 'the use of restraint practices and the circumstances pertaining to this'.

11.21 SAGE recommends that:

Records should be kept regarding restraint practices to document what steps were taken to prevent the use of a restraint practice, what threshold was applied to allow for a restraint practice to be used, and that the restraint was to prevent an imminent risk of serious harm, was a measure of last resort, was proportionate to the risk, was necessary, was the least restrictive approach, was in place for the shortest period of time, and that the views of the relevant person were respected.

11.22 The Law Society of Ireland and Safeguarding Ireland recommends that 'records relating to the exceptional practices that gave rise to the use of restraint of a relevant person' should be kept.

- 11.23 The NDA recommends that the person in charge (or healthcare professional acting on their behalf) should maintain ‘a record of the degree and extent of [the] supervision to which the relevant person is subject’.
- 11.24 The HSE National Safeguarding Office and HSE’s Older Persons’ Services suggest that records should be kept pertaining to ‘the exceptional circumstances and clinical decision-making process that gave rise to the use of restraint of a relevant person’.
- 11.25 HIQA suggests that consideration be given to ‘including a requirement to record all use of restrictive practices’.

#### Other comments

- 11.26 The College of Psychiatrists of Ireland opines that ‘all records mandated and usual in any medical facility must be maintained’.
- 11.27 Likewise, St. Luke’s Nursing Home, Cork opines that ‘all records should be kept by [the] relevant facility for inspection’.
- 11.28 Noting that ‘the duty to record [additional] matters’, such as ‘reasons for medication administration, or matters related to the exceptional use of restrictive practices, [...] already falls on registered professionals arising from their respective codes of professional conduct’, the INMO expresses the view that ‘the range of records’ detailed in subhead 2 is ‘appropriate’.
- 11.29 The MHC likewise observes that:

Professionals in the healthcare sector are required under the terms of their professional codes of conduct, or otherwise for professional reasons, to keep full and adequate records regardless of the specific lists that may be included in Part 13 and / or the regulations.

- 11.30 While acknowledging that ‘deprivation of liberty is a serious issue’ and that ‘clear records’ of admission decisions should be maintained, the CIB emphasises that ‘it is [...] important that the system does not become cumbersome or overly bureaucratic’ and suggests that ‘consideration should be given to incorporating such records into the individual care plan so that paperwork and duplication is minimised’.
- 11.31 Observing that ‘the records that are required to be kept appear to be confined to the person in charge or [to] the healthcare professional acting on [their] behalf’, an individual respondent emphasises that:

It is essential that independent healthcare professionals and the medical expert complete forms dealing with the capacity assessment referred to in Head 3(1)(b) together with the process of determination that the relevant person requires admission to a facility (Head 3(1)(a)). [...] There must also

be forms which allow for other professionals and e.g. the Gardaí to supply evidence under Head 5 concerning imminent risk of significant harm.

11.32 The NAS commends the requirement in subheads 2(a)–(d) for ‘records relating to the process’ to be kept, observing that the emphasis on ‘recording process rather than just outcomes is positive’ and ‘in line with what the ADMC [Act] 2015 would recommend’.

11.33 Observing that subhead 2(g) ‘doesn’t detail what specific records need to be kept’, the NAS suggests that it should be amended to read:

The basis upon which it was determined that the person required to be admitted and the process involved in this determination. Example of records...

11.34 The MHC recommends that:

The subcategories of records referred to in sub-heads (a) to (e) inclusive should be amended to reflect the specific decisions being made and the records that shall be required to be kept in order to verify those processes, decisions, determinations, notifications, applications and requests.

#### **Question 11.2: Do you have any other views specific to Head 11?**

#### **Respondents’ comments**

#### **Supporting regulatory compliance regarding record-keeping**

11.35 SPMHS suggests that ‘clear and ambiguous forms will assist with adherence to the regulations’.

11.36 Describing the list of records to be kept presented in subhead 2 as ‘fairly comprehensive’, the Rehab Group nevertheless emphasises that ‘clear guidance, documentation and training would be required for PICs [persons in charge] to ensure that they meet all regulatory requirements’.

11.37 The NRH suggests that ‘standardised documentation would assist in making consistent decisions based on all available information as the person moves across the health care system’ as well as supporting personnel to manage the process and facilitating ‘audit and inspections by HIQA and other agencies’.

11.38 Likewise, an individual respondent calls for ‘documentation that will be generic across all areas to avoid all the different sites creating different paperwork’.

11.39 NHI calls for the provision of ‘a national comprehensive education and training programme [...] to ensure all healthcare professionals are aware of their statutory obligations’.

- 11.40 NHI observes that, in order to ensure compliance with the proposed legislation, 'it is likely that the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) would be required to be amended'.

### **Data-protection issues**

- 11.41 NHI emphasises that, in order to ensure compliance with the GDPR [General Data Protection Regulation], 'all records would need to be clearly specified, including who should have access to them and the relevant retention periods that apply'.
- 11.42 Calling for 'due regard' to be shown 'to the implications of the GDPR on the holding and sharing of personal data' under the proposed legislation, the NDA calls for clarification of 'the records the Director [of the DSS] would be able to access for the purpose of carrying out investigations, as provided for under the 2015 [ADMC] Act'.
- 11.43 Stressing that 'data protection laws must not be misused to prevent those with a role under Part 13 from exercising their powers and duties towards the relevant person', an individual respondent comments:

The records ought to be made available for inspection and copying by an advocate appointed to support the relevant person, the person with lawful authority, the Director [of the DSS] and the appropriate person, and also to allow them to be filed in any relevant court application.

### **Inspection of records**

- 11.44 The NCPOP observes that, while Head 10 'introduces the concept of the Head of Mental Health Services as having some jurisdiction over the records', they would 'as yet, [...] have no jurisdiction in most "relevant facilities"'.
- 11.45 The MHC emphasises that:

The only persons to whom the records of a relevant person should be made available for inspection are those provided for by way of the 2015 Act, this Part 13 and / or provided for in other relevant legislation and/ or other court order. Any other person should have to apply to the court to be permitted to inspect the records of a relevant person.

- 11.46 Endorsing the provision in subhead 3 for the regulations to specify to whom the records will be made available for inspection', the Law Society of Ireland and Safeguarding Ireland emphasise that access to such records should also be extended to the Director of the DSS.

11.47 The NCPOP queries whether HIQA will ‘be given specific powers’ under the proposed legislation ‘to inspect the records of patients who are recipients of admissions decisions’ and, if so, what the ‘implications of this [will] be for persons in charge’.

11.48 NHI emphasises that the identity of ‘the primary regulator of this area, should any non-compliance be purported’, along with clarification of ‘whether the Director [of the DSS] or HIQA have the final say on matters relating to this proposed legislation’, should ‘be clearly communicated to nursing homes’.

#### Other comments

11.49 The IHREC recommends that:

record keeping should be mandatory in all of the circumstances set out in Head 11 as well as [in] any further circumstances in order to ensure that an individual has access to records where s/he applies to have their deprivation of liberty reviewed.

11.50 The NAS queries whether there will ‘be the same obligation on standalone services to keep records in line with HIQA etc’.

11.51 Noting that ‘the keeping of clear, comprehensive and relevant records in relation to Part 13 is critical and should be expressly stated, the MHC advises that, in subheads 1 and 2, ‘the word “may” [...] should be amended to “shall”’.

11.52 Noting that ‘the use of the word “may” rather than “shall” in Heads 11–12 does not ensure mandatory record keeping’, the IHREC expresses concern that ‘this may infringe on fair procedures, particularly where an individual may require access to records in the case of a review of deprivation of liberty’.

11.53 The DSBA argues that:

provision should be made for the release of the relevant person’s records to any legal representative appointed by the relevant person or for the relevant person in advance of any hearing or review

11.54 The IMHLA likewise argues that:

Head 11 should also deal with the issue of release of the relevant person’s records in advance of any court hearing to any legal representative appointed by the person or for the person.

11.55 Observing that ‘record keeping would also be relevant for the purposes of proper regulation and [...] that regulation has not been mentioned in the consultation document’, the IHREC suggests that:

The Department may wish to consider whether further legislative amendments are necessary in order to ensure an effective regulatory framework is in place once these legislative proposals become operational.

## Chapter 12: Head 12 – Regulations

Head 12 sets out the matters pertaining to the implementation of the proposed legislation on which the Minister ‘may prescribe by regulations’. As enumerated in subhead 1, these matters are:

- (a) Records to be kept under Head 11 to facilitate verification of compliance with this Part;
- (b) Regulations in relation to restraint practices under Head 10;
- (c) The manner in which the person in charge or the healthcare professional on behalf of the person in charge shall notify the relevant person and other specified people under this Part.

Subhead 2 empowers the Minister, ‘following consultation with the Director’, to prescribe by regulation procedures to give effect to the legislative provisions, including ‘the establishment by the Director of a panel of suitable persons willing and able to act as appropriate persons’. As stated in the Explanatory Notes:

It will also be necessary to amend certain provisions in Part 9 to give full effect to this additional function being conferred on the Director.

**Question 12.1: In subhead (1), do you think that the Minister should be empowered to make regulations on any other aspect of the Heads?**

### **Respondents’ comments**

#### **The relevant person’s capacity**

12.1 The HSE Assisted Decision Making National Office, the HSE National Safeguarding Office and HSE’s Older Persons’ Services call for the provision of regulations in respect of ‘when a person has capacity and decides to leave a relevant facility’.

12.2 An individual respondent observes that:

No mention has been made as to whether the relevant person may have capacity to litigate in the proceedings seeking an order relating to Part 13.

Noting that, ‘as capacity is decision-specific, it cannot be assumed that the person lacks such capacity’, the respondent suggests that:

Perhaps the regulations or a new section in the bill should state that the Director, any appropriate person or any other applicant seeking an order relating to Part 13 should be satisfied that the relevant person lacks capacity to make the application themselves.



## Restraint practices

12.3 The HSE Assisted Decision Making National Office calls for the provision of regulations in respect of ‘chemical / physical restraint and exceptional circumstances’.

12.4 The IHREC likewise recommends that:

The ‘exceptional circumstances’ in which restraint practices may be used should be prescribed in regulations and such regulations should be developed in accordance with Article 17 [UN]CRPD.

## Other comments

12.5 Opining that ‘statutory forms should be used, as is the case with the 2001 [Mental Health] Act’, the MHC recommends that:

Regulations in Parts 1 to 12 of the 2015 [ADMC] Act must be drafted in tandem with Part 13 to deal with all of the relevant issues to include the list of healthcare professionals, restrictive practices and records to be kept.

12.6 Recognising ‘the difficulties implementing such legislation’, an individual respondent calls ‘for the maximum retrospective flexibility once the difficulties in implementation become clear’.

12.7 The College of Psychiatrists of Ireland expresses the view that the Minister should be empowered to make regulations on other aspects of the proposed legislation, commenting that ‘this is usual custom and practice in this area’.

12.8 Likewise endorsing the empowerment of the Minister ‘to make regulations [...] as this will facilitate a more responsive and flexible system’, the CIB recommends that:

To avoid duplication and to streamline implementation, regulations with regard to these safeguards should replicate regulations that are in place elsewhere, for example, HIQA and HSE regulations.

12.9 The INMO suggests that:

The Minister should additionally be empowered to make regulations in relation to certain matters pursuant to Head 5, and additional regulations pursuant to Head 10.

12.10 The Law Society of Ireland and Safeguarding Ireland call for ‘regulations [...] with regard to the recording [of] the reasons for the administration of medication to a relevant person in a residential setting’.

12.11 The Law Society of Ireland and Safeguarding Ireland also opine that:

Regulations are required [...] to provide that the Director of the Decision Support Service may send out a Special Visitor to carry out audits if required.

12.12 The HSE Assisted Decision Making National Office calls for the provision of regulations in respect of 'the powers and function of an independent advocate'.

12.13 NHI calls for

regulations for general practitioners in respect of a new and revised GMS GP contract which adequately meets the needs of the resident, the nursing home and the GP.

**Question 12.2: In subhead (2), do you have a view on any other policy and procedure that should be included in this subhead?**

### **Capacity assessment and admission decisions**

12.14 The NDA recommends that the legislation should encompass provision for regulations to be made in relation to the

procedure for how a relevant person is assessed for their care by a healthcare professional, where there are concerns about their capacity to make the decision.

12.15 Calling for 'the regulations [...] to provide that professionals involved in assessments must be independent of the facility', an individual respondent calls for the expansion of Head 12

to set out a process for the appointment of an independent medical expert or healthcare professional (or the expanded professional category already suggested) who will furnish the independent capacity assessment which should also include reference to the person's physical and mental health or intellectual disability.

12.16 The NAS calls for

further detail [to] be added on how to challenge a decision made on a person's capacity / how the person may wish to access another independent assessment if they have serious concerns or how their rights can be protected in this regard.

- 12.17 On the assumption that ‘the court service will develop its own procedures on how an applicant takes an application relating to Part 13’, an individual respondent calls for ‘either the regulations or the bill’ to encompass

an appeal mechanism against an order made by the circuit court which is an admission decision, or [against] the court’s decision when reviewing an admission decision already made by the court or by a person with lawful authority.

- 12.18 Emphasising that ‘the guiding principles established by the Assisted Decision-Making (Capacity) Act 2015 should apply to the Minister in the formulation of any regulations’, the IHREC recommends that:

Head 12 should be amended to provide that the Minister shall make regulations outlining the procedures to be followed by healthcare professionals to ensure that a relevant person has been informed that s/he is free to leave a relevant facility.

- 12.19 Similarly, the HSE National Safeguarding Office and HSE’s Older Persons’ Services suggest ‘additional regulations [are] required for when a person has capacity and decides to leave a residential facility’.

- 12.20 SAGE calls for ‘a procedure [to be] undertaken to ensure that all persons residing within a “relevant facility” have consented to reside there’ and recommends that:

Regulations should be introduced for the circumstance of a person who has capacity deciding to leave a ‘relevant facility’.

### **Independent advocacy**

- 12.21 The NDA recommends that the legislation should encompass provision for regulations to be made in relation to ‘the establishment by the Director of a panel of suitable persons to act as independent advocates’ and the ‘procedure for the appointment of an independent advocate to relevant persons’.

- 12.22 Safeguarding Ireland comments that ‘regulations should provide for the appointment and functions of an independent advocate’.

- 12.23 The INMO recommends that ‘the Minister should be empowered to make relevant regulations akin to the provision made at subhead 2’ for the establishment of ‘the office of an independent advocate’, observing that ‘such an office seems apt to be administered by the Director’.

- 12.24 SAGE comments that ‘regulations should provide for access to independent advocacy, and the appointment and functions of an independent advocate’.

## Other comments

### 12.25 NHI calls for

regulations to strengthen the obligations on the Director of Decision Support Services to provide guidance, information, clinical guidelines, policies and procedures to assist nursing home staff.

### 12.26 The CIB calls for 'a detailed code of practice with clear definitions of all aspects of these safeguards' to be drawn up, recommending that:

The code of practice should contain illustrative examples and be easily understood and accessible for professionals, families and service-users.

### 12.27 Similarly, SPMHS notes that:

There is a requirement to produce rules and codes of practice that prescribe the methods by which the various processes contained in the Heads are carried out and documented.

SPMHS opines that 'the Director of the Decision Support Service would be best placed to undertake this.

### 12.28 Noting that 'the person in charge and medical professional may have conflicts of interests', the NAS opines that 'a code of conduct is required to address this'.

### 12.29 The HSE Assisted Decision Making National Office calls for 'the issue of people being deprived of their liberty in other settings [...], e.g. acute hospitals, respite, etc' to be addressed.

### 12.30 Likewise, the Law Society of Ireland and Safeguarding Ireland comments that:

[The] question arises as to whether the provisions of Part 13 apply to step down/respite/assisted-living facilities where there may be *de facto* detention.

### 12.31 Observing that 'the current policy document DoH [Department of Health] (2011), *Towards a Restraint Free Environment [in Nursing Homes]* is outdated', NHI emphasises that 'there should be clear and unambiguous clinical guidelines, policies and procedures around chemical restraint and restrictive practices'.

### 12.32 SAGE recommends that:

A procedure should be introduced to ensure that all persons residing in a 'relevant facility' are informed of their rights and safeguards in relation to consent and deprivation of liberty.

**Question 12.3: Do you have any other views specific to Head 12?**

12.33 The DSBA and IMHLA indicate their support for Head 12.

12.34 The NCPOP comments that the process outlined in subhead 2(b) in respect of the qualifications and procedure for appointment of an appropriate person 'would need extensive consultation with stakeholders'.

12.35 The MHC calls for 'shall' to be substituted for 'may' in subheads 1 and 2, further remarking that:

The section shall require to be further to the 'Fundamental Observations' above, that the Director [of the DSS] will not be making the proposed applications to Court.

12.36 MHR comments that:

Regulations on deprivation of liberty safeguards need to be developed in consultation with all relevant key stakeholders, including the community and voluntary sector.

12.37 Welcoming 'the ability to make regulations in respect of this legislation', and cognisant of 'the changes that the proposed deprivation of liberty safeguards will bring about', HIQA comments that:

This presents an opportunity for the Department to review the existing legislation and regulations to ensure that they are in line with what is proposed in these heads of bill and more broadly within the ADMC Act.

HIQA also seeks clarification in relation to the 'body [that] will be responsible for monitoring any regulations arising out of this legislation'.

## Chapter 13: Head 13 – Offences

Head 13 enumerates the offences pertaining to the proposed legislative provisions on the deprivation of liberty, and the fines and / or sentences for which offenders will be liable. As indicated in the Explanatory Notes, these offences encompass the deliberate contravention of the safeguards outlined in Heads 4, 5, 6 and 7 (as detailed in subhead 1), while subhead 2 ‘provides that a person who furnishes false information or tampers with a relevant document will be guilty of an offence’.

**Question 13.1: Do you have a view on the proposed offences set out in this Head?**

**Respondents’ comments**

**Additional proposed offences**

*Impeding access to an independent advocate*

13.1 The NDA calls for the ‘obstruction of the work of an independent advocate appointed to a relevant person’ and for the prevention of ‘their access to the relevant person’ to be considered for inclusion as an offence.

13.2 Safeguarding Ireland likewise recommends that ‘it should be an offence if any person debars a relevant person [from] access to an independent advocate’.

13.3 Similarly, MHR calls for Head 13 to

include a provision that it is an offence to bar an independent advocate from a person who falls under the deprivation of liberty safeguard legislation.

*Coercion of a relevant person into admission*

13.4 The Law Society of Ireland and Safeguarding Ireland recommend that:

It should be an offence for a person who uses coercion or undue influence to force another person to agree to admission to a ‘relevant facility.’

13.5 The HSE Assisted Decision Making National Office also calls for it to

be an offence if someone uses undue pressure or duress to force another person to agree to admission to a relevant facility’.

13.6 Likewise, SAGE opines that ‘it should be an offence to coerce a person into making a decision to reside in a “relevant facility” and ‘to conspire to admit a person to a “relevant facility”’.

### *Use of restraint practices*

- 13.7 An individual respondent queries why Head 10(3), which prohibits the use of restraint practices except in exceptional circumstances, is 'not listed as an offence'.

#### **Other comments**

- 13.8 The College of Psychiatrists of Ireland and the DSBA endorse the proposed offences set out in Head 13.

- 13.9 Commenting that subhead 1(b) 'is too vague to meet prosecution standards', an individual respondent recommends that this

should provide that if a person has capacity and wishes to leave, then if they are prevented from leaving, this constitutes an offence. Also, that there is an offence if the thresholds set in Head 7(1)(a)(ii) and Head 5(1) are not met.

- 13.10 NHI recommends that:

The proposed offences should be levied on the medical practitioner that knowingly prescribes a medication for the purposes of chemical restraint or who fails to adequately and frequently review the ongoing clinical indications for medicines already prescribed for therapeutic reasons.

- 13.11 The NDA advises that it will be

important that the offences provided for in the draft Heads of Bill are aligned to other offences provided for in the 2015 Act'.

#### **Question 13.2: Do you have any other views specific to Head 13?**

#### **Respondents' comments**

#### **'Deliberate contravention'**

- 13.12 Highlighting the importance of the inclusion of the adjective 'deliberate' in subheads 1(a) and 1(b), the HSE National Safeguarding Office and the HSE's Older Persons' Services call for it to

be evidenced that the staff have deliberately and in full knowledge violated, impeded and denied the human rights of the service-user in the deprivation of their liberty.

13.13 Noting the reference in subhead 1(a) to ‘deliberate’ contravention of Heads 4, 5, or 6, the CIB calls for greater clarity on how ‘inadvertent contravention of the safeguards’ will be prevented.

13.14 Emphasising the imperative for the person in charge to be ‘of sufficient experience, seniority and authority to [...] make decisions which have the potential to give rise to significant criminal liability’, the INMO comments that:

The use of the term deliberate seems inappropriate and should be replaced with the term intentional.

13.15 The IMHLA suggests that ‘the word “deliberate” should be omitted from this Head’.

### **Practical implications**

13.16 An individual respondent expresses concern about the ‘creation of crimes with such high penalties’ in respect of legislation which will apply nationally to ‘a chaotic and bureaucratic system’. Opining that ‘this seems contrary to natural justice’, the respondent suggests that ‘any such offences should wait until the legislation beds in’.

13.17 NHI expresses concern that the offences detailed in Head 13 will ‘severely negatively impact the recruitment and retention of PICs [persons in charge] and nurses to the nursing home sector due to the ever-increasing statutory obligations’.

13.18 Observing that ‘this aspect of the legislation will have an impact on how staff and organisations make decisions in challenging situations’, the NRH calls for the offences detailed in subheads 1(b) and 1(c) ‘to be underpinned by detailed standards of practice and guidelines in order to protect both clients and staff’.

13.19 The CIB expresses concern that ‘inadvertent contravention of the safeguards’ may be caused by ‘delays due to circumstances out of the control of a person making an admission, particularly in the case of urgent admissions’.

### **Other comments**

13.20 The NAS calls for ‘greater clarity on the reporting mechanism’ for offences.

13.21 The MHC comments that ‘these will be matters for the DPP [Director of Public Prosecutions], not the MHC or the Director of the DSS’.



13.22 Emphasising the necessity 'for a rights-based approach to comply with the UNCRPD', the Law Society of Ireland comments that:

Part 13 [...] appears to apply the 'disability tag' to some of the provisions set out and on the other hand, where the relevant person may need support and assistance, does not appear to comply with human rights standards.

## Chapter 14: General Questions

**Question 14.1: A number of the Heads – 5(2)(b), 5(3), 5(4), 5(7), 5(8), 7(6), 7(9), 7(11), 8(1) and 8(3) – set down time-frames within which certain actions must be taken. Do you have a view on any of these proposed timeframes?**

### Respondents' comments

#### Need for practical time-frames

- 14.1 Calling for 'an explanation of how these time-frames were arrived at', the NDA emphasises the imperative for them to be 'realistic and operational in practice' and suggests that, rather than being included in the proposed legislative provisions, 'they could be provided for in regulation or in [a] statutory code of practice'.
- 14.2 The NRH likewise emphasises that the time-frames should
- be practicable and take into account the speed of response which can realistically be expected from the person themselves, family members, advocates, the Decision Support Service and the courts.

#### Time-frames in individual Heads

- 14.3 The NAS calls for the time-frames stipulated in Head 5 to be shortened, recommending that relevant persons 'should be notified within 24 hours and an alternative medical assessment should be undertaken within 48 hours'.
- 14.4 The NAS observes that the reference to 'as soon as practicable' in Head 7(6), 7(9), and 7(11) 'is open to wide interpretation and should be time-limited'.
- 14.5 Likewise, noting the reference to 'as soon as practicable' in Head 7(9), SPMHS calls for a time-frame to be specified here, suggesting 3 days.
- 14.6 The NAS opines that the time-frame stipulated in Head 8(3) of 12 months and 1 day for the receipt by the person in charge of notification of a court application in respect of an existing resident is 'too long' and 'unreasonable when one compares the provisions of the Mental Health Act and similar provisions in other jurisdictions'.
- 14.7 NHI observes that the time-frame of 12 months and 1 day stipulated in Head 8(3) 'is likely to be overlooked in practice without any reminder mechanisms'.

## Resourcing issues

14.8 Expressing concern that ‘persons in charge would not be able to achieve these timelines in practice’, NHI calls for the introduction of ‘a centralised support system or mechanism in place to support the PIC [person in charge] and nursing homes in achieving compliance’.

14.9 Cautioning that ‘specification of timescales may be problematic, particularly at holiday periods or in areas where out-of-hours services are not properly resourced’, the CIB advises that:

It may [...] be better in some situations to increase the time-scale in order to access relevant details of the person’s previous medical history which would support a more informed decision in the person’s best interests.

14.10 Noting the ‘likely demand’ on the court for the applications for admission decisions provided for by the legislation, SAGE highlights the ‘risk of prolonged time-periods where a person is arbitrarily deprived of their liberty without timely access to a process’.

## Other comments

14.11 Noting the imperative for strict compliance with the time-frames stipulated in the legislation, St. Luke’s Nursing Home, Cork, requests clarity on how ‘3 days, 5 days, 10 days [...] is to be calculated’ while emphasising that ‘different situations can require different interpretation, based on medical evidence and fluctuating capacity’.

14.12 The NAS emphasises that ‘it is imperative that time-frames should be equal irrespective of diagnosis’.

14.13 The clients of St. Luke’s Nursing Home, Cork opine that the time-frames set out in the legislation should be cognisant of, *inter alia*, the time that it will take for relevant persons ‘to obtain a decision-maker’; the time required for the Garda vetting of the decision-maker; and the time required for courts to assess and hear applications.

14.14 The HSE Assisted Decision Making National Office recommends that the time-frames should ‘be considered in relation to other policies, procedures and legislation that exists, e.g. HIQA standards’.

14.15 The Law Society of Ireland and Safeguarding Ireland recommend that the time-frames should be ‘further considered when the legislative framework is further developed to comply with human rights standards and obligations’.

14.16 SPMHS cautions that ‘failure to adhere to these timeframes should not be an offence’.

**Question 14.2: The draft Heads apply to older people, persons with disabilities and people with a mental health illness. In terms of timeframes, and in light of the existing provisions of the Mental Health Act 2001, should those with mental health illness be treated differently to others?**

**Respondents' comments**

**Relationship between the proposed legislation and the Mental Health Act**

14.17 Noting that 'the protections afforded to persons under the Mental Health Act, 2001 have served to support persons [who have been] the subject of Admission / Renewal Orders under that Act', the DSBA comments that 'relevant persons who may be detained under the provisions of the [ADMC] 2015 Act would expect to be afforded the same protections'.

14.18 Opining that 'in relation to the MHA, it would make sense that the acts would align in some or all respects', the Rehab Group queries whether relevant persons would be treated differently 'in services where people with both mental health difficulties and learning disabilities reside' and whether one 'act would supersede the other' in instances in which 'people have a dual diagnosis'.

14.19 Noting that some 'patients have sustained complex disabilities such as spinal cord injury during an acute episode of mental illness but [...] require long-term care in the disability sector', the NRH queries whether the MHA or Part 13 of the ADCM Act 'would take precedence if a person has a dual diagnosis', such as 'a diagnosis of schizophrenia and acquired brain injury'.

14.20 NHI expresses the view that those with mental illness should be treated differently to others, noting the distinction in the MHA between a 'mental disorder' and 'mental illness', and the provisions under the Act

to arrange for an involuntary admission of a person to an approved centre on the grounds they are suffering from a mental disorder.

NHI emphasises that 'relevant persons with a mental disorder (as defined in the Mental Health Act 2001) need to have alternative options available to them', and that there should continue to be provision 'for involuntary admissions of these persons to approved centres under the Mental Health Act 2001 when a nursing home is no longer able to meet their assessed needs'.

14.21 Likewise noting that 'someone with a mental disorder can be involuntarily detained under the Mental Health Act, 2001', the HSE Assisted Decision Making National Office calls for

more clarity in the Heads regarding the difference between someone with mental health illness and a mental disorder.

14.22 The NDA notes that the statement in the Department of Health’s consultation paper that the Heads will apply to persons who have ‘mental-health issues but [who] are not suffering from a mental health disorder and [who] therefore cannot be involuntarily detained under the Mental Health Act’ implies ‘that the draft Heads of Bill will not apply to people with a mental disorder as defined under the Mental Health Act 2001 who are involuntarily detained against their wishes’. Accordingly, since question 14.2 stipulates that ‘the draft Heads apply to [...] people with a mental health illness’, the NDA seeks clarity about ‘who the new Part 13 [of the ADMC Act] applies to and does not apply to’.

14.23 Noting that ‘a person with a mental illness is not necessarily a person with a “mental disorder”’, the Law Society of Ireland and Safeguarding Ireland observe that ‘there appears to be confusion on this issue in the draft Heads’. Accordingly, they seek clarity on whether it is ‘intended that a person who has a “mental disorder” and can now be involuntarily detained be included or excluded from the provisions of Part 13’.

14.24 Observing that in England and Wales ‘the interface between the MHA and the DOL [deprivation of liberty] legislation is a fraught one’, an individual respondent cautions that:

If there is not an explicit account of the interface between the MHA and DOL legislation written into the latter, then you end up in the quagmire of evolving case law and the legislation becomes unusable for those on the front line.

Noting that in Ireland the MHA ‘actively encourages “voluntary” admissions which could well be considered “*de facto* detention” in other jurisdictions’, the respondent expresses concern that the ‘DOL safeguards will enter this system in a rather awkward fashion [...] granting people much more limited rights than under the MHA’. The respondent advises that this will mean that there will be ‘a cohort of the incapacitous [*sic*] voluntary patients who would now come under DOL legislation in approved centres’, and that the proposed legislation will create ‘a less flexible, less protective, parallel legal system for the management of mental illness’.

14.25 An individual respondent calls for ‘those detained in residential facilities’ to ‘have the same rights’ as ‘those deprived of their liberty under the Mental Health Act’, including the rights ‘to legal representation and advice, to challenge their detention and [to] periodic review of their detention’, as well as ‘access to an independent advocate’, ‘access to an independent medical opinion’, and ‘the right to be present and to be heard at any court hearing regarding their future’.

14.26 An individual respondent expresses the view that

The arrangements and protocols surrounding the involuntary incarceration of persons as defined in the Mental Health Act are not fit for purpose, wasteful and require a complete overhaul.

14.27 Noting that under the MHA “voluntary patients” do not have their admission to an approved centre independently reviewed’ because they are deemed to have consented to this, Family Carers Ireland (FCI) highlights

the difficulty [...] that the definition of ‘voluntary patient’ includes persons who are ‘incapacitated but compliant’ and by consequence in fact detained and therefore deprived of their liberty.

Accordingly, FCI emphasises the imperative for ‘special provision [to] be made within the DoLS [deprivation of liberty safeguards] to protect the rights of voluntary patients receiving mental health treatment’.

### **Treatment of persons with mental illness**

14.28 The NAS advises that:

The divisions between PWD [persons with disabilities], older people and people with a mental illness should come to an end because at the moment it leads to confusion and to the idea that people with a mental illness have a different set of rights. It could also lead to a potential difficulty when a person has a dual diagnosis and a query may arise around the procedural time-frames in such situations.

14.29 An individual respondent emphasises that, as per article 14 of UNCRPD, ‘under no circumstance should anyone with mental health illness be treated differently’.

14.30 Likewise, the IMHLA states that ‘the Association does not believe that those with mental health conditions should be treated differently than others in this Bill’.

14.31 MHR calls for the legislative proposals to

acknowledge that there are no circumstances in which a person will be deprived of their liberty on the basis of mental health difficulty (where that person lacks capacity) in any ‘facility’ other than an approved mental health inpatient unit, in accordance with mental health legislation.

14.32 Similarly noting that ‘it is in contravention of article 14 of [the] UNCRPD to deprive a person of their liberty based on their actual or perceived impairment’, SAGE stresses that ‘it is not appropriate to treat people differently on the basis of disability, age or existence of mental illness’. Accordingly, SAGE comments:

The Heads of Bill require clarity on how the proposed legislation would interact with mental health related legislation by ensuring the presumption of capacity is upheld, and that the individual’s right to self-determine and right to liberty are safeguarded.

14.33 Likewise, the Division of Neuropsychology of the PSI calls for

patients with mental health issues [to] be treated equally but with consideration that their symptoms may abate and render them to have liberty.

14.34 The Law Society of Ireland and Safeguarding Ireland emphasise that ‘persons with mental health illness have the same rights as others’.

14.35 Likewise, the HSE Assisted Decision Making National Office opines that ‘people who have mental health illness should [...] be provided with the same rights as everyone else’.

14.36 While acknowledging that ‘the provisions of the Mental Health Act should remain in force consistently’, SPMHS emphasises that ‘otherwise those with mental illness should be entitled to the same rights under law as all other citizens’.

#### **Scope of the application of the proposed legislation**

14.37 Seeking clarification of the origin of the ‘rather restricted list of people’ included in question 14.2, an individual respondent queries:

Would this legislation not apply to a young adult with a physical illness? Does this statement implicitly equate greater age, disability and mental illness with lack of mental capacity? Surely these Heads will apply to everyone who fulfils relevant legal criteria, regardless of age, level of ability or disability, or diagnosis?

14.38 The Division of Neuropsychology of the PSI calls for consideration to be given to ‘patients who have acquired brain injury but not mental illness’, noting that in Ireland

organic personality disorder is not commonly treated/managed by psychiatric services but patients with this disorder can present with profound lack of insight about their condition and needs, be disinhibited and neglectful necessitating intervention against their will and involving DOL [deprivation of liberty].

In addition, the Division of Neuropsychology of the PSI calls for consideration to be given to ‘adults with an intellectual disability’, noting that ‘many [...] who are currently in residential services will fail to pass the capacity threshold’.

- 14.39 Commenting that the statement that ‘the draft Heads apply to older people, persons with disabilities and people with a mental health illness’ is ‘incorrect and discriminatory’, the College of Psychiatrists of Ireland queries:

What about a young adult person with an acquired brain injury that leaves them lacking capacity to make decisions in respect of their on-going care?

- 14.40 Observing that ‘there are lots of people with disabilities, wheelchair users, sensory impairments etc’ and that ‘disability does not necessarily impact on decision-making ability’, the Division of Neuropsychology of the PSI suggests that ‘a descriptor such as “disability, mental health issue or medical condition that impacts upon decision-making ability” may be preferable’ to the use of the term ‘persons with disabilities’.

- 14.41 The Law Society of Ireland and Safeguarding Ireland advise that ‘Part 13 should apply to any person who is detained against their wish’ who ‘do[es] not come with[in] the excluded provision of the ECHR’.

- 14.42 Advising that ‘the proposed Part 13 of the 2015 Act should apply to any person who is deprived of their liberty and does not come within the excluded provisions of the European Convention of Human Rights’, the HSE Assisted Decision Making National Office notes that:

As the 2015 [ADMC] Act does not include a diagnostic test, the draft Heads should apply to anyone who falls under the definition of a relevant person in the 2015 Act and not apply to certain cohorts of people dependent on age or diagnosis.

- 14.43 The College of Psychiatrists of Ireland expresses the view that:

The Assisted Decision-Making (Capacity) Act, 2015, and specifically the provisions regarding the deprivation of liberty, should not apply to acute psychiatric units and mental health hostels.

- 14.44 Saint John of God Community Services emphasises that, as per article 14 of the UNCRPD, ‘there is an absolute prohibition on the detention of a person on the basis of disability’.

- 14.45 While welcoming the protection that the proposed legislation will afford to ‘older adults, adults with a disability and adults with mental health conditions living in [...] designated centres’, the IASW cautions that:

One must not lose sight of these same human beings who are deprived of their liberty and experiencing chemical and other forms of restraint in hospital, community and home-based settings.



14.46 The IHF opines that:

The safeguarding proposals should apply to all persons residing at home, in community homes, in supported living accommodation, in housing associations, in acute hospital or in respite care that are at risk of being deprived of their liberty.

**Question 14.3: Do you have any other views on the draft provisions?**

**Respondents' comments**

**Imperative to support independent living**

14.47 FCI, the IHF, MS Ireland, the NDO and the ASI, and the NRH emphasise that people are detained in hospitals, nursing homes and other residential facilities – and thereby deprived of their liberty – because of the insufficient supply of home-care services in Ireland.

14.48 The DFI calls for clarity in relation to

whether this Bill will apply when someone is effectively deprived of their liberty due to a lack of resources and support for the individual to live at home or in the community.

14.49 The CDLP comments that ‘it is well-established that deprivation of liberty only occurs where the person has not enough support or options to live in the community’.

14.50 FCI expresses concern about the exclusion of patients in acute hospitals from the proposed legislation, remarking that the Department of Health

is failing to recognise a significant and increasing cohort of vulnerable adults whose discharge from hospital is delayed because there is no alternative care arrangement in place for them.

14.51 Noting that ‘the current provisions [...] are focused predominantly on assessment [...] and subsequent practices of deprivation of liberty’, MHR recommends that they ‘should place a greater emphasis on supporting the person in the community for the purposes of avoiding the practices of coercion’.

14.52 Inclusion Ireland recommends that the ‘responsibility to exhaust non-institutionalised forms of residential care services should be included’ in the proposed legislation with a view ‘to minimis[ing] the incidences of deprivation of liberty’.

## Capacity assessment and decision-making

14.53 The IHF notes that, in the absence of the commencement of the ADMC Act, there is neither a statutory obligation to use a functional approach to [...] determine the person's capacity to consent to reside in an institution, nor a process to support [...] the person to make that decision.

Accordingly, the IHF emphasises that the proposed legislation is 'essential to support the culture shift that is required to facilitate the application of functional capacity assessment'.

14.54 FCI expresses concern that the provision in the ADMC Act for multiple decision-makers to be assigned with responsibility for different levels of decision-making [...] will lead to conflict and disagreement among decision-makers.

14.55 MHR expresses concern that:

The draft safeguards place too great an emphasis on the role of the decision-making representative (DMR), the attorney and the courts in determining decisions of deprivation of liberty.

Suggesting that 'the decision-making representative is not the appropriate person to make a decision about deprivation of liberty' and that the courts system is not 'a sufficient remedy to assess and/or review such a decision', MHR emphasises the imperative for the courts to be 'accessible to the person whose liberty is in question'.

14.56 Opining that 'the proposed safeguards are overly medically focused', and expressing 'concern about the level of autonomy that is afforded to the "person in charge" in terms of making decisions relating to a deprivation of liberty', MHR calls for the amendment of the proposed legislation 'to ensure the involvement of multidisciplinary teams' in decision-making and to promote 'the involvement of "the person" as an equal partner in service delivery'.

14.57 St. Luke's Nursing Home, Cork calls for 'the current healthcare model of beneficence', in which 'medically qualified persons' take 'healthcare decisions', to be maintained, rather than this role being 'transferred to an unqualified decision-maker where "duress", "bias" and / or "abuse" can pose a real threat'.

14.58 An individual respondent suggests that 'the use of fairly vague definitions and [the] reliance on the courts for decisions' will result in 'wildly fluctuating decisions and precedents that leave those trying to implement the legislation [...] unsure of what they are supposed to do'.

## Role of the person in charge

14.59 Calling for decisions ‘to be made in a multi-disciplinary manner’ by ‘a number of people involved in the person’s care’, the HSE Assisted Decision-Making National Office expresses concern that:

A disproportionate amount of responsibility is being placed on the person in charge to make decisions about people in their care with respect to deprivation of liberty.

14.60 NHI also notes the ‘over-reliance on the role of the person in charge’ in the legislative proposals, opining that ‘the responsibility for compliance and statutory obligations should not be conferred on the role’.

14.61 St. Luke’s Nursing Home, Cork queries whether it would be practicable for

a competent person (i.e. PIC [person in charge]) [to] be granted authority to make applications for all residents once deemed appropriate [...], ordered by the courts and registered with the courts.

14.62 Observing that ‘there is significant responsibility [...] placed on the person in charge [...] to take action and make determinations in relation to a person’s decision-making capacity’, the IHF emphasises that:

It is essential that these people receive adequate training and education as well as resources to apply the necessary actions that will be stipulated through this legislation and that of the ADM[C Act].

14.63 The NAS also highlights the need for the provision of ‘mandatory training’ for persons in charge and those acting on their behalf to support the implementation of the legislation.

## Protecting human rights

14.64 Noting that ‘article 9 ICCPR [International Covenant on Civil and Political Rights], article 5 ECHR and the Irish Constitution guarantee the right of *habeas corpus* for any person deprived of their liberty’, the ICCL expresses the view that the draft Heads of Bill are ‘seriously inadequate to ensure adequate protection from arbitrary detention and mistreatment in care settings’, as enshrined in international human rights law. The ICCL notes that the draft Heads ‘do not cover numerous care settings’; that they ‘offer no protection from arbitrary detention to people who are deemed capable of making care-related decisions’; and that ‘there are wholesale exemptions from the requirement for deprivations of liberty to be authorised by law’.

The ICCL further notes that ‘the grounds for triggering an application to court to authorise a deprivation of liberty’ are not in compliance with the ADMC Act or with the CRPD; that ‘there is no statutory right to the alternatives to institutional care or restraint’; that ‘there are no requirements [...] for care providers to obtain

informed consent'; that 'there is no statutory right to [...] independent advocacy services'; and that Ireland has not ratified the United Nations' OPCAT, under which signatories are required 'to inspect and monitor all places of deprivation of liberty in order to prevent arbitrary detention or torture or ill-treatment'.

14.65 Inclusion Ireland calls for the proposed legislation to be 'reviewed for consistency with the principles and tone of the Assisted Decision-Making Act'.

14.66 Commenting that 'all decisions relating to the DOLS [deprivation of liberty safeguards] must be made in accordance with the principles of the Assisted Decision-Making (Capacity) Act', MHR recommends that:

The application of the ADMC Act principles to the DOLS should be clearly recognised in the legislation to avoid the risk of ambiguity and misinterpretation in this regard.

MHR also emphasises that the legislation must be in compliance with the ECHR and the UNCRPD.

14.67 Observing that clinicians and family-members often pressurise older people into agreeing to admission to nursing homes prematurely, an individual respondent expresses concern that the draft legislative proposals 'do not represent safeguards for these realities', that they 'are disrespectful of the rights of the persons directly affected', and that they 'run counter to the fundamental philosophy and intention of the Assisted Decision-Making (Capacity) Act'. The respondent suggests that 'the current proposals would facilitate what would often be life-long detention' of relevant persons, falling short of the protections afforded 'to other citizens subject to admission and detention, such as people who are imprisoned [...] and those with severe mental illness'. Noting that 'older people embrace risk and prioritize independence whereas family members and healthcare staff act in more paternalistic ways', the respondent calls for decision-making to be cognisant of 'the current and past will and preferences of the person, their quality of life, [and] their overall interests', rather than being 'solely based on "safety" and "harm"'.

14.68 Saint John of God Community Services also calls for the legislative proposals to 'clearly align and interface with' the UNCRPD and the ECHR, and for the adoption of a 'human rights-based approach'.

14.69 The CDLP expresses concern that, rather than addressing relevant persons' needs, the proposed legislation

sets out the criteria according to which organisations or public servants will be protected from liability for admitting persons to relevant facilities without their consent.

Accordingly, calling for 'measures to respect and protect [a] person's rights against the interference of third parties', the CDLP opines that 'the approach of

the heads of bill constitutes a violation of the right to liberty enshrined in the CRPD’.

- 14.70 Expressing concern that the proposed legislation ‘does not appear to comply with human rights standards’, Safeguarding Ireland and the Law Society of Ireland also call for ‘a rights-based approach to comply with the UNCRPD’.

### **Relevant persons’ will and preferences**

- 14.71 Noting the lack of reference to the relevant person’s will and preferences in the legislative proposals, the Division of Neuropsychology of the PSI calls for the term ‘to be made explicit’.

- 14.72 Expressing concern that ‘the draft provisions concentrate heavily on the responsibilities of the person in charge and the processes to be followed’, the NAS calls for ‘greater emphasis’ to be placed on ensuring that the relevant person’s will and preferences are respected.

- 14.73 The NRH calls for the reconciliation of the proposed approach to the deprivation of liberty safeguards with ‘the presumption of capacity as outlined in the ADM[C] Act’, querying how the ‘will and preferences of the person’ will be respected

in a situation where a person clearly does not wish to be in residential care but is deemed not to have capacity to make this particular decision.

- 14.74 While endorsing the centrality of respect for the relevant person’s will and preferences to the guiding principles of the ADMC Act, FCI calls for

the same consideration [to] be extended to families who must be free to decide if, and to what extent, they agree to provide care in respect of a loved one whose preference is to be cared for at home.

To this end, FCI calls for the proposed legislation to encompass ‘a statutory definition of where the ultimate responsibility for care should be located’, arguing that ‘primary responsibility’ should rest with the family ‘with a secondary duty on the state to support this endeavour’.

### **Advance healthcare directives**

- 14.75 The DSBA calls for clarification ‘that any advance healthcare directive prepared by the relevant person continues to apply following the making of an admission order’.

- 14.76 Likewise, the IMHLA recommends that:

It should be clarified that any advance healthcare directive regarding treatment continues to apply while the person is deprived of his/her liberty.

14.77 Noting that there is ‘no acknowledgement of advance healthcare directives in decisions relating to deprivation of liberty’, MHR advises that:

In the context of mental health, there is a general consensus that advance directives must apply equally as to other areas of health.

### Supporting relevant persons

14.78 An individual respondent enquires about the ‘financial, physical, medical [and] psychological’ supports that will be made available to relevant persons who have been ‘deemed competent to leave [their] current residential setting’.

14.79 Emphasising that ‘it is important that appropriate registered professionals are available to all persons who may be affected by this legislation’, and ‘that failure to provide appropriate persons to assist a relevant person may lead to [...] a more limited approach than necessary being adopted’, the INMO recommends that older persons and persons with disabilities should have access to ‘appropriately qualified and experienced registered nurses’ to assess their needs and plan their care.

14.80 Noting that ‘detaining a person against their will can be a violation of article 12 of the UNCRPD’, and that the ADMC Act ‘places a strong emphasis on the “will and preferences” of the individual’, the DFI expresses concern that ‘there is no recognition of the presumption of capacity in these draft Heads of Bill’ or ‘of supports for individuals to assist them in making decisions’.

14.81 Highlighting the ‘risk of psychological difficulties or trauma as a result of the relevant person being admitted to a relevant facility’, Saint John of God Community Services queries how the legislative proposals will ‘consider risk in these areas in the context of the admission decision’ and recommends that reference be made to the HSE’s *Safeguarding Vulnerable Persons at Risk of Abuse: National Policy and Procedures* (2014).<sup>43</sup>

14.82 Expressing concern that ‘the measures as currently formulated will increase the extent and remit of coercion’, an individual respondent emphasises the imperative for the proposed legislation ‘to safeguard liberty in situations where liberty is currently being compromised rather than mandating further deprivation of liberty’. To this end the respondent calls for reconsideration of the ‘remit of the proposed measures’ and of the stipulated time-frames; for the mandatory provision of independent advocates to relevant persons; for the specification of ‘appeal mechanisms’; for greater ease of access to legal aid; and for the monitoring of the implementation of the legislation ‘to ensure [that] the new measures regulate “deprivation of liberty” rather than promote it’.

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<sup>43</sup> See Health Service Executive, *Safeguarding Vulnerable Persons at Risk of Abuse: National Policy and Procedures* (2014), <https://www.hse.ie/eng/services/publications/corporate/personsatriskofabuse.pdf>.

14.83 An individual respondent queries the extent to which there is ‘room for manoeuvre’ and ‘for error of judgement’ in an instance in which a relevant person

deemed to have capacity when making a decision on where to live [...] changes their mind, especially if a person leaves a service and then wants to return.

14.84 While acknowledging the difficulties that will arise, FCI calls for the proposed legislation to

address a significant discrepancy in the Fair Deal legislation, where no provision is made to allow a person to leave a nursing home if they change their mind or express a wish to return home.

## Advocacy

14.85 Noting that there are ‘various forms of advocacy which could assist the relevant person to develop, express and communicate his or her will and preferences’ and that the provision of such advocacy is essential for compliance with the ECHR, the DFI voices concern that ‘there is no mention of the need for access to advocacy services, nor is there mention of “special visitors” in these draft Heads of Bill’. The DFI expresses its support for ‘a statutory right to independent advocacy’ and, noting that ‘the Citizens Information Act, 2007 includes provisions for an independent Personal Advocacy Service for people with disabilities’, calls for the commencement of this legislation as well as for the provision of ‘a role for advocacy in these safeguards’.

14.86 Observing that, to support the implementation of the Mental Capacity Act, 2005 in the U.K., ‘an Independent Mental Capacity Advocacy system was introduced to protect the [...] rights of relevant persons’, the CIB calls for the introduction of such an advocacy system in Ireland, to be ‘resourced by the State’ and to ‘work in tandem with the proposed Decision Making Support Service’.

14.87 Emphasising that ‘access to independent advocacy is a vital element of [ECHR] article 5 protection’, the NAS calls for ‘this [to] be incorporated into the deprivation of liberty document as a key consideration / requirement’.

Reporting that the NAS has ‘developed a comprehensive set of policies governing [its] advocacy practice’ and that it is ‘developing a framework for standards for advocacy’ and ‘collaborating with the Department of Health [National] Patient Safety Office regarding [a] patient advocacy competency framework’, the NAS opines that ‘advocacy services need to be provided under an appropriate framework and with a standards framework’. Observing that there is at present ‘no overarching framework for advocacy’ and that ‘advocacy services have developed largely in an *ad hoc* fashion’, the NAS indicates its willingness ‘to work collaboratively with the Department of Health’ on this.



- 14.88 Observing that ‘the draft safeguards include no reference to advocacy supports’, MHR calls for this omission to be remedied to provide ‘immediate access to an independent advocate for any person who falls under the legislation’. Noting that ‘there is a fundamental requirement for individuals to be provided the opportunity to [...] participate in decisions related to deprivation of liberty and to challenge such decisions’, MHR also highlights the need for existing advocacy services to be expanded.
- 14.89 Inclusion Ireland recommends that ‘a right to independent advocacy should be included’ in the legislative provisions.
- 14.90 Saint John of God Community Services emphasises that ‘advocacy and legal representation services will need to be available to the relevant person’.

### **Enabling appeals**

- 14.91 The DSBA recommends that the legislative provisions
- should provide that decisions to admit to a relevant facility may be appealed to a court; and further that a relevant person may also apply to court to challenge continuation in a relevant facility at any time.
- The DSBA calls for such applications to be processed within a ‘short time-frame’ and to be supported by legal aid, as per the ADMC Act.
- 14.92 Expressing concern about the lack of detailed information on the mechanisms for appeal in the proposed legislation and emphasising that ‘it is exceptionally important that people have access to independent advocates / supports if appealing’, the NAS calls for the provision of ‘a robust appeal process and appropriate supports from the outset for the [relevant] person’.
- 14.93 Noting that ‘currently within the draft Heads, there is no provision for an appeals mechanism’, the HSE Assisted Decision Making National Office calls for there to be a process in which a relevant person can engage in an instance in which they believe
- that they have the capacity to decide where to reside, but a medical professional believes that they do not and therefore deprives them of their liberty in a relevant facility.
- 14.94 The IMHLA recommends that the Heads of Bill should stipulate that ‘decisions to deprive a person of their liberty may be appealed from the Circuit Court to the High Court’ and that ‘a relevant person may also apply to court to challenge continuation in residential care at any time’.



## Monitoring and reporting

14.95 The IMHLA recommends that:

The Bill should state that persons may only be admitted or continue to reside in a residential setting which is subject to independent monitoring by a state body such as HIQA.

In addition, the IMHLA calls for ‘an appropriate public body or bodies’, such as the DSS, the IHREC, HIQA or the NDA, to be empowered to ‘carry out audits of samples of decisions to admit and continue care’; to ‘impose sanctions’; and to ‘deal with complaints from relevant persons or others concerning breach of the safeguards’.

14.96 Saint John of God Community Services queries ‘who or what agency will audit this process’.

14.97 The Division of Neuropsychology of the PSI queries whether the proposed legislative provisions can ‘be dovetailed’ with existing ‘HIQA regulations and reporting systems’ and ‘national safeguarding procedures’, or whether they will ‘replace existing procedures, such as HIQA restrictive practices reporting’.

## Resourcing challenges

14.98 Observing that ‘over 60% of nursing-home residents are likely to lack mental capacity to make certain decisions at certain times’ and that, accordingly, ‘the entire [legislative] framework proposed presents a substantial resource challenge, especially to the courts system’, an individual respondent emphasises that the ‘resource implications of the proposed new measures need to be considered with care’.

14.99 Similarly, noting the ‘emphasis [...] placed on the court with the deprivation of liberty safeguards’, the NAS expresses

concern that without additional resources, the courts will struggle to process orders in a timely fashion and that the strain could become evident quite quickly.

14.100 Likewise noting that ‘the process as outlined in the draft Heads would place undue pressure on the courts system, [...] causing a delay in making decisions’, the HSE Assisted Decision Making National Office calls for the Department of Health to ‘consider further exploration of a process similar to the mental health tribunals to ensure that decisions are made in a timely manner’.

14.101 Emphasising that ‘in order to effectively protect individuals [...] the legislation must be complemented with the required resources’, MHR calls for the Department of Health to conduct ‘a detailed cost analysis of the resources required’, suggesting that ‘the provision of advocacy supports will be less

costly and timely than the courts system' and that it 'may result in a reduction in court time and expenses'.

14.102 Noting the 'reliance on the courts for decisions', and the 'clear mismatch' between the scope of the draft Heads of Bill and 'the resources available to actually implement the legislation (in the healthcare sector, in the judicial system, etc)', an individual respondent highlights the 'high risk of legislative failure'.

14.103 FCI emphasises that:

Consideration must be given to the financial and caseload pressures that the DOLS [deprivation of liberty safeguards] will place on an already overburdened and under-funded sector.

14.104 Acknowledging that 'very significant additional resources [...] will have to be made available if the Assisted Decision Making (Capacity) Act 2015 is to be commenced', the College of Psychiatrists of Ireland expresses 'significant concerns that these resources will not be available'

14.105 Observing that persons in charge of relevant facilities are already subject to 'HIQA regulations and reporting systems' as well as to 'national safeguarding procedures and other systems of regulations', the Division of Psychology of the PSI emphasises that 'any DOL [deprivation of liberty] standards must be manageable from all perspectives, e.g. clinical, nursing, pragmatic and administrative'.

14.106 St. Luke's Nursing Home, Cork observes that the enactment of Part 13 of the ADMC Act will place 'detailed and continuous obligations' on 'persons and bodies who must comply with the statutory provisions' and 'add to the burdens that must already exist in management control and statutory compliance'.

14.107 Noting that the legislative proposals are dependent on the 'court-appointed decision-makers' whose role and responsibilities are set out in the ADMC Act, FCI expresses concern that 'the lack of detail provided' about the reporting requirements attendant upon the role, the burden placed on the individuals concerned, and the lack of supports for such individuals will result in people being 'simply unwilling to enter into such arrangements'.

14.108 Noting that 'PICs [persons in charge] and medical practitioners (GPs) are already overstretched and under-resourced' and acknowledging 'the legal implications and processes involved in [the] proposed legislation', NHI recommend that 'a dedicated social worker or solicitor for older persons should take the lead responsibility for the implementation and compliance'.

## Information provision

14.109 The DSBA calls for the provision of information to the relevant person ‘in a way that is appropriate to the[ir] circumstances’, and for this to set out ‘the intention to apply for and [the] making of the admission order’, ‘the applicant’s details’, ‘the basis of the decision and the duration of admission’, ‘information on reviews and appeals’ and ‘details of the monitoring body’.

14.110 Likewise, the IMHLA calls for the Heads of Bill to

provide that written information on the procedure and their rights must be provided to the relevant person [...] in a way that is appropriate to the person’s circumstances (whether using clear language, visual aids or any other means).

The IMHLA recommends that this information should ‘include the basis for admission, the duration of admission, [and] the right to a legal representative’, and that it should stipulate that ‘the person may make representations directly to the relevant monitoring body’. The IMHLA also calls for ‘written information on reviews and appeals [to] be provided to the relevant person’.

14.111 The IMHLA also calls for the legislation to require the State or the DSS to

provide information and education to the general public about the rights of persons to live in the community, choose where they live and not to be subject to arbitrary deprivation of liberty arrangements.

## Supporting engagement with relevant persons

14.112 Emphasising that ‘further consultation with people with lived experience of institutions and deprivation of liberty is essential in the further development of these safeguards’, Inclusion Ireland calls for the Department of Health to provide ‘materials in an easy-to-read format for future engagement’, noting that this ‘was absent from this consultation’.

14.113 Likewise, noting that ‘the Act relates to people with disabilities and older people’, the CDLP observes that:

The Heads of Bill and consultation documents should have been made available in a variety of accessible formats, including an easy-to-read version.

The CDLP calls for accessibility to the enacted legislation to be improved ‘so that those directly affected by the law can understand its implications for their lives and rights’.

14.114 Criticising the accessibility of the 47-page draft Heads of Bill, FCI calls for the provision of

practical advocacy supports and easy-to-read guides [...] to ensure that the persons whom the Bill is designed to protect are supported to understand it.

FCI also calls for family carers to ‘be supported to fully understand their role and responsibilities and to address any practical difficulties they may encounter’.

14.115 Saint John of God Community Services emphasises that ‘accessible information for the relevant person on this Bill will be required’.

### **Suggested amendments to draft Heads**

14.116 An individual respondent calls for the inclusion of an additional Head in the draft legislation which

should require the relevant facility to prepare as part of its (revisable) plan for the care and treatment of the confined person *an activation programme the purpose of which is to provide for the relevant person’s essential needs in relation to (i) self-care activities, (ii) recreational activities, (iii) productive tasks, and (iv) activities of daily living that are as close as practicable to the regular circumstances of life in the community.*

14.117 Seeking ‘clarity on how relevant persons lacking capacity to consent to being admitted [...] to respite care facilities for short breaks, where they are “under continuous supervision and control”, would fall under the draft Heads of Bill’, the NDA suggests that:

A separate Head [...] may need to be included to cover this cohort and ensure that they have access to the same safeguards as all others covered by the draft Heads of Bill.

14.118 An individual respondent calls for the insertion into the draft Heads of

a provision clarifying whether the doctrine or principle of necessity will still exist at common law or whether the Bill is [...] impliedly repealing it.

Noting that frontline staff may rely on the principle to ‘informally detain’ a relevant person if they think that this ‘is necessary and in the resident’s interests’, the respondent observes that the introduction of the deprivation of liberty safeguards in the U.K. stemmed from a ECtHR ruling that ‘the doctrine of necessity did not provide sufficient procedural safeguards’ and that ‘reliance on it was in breach of [article] 5 of the ECHR’.

14.119 Noting that article 31 of the UNCRPD ‘calls for statistics and data collection to enable improved formulation and implementation of policies’; that ‘the Sustainable Development Goals (SDGs) [...] have called for data collection on disability’; and that ‘the Office of the [United Nations] High Commissioner for Human Rights (OHCHR) has published a [...] guide to respond to the

increasing need for indicators to use in human rights assessments’, the CDLP calls for the insertion of an additional section in the draft legislation ‘on statistics and data collection’ in order ‘to identify causes, barriers, and challenges and to improve policies and services, as well as measuring the impact of actions’.<sup>44</sup> The CDLP recommends that the Heads of Bill should require

relevant facilities and the healthcare sector to collect disaggregated data on the number of applications, duration of admission and resolutions under this Bill, financial disclosure and [...] the alleged risks or reasons to admit a person.

14.120 Noting that reference to ‘the degree and extent’ of the deprivation of liberty of the relevant person is only referred to in Head 9, the NAS recommends that the term

should appear at the point of [the] admission decision to ensure that the degree and extent of the deprivation of liberty is justifiable, proportionate and reasonable.

The NAS also recommends that there should be a requirement under Head 11 for a record of this to be kept.

#### Other comments

14.121 An individual respondent expresses concern that the ‘lack of agility’ of the draft legislative proposals will militate against

positive risk-taking and trials of home-leave and will lead to people spending extended periods languishing on acute medical and psychiatric wards awaiting [...] decisions in the courts which will then be effectively set in stone.

14.122 Emphasising that ‘nursing homes are first and foremost a person’s home and [...] not an approved mental health facility’, that ‘they are regulated differently’, and that in nursing homes ‘staff have different knowledge and skills and treatment options available to them’, NHI expresses ‘concern that the court orders referred to within this proposed legislation could provide a “*de facto*” involuntary admission to a nursing home’. Commenting that ‘it is assumed that older persons referred to here would indicate all persons living in designated centres for older people, registered under the Health Act, 2007’, NHI further notes that ‘there are a number of persons living in nursing homes that are below the age of 65 years’.

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<sup>44</sup> See the Office of the United Nations High Commissioner for Human Rights, *Human Rights Indicators: A Guide to Measurement and Implementation* (United Nations, 2012), [https://www.ohchr.org/documents/publications/human\\_rights\\_indicators\\_en.pdf](https://www.ohchr.org/documents/publications/human_rights_indicators_en.pdf).

14.123 The NAS comments:

The involvement of the HSE social care / safeguarding / acute / primary care teams and their role in the arrival [of a relevant person] at a residential setting is completely absent in the heads of bill and needs to be addressed.

14.124 Saint John of God Community Services queries whether the 'temporary deprivation of liberty' will 'only occur within the court system' and, if so, 'how [this] will be managed'.

## PART III: CONCLUSION

### Key findings

The respondents to the public consultation express a wide range of opinions and identify a host of issues for consideration as the legislative proposals are refined. This section of the report provides an overview of the key findings on which a degree of consensus emerged.

### Scope of the safeguards

Respondents call for clarity on the ambit of the proposed legislative provisions, including the settings and circumstances in which they will apply. Respondents also recommend that the deprivation of liberty safeguards should apply to wards of court, observing that their exclusion from the legislation is not in compliance with the UNCRPD or the ECHR.

### Definitions

#### *'Admission decision'*

Respondents raise a number of concerns about the definition of 'admission decision' provided in Head 1. In particular, the two-fold definition provided, which requires that the relevant person will be both 'under continuous supervision and control' and that they 'will not be free to leave', is identified as problematic. Respondents call for a definition of 'under continuous supervision and control' in order to provide clarity about what this encompasses. Concern is expressed that the term 'admission decision' is euphemistic and 'over-medicalised', failing to fully recognise the human right to liberty and dignity of the relevant person. It is also observed that confusion may arise between an 'admission decision' and hospital admissions.

#### *'Relevant facility'*

Respondents request clarification of the settings which are encompassed by the term 'relevant facility'. Acknowledging that people are routinely deprived of their liberty because of a lack of support to enable them to live independently or due to the absence of more suitable accommodation, respondents call for the definition of 'relevant facility' to be broadened to include, *inter alia*, acute hospitals, hospices, respite and transitional care facilities, day-care services, and other residential settings.

#### *'Other medical expert'*

While it is noted that a 'medical expert' is by definition a registered medical practitioner, respondents call for the definition of 'other medical expert' to encompass a range of healthcare professionals including, *inter alia*, nurses, social workers, psychologists, and therapists. This is with a view to enabling a multi-disciplinary approach to the assessment of a relevant person's capacity which takes all relevant information into account.

### *'Deprivation of liberty'*

Respondents call for a definition of the 'deprivation of liberty', seeking clarity in relation to its scope and to the circumstances and settings in which it applies.

### *'Healthcare professional'*

Given the central role assigned to 'a healthcare professional' in the assessment of a relevant person's capacity in Head 3, respondents seek clarity on the definition of the term. In addition, respondents query how its usage in Head 3 relates to the references throughout the proposed legislation to a 'healthcare professional [acting] on behalf of the person in charge'.

### **Admission procedure**

In light of the functional approach to capacity assessment provided for in the ADMC Act, respondents call for the evidence on which admission decisions are based to be multi-disciplinary and for the assessment to be undertaken by more than one healthcare professional. Noting that article 5 of the ECHR only provides for the reliance on medical evidence to justify the deprivation of a relevant person who is 'of unsound mind', respondents emphasise that article 14 of the UNCRPD states that 'the existence of a disability shall in no case justify a deprivation of liberty'.

Observing that the criteria for the admission of a relevant person to a relevant facility variously refer to the prevention of the risk of 'harm' and 'significant harm' to the relevant person and to others throughout the draft Heads, respondents request consistency in the use of terminology and clarification of the meaning of 'harm' / 'significant harm'.

In accordance with the guiding principles of the ADMC Act, respondents call for greater emphasis to be placed on respecting the will and preference of the relevant person in the procedure for making an admission decision. Emphasising the importance of ensuring the necessity and proportionality of an admission decision, respondents also recommend the incorporation of a risk assessment into the admission procedure.

Respondents call into question the appropriateness of the reference to a 'routine admission' in Head 4 given the gravity of depriving a person of their liberty.

### **Admission in urgent circumstances**

Noting that the criteria for 'urgent' admissions detailed in Head 5 appear to mirror those applying to persons detained under the MHA, respondents call for clarification of the scope of the 'urgent circumstances' in which a relevant person may be admitted to a relevant facility. In addition to requesting the definition of 'significant harm', 'imminent risk' and 'urgent', they recommend the replacement of 'urgent admission' with 'emergency admission', as defined in the Health Information and Quality Authority



(HIQA)'s *National Standards for Residential Services for Children and Adults with Disabilities* (2013).<sup>45</sup>

Respondents emphasise the importance of ensuring the necessity and proportionality of an urgent admission as the least restrictive available option. They also express concern that the stated criteria for an urgent admission contravene the principle of respect for the relevant person's will and preference which is enshrined in the ADMC Act and in the UNCRPD.

### Independent advocacy

Respondents recommend that the legislation should make provision for the appointment of an independent advocate to a relevant person to enable them to articulate their will and preference and to make a decision about their proposed care arrangements, in line with the guiding principles of the ADMC Act. Recommending that a panel of independent advocates should be established by the Director of the DSS, respondents call for the legislation to encompass a definition of an 'independent advocate'.

The suggested functions of an independent advocate include, *inter alia*:

- Supporting a relevant person to make a decision about their care-arrangements and to articulate their will and preferences;
- Ensuring that all possible alternatives are explored before a relevant person is deprived of their liberty;
- Supporting a relevant person with fluctuating capacity with a view to ensuring that their will and preferences are respected;
- Notifying the Director of the DSS of the need for an application to court in an instance in which a relevant person lacks the capacity to make a decision about their admission to a relevant facility;
- Supporting the review of admission decisions;
- Supporting the relevant person to lodge an appeal about their care arrangements.

### Fluctuating capacity

While calling for a definition of 'fluctuating capacity', respondents highlight the challenges of assessing and regulating this as well as of defining a 'short period' – challenges documented in the Law Commission's report, *Mental Capacity and Deprivation of Liberty* (2017).<sup>46</sup> Accordingly, respondents call for the development of a code of practice or further guidance on the issue. Some respondents argue that the assessment of fluctuating capacity should be based on medical evidence and be undertaken by a medical practitioner. However, others call for it to be based on a multi-disciplinary healthcare assessment. With concern voiced about the burden placed on

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<sup>45</sup> HIQA, *National Standards for Residential Services for Children and Adults with Disabilities*, 109. HIQA defines an 'emergency admission' as 'an admission to a residential service that is unplanned, unprepared or not consented to in advance'.

<sup>46</sup> See Law Commission, *Mental Capacity and Deprivation of Liberty*.

the person in charge in the determination of fluctuating capacity in Head 7, respondents call for it to be independently assessed by more than one person.

Respondents emphasise the importance of supporting relevant persons to maximise their decision-making capacity, with many calling for the assignment of independent advocates to those whose capacity is fluctuating. The requirement, detailed in Head 7(4), for an application to court to be made on behalf of a relevant person who voluntarily elected to live in a relevant facility but who subsequently lost the capacity to decide to continue to do so is deemed by respondents to be unnecessary.

## **Time-frames**

Respondents emphasise that the time-frames set within the legislative provisions will need to be practical given the onus that they will place on all parties involved in the implementation of the deprivation of liberty safeguards. Concern is expressed that the proposed time-frames may be unachievable given the current resourcing of relevant facilities and of the courts.

Respondents express concern that the proposed time-frames may result in the arbitrary deprivation of liberty of relevant persons in certain circumstances. For example, respondents call for the time-frames set out in Head 5 in respect of admissions in urgent circumstances to be shortened. Seeking clarification of the meaning of the references to 'as soon as practicable' in Head 7, respondents also express the view that the timeframes outlined in Head 7(11) for an application to court to be made in respect of a relevant person who has regained capacity are 'inordinate' and 'excessive'. Likewise, respondents deem the period of 12 months and 1 day for the receipt by the person in charge of notification of a court application in respect of an existing resident, as indicated in Head 8(3), to be too lengthy.

In addition, respondents call for the specification in the legislation of the intervals at which admission decisions will be reviewed by the court, arguing that this should not be at the court's discretion.

## **Chemical restraint and restraint practices**

Respondents indicate broad support for the prohibition of chemical restraint while also highlighting the challenges that this entails. It is, for example, noted that doctors, rather than the persons in charge of relevant facilities, have responsibility for the prescription of medication, which may complicate the provisions set out in Head 10. Respondents suggest that the introduction of regulations or of clinical guidelines on the appropriate administration of medication, along with the effective monitoring and oversight of this, may help to prevent its misuse as a form of chemical restraint.

Welcoming the prohibition of restraint practices in all but exceptional circumstances proposed in Head 10, respondents call for a definition of 'exceptional circumstances' as well as seeking clarity on the definition of 'restraint practices'. A number of respondents recommend the substitution of 'restrictive practice' for 'restraint practice' with a view to broadening the scope of the definition. Some respondents call for the

introduction of regulations or clinical guidelines on the circumstances in which such practices may be utilised, emphasising the imperative for these to pay heed to HIQA's *Guidance for Designated Centres: Restraint Procedures* (2014; rev. 2016) and to the Mental Health Commission's *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* (2009).<sup>47</sup> Other respondents call for restraint practices to be fully prohibited

Observing that the use of chemical restraint and restraint practices and the staffing of relevant facilities are inextricably linked, respondents question how their usage will be phased out.

## Record keeping

While indicating broad support for the categories of records to be kept for inspection in relevant facilities detailed in Head 11, respondents suggest that, in addition, records should be maintained of the relevant person's will and preferences, of the decision-making supports provided to relevant persons, of the process by which a relevant person's capacity is assessed, and of the administration of medication as well as of restraint practices utilised.

As well as emphasising the need for record-keeping in relevant facilities to comply with the European Union's GDPR, respondents suggest that access to the records should be extended to the Director of the DSS as well as to legal representatives of relevant persons.

## Regulations

Respondents recommend that Head 12(2) should empower the Minister to prescribe by regulation procedures for the assessment of relevant persons, for the appeal by relevant persons of admissions decisions, and for the appointment of independent advocates to relevant persons, as well as the procedures to be followed when a relevant person with decision-making capacity decides to leave a relevant facility. Respondents also call for the prescription by regulation of a code of practice for the implementation of the proposed legislation.

## Offences

Respondents recommend that the offences in relation to the proposed legislation detailed in Head 13 should include coercing or exerting undue influence on a relevant person to agree to admission to a relevant facility and preventing a relevant person from accessing an independent advocate.

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<sup>47</sup> See HIQA, *Guidance for Designated Centres: Restraint Procedures* and Mental Health Commission, *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint*.

## Resources required

Respondents express concern that the existing resources of the Courts Service and of the DSS will be insufficient to support the implementation of the proposed legislation, variously suggesting that the provision of advocacy supports or the introduction of a tribunal system would be more practicable.

## Recent developments

### Court of Appeal judgement

On 2<sup>nd</sup> July 2018 the Court of Appeal found that Cork University Hospital acted unlawfully in 2016 by preventing an elderly woman with dementia from leaving, notwithstanding the hospital's concern that discharging her was not in her best interests. The ruling stems from the fact that, although the clinical consensus was that the woman did not have the capacity to make a decision to go home, there is currently no statutory or common law power which would enable the hospital to detain a patient in such circumstances.

This judgement has been appealed and is expected to be heard in the Supreme Court in May 2019. It is anticipated that the judgement of the Supreme Court, when given, will further inform the development of the deprivation of liberty safeguards.

### Assisted Decision-Making (Capacity) Act, 2015 implementation

The approach taken in the draft Heads makes use of the decision-making procedures, supports and safeguards that already exist under the ADMC Act as well as encompassing additional safeguards specific to the deprivation of liberty. The legislative proposals also build on the machinery of the DSS, which is provided for under this Act. At the time of writing, only a limited number of provisions of the ADMC Act have been commenced and it is understood that the current target date for operationalisation of the DSS is Q4 2020.

## Next steps

In the light of the Court of Appeal judgement, it is likely that the deprivation of liberty safeguards will need to be extended to hospital settings. This will result in a significant increase in the number of people who will require safeguards under the new system and highlights the need to design an approach that is workable and practical. As noted by the Office of the Public Advocate, Victoria, one of the major challenges arising is to develop 'appropriately robust safeguards for liberty and contributes tangible benefits to people's lives without being excessively bureaucratic or practically unworkable'.<sup>48</sup> Within this context, the findings of the public consultation will form part of the evidence-base for the refinement of the draft Heads by the Department of Health.

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<sup>48</sup> Office of the Public Advocate, *Designing a Deprivation of Liberty Authorisation and Regulation Framework*, 6.

The Department of Health continues to prioritise the development of the deprivation of liberty safeguards. While a number of complex policy and legal issues remain to be resolved, every effort is being made to progress the legislation as quickly as possible.

## **APPENDICES**

### **Appendix 1: Preliminary draft Heads of Bill**

#### **Part 13 of the Assisted Decision-Making (Capacity) Act 2015**

#### **Preliminary Draft Heads of Bill for Public Consultation Purposes Only**

- Head 1      Definitions**
- Head 2      Application and Purpose of this Part**
- Head 3      Person’s Capacity to Make a Decision to Live in a Relevant Facility in Advance of an Application to enter the Relevant Facility**
- Head 4      Procedure for Routine Admission of a Relevant Person to a Relevant Facility**
- Head 5      Procedure for Admission of a Relevant Person to a Relevant Facility in Urgent Circumstances**
- Head 6      Procedure for making an Admission Decision**
- Head 7      Persons Living in a Relevant Facility**
- Head 8      Transitional Arrangements for Existing Residents on Commencement of this Part**
- Head 9      Review of Admission Decisions**
- Head 10     Chemical Restraint and Restraint Practices**
- Head 11     Records to be Kept**
- Head 12     Regulations**
- Head 13     Offences**

## Head 1 – Definitions

In this Part-:

“admission” , in relation to a relevant facility, means entry to, or residence in, a relevant facility where the relevant person will be under continuous supervision and control and will not be free to leave.

“admission decision” means a relevant decision that a relevant person will live in a relevant facility where he or she will be under continuous supervision and control and will not be free to leave.

“appropriate person” means a person identified in accordance with regulations made by the Minister under Head 12(2) to make an application to court under Part 5 on behalf of a relevant person.

“chemical restraint” means the use of medication to control or modify a person’s behaviour when no medically identified condition is being treated, or where the treatment is not necessary for the medically identified condition or the intended effect of the medication is to sedate a person for convenience or disciplinary purposes or to ensure that a person is compliant or is not capable of resistance.

“Minister” means the Minister for Health

“other medical expert” includes a ..... [Note: The issue of “other medical experts” is included as a question in the associated consultation paper]

“person in charge” means the person in charge of the relevant facility.

“relevant facility” means:

- (d) a designated centre as defined in section 2(1)(a)(ii), 2(1)(a)(iii) and (c) of the Health Act 2007, as amended; or,

- (e) an approved centre as defined in section 2(1) of the Mental Health Act 2001; or,
- (f) an institution at which residential services are provided by the Health Service Executive, a service provider or a person that is not a service provider but who receives assistance under Section 39 of the Health Act 2004 to persons in receipt of mental health services as defined by section 2(1) of the Mental Health Act 2001 but does not include any of the following:
  - v. an institution managed by or on behalf of a Minister of the Government; and,
  - vi. that part of an institution in which the majority of persons being cared for and maintained are being treated for acute illness or provided with palliative care; and,
  - vii. an institution primarily used for the provision of educational, cultural, recreational, leisure, social or physical activities; and,
  - viii. a special care unit provided and maintained in accordance with section 23K of the Child Care Act 1991.
- (d) such other facility as the Minister may prescribe by regulation

“restraint practice” means the use of practices for non-therapeutic purposes that result in the intentional restriction of a person’s movement or behaviour and does not include chemical restraint.

“temporary admission decision” has the meaning assigned to it in Head 5.

“ward” means a relevant person in the wardship of a wardship court.



## Explanatory Notes

1. This Head sets out the main definitions for this Part of the Act.
2. The Heads do not define “deprivation of liberty” but deprivation of liberty is captured in the definition of “admission” and “admission decision” as meaning entry to or residence in a relevant facility where the relevant person will be under continuous supervision and control and will not be free to leave.
3. “admission decision” is defined because in order that the law be accessible and foreseeable the legislation needs to be make clear when a decision may be taken which will result in the relevant person being deprived of their liberty.
4. The introduction of “appropriate person” is intended to ensure that a mechanism is available whereby the Minister may have persons appointed to make applications to court under Part 5 on behalf of a relevant person if no one else makes such an application, i.e. as a last resort.
5. “chemical restraint” is as defined.
6. “other medical expert” is required to be defined so as to include experts who might not, strictly speaking, be considered “medical” but whose expertise is the appropriate one for decisions on the admission of certain categories of persons, e.g. psychologists. The case law of the European Convention on Human Rights (ECHR) requires medical evidence to justify a decision to deprive a person of their liberty under Article 5(1)(e).
7. The “person in charge” is the acting manager with overall responsibility at any given time. There is no relevant statutory definition of person in charge. The concept mirrors that of the person in charge referred to in S.I. No 415 of 2013 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and in S.I. No 367 of 2013 (Care and Support Regulations for Designated Centres for Persons with Disabilities). In the majority of designated centres for older people, the person in charge would be a nurse. In designated centres for persons with disabilities the person in charge tends to be a nurse or social care professional. The person in charge also includes the clinical director of approved centres appointed by the relevant governing body.
8. A definition of “relevant facility” is required to differentiate it from a “designated centre” defined in section 2 of this Act because it is not intended to cover child care centres or institutions in the deprivation of liberty provisions of the Act. Relevant facility is the place where the relevant person is to be admitted pursuant to an admission decision. The inclusion of a definition of relevant facility is necessary for clarity as to which facilities are considered in this Part (i.e. nursing homes and care/residential accommodation in addition to approved centres under the Mental Health Act 2001). As a number of mental health residential facilities do not have a statutory definition it is necessary to have a definition encompassing a number of these facilities. The definition includes the sections of the Health Act 2007.
9. There is currently no statutory definition of restraint practices. The definition is taken in part from a Department of Health policy document entitled ‘Towards a restraint free

environment in nursing homes' (page 6). As HIQA's Guidance for Designated Centres: Restraint Procedures (updated April 2016) notes:

*"Restrictive procedures should only be used in limited circumstances after other options to keep people safe have been exhausted. Such procedures should only be used in strict adherence to international human rights instruments, national legislation, regulations, policy and evidence-based practice guidelines. An unwise decision by a resident is not always evidence of lack of capacity or the need for restrictive procedures, nor is the use of such procedures in one instance a reason to use them later without trying all other options first."*

## **Head 2 - Application and Purpose of this Part**

- (1) This Part applies in circumstances where it is proposed that a relevant person is to live in, or, is already living in a relevant facility and
  - (a) where he or she is or will be under continuous supervision and control; and
  - (b) is not or will not be free to leave; and
  - (c) there is reason to believe that the person lacks capacity to make a decision to live in the relevant facility
  
- (2) This Part does not apply to wards.
  
- (3) Further to subhead (1), the purpose of this Part is to:
  - (a) establish a procedure for when a person, who is to be admitted to a relevant facility, is reasonably believed to lack the capacity to make a decision to live in a relevant facility;
  - (b) put in place safeguards for when a person is admitted to a relevant facility in the circumstances set out in subhead (1);
  - (c) establish a procedure for when a person, who is living in a relevant facility is reasonably believed to lack the capacity to make a decision to leave the relevant facility;
  - (d) establish a procedure for when a person, who is living in a relevant facility is reasonably believed to lack the capacity to make a decision to continue living in the relevant facility;
  - (e) establish transitional arrangements for persons who are living in relevant facilities on commencement of this Part;
  - (f) prohibit the use of chemical restraint in a relevant facility; and
  - (g) prohibit the use of restraint practices in relevant facilities unless there are exceptional circumstances and in accordance with regulations prescribed by the Minister.

## Explanatory Notes

1. Ireland signed the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and Optional Protocol in 2007. Existing legislation satisfies a number of Articles in the UNCRPD. Existing legislation in the form of the Assisted Decision-Making (Capacity) Act 2015 and the Mental Health Act 2001 do not provide a procedure for admitting persons without capacity to relevant facilities when they will be under continuous supervision and control and will not be free to leave, nor do they provide procedural safeguards to ensure that such persons are not deprived of their liberty unlawfully.
2. The policy is to meet the obligations of the UNCRPD by making legislative provision for the act of intervening to deprive a relevant person of their liberty in circumstances where the capacity to make a decision to live in a relevant facility is in question or is not present at that time, and to ensure the legislative provisions are aligned with Article 14 of the UNCRPD.
3. Subhead (1) provides that this Part of the Act is confined to circumstances which amount to deprivation of liberty. Deprivation of liberty is not synonymous with living in a residential facility as it requires in addition that the relevant person who lacks capacity be under continuous supervision and control and not be free to leave the relevant facility. This subhead provides that the safeguards in this Part will apply when a person has been or is being admitted to a relevant facility and where they are or will be under continuous supervision and control, will not or are not free to leave.
4. A UK Supreme Court ruling in March 2014 (“Cheshire West case”) made reference to the ‘acid test’ to see whether a person is being deprived of their liberty. If a person without capacity is under continuous supervision and control and is not free to leave then this amounts to a deprivation of liberty within the meaning of Article 5 of the European Convention on Human Rights.
5. Subhead (2) provides that this Part shall not apply to wards.
6. Subhead (3) sets out the purpose of this Part of the Act so as to clarify the point at which it applies, i.e. where a personal welfare decision is being taken under the Act that a relevant person should live in a relevant facility and where it is also necessary, for good and valid reasons, to take a further step to curtail their freedom or prevent them from leaving the relevant facility.

### **Head 3 – Person’s Capacity to Make a Decision to Live in a Relevant Facility in Advance of an Application to enter the Relevant Facility**

(1) Where a healthcare professional, in accordance with the guiding principles of this Act under section 8 -

- (a) determines that a relevant person requires admission to a relevant facility in line with the circumstances described in Head 2(1) and
- (b) has reason to believe that he or she lacks the capacity to decide to live in the relevant facility,

the healthcare professional shall make enquiries as to whether:

- (i) a registered co-decision making agreement in respect of personal welfare matters, including a decision that the relevant person should live in a relevant facility;
- (ii) an order under section 37 (3) declaring lawful an intervention in respect of personal welfare matters, including a decision that the relevant person should live in a relevant facility;
- (iii) an order under section 38(2)(a) in respect of personal welfare matters, including a decision that the relevant person should live in a relevant facility;
- (iv) an order under section 38(2)(b) appointing a decision-making representative for the purposes of making a decision in respect of personal welfare matters, including a decision that the relevant person should live in a relevant facility;
- (v) an interim order under section 48 making a decision in respect of personal welfare matters, including a decision that the relevant person should live in a relevant facility; or
- (vi) a registered enduring power of attorney or an enduring power of attorney under the 1996 Act conferring authority on the attorney in relation to personal welfare or personal care matters, including a decision that the relevant person should live in a relevant facility.

is in place.

- (2) Where a healthcare professional, following enquiries, believes that there is no admission decision in place but that a co-decision maker, a decision-making representative or an attorney has been appointed under a registered enduring power of attorney or an enduring power of attorney under the 1996 Act, he or she may, for the purpose of affording them the opportunity to make an application to court under Part 5 where necessary, notify such of them as have been appointed and the relevant person and any other person or persons that may be specified by the relevant person, in writing in the prescribed manner, of his or her determination that the relevant person requires to be admitted and that he or she has reason to believe that the relevant person lacks the capacity to decide to live in the relevant facility .
  
- (3) Where a healthcare professional, following enquiries, believes that there is no admission decision in place and that no co-decision maker, decision-making representative or attorney has been appointed, he or she may, for the purpose of affording them the opportunity to make an application to court under Part 5, notify the relevant person and any other person or persons that may be specified by the relevant person, in writing in the prescribed manner, of his or her determination that the relevant person requires to be admitted and that he or she has reason to believe that the relevant person lacks the capacity to decide to live in the relevant facility.

## Explanatory Notes

1. The purpose of this Head is to ensure that concerns about an individual's capacity are identified as early in the process of planning for admission to a relevant facility as possible (effectively at the time of the visit to the person's doctor or public health nurse, at which the need for residential care is determined). This aims to facilitate applications to court under Part 5 at an early stage and avoid situations where the first time the issue of capacity arises is as part of the admission as outlined in Heads 4 or 5.
2. It is anticipated that a campaign encouraging the use of the decision support mechanisms of the Assisted Decision Making (Capacity) Act and enduring powers of attorney will coincide with the commencement of the Act to avoid the need to attend court.
3. Subhead (1) provides that at the time that a healthcare professional determines, in line with the guiding principles of the Act, that admission to a relevant facility is required and the person will be under continuous supervision and control and not free to leave, and, having formed a view that the relevant person does not have capacity to make a decision in relation to where they will live, they should seek to ascertain whether any third party has legal authority to admit the person to a relevant facility. Section 8 of the Act, which sets out the principles, can be found at Appendix A.
4. Subhead (2) provides that, in situations where there is no admission decision but a decision-making representative, co-decision making agreement, EPA is in place, the healthcare professional is empowered to notify in writing any person appointed under those instruments as well as the relevant person and other specified people of their determination that the relevant person requires residential care and their belief that the relevant person lacks the capacity to make a decision to live in the relevant facility so to alert them to the need for an application to court under Part 5. This may result in such a third party applying to court for an admission decision. By making the application to court on behalf of the relevant person, legal aid can be availed of.
5. Subhead (3) provides that, in situations where there is no admission decision and no decision making representative, co-decision making agreement, EPA or an EPA under the 1996 Act in place, the healthcare professional may notify in writing the relevant person and other specified people of their determination that the relevant person requires residential care and their belief that the relevant person lacks the capacity to decide to live in a relevant facility so to alert them to the need for an application to court under Part 5. This may result in such a third party applying to court for an admission decision. By making the application to court on behalf of the relevant person, legal aid can be availed of.

#### **Head 4 – Procedure for Routine Admission of a Relevant Person to a Relevant Facility**

- (1) Subject to Head 5, no relevant person shall be admitted to a relevant facility where he or she will be under continuous supervision and control and will not be free to leave unless an admission decision has been made in their regard.
- (2) Subject to Head 5 where, in accordance with the guiding principles in section 8,
  - (a) it is determined, that it is necessary for a relevant person to be admitted to a relevant facility where he or she will be under continuous supervision and control and will not be free to leave, and
  - (b) the person in charge or healthcare professional on behalf of the person in charge has reason to believe that the relevant person lacks capacity to make a decision to live in a relevant facility

then -

(i) if evidence of

- (a) an order under section 37 (3) declaring lawful an intervention in respect of personal welfare matters, including an admission decision;
  - (b) an order under section 38(2)(a) in respect of personal welfare matters, including an admission decision;
  - (c) an interim order under section 48 making an admission decision
- is produced to the person in charge or the healthcare professional on behalf of the person in charge,

or

(ii) if evidence of

- (a) an order under section 38(2)(b) appointing a decision-making representative for the purposes of making an admission decision; or
  - (b) a registered enduring power of attorney conferring authority on the attorney in relation to personal welfare matters, including making an admission decision;
- is produced to the person in charge or the healthcare professional on behalf of the person in charge and the intervener has made an admission decision,



the person in charge or the healthcare professional on behalf of the person in charge may admit the relevant person.

- (3) Subject to Head 5 where no evidence of any of the items listed in subhead (2) (a) and (b) is produced to the person in charge or the healthcare professional on behalf of the person in charge, then the person in charge shall inform any co-decision maker, a decision-making representative or an attorney appointed under an registered enduring power of attorney or an enduring power of attorney under the 1996 Act, for the purpose of affording them the opportunity to make an application to court under Part 5 where necessary, notify such of them as have been appointed and the relevant person and any other person or persons that may be specified by the relevant person, in writing in the prescribed manner, of his or her determination that the relevant person requires to be admitted and that he or she has reason to believe that the relevant person lacks the capacity to decide to live in the relevant facility and that the relevant person may not be admitted to the relevant facility in the absence of an admission decision.

## **Explanatory Notes**

1. This Head relates to the requirements for admission to the relevant facility in routine circumstances (i.e. the day the person arrives at the residential facility).
2. Subhead (1) provides that no relevant person should be admitted to a relevant facility without an admission decision, subject to Head 5 which addresses admissions to relevant facilities in urgent circumstances.
3. Subhead (2) provides that where there is concern that a relevant person lacks capacity and will be under continuous supervision and control and will not be free to leave, the person in charge cannot admit the relevant person unless they receive documentary evidence that (a) another person has the legal authority to admit the person and that person consents to admission or (b) an appropriate court order has been made.
4. Subhead (3) provides that where a decision-making representative under this Act has been appointed but no admission decision has been made, then the person in charge or healthcare professional on behalf of the person in charge will inform the decision-making representative or the attorney, as well as the relevant person and other specified persons that it has been determined that the relevant person requires to be admitted and the person in charge believes the relevant person lacks capacity. The purpose of the notification is to alert such persons to the position and give them an opportunity to make the relevant application to court. By making the application to court on behalf of the relevant person, legal aid can be availed of.

## **Head 5 – Procedure for Admission of a Relevant Person to a Relevant Facility in Urgent Circumstances**

- (1) Where the person in charge of the relevant facility or a healthcare professional on behalf of the person in charge
  - (a) has reason to believe that the immediate admission of the relevant person is necessary—
    - (i) to prevent an imminent risk of significant harm to the person’s health or welfare, or
    - (ii) is necessary to prevent an imminent risk of significant harm to another person;
  - (b) has reason to believe, upon an application of the guiding principles in section 8, that the relevant person lacks capacity to decide to live in the relevant facility; and
  - (c) evidence of an admission decision is not produced;

the person in charge or the healthcare professional on behalf of the person in charge may make a temporary admission decision to admit the relevant person to the relevant facility under his or her authority.

- (2)
  - (a) In deciding whether to make a temporary admission decision the person in charge shall take into account any and all the medical evidence which may be available.
  - (b) The person in charge or the healthcare professional on behalf of the person in charge shall seek the advice of a registered medical practitioner or medical expert as soon as practicable but in any case, no later than 3 days of making the temporary admission decision and if advised by the registered medical practitioner or medical expert that the conditions in subhead (1) (a) or (b) have not been met the person in charge shall revoke the temporary admission decision.
- (3) The person in charge of the relevant facility or the healthcare professional on behalf of the person in charge shall, no later than 5 days of making the temporary admission

decision referred to in subhead (1), notify the relevant person and any other person or persons who may be specified by the relevant person in writing of

- (a) the making of the temporary admission decision,
  - (b) the reasonable belief of the person in charge or a healthcare professional on behalf of the person in charge that the relevant person lacks capacity to make this decision; and
  - (c) the reasons for making the temporary admission decision, including the grounds for the necessity for the immediate admission of the relevant person.
- (4) Where evidence of a
- (a) a registered co decision making agreement in respect of personal welfare matters;
  - (b) an order under section 38(2)(b) appointing a decision making representative in relation to personal welfare matters; or
  - (c) a registered enduring power of attorney or an enduring power of attorney under the 1996 Act conferring authority on the attorney in relation to personal welfare matters;

is produced to the person in charge or the healthcare professional on behalf of the person in charge, the person in charge or the healthcare professional on behalf of the person in charge shall notify, within 5 days, the co-decision maker, the decision making representative or the attorney or attorney under the 1996 Act, or such of them as have been appointed, of the matters set out in subhead (3), informing them that a formal admission decision is required.

- (5) Where a decision-making representative or attorney under a registered enduring power of attorney conferring authority on the attorney in relation to personal welfare matters has been appointed, the temporary admission decision shall be replaced by a formal admission decision given by the decision-making representative under section 44(6) or

by an attorney under section 62 where the authorisation authorises restraint to the like extent as the temporary admission decision.

- (6) Where a temporary admission decision is in place, any person making an application to the court under Part 5 of the Act shall notify the person in charge of the making of the application.
- (7) Where the person in charge or the healthcare professional on behalf of the person in charge does not receive notice of an application under Part 5 within 10 days of the date on which the notification under subheads (3) and (4) was issued, the person in charge shall contact the Director and request that an appropriate person be assigned to make an application to court under Part 5 on behalf of the relevant person as soon as practicable but no later than a further 10 days.
- (8) A temporary admission decision shall continue in force until the expiration of 25 days from the date of its making and shall then lapse unless at the return date for an application made under Part 5 of the Act for an interim order or an order making an admission decision the court orders that the temporary admission decision shall continue until the court has disposed of the application.

## Explanatory Notes

1. This Head sets out the circumstances in which an exception may be made to the general principle set out in the previous Head that an admission decision is required before a person who lacks capacity may be admitted to a relevant facility, namely in situations of extreme urgency.
2. Subhead (1) provides that if the person in charge has concerns that the relevant person may not have capacity, that he or she shall apply the guiding principles in respect of that issue. If the person in charge has reason to believe that the relevant person lacks capacity, and if there is no court order, decision making representative or enduring power of attorney in place, they may admit that relevant person under their own authority if there is an imminent risk of significant harm to the person's health or welfare or an imminent risk of harm to another person, pending the making of an application to court under Part 5.
3. Subhead (2)(a) provides that medical evidence should be taken into account by the person in charge when making a temporary admission decision. Subhead (2)(b) provides that the person in charge should take account of any medical evidence available in making a temporary admission order.
4. Subhead (3) provides that the person in charge or a healthcare professional on behalf of the person in charge will give written notification within 5 days of the urgent admission of the relevant person, to the relevant person and other specified people. The written notification will detail the belief of the person in charge or healthcare professional that the relevant person lacks the capacity and requires to be admitted.
5. Subhead (4) provides that where the person in charge or a healthcare professional on behalf of the person in charge has evidence that there is a co-decision maker, decision making representative or attorney, that the person in charge will give written notification within 5 days of the urgent admission of the relevant person, to any co-decision maker, decision making representative or attorney who has been appointed. The written notification will detail the belief of the person in charge or healthcare professional that the relevant person lacks the capacity and requires to be admitted.
6. Subhead (5) provides that where there is a decision-making representative or attorney, that the temporary admission decision will be replaced by any formal admission decision which the decision-making representative or attorney may give or have given where this coincides in scope with the temporary admission decision. The purpose of this provision is to ensure that decisions are made, where possible, by the person closest to the relevant person.
7. Subhead (6) provides that where a person makes an application to court they shall notify the person in charge.
8. These notifications act as a safeguard and may lead to an application being made to the court under Part 5 by a co-decision maker, decision making representative, attorney or anyone with a bona fide interest in the relevant person. By making the application to court on behalf of the relevant person, legal aid can be availed of.

9. Subhead (7) provides that where the person in charge does not receive a notification that an application has been made to court within 10 days, the person in charge shall contact the Director and request that an Appropriate Person make the application within a further 10 days.
10. Subhead (8) provides that a temporary admission decision shall be valid for 25 days and shall then lapse unless the court makes an order continuing the decision. The term of validity of the temporary admission decision allows a court application to be made during the course of which the court may decide to continue with the temporary admission pending a determination of the application.

## **Head 6 – Procedure for making an Admission Decision**

- (1) Subject to subhead (2) and (3), a decision-making representative or attorney under a registered enduring power of attorney who is authorised to make an admission decision on behalf of the relevant person may do so only
  - (a) in accordance with the guiding principles set out in section 8; and
  - (b) where a medical expert is of the opinion that
    - (i) such a decision is necessary in order to protect the relevant person from significant harm and
    - (ii) that there is no other appropriate, practicable and less intrusive manner to protect the relevant person from harm.
- (2) For the purposes of making an admission decision under subhead (1) the decision-making representative may rely on the evidence provided by a medical expert to the court where the court has authorised the decision making representative to make an admission decision where that evidence is still relevant.
- (3) The court shall not make a declaration that an intervention which is or includes an admission decision under section 37(3) is lawful, make an order making an admission decision under section 38(2)(a) or make an order appointing a decision-making representative for the purposes of making an admission decision unless the court is satisfied, having considered the evidence of a medical expert, that
  - (a) an admission decision is necessary in order to protect the relevant person from harm and
  - (b) there is no other appropriate, practicable and less intrusive manner of to protect the relevant person from harm.
- (4) Where the court declares lawful an intervention which includes an admission decision or makes an order making an admission decision the court shall make an order appointing a decision-making representative or shall amend an existing decision making representation order under section 38(2)(b).



## **Explanatory Notes**

1. This Head is intended to ensure that an admission decision is based on medical evidence, as required by the ECHR.
2. Subhead (1) specifies that an admission decision may be made by a decision making representative or attorney but only where there is medical evidence to that effect. It also requires the decision making representative or attorney to ensure the necessity and proportionality of the decision (in line with section 36(5)).
3. Subhead (2) allows a decision-making representative to rely on the medical evidence provided to the court where this is still relevant.
4. Subhead (3) requires the court, where it is making a declaration as to the lawfulness of an admission decision or when it is making an admission decision to consider medical evidence and to also consider the necessity and proportionality of the decision.
5. Subhead (4) obliges the court, when an admission order is declared lawful or an admission decision is made by the court, to appoint a decision making representative for the relevant person or amend an existing decision making representation order. This is intended to assist operationally by having the relevant person represented for any consequential decisions.
6. It will also be necessary to amend section 44 of the Act by the insertion of:

“(9) For the purpose of this section, a decision making representative for a relevant person does not restrain the relevant person if he or she makes an admission decision as provided for in and in accordance with Part 13, provided that such a decision has been specified in the decision-making representation order.”
7. Section 62 will also have to be amended by the insertion of:

“(4A) For the purpose of this section, an attorney does not restrain the donor if he or she makes an admission decision as provided for and in accordance with Part 13, provided that such a decision has been authorised by the enduring power of attorney.”

## **Head 7 – Persons Living in a Relevant Facility**

Person who is living in a relevant facility either before or after commencement of this Part and wishes to leave it

(1)

(a) Where -

(i) a relevant person who is living in a relevant facility, whether they have entered and lived in the facility before or after commencement of this Part, expresses a desire to leave the relevant facility; and

(ii) the person in charge or a healthcare professional on behalf of the person in charge, in accordance with the guiding principles of the Act in section 8, has reason to believe that the relevant person lacks the capacity to make the decision to leave the relevant facility,

the person in charge, or a healthcare professional on behalf of the person in charge may temporarily prevent the relevant person from leaving the relevant facility under the authority of the person in charge provided that the conditions in Head 5(1) are met.

(b) The provision of Head 5 (2) to (8) shall apply, *mutatis mutandi*, as though the decision temporarily to prevent the relevant person from leaving the relevant facility were a temporary admission decision.

(2) Subheads (1) shall not apply where the person in charge or a healthcare professional on behalf of the person in charge reasonably believes, in accordance with the guiding principles in section 8, that the change in capacity is likely to fluctuate and that the loss of capacity will only last for a short period.

(3) A person in charge or a healthcare professional on behalf of a person in charge who acts in accordance with this section shall not incur any liability where, during the time in which the relevant person is temporarily prevented from leaving is in place, the capacity of the relevant person fluctuates.

Person Who After Commencement of this Part Had Capacity to Decide to Live in a Relevant Facility and May Now Lack Capacity

- (4) Subject to subhead (8), where the person in charge or a healthcare professional on behalf of the person in charge, in accordance with the guiding principles of the Act in section 8, has reason to believe that a relevant person who voluntarily entered and lived in at relevant facility after commencement of this Part no longer has capacity to make a decision to continue to live in the relevant facility, the person in charge of the relevant facility, or a healthcare professional on behalf of the person in charge shall notify as soon as practicable, in writing in the prescribed manner, for the purpose of affording them the opportunity to make an application to court under Part 5, the relevant person and any other person or persons that may be specified by the relevant person, informing them that he or she has reason to believe that the relevant person lacks the capacity to make the decision to continue to live in the relevant facility.
- (5) A person making the application under Part 5 shall notify the person in charge or the healthcare professional on behalf of the person in charge of the making of the application.
- (6) Subject to subhead (8), where the person in charge or the healthcare professional on behalf of the person in charge does not receive notice of an application under subhead (5) within 3 months of the date on which the notification under subhead (4) was issued, the person in charge shall contact the Director and request that an appropriate person be assigned to make an application to court under Part 5 on behalf of the relevant person as soon as practicable but no later than a further 21 days.
- (7) Subheads (4) and (6) shall not apply where evidence of:
  - (a) an interim order under section 48 authorising the admission of the relevant person;
  - (b) an order under section 37(3) declaring a proposed admission of the relevant person lawful;
  - (c) a decision-making order made under subsection 38(2)(a) authorising the making of an admission decision in respect of the relevant person;
  - (d) an order under section 38(2)(b) appointing a decision making representative in relation to personal welfare matters; or

- (e) a registered enduring power of attorney authorising an attorney(s) to make an admission decision in respect of the relevant person

is produced to the person in charge or the healthcare professional on behalf of the person in charge.

- (8) Subhead (6) shall not apply in cases where the person in charge or a healthcare professional on behalf of the person in charge reasonably believes, in accordance with the guiding principles of the Act, that:
  - (i) the change in capacity is likely to fluctuate and that the loss of capacity will only last for a short period, or
  - (ii) there is a high probability of the person's demise within a short period.

#### Person Who Previously Lacked Capacity and May Have Regained it

- (9) Where the person in charge or a healthcare professional on behalf of the person in charge has reason to believe, in accordance with the guiding principles in section 8, that a relevant person in relation to whom the court has made an order pursuant to section 37(1)(b), may have regained capacity to decide to live in the relevant facility the person in charge or the healthcare professional on behalf of the person in charge shall notify as soon as practicable, in writing in the prescribed manner, the relevant person and any decision making representative appointed under section 38, any attorney appointed under section 68 or attorney under 1996 Act, and the Director of his or her belief for the purpose of affording them the opportunity to make an application under section 49 for a review of the court order.
- (10) A person making the application under section 49 shall notify the person in charge or the healthcare professional on behalf of the person in charge of the making of the application.
- (11) Where the person in charge or the healthcare professional on behalf of the person in charge does not receive notice of an application under subhead (10) within 21 days of the date on which the notification under subhead (9) was issued, the person in charge shall or the healthcare professional on behalf of the person in charge contact the Director and

request that an appropriate person be assigned to make an application to court under Part 5 on behalf of the relevant person as soon as practicable but no later than a further 21 days.

- (12) Subhead (11) shall not apply where the person in charge or a healthcare professional on behalf of the person in charge reasonably believes, in accordance with the guiding principles of the Act, that the change in capacity is likely to fluctuate and that the regaining of capacity will only last for a short period.

## **Explanatory Notes**

1. This Head outlines the safeguards for those people who live in relevant facilities. The Head sets out a procedure for:
  - (i) a relevant person (whether they have entered and lived in the facility before or after commencement of this Part) who desires to leave a relevant facility where the person's capacity to decide to leave is in question;
  - (ii) a relevant person who entered and lived in a relevant facility voluntarily after commencement of this Part but has lost capacity;
  - (iii) a person who is living in a relevant facility whom the court has determined lacks capacity, regains it.

### Person who is living in a relevant facility either before or after commencement of this Part and wishes to leave it

2. Subhead (1) provides that if a relevant person, who entered and lived in the relevant facility either before or after commencement of this Part, wishes to leave a relevant facility but the person in charge or healthcare professional on behalf of the person in charge has reason to believe that they lack capacity to make that decision, having applied the guiding principles, the person in charge may prevent the relevant person from leaving provided that the conditions in Head 5(1) are met, that is to say that it is necessary to prevent the relevant person from leaving in order to prevent an imminent risk of significant harm to the person's health or welfare or significant harm to another person.
3. Subhead (1) goes on to provide that the provisions of Head 5(2) to (8) shall then be applied as though the decision temporarily to prevent the relevant person from leaving were a temporary admission decision. These subheads require the person in charge to notify various people of the person in charge's decision to prevent the relevant person leaving, allow the substitution of the person in charge's decision with that of the decision-making representative or the attorney, where such is available, and allow the person in charge to seek the appointment by the Director of an appropriate person to make an application to court for a declaration of capacity and an admission decision when no one else has made such an application.
4. Subhead (2) provides that subhead (1) shall not apply where the capacity of the relevant person is fluctuating. This is required in order to avoid a situation where fresh applications are required to be made more frequently than the court can hear such applications.
5. Subhead 3 provides that a person in charge or healthcare professional on behalf of the person in charge shall not incur a liability should they not allow a relevant person to leave a relevant facility because the capacity of the relevant person fluctuates.

### Person Who After Commencement of this Part Had Capacity to Decide to Live in a Relevant Facility and May Now Lack Capacity

6. Subhead (4) provides that where a person entered and lived in a relevant facility voluntarily after commencement of this Part and on an application of the guiding principles in section 8 the person in charge has reason to believe that the relevant person

may lack the capacity to make a decision to continue to live in the relevant facility, the person in charge or a healthcare professional on behalf of the person in charge shall, give written notification to the relevant person and other specified people of their belief that the relevant person lacks capacity to make a decision to continue to live in the relevant facility thereby affording them the opportunity to make an application to court under Part 5. Existing residents at the time of commencement (i.e. will not have been admitted since this Part was commenced) will be subject to the process as outlined in Head 8.

7. Subhead (5) provides that the person in charge must be notified of the making of an application to Court under Part 5.
8. Subhead (6) provides that where the person in charge does not receive notice of an application to court within 3 months of the date on which notification under subhead (4) issued, the person in charge shall contact the Director of the Decision Support Service to request that an appropriate person be assigned to the relevant person to make the application to court on behalf of the relevant person within a further 21 days. By making the application to court on behalf of the relevant person, legal aid can be availed of.
9. Subhead (7) provides that an application to court under subheads (4) and (6) does not need to be made if there is an enduring power of attorney or decision making representative authorised to make an admission decision or an admission decision is ordered by the court or declared to be lawful by the court.
10. Subhead (8) provides that the person in charge or healthcare professional on behalf of the person in charge is not obliged to issue a notification under subhead (4) or contact the Director under subhead (6) if they reasonably believe that the lack of capacity is fluctuating and the loss of capacity will only last for a short period or if there is a high probability of the person's demise within a short period.

#### Person Who Previously Lacked Capacity and May Have Regained it

11. Subhead (9) provides that if the person in charge or healthcare professional on behalf of the person in charge has reason to believe, in accordance with the guiding principles in section 8, that a relevant person in regard to whom the court previously declared they lacked capacity, has now regained capacity the person in charge shall inform the relevant person and the any decision making representative or attorney and the Director of his or her belief for the purpose of affording them the opportunity to make an application to the court for a review of its declaration.
12. Subhead (10) provides that the person in charge shall be notified of the application to the court to have the declaration of the court reviewed.
13. Subhead (11) provides that if the person in charge does not receive notice within 21 days of the issuing of the notification under subhead (9) that another person has made an application to court as provided for under subhead (10), the person in charge shall contact the Director to request that an appropriate person be assigned to the relevant person to make the application on behalf of the relevant person within a further 21 days. Legal aid is available for an application to be made on behalf of the relevant person.
14. Subhead (12) provides that the person in charge or healthcare professional on behalf of the person in charge is not obliged to inform the relevant person's decision making

representative or attorney and the Director if they reasonably believe that the person's capacity is fluctuating and the regaining of capacity will only last for a short period.



## **Head 8 – Transitional Arrangements for Existing Residents on Commencement of this Part**

- (1) Where, at the commencement of this Part, the person in charge or healthcare professional on behalf of the person in charge, in accordance with the guiding principles of the Act in section 8, has reason to believe that a person living in the relevant facility at the date of commencement lacks the capacity to make a decision to decide to live in the relevant facility in line with the circumstances as outlined in Head 2(2), the person in charge or a healthcare professional on behalf of the person in charge shall notify within 10 days, for the purpose of affording them the opportunity to make an application to court under Part 5, in writing in the prescribed manner, the relevant person and any other person or persons that may be specified by the relevant person, informing them that he or she has reason to believe that the relevant person does not have the capacity to decide to continue to live in the relevant facility.
- (2) A person making the application under Part 5 shall notify the person in charge or the healthcare professional on behalf of the person in charge of the making of the application.
- (3) Subject to subheads (4) and (5), if the person in charge or the healthcare professional on behalf of the person in charge does not receive notice of an application under subhead (2) within 12 months and 1 day of the date notification under subhead (1) was issued, the person in charge shall contact the Director and request that an appropriate person be assigned to make an application to court pursuant to Part 5 on behalf of the relevant person as soon as is practicable but no later than a further 21 days.
- (4) Subheads (1) and (2) do not apply in circumstances where evidence of
  - (a) an interim order under section 48 authorising the admission of the relevant person;
  - (b) an order under section 37(3) declaring a proposed admission of the relevant person lawful;
  - (c) a decision-making order made under subsection 38(2)(a) authorising the making of an admission decision in respect of the relevant person; or
  - (d) a registered enduring power of attorney authorising an attorney(s) to make an admission decision in respect of the relevant person; or
  - (e) an order under section 38(2)(b) appointing a decision-making representative for the purposes of making a decision in respect of personal welfare matters, including an admission decision.

is produced to the person in charge or the healthcare professional on behalf of the person in charge.

- (5) Subhead (1) shall not apply in cases where the person in charge or a healthcare professional on behalf of the person in charge reasonably believes that:
  - (i) the change in capacity is likely to fluctuate and that the loss of capacity will only last for a short period, or
  - (ii) there is a high probability of the person's demise within a short period.

## **Explanatory Notes**

1. This Head relates to those people who are resident in relevant facilities prior to the date of this Part of the Act coming into operation. Head 7, subheads (1) to (3) also applies where a person has entered and lived in a relevant facility before this Part commenced.
2. Subhead (1) provides that if a person in charge or healthcare professional on behalf of the person in charge has reason to believe that a relevant person who is living in the relevant facility lacks capacity to make a decision to continue to live in the facility, the person in charge or healthcare professional on behalf of the person in charge shall give written notification within 10 days of their belief to the relevant person and other specified people affording them the opportunity to make an application to court under Part 5.
3. Subhead (2) provides that the person in charge must be notified of the making of an application to Court under Part 5.
4. Subhead (3) provides that if the person in charge does not receive notification, within 12 months and 1 day of the issue date of notification that the relevant person lacks the capacity to make a decision as to their ongoing accommodation, the person in charge shall contact the Director to request that an appropriate person be assigned to the relevant person to make the application on behalf of the relevant person within a further 21 days. Legal aid is available for such an application.
5. Subhead (4) provides that the person in charge is not obliged to make an application to court under subhead (3) if a decision making representative or attorney with authority to make an admission decision or a court order making or authorising an admission decision is already in place.
6. Subhead (5) provides that the person in charge is not obliged to make an application to court under subhead (4) if they reasonably believe, on the application of the guiding principles in section 8, that the lack of capacity is fluctuating and the loss of capacity will only last for a short period or if there is a high probability of the person's demise within a short period.
7. The provisions of Head 7 subheads (1) to (3) also apply to existing residents on the commencement of this Part.

## **Head 9 – Review of Admission Decisions**

- (1) Where, pursuant to section 49(1), the court specifies the intervals at which it shall review a declaration under section 37(1), the court shall also make an order specifying the intervals at which an admission decision shall be reviewed by the court.
- (2) Where, having reviewed the admission decision and having heard medical evidence in its regard, the court is satisfied that an admission decision is no longer required the court may
  - (a) make an order revoking or amending, as appropriate, the declaration under section 37(3)
  - (b) make an order varying or discharging, as appropriate, a decision-making order or decision making representation order which makes or authorises the making of an admission decision, and
  - (c) give such directions as it thinks appropriate for the order or orders to have full effect.
- (3) Where, having reviewed the admission decision, the court is satisfied having heard medical evidence that an admission order remains necessary in order to protect the relevant person from significant harm and that there is no other appropriate, practicable and less intrusive manner of protecting the relevant person from significant harm the court shall make an order confirming the admission decision.
- (4) Where a relevant person has been admitted to a relevant facility the person in charge or the healthcare professional on behalf of the person in charge shall monitor and keep under review the degree and extent of supervision and control and lack of freedom to leave the relevant facility to which the relevant person is subject and inform relevant decision making representative or attorney of the need to make a decision to adjustment to the degree and extent of supervision and control and lack of freedom to leave the relevant facility to accord with the needs and interests of the relevant person.

## Explanatory Notes

1. The ECHR requires that where a person is deprived of their liberty the decision depriving them of their liberty should be subject to regular review and that the person should be entitled to challenge the lawfulness of their deprivation of liberty to a court. The review need not be a judicial one but as the Act already provides for a review of capacity, and as the lack of capacity is what gives rise to the deprivation of liberty, it seems appropriate to hook the deprivation of liberty review to the review of capacity.
2. Subhead (1) incorporates the review of the admission decision into the review of capacity under section 49. This is done because (a) the deprivation of liberty of the relevant person only arises because they lack capacity and (b) in order to minimise the number of court applications and appearances required.
3. Subhead (2) allows the court to discharge or vary an admission decision where there is medical evidence that it is no longer necessary.
4. Under subhead (3) allows the court to confirm an admission decision but only where, on the basis of, *inter alia*, medical evidence, an admission decision is necessary. The ECHR requires that there be medical evidence.
5. Subhead 4 puts in place a continuing obligation on the person in charge to monitor and inform the decision making representative or attorney of the need to make a decision to adjust the degree and extent of the deprivation of liberty to which an admitted relevant person is subject in line with their needs and interests.

## **Head 10 - Chemical Restraint and Restraint Practices**

- (1) The Court, decision-making representative, or attorney shall not authorise the person in charge or healthcare professional on behalf of the person in charge to administer a medication which is not necessary for a medically identified condition, with the intention of controlling or modifying the relevant person's behaviour or ensuring that he or she is compliant or not capable of resistance.
- (2) The person in charge or healthcare professional on behalf of the person in charge shall not administer or cause to be administered a medication which is not necessary for a medically identified condition, with the intention of controlling or modifying the relevant person's behaviour or ensuring that he or she is compliant or not capable of resistance.
- (3) The person in charge or the healthcare professional on behalf of the person in charge shall not subject a relevant person or cause a relevant person to be subjected to a restraint practice unless there are exceptional circumstances and such practice is in accordance with Regulations prescribed by the Minister under Head 12.

## **Explanatory Notes**

1. Subhead (1) prohibits the Court, decision making representative or attorney from authorising a person in charge or healthcare professional on behalf of the person in charge from the use of chemical restraint in a relevant facility. Subhead (2) prohibits the use of chemical restraint in a relevant facility. The use of chemical restraint is in breach of Article 3 of the European Convention on Human Rights as inhuman and degrading treatment.
2. Subhead (2) provides that persons in charge or healthcare professionals on behalf of the person in charge are prohibited from the use of chemical restraint in a relevant facility.
3. Subhead (3) provides that a person should not be subjected to a restraint practice unless there are exceptional circumstances and such practice is in accordance with Regulations prescribed by the Minister.
4. It will also be necessary to amend section 44 and 62 to ban outright the use of chemical restraint.

## **Head 11 – Records to be Kept**

- (1) The Minister may prescribe by regulations the categories of records to be kept by relevant facilities and other persons under this Part to facilitate verification of compliance with this Part.
- (2) The categories of records which may be required to be kept by Regulations made by the Minister under subhead (1) may include
  - (a) records relating to the process whereby the person in charge or a healthcare professional on behalf of the person in charge had reason to believe that a person lacked the capacity to make a decision to consent to admission in accordance with the guiding principles of the Act;
  - (b) records relating to the process whereby the person in charge or healthcare professional on behalf of the person in charge had reason to believe that a person that had capacity to make a decision to consent to admission to a relevant facility and subsequently lost it;
  - (c) records relating to the process whereby the person in charge or healthcare professional on behalf of the person in charge had reason to believe that a person who lacked capacity and subsequently regained it;
  - (d) records relating to the process whereby the person in charge or a healthcare professional on behalf of the person in charge formed the view that any change in capacity was likely to fluctuate and that the gaining or loss of capacity would only last for a short period as well as a record setting out the frequency of the loss and regaining of capacity;
  - (e) the documentary evidence to be provided on admission under Head 4(2);
  - (f) the basis upon which it was determined that immediate admission was required under Head 5(1);
  - (g) the basis upon which it was determined that the person required to be admitted;
  - (h) the notifications issued to the relevant person and other specified people under this Part; and
  - (i) the requests made to the Director in relation to appropriate persons.



- (3) The Regulations shall specify to whom the person in charge or the healthcare professional on behalf of the person in charge shall make any of the records prescribed by regulations made under subhead (1) available for inspection.

## **Explanatory Notes**

1. This Head sets out the records that must be kept for inspection by HIQA and the Inspector of Mental Health as part of their regular inspections of relevant facilities.
2. Subhead (1) provides that the Minister may make regulations setting out the type of records that must be kept and indicates that the purpose of the record keeping is to facilitate verification of compliance with this Part.
3. Subhead (2) sets out the types of records that the Minister may, by regulation, determine that a relevant facility must keep. The records required to be kept are those evidencing the various decisions and notifications which a person in charge may or is required to make.
4. Subhead (3) provides that the regulation shall prescribe to whom the records under subhead (1) must be made available.

## **Head 12 – Regulations**

- (1) The Minister may prescribe by regulations the following matters:
  - (a) Records to be kept under Head 11 to facilitate verification of compliance with this Part;
  - (b) Regulations in relation to restraint practices under Head 10;
  - (c) The manner in which the person in charge or the healthcare professional on behalf of the person in charge shall notify the relevant person and other specified people under this Part.
  
- (2) The Minister may, following consultation with the Director, by regulation prescribe –
  - (a) the procedure whereby a person in charge or the healthcare professional on behalf of the person in charge shall request the Director to appoint an appropriate person,
  - (b) the qualifications of, and procedure for appointment of, an appropriate person who may make an application under Part 5 on behalf of a relevant person,
  - (c) the establishment by the Director of a panel of suitable persons willing and able to act as appropriate persons,
  - (d) the procedure whereby the Director will provide the names of appropriate persons.

## **Explanatory Notes**

1. The Minister requires regulatory power in order to put in place rules setting out the procedures for the implementation of the processes described in this Part.
2. This Head provides that the Minister may make regulations to fill out the detailed requirements to give effect to the provisions of this Part. The Head also provides that the Minister, following consultation with the Director, shall make regulations setting out the procedure for the establishment of a panel of appropriate persons to act for relevant persons under this Part. It will also be necessary to amend certain provisions in Part 9 to give full effect to this additional function being conferred on the Director.

## Head 13 – Offences

(1) A person who—

- (a) admits a relevant person to a relevant facility in deliberate contravention of Head 4, 5, or 6;
- (b) prevents a relevant person from leaving a relevant facility in deliberate contravention of Head 7; or
- (c) uses or authorises the administration in a relevant facility of a medication which is not necessary for a medically identified condition, with the intention of controlling or modifying the relevant person’s behaviour or ensuring that he or she is compliant or not capable of resistance;

commits an offence and shall be liable -

- (i) on summary conviction, to a class A fine or imprisonment for a term not exceeding 12 months, or both, or
- (ii) on conviction on indictment, to a fine not exceeding €50,000 or imprisonment for a term not exceeding 5 years, or both.

(2) A person who –

- (a) knowingly creates, falsifies or alters a document knowing that a person in charge or healthcare professional on behalf of the person in charge will rely on the document to make a temporary admission decision or to prevent a relevant person leaving a relevant facility; or
- (b) gives to a person in charge particulars or information which he or she knows to be false or misleading for the purpose of obtaining, or enabling another person to obtain, an admission decision or a decision to prevent a relevant person leaving a relevant facility;

commits an offence and shall be liable -

- (i) on summary conviction, to a class A fine or imprisonment for a term not exceeding 12 months, or both, or
- (ii) on conviction on indictment, to a fine not exceeding €50,000 or imprisonment for a term not exceeding 5 years, or both.

## **Explanatory Notes**

1. In line with other parts of the Assisted Decision Making (Capacity) Act 2015, offences in relation to the procedures applicable to the deprivation of liberty are included here.
2. Subhead (1) provides that a person who deliberately contravenes the safeguards in Heads 4, 5, 6, or 7 commits an offence.
3. Subhead (2) provides that a person who furnishes false information or tampers with a relevant document will be guilty of an offence.

## **Appendix A – Section 8 of the Assisted Decision Making (Capacity) Act 2015**

### **PART 2**

Principles that Apply before and during Intervention in respect of Relevant Persons

#### **Guiding principles**

- 8.(1) The principles set out in subsections (2) to (10) shall apply for the purposes of an intervention in respect of a relevant person, and the intervener shall give effect to those principles accordingly.
- (2) It shall be presumed that a relevant person who falls within paragraph (a) of the definition of “relevant person” in section 2(1) has capacity in respect of the matter concerned unless the contrary is shown in accordance with the provisions of this Act.
- (3) A relevant person who falls within paragraph (a) of the definition of “relevant person” in section 2 (1) 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.
- (4) A relevant person who falls within paragraph (a) of the definition of “relevant person” in section 2 (1) 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.
- (5) There shall be no intervention in respect of a relevant person unless it is necessary to do so having regard to the individual circumstances of the relevant person.
- (6) An intervention in respect of a relevant person shall—
- (a) be made in a manner that minimises—
    - (i) the restriction of the relevant person’s rights, and
    - (ii) the restriction of the relevant person’s freedom of action,
  - (b) have due regard to the need to respect the right of the relevant person to dignity, bodily integrity, privacy, autonomy and control over his or her financial affairs and property,
  - (c) be proportionate to the significance and urgency of the matter the subject of the intervention, and
  - (d) be as limited in duration in so far as is practicable after taking into account the particular circumstances of the matter the subject of the intervention.
- (7) The intervener, in making an intervention in respect of a relevant person, shall—
- (a) permit, encourage and facilitate, in so far as is practicable, the relevant person to participate, or to improve his or her ability to participate, as fully as possible, in the intervention,
  - (b) give effect, in so far as is practicable, to the past and present will and preferences of the relevant person, in so far as that will and those preferences are reasonably ascertainable,

(c) take into account—

(i) the beliefs and values of the relevant 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 relevant 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 intervener reasonably considers that it is not appropriate or practicable to do so, consider the views of—

(i) any person named by the relevant person as a person to be consulted on the matter concerned or any similar matter, and

(ii) any decision-making assistant, co-decision-maker, decision-making representative or attorney for the relevant person,

(e) act at all times in good faith and for the benefit of the relevant person, and

(f) consider all other circumstances of which he or she is aware and which it would be reasonable to regard as relevant.

(8) The intervener, in making an intervention in respect of a relevant person, may consider the views of—

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

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

(c) healthcare professionals.

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

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

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

(10) The intervener, in making an intervention in respect of a relevant person—

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

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

(c) shall take reasonable steps to ensure that relevant 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.



## **Deprivation of Liberty: Safeguard Proposals**

### **Consultation Paper**

*(Please read in conjunction with  
the accompanying draft Heads of Bill)*

**The closing date for submitting your views is 9<sup>th</sup> March 2018.**

### **Your Opinion Matters**

The Department of Health has prepared draft Heads of Bill on deprivation of liberty safeguards which will form a new part of the Assisted Decision-Making (Capacity) Act 2015. The Department would like your views on these draft provisions which are available for download at <http://health.gov.ie/consultations/>.

This consultation paper provides some background information on the development of the draft Heads of Bill along with some questions on which we would like your views. It should be read in conjunction with the draft Heads of Bill.

Submissions should be made by e-mail to [deprivationofliberty@health.gov.ie](mailto:deprivationofliberty@health.gov.ie) or by post to:

Deprivation of Liberty Safeguard Consultation  
Room 204  
Department of Health  
Hawkins House  
Hawkins Street  
Dublin 2, D02 VW90

If you would like a paper copy of this consultation paper or the draft Heads sent to you, please contact the Department of Health at the address above or by:

Email: [deprivationofliberty@health.gov.ie](mailto:deprivationofliberty@health.gov.ie)

Phone: (01) 6354402 or (01) 6354732

Please also contact the Department if you have any questions in regard to this public consultation.

### **Closing date**

The closing date for submitting your views is **Friday, 9 March 2018**.

### **Data Protection and Privacy Provisions**

The information shared by you in this consultation will be used solely for the purposes of policy development and handled in accordance with data-protection legislation. An analysis of submissions received as part of the public consultation will be published online and will include a list of organisations and representative bodies which responded. Comments submitted by individuals may be used in the final consultation report but these will be anonymised. All personal data is securely stored and subject to data-protection laws and policies. For more information, see <http://health.gov.ie/data-protection/>.

Please note that submissions received by the Department are subject to the Freedom of Information (FOI) Act 2014 and may be released in response to an FOI request.

## Background

1. Legislative clarity on the issue of deprivation of liberty in residential facilities for older people, those with a disability or mental health issues is required in order to meet our obligations under the United Nations Convention on the Rights of Persons with Disabilities<sup>49</sup>.
2. The draft Heads of Bill, which accompany this consultation paper, have been prepared by the Department of Health with the assistance of the Department of Justice and Equality. It is intended that the draft deprivation of liberty safeguard proposals will form a new part of the Assisted Decision Making (Capacity) Act 2015<sup>50</sup>.
3. Please note that these draft Heads of Bill are for consultation purposes only and will be subject to change.

## What is the Purpose of the Heads?

4. The central issue to be addressed is that existing legislation in the form of the Assisted Decision-Making (Capacity) Act 2015 and the Mental Health Act 2001<sup>51</sup> do not provide a procedure for admitting persons without capacity to relevant facilities in which they will be under continuous supervision and control and will not be free to leave, nor do they provide procedural safeguards to ensure that such persons are not unlawfully deprived of their liberty. The draft Heads seek to address this gap.
5. Essentially, the draft deprivation of liberty provisions set out a process which aims to ensure that people are not unlawfully deprived of their liberty. The provisions are intended to provide safeguards for older people and persons with a disability in instances in which they are living in, or it is proposed that they will live in, a residential facility and there is reason to believe they lack the capacity to decide to live there. It is intended that these safeguards will also apply to mental health facilities in instances in which such persons have mental-health issues but are not suffering from a mental disorder and therefore cannot be involuntarily detained under the Mental Health Act 2001.

## Where and When Will the Deprivation of Liberty provisions apply?

6. The provisions will apply to residential centres for persons with disabilities, nursing homes and some mental health facilities.
7. The deprivation of liberty proposals will apply in circumstances in which it is proposed that a relevant person is to live in, or is already living in, a relevant facility and
  - (a) he or she is, or will be, under continuous supervision and control; and
  - (b) is not, or will not, be free to leave; and
  - (c) there is reason to believe that the person lacks capacity to make a decision to live in the relevant facility.

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<sup>49</sup> <http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf>

<sup>50</sup> <http://www.irishstatutebook.ie/eli/2015/act/64/enacted/en/html>

<sup>51</sup> <http://www.irishstatutebook.ie/eli/2001/act/25/enacted/en/html>

## Approach Taken

8. The approach taken in the Heads builds on the decision-making procedures, supports and safeguards already provided by the Assisted Decision Making (Capacity) Act 2015 and also includes some additional safeguards specific to deprivation of liberty.
9. In line with the Assisted Decision Making (Capacity) Act 2015, a person's capacity to decide to live in a relevant facility (in circumstances which amount to a deprivation of liberty) is to be construed functionally. If there is reason to believe that a person lacks capacity to make this decision and there is no third party with the legal authority to make the decision, an application must be made to the Circuit Court under Part 5 of the Assisted Decision Making (Capacity) Act 2015 seeking a declaration that the person lacks capacity to make the decision. The Court can either make the decision to admit the person itself, or appoint a Decision-Making Representative and give that person the authority to make the decision.

## Challenges

10. The development of legislative provisions relating to deprivation of liberty is a highly complex undertaking. In addition to satisfying the requirements of the UN Convention on the Rights of Persons with Disabilities, the provisions must also align with our obligations under the European Convention on Human Rights<sup>52</sup>.
11. Other countries, including the UK, have experienced significant difficulties in developing and implementing workable solutions while adhering to these requirements and appropriate case law. In Ireland we must also ensure that the new provisions appropriately align with the existing Assisted Decision Making (Capacity) Act 2015 and the Mental Health Act 2001.
12. It is acknowledged that the draft provisions represent a very significant cultural change and may be viewed as an imposition on families at what can be a difficult time. However, in order to satisfy the requirements of the Convention and to align with the approach adopted in the Assisted Decision Making (Capacity) Act 2015, a more formal process than that which currently prevails, with the involvement of the court in certain circumstances, is required.
13. The Department also acknowledges the impact that these draft proposals will have on the Circuit Court and on the health service. As we continue to refine the draft Heads we will seek to minimise the impact as much as possible.

## Next Steps

14. The submissions received through this public consultation will be analysed and will be considered by the Department in developing the final General Scheme and Heads of Bill which will be submitted to Government for approval.

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<sup>52</sup> [http://www.echr.coe.int/Documents/Convention\\_ENG.pdf](http://www.echr.coe.int/Documents/Convention_ENG.pdf)

15. The findings will be published on the Department of Health’s website in due course. If you would like to receive a copy of these findings, please include your contact details in your submission.
16. A small number of outstanding legal issues relating to the Heads (such as a mechanism to be able to challenge a lawful deprivation of liberty), will also be considered as part of this process.

## **Main Provisions and Questions**

17. A summary of the main provisions is set out below and should be read in conjunction with the draft Heads of Bill. We welcome your views on any aspect of the Heads but have included some specific questions on which we would particularly like your views. Some general questions are included at the end of this document.

### ***Head 1 – Definitions***

This Head sets out definitions of key words and terms used in the draft Heads. One such key term is “admission decision” which is used to describe the decision that a relevant person will live in a relevant facility in which he or she will be under continuous supervision and control and will not be free to leave i.e. where a person will be deprived of their liberty. Please note that the definitions in section 2 of the Assisted Decision Making (Capacity) Act 2015 also apply to these Heads.

#### **Questions on Head 1:**

- 1.1 Do you have any views on the definitions currently included in this draft Head?
- 1.2 In particular, do you have any views as to the types of healthcare professionals that should be included within the definition of “other medical expert”?
- 1.3 Do you have any other views specific to Head 1?

### ***Head 2 – Application and Purpose of this Part***

This Head provides that these legislative proposals only apply to circumstances in which a person will be deprived of their liberty.

#### **Questions on Head 2:**

- 2.1 Do you have any views specific to Head 2?

### ***Head 3 – Person’s Capacity to Make a Decision to Live in a Relevant Facility in Advance of an Application to Enter the Relevant Facility***

This Head provides that, where the healthcare professional who is determining a person’s requirement for residential care which is likely to result in a deprivation of liberty, has concerns about an individual’s capacity to make a decision to live in a relevant facility, he or she must notify people specified by the relevant person of this concern thereby affording them the opportunity to make an application to court under Part 5 of the ADMC Act for a declaration that the relevant person lacks capacity to decide to live in a relevant facility.

#### **Questions on Head 3:**

- 3.1 Do you have any views specific to Head 3?

#### ***Head 4 – Procedure for Routine Admission of a Relevant Person to a Relevant Facility***

This Head provides that the person in charge shall not admit a relevant person to a relevant facility in which they will be deprived of their liberty without: (i) evidence that the court has made an admission decision; or (ii) evidence that a third party has the legal authority (Decision-Making Representative or Enduring Power of Attorney) to make this decision and that third party made an admission decision.

##### **Questions on Head 4:**

- 4.1 Do you think the term “under continuous supervision and control” should be defined? If so, what should this definition include?
- 4.2 When the person in charge<sup>53</sup> has reason to believe that a relevant person may lack capacity to decide to live in a relevant facility, who should be notified with a view to affording them the opportunity to make an application to Court under Part 5 of the Act? This issue also arises in Heads 3(3), 7(4) and 8(1).
- 4.3 Do you have any other views specific to Head 4?

#### ***Head 5 – Procedure for Admission of a Relevant Person to a Relevant Facility in Urgent Circumstances***

This Head provides that the person in charge can, on the basis of medical evidence, authorise a temporary admission-decision in instances in which there is an imminent risk of significant harm to the person’s health or welfare or to prevent an imminent risk of significant harm to another person, and there is a concern that the relevant person lacks capacity to decide to live in a relevant facility. In such circumstances, the person in charge must notify people specified by the relevant person affording them the opportunity to make an application to court for an admission-decision. Where no such application is made within a specified time-period, the person in charge must contact the Director of the Decision Support Service and request that an appropriate person be assigned to the relevant person to make the application on their behalf.

##### **Questions on Head 5:**

- 5.1 In subhead (1), what are your views on the proposed circumstances in which an urgent admission can be made?
- 5.2 In subhead 2(b), should a health professional other than a registered medical practitioner be able to provide medical evidence? If so, what type of healthcare professional? This issue also arises in Head 6(2).
- 5.3 In subhead (7), who should make the application to Court if no one else does so? Do you have a view on the proposed role of the Director of the Decision Support Service? This issue also arises in Heads 7(6), 7(11) and 8(3).
- 5.4 Do you have any other views specific to Head 5?

#### ***Head 6 – Procedure for Making an Admission Decision***

This Head sets out the procedure for making an admission-decision. Under the European Convention on Human Rights, any decision to deprive a person of their liberty requires medical evidence.

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<sup>53</sup> In every place “person in charge” appears in this consultation paper, please read as “person in charge or healthcare professional on behalf of the person in charge”

**Questions on Head 6:**

- 6.1 Is the evidence of one medical expert sufficient?
- 6.2 Do you have any other views specific to Head 6?

**Head 7 – Persons Living in a Relevant Facility**

- (i) *Person who is living in a relevant facility either before or after the commencement of this legislation and wishes to leave it.*

If a person wishes to leave a relevant facility, they shall not be prevented from doing so. However, if there is a reason to believe that the relevant person lacks capacity to make this decision, the person in charge may temporarily prevent the relevant person from leaving the relevant facility. In such circumstances, the procedure under Head 5 must then be followed.

- (ii) *Person who after commencement of this legislation had capacity to live in a relevant facility and may now lack capacity*

If a person in charge has reason to believe that a relevant person who is living in a relevant facility may now lack capacity to make a decision to continue to live there, he or she must notify people specified by the relevant person of this belief, thereby affording them the opportunity to make an application to court for an admission-decision. Where the person in charge does not receive notification of this application within a specified time-period, he or she shall contact the Director of the Decision Support Service and request that an appropriate person be assigned to the relevant person to make the application on their behalf. The requirement to apply to court does not apply where the person in charge/healthcare professional considers the individual has fluctuating capacity or where there is a high probability of the person's demise within a short period.

- (iii) *Person who previously lacked capacity and may have regained it*

If a person in charge has reason to believe that a relevant person may have regained capacity to make a decision to live in the relevant facility, he or she must notify the appropriate Decision-Making Representative or Attorney. This will allow an application to be made to court for a review of the court declaration that the person lacked capacity. Where the person in charge does not receive notification of this application within a specified time-period, he or she shall contact the Director of the Decision Support Service and request that an appropriate person be assigned to the relevant person to make the application on their behalf.

**Questions on Head 7:**

- 7.1 In subhead (2), do you have views on how the issue of fluctuating capacity should be addressed?
- 7.2 In subhead (2), do you have a view on the length of time that would be considered a "short period"? This issue also arises in Heads 7(8), 7(12) and 8(5)
- 7.3 Do you have any other views specific to Head 7?



### ***Head 8 – Transitional Arrangements for Existing Residents on Commencement of this Part***

This Head provides that in instances in which a relevant person is living in a relevant facility on commencement of this Part and there is reason to believe that they lack capacity to make a decision to continue to live in the relevant facility, the person in charge shall notify people specified by the relevant person of their belief. This is done to afford them the opportunity to make an application to court under Part 5 of the ADMC Act. Where the person in charge does not receive notification of such an application within a specified time-period, they shall contact the Director of the Decision Support Service and request that an appropriate person be assigned to the relevant person to make the application on their behalf.

#### **Questions on Head 8:**

8.1 Do you have any views specific to Head 8?

### ***Head 9 – Review of Admission Decisions***

This Head provides for the review of an admission decision.

#### **Questions on Head 9:**

9.1 Do you have any views specific to Head 9?

### ***Head 10 – Chemical Restraint and Restraint Practices***

This Head prohibits the use of chemical restraint for non-therapeutic reasons in the context of deprivation of liberty and also provides that a person should not be subjected to restrictive practices unless there are exceptional circumstances and such practice is in accordance with Regulations prescribed by the Minister.

#### **Questions on Head 10:**

10.1 Do you have any views specific to Head 10?

### ***Head 11 – Records to be Kept***

This Head sets out the records that must be kept by relevant facilities for inspection.

#### **Questions on Head 11:**

11.1 Do you have a view on the types of records that must be kept under this Head?

11.2 Do you have any other views specific to Head 11?

### ***Head 12 – Regulations***

This Head provides power to the Minister to make regulations in regard to certain matters.

#### **Questions on Head 12:**

12.1 In subhead (1), do you think that the Minister should be empowered to make regulations on any other aspect of the Heads?

12.2 In subhead (2), do you have a view on any other policy and procedure that should be included in this subhead?

12.3 Do you have any other views specific to Head 12?

### **Head 13 – Offences**

This Head sets out the offences in relation to deprivation of liberty.

**Questions on Head 13:**

- 13.1 Do you have a view on the proposed offences set out in this Head?
- 13.2 Do you have any other views specific to Head 13?

### **14 - General Questions**

- 14.1 A number of the Heads - 5(2)(b), 5(3), 5(4), 5(7), 5(8), 7(6), 7(9), 7(11), (8(1) and 8(3) - set down timeframes within which certain actions must be taken. Do you have a view on any of these proposed timeframes?
- 14.2 The draft Heads apply to older people, persons with disabilities and people with a mental health illness. In terms of timeframes and in light of the existing provisions of the Mental Health Act 2001, should those with mental health illness be treated differently to others?
- 14.3 Do you have any other views on the draft provisions?

### **Appendix 3: Organisations from which submissions were received**

Acquired Brain Injury Ireland  
Alzheimer Society of Ireland  
Catholic Institute for Deaf People  
Central Remedial Clinic  
Centre for Disability Law and Policy, National University of Ireland, Galway  
Citizens Information Board  
College of Psychiatrists of Ireland  
Disability Federation of Ireland  
Dublin Solicitors' Bar Association  
Family Carers Ireland  
Health Information and Quality Authority  
HSE Assisted Decision Making National Office  
HSE National Safeguarding Office  
HSE Older Persons' Services  
Inclusion Ireland  
Irish Association of Social Workers  
Irish Council for Civil Liberties  
Irish Hospice Foundation  
Irish Human Rights and Equality Commission  
Irish Mental Health Lawyers Association  
Irish Nurses and Midwives Organisation  
Law Society of Ireland  
Mental Health Commission  
Mental Health Reform  
Multiple Sclerosis Society of Ireland  
National Advocacy Service for Older People with Disabilities  
National Clinical Programme for Older People  
National Dementia Office<sup>54</sup>  
National Disability Authority  
National Rehabilitation Hospital  
Nursing Homes Ireland  
Psychological Society of Ireland (Division of Neuropsychology)  
Rehab Group  
Safeguarding Ireland<sup>55</sup>  
SAGE  
Saint John of God Community Services  
St. Patrick's Mental Health Services  
St. Luke's Nursing Home, Cork

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<sup>54</sup> A joint submission was received from the National Dementia Office and the Alzheimer Society of Ireland.

<sup>55</sup> The National Safeguarding Committee, from which a submission was received, was renamed Safeguarding Ireland in the summer of 2018.

## Appendix 4: Acronyms and abbreviations

ABI Ireland	Acquired Brain Injury Ireland
ADMC Act	Assisted Decision-Making Capacity Act, 2015
AHCD	Advance Health Care Directive
AMHP	Approved mental health professional
ASI	Alzheimer Society of Ireland
CDLP	Centre for Disability Law and Policy
CIDP	Catholic Institute for Deaf People
CIB	Citizens Information Board
CRC	Central Remedial Clinic
DFI	Disability Federation of Ireland
DPP	Director of Public Prosecutions
DSBA	Dublin Solicitors Bar Association
DSS	Decision Support Service
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
EPA	Enduring power of attorney
FCI	Family Carers Ireland
FLAC	Free Legal Advice Centre
GDPR	General Data Protection Regulation
GMS	General Medical Services
GP	General practitioner
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
IASW	Irish Association of Social Workers
ICCL	Irish Council for Civil Liberties
ICCPR	International Covenant on Civil and Political Rights
IHF	Irish Hospice Foundation
IHREC	Irish Human Rights and Equality Commission
IMHLA	Irish Mental Health Lawyers Association
IMCA	Independent mental capacity advocate
IMO	Irish Medical Organisation
INMO	Irish Nurses and Midwives Organisation
MHA	Mental Health Act, 2001
MHC	Mental Health Commission
MHR	Mental Health Reform
MS Ireland	Multiple Sclerosis Society of Ireland
NAS	National Advocacy Service for People with Disabilities
NCPOP	National Clinical Programme for Older People
NDA	National Disability Authority
NDO	National Dementia Office
NHI	Nursing Homes Ireland
NHSS	Nursing Homes Support Scheme
NMBI	Nursing and Midwifery Board of Ireland
NRH	National Rehabilitation Hospital
OPCAT	Optional Protocol to the Convention Against Torture
PRN	Pro re nata
PSI	Psychological Society of Ireland
SPMHS	St. Patrick's Mental Health Services

UNCRPD

United Nations Convention on the Rights of Persons with  
Disabilities

WRAP

Wellness Recovery Action Plan